Providers' News

Arkansas BlueCross BlueShield

To: All Providers

From: Provider Network Operations

Date: March 24, 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

Effective July 1, 2000, ABCBS will develop the professional fee schedule using the 2000 version of Relative Value Units (RVU's), as developed and published by the Health Care Financing Administration (HCFA). Included in this change will be variations in allowances based on the site where the service is delivered.

ABCBS began using RVU's to establish fees in 1998. RVU's were developed and are maintained under the oversight of HCFA, in cooperation with the American Medical Association. In establishing the relative value of health care services, RVU's categorize service delivery into three major components. Physician Work Units reflect the intensity of the service provided, including pre-procedure work, intra-procedure work and post-procedure work. Practice Expense Units include the overhead costs associated with a practice, and Malpractice Expense Units consider the cost of liability insurance as a percentage of a physician's revenue.

Even though HCFA updates the RVU's each year, ABCBS has continued to utilize the 1997 version of RVU's. There was an official challenge to the RVU's published for 1998, and in 1999 HCFA began implementing site of service variations in the Medicare fee schedule. In order that the ABCBS fee schedule not be affected by these activities, the 1997 RVU's were retained as the basis for calculating fees.

In order to derive a fee for a given service, the RVU for that service must be multiplied by a Conversion Factor. ABCBS is not changing the existing conversion factors. For the traditional, "Blue Book" network, allowances are calculated using the following: (a) Evaluation and Management services are based on a Conversion Factor of $44; (b) Physical Medicine services are based on a Conversion Factor of $48.89; and, (c) All other services are based on a Conversion Factor of $58.28.

In addition to adopting the 2000 version of RVU's, the ABCBS fee schedule will take into account the site of service delivery. This methodology provides for variations in the cost of delivering services. For instance, if a physician provides a service in an office

setting, that physician must bear the entire expense associated with delivering the service. If this service were delivered in a hospital or ambulatory surgery center, the facility would bear a portion of the cost associated with the provision of services. The new fee schedule will recognize these variations in the cost of providing services, similar to the method HCFA currently utilizes for Medicare payments.

Regional provider meetings and distribution of the fee schedule will precede the July 1 implementation.

Services Provided by Nurse Practitioners ABCBS and Health Advantage

Several inquiries have been received regarding ABCBS' position on reimbursement of services provided by Nurse Practitioners. Following is the policy of both ABCBS and Health Advantage:

Advanced Practice Nurses are registered nurses with the advanced education and clinical competency necessary for the delivery of primary health and medical care. Reimbursement for Advanced Practice Nurses (APN's) or Advanced Nurse Practitioners (ANP's) is limited to ANP's who are licensed in the state of Arkansas and have met the requirements for **and possess a certificate of prescriptive authority. The ANP must work in collaboration with the physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision.**

ANP's providing services for ABCBS members must comply with the following policy to qualify for reimbursement:

- The ANP must have a written and signed collaborative agreement with a supervising medical doctor (MD) or doctor of osteopathy (DO). A copy of the agreement must be provided to ABCBS.
- The ANP adheres to collaborative responsibilities by participating as a team member in the provision of medical and health care, interacting with physicians to provide comprehensive care according to established and documented protocols.
- ANP services submitted by the supervising physician will be paid at the physician level to the physician.
- ANP's will not receive direct reimbursement.
- Services provided by ANP's are limited to those patients presenting problems of low to moderate severity and the medical decision making involved does not exceed that same level. Patients with more severe problems must be referred to physicians.
- ANP's can bill for services in a collaborative practice with a physician, but are limited to the use of E & M CPT codes 99201, 99202 and 99203 for new patients and CPT codes 99211, 99212 and 99213 for established patients. Current published guidelines for assigning CPT codes to services and documentation to support the "medical necessity" of all services must be met.
- Services performed in an inpatient/acute facility will not be paid.
- ANP's may order diagnostic laboratory and x-ray studies that are medically indicated for the level of service as indicated above in accordance with established and documented protocols.
- The service provided by the ANP must be concordant with the specialty of the supervising physician.

