Providers' News

To: All Providers

From: Provider Network Operations

Date: October 13, 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.

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"Any five-digit Physician's Current Procedural Terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 1999 American Medical Association. All Rights Reserved."

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. Providers located in the Southeast and Southwest Regions should contact Access Health for referrals.

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

Benefit Changes for Public School Employees

Effective October 1, 2000 benefit changes were implemented in the Public School Employees Group. The major benefit change is Health Advantage is offering both an HMO and a POS product to this group.

Benefits for members on the Blue Cross Plan and the Health Advantage Plan that may impact the reimbursement are as follows:

1. All services related to obesity, including gastric bypass, are excluded.
2. Self-inflicted injuries, including drug overdose, are excluded.
3. Physical, Occupational and Speech Therapy are limited to 20 visits per therapy per year.
4. Chiropractic services do not apply toward the physical therapy limitation.
5. Home Health Nurse Visits are limited to $1000 per year.
6. Annual pap smears and mammograms are covered.
7. Infertility services
   BC—Infertility services will be covered. In-vitro fertilization is limited to $15,000 per lifetime.
   HA—Testing and consultations are covered. All other infertility services are non-covered.
8. Mental Health services
   BC—Inpatient days and visits are limited to 20 per year (payable at 80%).
   Out patient visits are limited to 20 per year (payable at 50%).
   HA—Inpatient days and visits are limited to 20 per year (payable at 90%).
   Out patient visits are limited 20 per year $50 copayment per visit).
   (There are no out-of-network Mental Health benefits on the HA POS plan)
9. Ambulance services are limited to $1000 per year.
10. Routine vision exam—HA only (one every 24 months—no referral required)
11. Routine dental services—HA only (one every 6 months—no referral required)
12. Health Advantage provider copayments (in-network services) are as follows:

PCP—$20 copayment, 0 coinsurance
OB/GYN (routine visits)—$20 copayment, 0 coinsurance
Specialist—$25 copayment, 0 coinsurance
Allergy injections or children's immunizations—0 copayment, 0 coinsurance

Out patient ER Facility/Surgery—$100 copayment, 0 coinsurance

Out patient physician care—0 copayment, 0 coinsurance
Out patient diagnostic testing—0 copayment, 0 coinsurance

Inpatient Admission Facility—$250 copayment, 10% coinsurance

Inpatient physician care—0 copayment, 10% coinsurance

Physical, Occupational and Speech Therapy—0 copayment, 20%coinsurance

Durable Medical Equipment—20% copayment, 0 coinsurance ($10,000 max)

Home Health Nurse Visits—0 copayment, 0 coinsurance

Helpful Telephone Numbers

ABCBS Provider Service
1-800-827-4814 (Arkansas policies only) ID numbers begin with (examples) XCA, XCJ, XCP

BlueCard Service
1-800-880-0918 (Status for out of state policies only) ID numbers are formatted XXX+Social Security Number

The BlueLine
1-800-676-2583 (Benefits for all out of state policies) ID numbers are formatted XXX+Social Security Number

FEP Service
1-800-482-6655 (Federal Policies Only) ID numbers begin with R

State and School Employee Service
1-800-817-7891 (State and School Employee policies only) ID numbers begin with XCS or PSE

Health Advantage Service
1-800-843-1329 (HMO Policies only) ID numbers are formatted Social Security Number+01, 02 etc

USAble Service
1-800-648-0271 (USAble policies only) ID numbers are formatted XXX+Social Security Number

Access Health
1-800-451-7302 (Precertification of inpatient admissions only)

Health Advantage and the BlueCard Program

Health Advantage is adding a new benefit for its members by joining the BlueCard Program.

Beginning October 1, 2000, with the Public School Employee group, these members will have their claims filed electronically by the out-of-area Blue Cross and Blue Shield Plan when receiving emergency services outside of Arkansas.

This means greater savings to the member and to Health Advantage-the allowed charges from the servicing provider will be held to the other plan's contracted rate in their traditional BlueCard network.

The most noticeable change the member and all Arkansas servicing providers will see is the addition of the XCH prefix to the member's ID card.

All members will receive new ID cards as their benefits renew throughout the next nine months, showing this new prefix with their old ID number. The XCH prefix does not have to be filed on the Health Advantage claim form, only the numerical ID#.

Members also will receive additional information regarding their BlueCard benefits. Arkansas providers will not have to change any claims filing procedures as a result of this benefit. For more information, contact Health Advantage Customer Service at 1-800-843-1329.

FEP Claims Payments

Beginning in October, all FEP claims payments will have your Employer Identification Name and Number listed on the check as a memo item. The Employer Identification Name is identified on the check as the EINM and the Employer Identification Number is identified as the EIN. If the tax information is incorrect, please notify your provider enrollment representative to ensure accurate 1099 reporting. At this time, we are working on adding this tax information to all other claims payments.