Physicians wishing to bill for services provided by ANP's to ABCBS members should send copies of the ANP's collaborative agreement to: Arkansas Blue Cross and Blue Shield, Division of Medical Management, P.O. Box 2181, Little Rock, Arkansas 72201.

Provider Service and the BlueLine®

Each call is important to us and we strive to provide you with the information you need to service our customers. Currently, we are experiencing an increase in the number of telephone inquiries. To reduce your wait time, please utilize the BlueLine® for routine inquiries. The BlueLine® offers up-to-date, detailed information on eligibility and claims status, and is available 24 hours a day, seven days a week. With one quick and convenient call, you can obtain eligibility information on an unlimited number of patients and check the status of an unlimited number of claims, with no busy signal or wait time. This automated system allows you to use your touch-tone telephone keypad to access our member's information. ***It provides the same information that is available from a representative.***

BlueLine® offers you the option to transfer to a service representative at any time during your call within regular business hours (8 a.m. to 5 p.m.). Should a patient's eligibility or claim status need a special explanation, BlueLine® will refer you to a representative for personal assistance. We realize that no one likes to wait, and appreciate your

patience while we handle the calls in the order in which they are received.

Another time-saving step is to check remittance advices before calling. Also, if you utilize the services of a billing agency, please be aware that they must have access to the appropriate ABCBS remittance advice.

Women's Health Services-Health Advantage

Female Health Advantage Members may see a participating in-network OB/GYN for any gynecological condition without a referral from their PCP. The PCP copayment will apply only when an annual exam is done. The OB/GYN should bill annual exams using CPT Codes 99381-99397 based on the member's age. Any other visit to an OB/GYN will be subject to a specialty copayment. Annual exams are covered ONLY when services are provided by an in-network physician.

Health Advantage Referral Reminder

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

The following process is for providers located in the: Central, West Central, South Central, Northwest and Northeast Regions (see map page 5).

Primary Care Physicians (PCP's) Participating with Health Advantage: For referrals to participating in-network specialist providers, please complete the 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 referral sheet in field 23 of the HCFA-1500 form. 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.

Pulmonary Rehabilitation

For Health Advantage members, coverage is provided for outpatient pulmonary rehabilitation with prior authorization from Medical Audit and Review. A pulmonary rehabilitation program is designed to help people who have a chronic lung disease that limits their ability to perform daily activities. Inpatient admissions that are exclusively for pulmonary rehabilitation are not covered. However, pulmonary rehabilitation done while a patient is in the hospital for medical care is covered as part of the hospital charges.

ABCBS coverage of outpatient pulmonary rehabilitation will be paid at a global price that includes: pulmonary function tests, physical therapy, occupational therapy, chest x-rays, CT scans etc. The following codes are all included in the global price:

36600, 36620, 71010, 71020, 71260, 78460, 78461, 78472, 78473, 78481, 78483, 78596, any codes in the 80000 series, 93000, 93005, 93010, 93720, 93721, 93722, 94010, 94060, 94070, 94150, 94200, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94620, 94642, 94650, 94651, 94656, 94657, 94660, 94662, 94664, 94665, 94667, 94668, 94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762, 94770, 95070, 95071, 95805-95811, 95831, 95834, 95851, 96100, 96105, 96115, 96117, 97150, 97110, 97113, 97116, 97124, 97350, 97535, 97537, 97542, 97545.

The American Association of Cardiovascular and Pulmonary Rehabilitation has defined five essential components of pulmonary rehabilitation: 1)Team assesment: includes input from a physician, respiratory care practitioner, nurse and psychologist; 2)Patient training: includes breathing retraining, bronchial hygiene, medications and proper nutrition; 3)Psychological intervention: includes support systems and dependency issues; 4)Exercise: includes strengthening and conditioning; 5)Follow-up: includes group meetings and exercise maintenance.

ABCBS will allow only one pulmonary rehab per lifetime. Any facility that wishes to do pulmonary rehab should supply their selection criteria before payment is allowed.

Type Of Service Codes-Year 2000

Attached on pages 6-7 please find an updated listing of the type of service codes for the year 2000.

General Electric-National Account

Effective April 1, 2000, General Electric employees and their covered dependents who enrolled under the General Electric Medical Benefits (GEMB-PPO) Plan become eligible for health care benefits provided by Blue Cross Blue Shield's BlueCard PPO Network. BlueCard PPO members can be identified by the "PPO suitcase" logo on the front of the card.

Effective April 1, 2000, all claims (regardless of the date of service) should be filed with ABCBS. Claims should include the GEN alpha prefix and the employee's social security number. If the claim is filed without the three character alpha prefix, the member cannot be located and the claim will be returned. Questions about eligibility, benefit coverage, or claims payment should be directed to 1(800)655-5392.

Claims Processing

ABCBS is now processing all Private Business (excluding Medicare) paper claims through a new scanning and imaging system. The most common things that cause claims to be delayed or returned are:

- No provider number in blocks 24K and 33.
- Invalid Place of Service and Type of Service Codes.
- Invalid CPT or ICD – 9 codes.
- Misaligned information on the form. Make sure your information is inside the form blocks.
- Narrative text in numeric fields on the HCFA 1500 form.

As part of this change in claims processing all paper claims are now processed through “front end” edits that verify eligibility information. You will receive a letter (see following example) for claims that reject because we can not identify the patient or the eligibility information is incorrect. Verify the information on the patient’s insurance card prior to claims submission. Submit these claims as **NEW** claims; do not resubmit them as “Corrected“ claims. Returned claims have been rejected before they ever entered any of our systems.

03/02/2000

EXAMPLE
JOHN Q WORLD MD
500 S ANYWHERE ST
LITTLE ROCK, AR, 72205

Provider Number: 12345

Dear Provider:

Attached is a report of paper claims that were submitted to Arkansas BlueCross Enterprise: BlueCross, USAble, Health Advantage, FEP, FirstSource, BlueCard/Out of area, and Health Advantage Medi-Pak HMO that were rejected.

The report first lists patients that could not be found on any of the eligibility files for the Enterprise. Then for each line of business the patients will be listed alphabetically with the error message for each claim.

* Claims with patients not members of any Arkansas Blue Cross Enterprise:

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Patient	: John E Doe	ID#	: 123456789
PatAcct	: ABCDEF	Payor	: E – AR BCBS
Provider	: 12345	PyrAlias	: G
PayerKey:	G	Bill Type	: HCF
StmtFrom:	2000-02-25	ICN/PCN	: EIP00061548000
Encoder	: 20000610551305	BatchID	: 0001BTCH00093619
ClaimID	: 01HCFA00111DB5	Total Chg:	79.00

Please correct the listed error for each claim and resubmit on a new form.

REMINDER: ALL CLAIMS MUST BE SUBMITTED ON A RED HCFA OR UB92.

Check the member’s identification card and submit the claim with the information printed on the ID card. If you need assistance, please call the customer service number indicated on the back of the identification card. If you resubmit the claim, please do NOT stamp or write “Corrected Claim” on the claim form.