Three Tier Formulary Changes

The number of members covered by Arkansas Blue Cross and Blue Shield and Health Advantage that are currently under the three tier copay design has grown to approximately 37%. This number will continue to increase as more groups attempt to stabilize their rising pharmacy expenditures, which is becoming a major contributor to their increasing premium cost for health insurance. Pharmacy costs have been demonstrating a steeply rising trend for about eight years with predictions that future trends will worsen. The exorbitantly high cost of new medications being introduced to the market along with increasing member utilization of prescription medications are combining to produce an expensive explosion in pharmacy costs. Spending on pharmaceuticals in the prior decade amounted to nine to ten percent of health care costs. That percentage has risen above 20% in most areas of our country with a predicted expansion beyond the 30% level within the next five years.

The three tier copay design allows for a low copay for generic medications, a mid level copay for preferred and moderately priced medications and a higher copay for non preferred medications and medications that are expensively priced by their manufacturers.

Changing patterns of prescribing along with new medication introductions compel the three tier formulary along with all other formularies, to be a living document that must evolve and develop as changes occur. We are attempting to limit thee tier changes to once a year in order to lessen confusion among members, pharmacists and physicians.

The next change of medications to the third tier copay will be effective October 1, 2000. Changes were made due to medication cost, non preferred status, or multi-source availability. The specific medications in their various dosage strengths that will move to the highest tier on October 1 are:

Accutane	All Prior Authorized Injectables
Arava	Relenza
Aricept	Sporanox Tablets (if covered)
Cognex	Tamiflu
Enbrel	Ticlid
Lamasil Tablets	
Lupron	

Non-Preferred Oral Contraceptives (when covered)

Branded Medications with Generic Equivalents

Corgard	Glynase
Cardizem CD	Micronase
Cleocin T	Librax
Diabeta	

Ovulation Inducing Agents (Non Covered by HA)

Antagon	Lutrepulse
Chorex	Pergonal
Choron	Pregnyl
Clomid	Profasi
Fertinex	Repronex
Follistim	Serophene
Ganirelix	Supprelin
Gonal-F	Synarel
Humegon	

New Medication-Sarafem (fluoxitene) is NOT COVERED by Arkansas Blue Cross or Health Advantage. Prozac or generic fluoxitene (when available) should be used.

Electronic Submission of DME Claims

DME Providers may now electronically submit claims for members of ABCBS, Health Advantage and USAble through EMC ABCBS. If you are not currently enrolled with ABCBS for electronic claims transmission, please contact 378-2419 and they will provide the necessary documentation for enrollment.

Effective immediately, all claims filed electronically to and processed by Arkansas BlueCross BlueShield (ABCBS) must be in compliance with the following changes:

National Standard Format (NSF) 320 -

- AA0 Record, Field 19.0, Positions 244-248 must contain a valid NSF Version Code in the correct format.
- DA0-**01** Record, Fields 7.0 and 8.0, Positions 27-35 must equal spaces.

NSF UB192 -

- 01 Record, Field 22.0, Positions 190-192 must contain a valid NSF Version Code in the correct format (i.e. 060 for NSF version 6.0).
- 30-**01** Record, Fields 5.0 and 6.0, Positions 26-34 must equal spaces.

American National Standards Institute (ANSI) 3051-

- Segment 0-020-GS, Field 08 must contain a valid version code.
- Segment 2-325.A-NM109 "Payer Organization ID" must equal spaces.

Please contact your software vendor to ensure that the changes are made to your electronic claims format. If you have questions, please contact Electronic Services at (501) 378-2419.

Coronary Artery Modifiers

The June 2000 Issue of the Providers' News contained an article about the necessity of using certain modifiers with coronary artery interventions. The modifier for the left main coronary artery was listed as -LMCA. Providers have indicated this four place modifier has caused some problems with billing. This modifier is being changed to -LM. The updated list of modifiers for use in billing CPT codes 92980-92984 and 92995-92996 is as follows:

-LD (left anterior descending artery)
-LC (left cirumflex artery)
-RC (right coronary artery)
-LM (left main coronary artery)

DaimlerChrysler New Alpha Prefix

A new DaimlerChrysler prefix, NCE, has been introduced and will appear on identification cards for subscribers enrolled in the Standard Plan when all members on the contract have Medicare coverage (full Medicare contracts). This new alpha prefix NCE will achieve better processing when retirees reside or travel in BlueCard areas. This change is effective as of August 15, 2000. Contracts that have non-Medicare members (split contracts) will continue to use the existing NCH prefix. Using the correct prefix will help reduce misrouted and delayed claims.