The Providers' News

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

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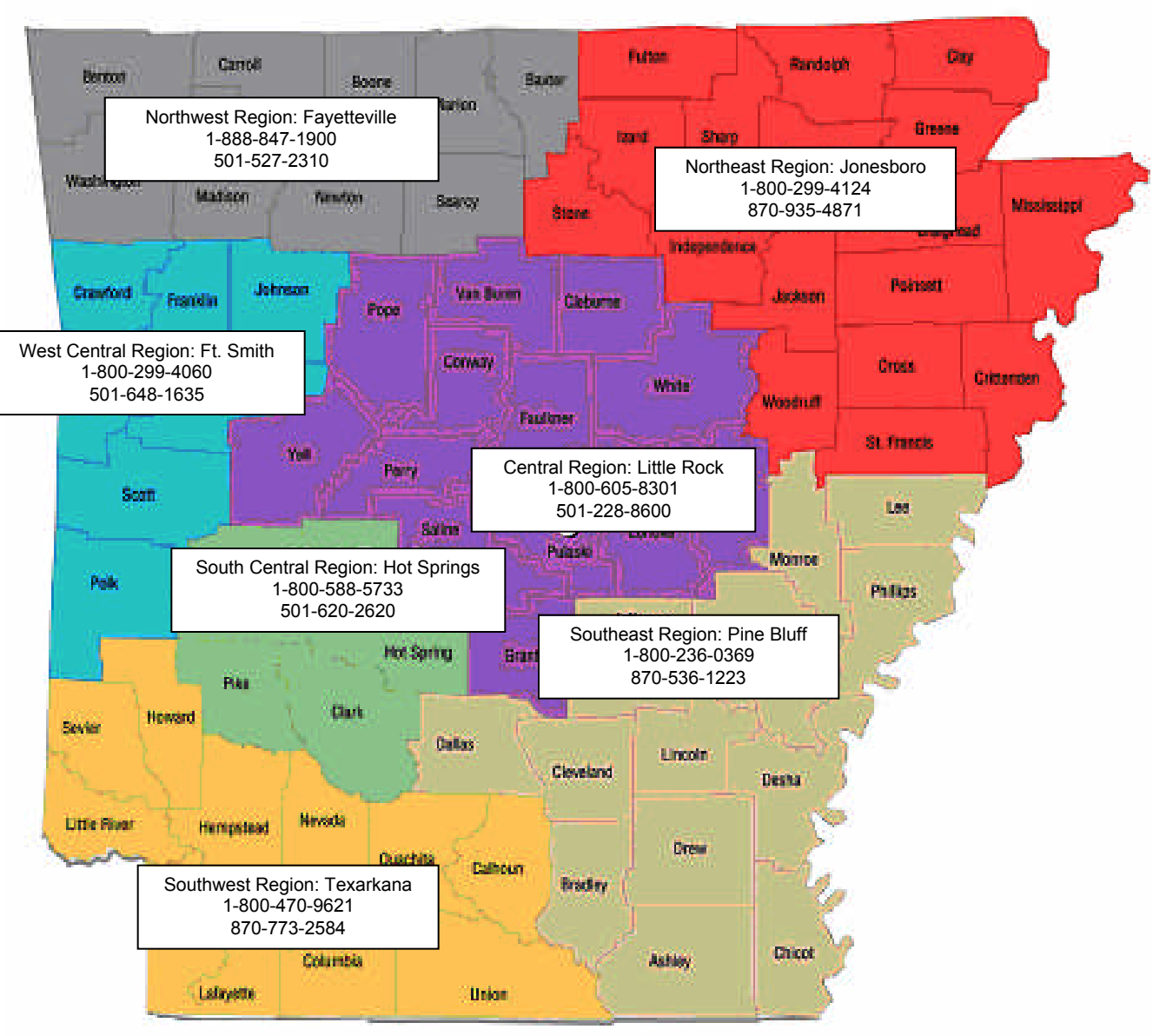
Arkansas Blue Cross Blue Shield
PO Box 2181
Little Rock AR 72203
Email: kchartsfield@arkbluecross.com