Dental Claims Information

Please use the following addresses for dental claims for Arkansas Blue Cross and Blue Shield, Health Advantage Arkansas State and Public School Employee Program, and USAble: (these addresses were effective 6/1/00)

For submission of dental claims and predeterminations:
Arkansas Blue Cross/USAble Claims Unit
PO Box 69413
Harrisburg, PA 17106

For dental questions and correspondence:
Arkansas Blue Cross/USAble Customer Service Unit
PO Box 69420
Harrisburg, PA 17106

For second reviews:
Arkansas Blue Cross/USAble Claims Unit
Attn: Dental Advisor Area
PO Box 69420
Harrisburg, PA 17106

Assistant Surgeon Modifier 80

The assistant surgeon modifier 80 should be on service lines when there is a surgical assistant during surgery. We are seeing numerous claims from multiple surgeons and the modifier is being left off the claim. When this occurs the member has a higher coinsurance payment and calls this to our attention. Assistant Surgery allowable is 20% of the surgical allowance. If the participation of the second surgeon is for only a small part of the procedure, modifier -81 should be used. Modifier -81 is allowed only for those services for which modifier -80 is allowed and is reimbursed at 15% of the allowed amount for the specific surgery.

When the modifier is not on the claim form this causes delays in claims adjudication and also claims refunds requests for the overpayment and then refunds to the members from the assistant surgeon for the over collection of coinsurance. Several members have called complaining of this practice. We ask that you always remember to use modifier 80 when billing for Assistant Surgery.

Anesthesia Billing

How to bill for anesthesia time when filing paper HCFA Form 1500s.

Recently we began scanning and imaging paper claims to improve our processing of claims. If you file paper claims for anesthesia services, these guidelines will help your claims get processed correctly.

We receive anesthesia service claims with the anesthesia time billed in a wide variety of ways. In the past, we manually reviewed anesthesia claims and corrected the time. This practice perpetuated problems, as it never gave you feedback on the correct way to record this element. We would prefer you file electronically but if you must file on paper HCFA Form 1500s follow these guidelines for **ABCBS, Health Advantage, First Source, First Pyramid Life, and USAble members**.

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in block 24g of the HCFA form 1500. If no time units are indicated on the claim the claim will be denied.

Base Units

Base unit values have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual preoperative and postoperative care and evaluation. We use the anesthesia base units recommended by the American Society of Anesthesiologists.

Do not report base units in the units field (block 24g) on your claim submissions, report the actual total minutes that anesthesia was administered. Our claim processing system automatically determines the base units based on the reported procedure code and modifiers. If your software automatically prints a comment line below the service line with the base units, it will not interrupt the processing of your claim as long as no data prints in the date of service or charge fields.

Time Units

Anesthesia time involves the continuous actual presence of the anesthesiologist or CRNA and begins when the physician or anesthetist begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Anesthesia time ends when the anesthesiologist/CRNA is no longer in personal attendance, i.e., when the patient may be safely placed under post-operative supervision. The anesthesiologist/CRNAs should report the total anesthesia time on the HCFA claim form as the sum of the continuous anesthesia block times. The medical record should be documented so that a medical record auditor can see the continuous and discontinuous periods and that the reported total anesthesia time sums to the blocks of continuous time.

Time units are determined on the basis of total minutes. Providers should report the total anesthesia time in minutes on the claims. For example, if the total time is 1 hour and 35 minutes, report “95” in the units file (block 24g) of the HCFA Form 1500.

Physical Status Modifiers

The following are physical status modifiers are used to give us additional information about the level of complexity of the anesthesia service provided. The points are additional units added to the total time. Bill for only one (1) physical status modifier per procedure.

	POINTS
P1 – A normal healthy patient	0
P2 – A patient with mild systemic disease	0
P3 –A patient with severe systemic disease	1
P4–A patient with severe systemic diease that is constant threat to life	2
P5 -A moribund patient who is not expected to survive for 24 hours with or without the operation	3
P6-A declared brain-dead patient whose organs are being removed for donor purposes	0

Anesthesia Reimbursement

Anesthesia services are paid based on the Anesthesia Relative Value Units. The customary values for reimbursement of anesthesia services are based on the sum of the following components:

- Base units for the primary procedure
- Total time
- Physical status

The following formula is used to determine reimbursement:

(Anesthesia + Physical + Total time) x Conversion = Anesthesia X Contractual
base unit modifying (units) factor
fee allowance allowance
units

For example – 00865P3 performed in total time of 1 hour and 25 minutes

7 units + 1 unit + 6 units* = 14 units X $34 = $476
$476 X contract benefit. In other words, if you have agreed to accept 90% of the ABCBS allowable your reimbursement would be $476 X 90% = $428.40.
* partial units are rounded to the next whole unit , 1 unit = 15 minutes. So, 85 minutes/ 15 minutes = 13.67 units which = 14 units.

Documentation Requirements
ABCBS does not require the anesthesia record with each claim submission. Do not submit anesthesia records unless it is requested, then follow the instructions in the letter of request. The following are the most common situations in which ABCBS requests anesthesia notes:

1) Procedures in the Monitored Anesthesia Care policy may require a letter documenting why monitored anesthesia was necessary for the particular patient.
2) Submission of any miscellaneous procedure codes. Most miscellaneous codes end in 999 (i.e., 01999). The record is required to identify the actual procedure performed, since the code does not provide sufficient information.
3) Anesthesia administered for dental procedures. Since ABCBS's coverage guidelines are limited, the anesthesia record permits us to make a coverage determination on the particular case.
4) If two different anesthesia services are billed on the same claim, the anesthesia record is needed to document that two different operative sessions occurred on the same day.
5) If a procedure is billed that is not site specific, i.e., removal of a foreign body, ABCBS may request the anesthesia record to determine the site to ensure coverage should be allowed.

Policyholder's Benefit Certificate, Article XII-Benefits and Services not Included

Article XII of the Policyholder's Benefit Certificate states that "Services by an immediate relative" are not included. Immediate relative is defined as the spouse, parent, child, brother, sister or legal guardian of the person receiving the services. Professional services performed by a person who ordinarily resides in the covered member's home or is related to the covered member as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Call BlueCard *Eligibility* for Easy Access to Membership and Coverage Information

Not sure what to do when a patient hands you an identification card from another Blue Cross and Blue Shield Plan? First, look for the three-character alpha prefix that precedes the identification number on the ID card. The alpha prefix identifies whether the patient is a member of the BlueCard Program and the member's Blue Cross and Blue Shield Plan or national account. It is also critical for confirming 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. Once you've identified the alpha prefix, pick up the phone and call the **BlueCard *Eligibility*®** line at **1-800-676-BLUE (2583)** to verify the patient's eligibility and coverage.

An operator will ask you for the alpha prefix and will connect you directly to the appropriate membership and coverage unit at the patient's Blue Cross and Blue Shield Plan. If you can't find an alpha prefix on the ID card, this may indicate the claims are handled outside the BlueCard Program. Check the back of the patient's ID card for instructions or a telephone number for how to file these claims.

Once the patient receives care, submit the claim to us at Arkansas Blue Cross and Blue Shield, BlueCard, Post Office Box 2181, Little Rock, Arkansas 72203-2181. Make sure you include the patient's complete identification number, which incorporates the three-character alpha prefix. *Do not make up or guess an alpha prefix*. Some alpha prefixes are assigned to specific accounts, not Plans. Incorrect or missing alpha prefixes and identification numbers delay claims processing. Also, make sure you price the claim according to your contract with us, including our hold harmless agreement.

After we receive your claim, we will electronically route it to the patient's Blue Cross and Blue Shield Plan. The patient's Plan then processes the claim and authorizes payment. We will then pay you according to our contract with you.

So if you're interested in facilitating quicker payments, take the easy route and call **BlueCard *Eligibility*®** at **1.800.676.BLUE (2583).**

For further information about **BlueCard *Eligibility*®**, please call us at **800-880-0918.**

Exceptions to BlueCard Claims Submissions

Usually, when a member from another Blue Cross Blue Shield Plan presents an identification card with an alpha prefix, you would submit the claim directly to Arkansas Blue Cross and Blue Shield for processing through the BlueCard Program. Occasionally, exceptions may arise in which Arkansas Blue Cross and Blue Shield will

require you to file the claim directly with the member's Plan. Here are some of those exceptions.

- If you contract with the Blue Plan where the member is enrolled, you should submit claims to that Blue Plan.
- When there is no alpha prefix on the ID card, you should file the claim directly to the member's Blue Plan. No alpha prefix on an ID card may indicate that an account or a product may be exempt from the BlueCard Program or the ID card may be outdated (always ask for the patient's most current ID card).
- A claim is returned to you from Arkansas Blue Cross and Blue Shield because no alpha prefix was included on the original claim that was submitted.

In some cases, **Arkansas Blue Cross and Blue Shield** will ***request*** that you file the claim directly with the patient's Plan. For instance, there may be a temporary processing issue at **Arkansas Blue Cross and Blue Shield**, the member's Blue Plan or both that prevents completion of the claim through the BlueCard Program.

When in doubt, it's always a good idea to send the claim to **Arkansas Blue Cross and Blue Shield, BlueCard, Post Office Box 2181, Little Rock Arkansas 72203-2181** and we will handle the claim for you. If you have any further questions about BlueCard claims exceptions, please call **Arkansas Blue Cross and Blue Shield** at **800-880-0918**.

ABCBS Fee Schedule Corrections

The CPT codes found on pages 8-9 of the newsletter were incorrect in the July 1, 2000 fee schedule. These are the corrected allowances. Please accept our apology for any confusion this may have caused.

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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