Arkansas Blue Cross Blue Shield Regional Offices



Type of Service Codes 2000

Beginning	Ending	NSF TYPE		Beginning	Ending	NSF TYPE
A0021	A0999	01				
A4000	A4640	12		K0050	K0104	12
A4641	A4647	04		K0050	K0104	18
A4648	A8999	12		K0105	K0105	12
A9500	A9500	04		K0106	K0118	12
A9503	A9503	04		K0106	K0118	18
A9505	A9505	04		K0119	K0123	09
A9507	A9507	04		K0124	K0136	12
A9605	A9605	04		K0124	K0136	18
A9900	A9901	12		K0137	K0412	12
B4000	B9999	12		K0415	K0418	09
B4000	B9999	18		K0419	K0461	12
E0100	E0784	12		K0462	K0462	12
E0100	E0784	18		K0462	K0462	18
E0785	E0785	12		K0463	K0501	12
E0786	E9999	12		K0503	K0528	09
E0786	E9999	18		K0529	K0530	12
G0001	G0001	05		K0531	K0534	12
G0002	G0002	02		K0531	K0534	18
G0003	G0007	05		L0100	L0119	12
G0008	G0010	01		L0100	L0119	18
G0015	G0027	05		L0120	L1120	12
G0030	G0050	04		L1200	L1290	12
G0101	G0103	05		L1300	L1300	12
G0104	G0106	02		L1300	L1300	18
G0107	G0107	05		L1310	L1499	12
G0108	G0109	01		L1500	L2999	12
G0110	G0116	01		L1500	L2999	18
G0120	G0121	02		L3000	L3100	12
G0122	G0122	04		L3140	L8039	12
G0123	G0126	05		L3140	L8039	18
G0127	G0127	02		L8100	L8239	12
G0128	G0129	01		L8300	L8330	12
G0130	G0132	05		L8400	L8699	12
G0141	G0141	05		L8400	L8699	18
G0143	G0148	05		L9084	L9084	12
G0151	G0156	01		L9900	L9900	12
G0159	G0160	02		L9900	L9900	18
G0161	G0165	04		M0005	M0064	01
G0166	G0167	01		M0075	M0100	01
G0168	G0171	02		M0101	M0101	02
G0168	G0171	08		M0102	M0300	01
G0172	G0172	01		M0301	M0302	05
H5300	H5300	01		P0000	P9999	05
J0000	J9999	09		Q0035	Q0035	05
J0000	J9999	01		Q0068	Q0068	05
K0000	K0048	12		Q0081	Q0086	01
K0000	K0048	18		Q0091	Q0091	05

Type of Service Codes 2000

Beginning	Ending	NSF TYPE		Beginning	Ending	NSF TYPE
Q0092	Q0092	04		93727	93727	04
Q0103	Q0104	01		93728	93740	05
Q0111	Q0115	05		93741	93744	04
Q0132	Q0132	12		93745	93999	05
Q0136	Q0157	09		94010	94799	05
Q0163	Q0185	09		95004	95199	01
Q0186	Q0186	01		95805	95999	05
Q0187	Q0187	09		96100	96105	01
Q1001	Q1005	12		96110	96110	01
Q1001	Q1005	18		96111	96549	01
Q9920	Q9940	9		96552	96552	12
R0070	R0076	04		96570	96571	02
V0000	V2799	01		97001	99142	01
V5000	V5299	05		99167	99169	12
W0009	W0009	01		99170	99170	02
W7230	W7230	02		99171	99171	12
W7240	W7240	02		99173	99173	01
W9122	W9122	01		99175	99192	01
W9123	W9124	01		99193	99194	12
W9220	W9220	02		99195	99199	01
W9450	W9450	12		99201	99240	01
X9150	X9915	12		99241	99275	03
Y9120	Y9120	12		99276	99499	01
Y9121	Y9122	01				
Y9123	Y9124	12				
Y9125	Y9130	01				
00100	01999	07				
06360	07999	01				
10000	69999	02				
10000	69999	08				
70010	77260	04				
77261	77799	06				
77800	79999	04				
80049	85094	05				
85095	85095	02				
85096	88299	05				
88300	88499	02				
88500	89399	05				
90281	90911	01				
91000	91299	05				
92012	92015	01				
92018	92019	02				
92020	92499	01				
92500	92599	01				
92950	92971	01				
92975	92998	02				
93000	93499	05				
93500	93660	02				
93700	93726	05				