Providers' News

To: All Providers

From: Provider Network Operations

Date: March 30, 2001

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. The Southeast and Southwest Regions will begin following the procedures listed below effective March 1, 2001.

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

Maternity Benefits – Correction

The *Providers' News* of December 1, 2000 stated that the Triple Screen (AFP/HCG/Estriol) may be offered in high-risk pregnancies. This is incorrect. The Triple Screen may be offered to all pregnant women.

This same article listed all of the laboratory procedures considered to be standard studies when performed during the course of pregnancy. The list did not include the Obstetric Panel code, CPT 80055, which may be billed when all tests specified in the panel description are

performed and when the code is used instead of billing individual tests.

Please accept our apology for any confusion this may have caused.

Osteochondral Autograft Transfer

Mosaicplasty and Osteochondral Autograft Transfer System (OATS) involve removing small cylinders of cartilage and attached subchondral bone from the "normal", non-weight bearing femoral condyle or notch, and transplanting the cylinders into holes drilled into areas of chondral defects associated with anterior cruciate ligament disruption, biomechanical chondropathy, and osteochondritis dissecans of the knee.

There is no specific CPT code for this procedure. It is correctly billed with CPT 29909 – unlisted procedure, arthroscopy. A copy of the operative note documenting the performance of the OATS procedure will need to be submitted with the claim.

Wellness Benefit Update-Pap Smear Coding

The following codes may be used when billing pap smears:

CPT codes 88142, 88143, 88144, 88145, 88147, 88148, 88150, 88153, 88154, 88164, 88165, 88166, 88167 all have a $23 (prof $10 and tech $13) allowed amount.

Claims submission improvement

Please note: On all Health Advantage identification cards with 2001 effective dates, **the member's date of birth is now printed on card**. This was done at the request of providers who indicated that claims are sometimes mis-directed because the date of birth on the Health Advantage records differs from the date of birth in your records. To expedite claims processing use the date of birth and the name exactly as presented on the Health Advantage id card for all future Health Advantage claims submissions.

Health Advantage and Medi-Pak HMO Provider Manuals

The Health Advantage Provider Manual may now be accessed on-line at www.healthadvantage-hmo.com. The HA Medi-Pak HMO Provider Manual will be on line by May 1, 2001.

If you have questions about any of the information contained in the Provider Manual please contact your Network Development Representative.

Blue On-line

Searching for a doctor, dentist, hospital or pharmacy is easy using *arkansasbluecross.com* or *healthadvangtage-hmo.com*. The "Provider Directory" is accessible after entering any of the main sections ("Guests," "Members," "Employers," "Providers," "Agents"). Look for the link on the menu bar on the left side of the pages.

The directory contains providers participating in Arkansas Blue Cross and Blue Shield, Health Advantage and Arkansas' FirstSource health plans. To use the directory, click on the name of a plan.

When you click on a plan, you will see a drop-down menu listing the type of searches available:

- physician or other medical practitioner (includes optometrists, podiatrists, chiropractors and psychologists)
- hospital or other medical facility/vendor (includes outpatient surgery centers, rehabilitation centers, home health agencies and providers of durable medical equipment)
- dentist (School or state employees will not have this choice since their dental directory is accessible from the "Introduction" page.)
- pharmacy

Once you select a search type, you can enter a name, specialty, state, city, county or region. You can select only one location field. The radio button to the left of the field you select will "turn on."

If you want to search by region but don't know which region to choose, use the map at the bottom of the page. If you click on Washington County, for example, the *Region* field automatically fills in with *Northwest*.

If you want to know if a particular doctor participates in a health plan, you can search by name. You can search for providers named *Jones* in your city, for example. You also can search for providers by name without entering a location.

If you are looking for a specialist, you can select the specialty and then select your state, city, county or region. The "Search Results" page will display a list of the specialists available in the location of your search for a health plan. For example, you can search for *hand surgeons* in *Arkansas*. You also can search by specialty without entering a location.

Editor's Note: The Provider Directory is updated frequently. However, the information could have changed since it was given to us. Even though a provider is listed in the directory, you might not be

covered for that provider's services. Consult your individual policy or group contract to determine whether you have dental, pharmacy or specific medical benefits. Also remember that you must follow your health plan rules for referrals to specialists.

Anesthesia Units

CODE	BASE UNITS
00537	10
00550	10
00563	25
00566	25
00635	5
01112	4
01214	10
01215	8
01951	3
01952	5
01953	1

Remittance Advice Notices

Beginning in March 2001, the schedule for issuing remittance advice notices and assigned payments has changed. This means you may receive remittances more often, as we have added an additional check "write" date. Provider remittances are mailed now on Wednesday and Friday of each week with special scheduling at month-end. Previously, the normal mail date has been on Friday only.

We will continue to indicate the claim process dates in the box at the top right hand corner of the remittance. By increasing the check writing cycle to twice a week, you'll get your remittance faster!

- **Monday and Tuesday's adjudicated claims will be included on the Friday check date and**
- **Wednesday thru Friday/Saturday's adjudicated claims will be included on the Wednesday check date.**

This information does not apply to FEP, Medipak, or BlueCard/ITS claims.

If you have questions, please call 501-378-2307 or toll free 1-800-827-4814.

Claims Filing Guidelines –UB92

Most claims submitted to ABCBS, Health Advantage and Usable Administrators are submitted electronically. However, some claims are still received on paper through the mail. To enable us to process paper claims more efficiently and with improved accuracy, we will be installing a process to scan and OCR (Optical Character Recognition) all paper UB-92 claims. This process has been used for some time now on paper HCFA-1500 claims. (Call our Electronic Claims Service Section TODAY at (501) 378-2419 to find out more about how to submit claims electronically.)

Please use the following guidelines when submitting UB-92 claims on paper.

- Paper claims must be filed using the **RED** UB-92 claim form. Use of black claim forms will be accepted but will require additional effort to process, and could delay payment.
- Align the information on the form so that data is within the boxes on the form.
- Use only black ink or toner on printed information. Above all, do not use red ink.
- Use only upper case (CAPITAL) letters on your alphabetic entries.
- Use 10-point or 12-point type font size.
- Please use the "Pica" typewriter interface or standard dot-matrix fonts.
- Do not mix font types or sizes on your claims.
- Do not use italics or script fonts.
- In money fields, do not use the dollar signs or decimal points. For example, enter $1,332.20 as 1332 20.
- In the name fields, do not use titles such as "Mr.", "Mrs." or "Dr.".
- For name fields, enter the last name first, followed by a comma, followed by the first name. (Example – LASTNAME, FIRSTNAME)
- The print quality is extremely important, so please make sure that the print quality is not faint or fading. Change your print ribbons or toner cartridges often.
- Please don't write or stamp any extra information in the body of the claims.

- Avoid the use of hand-written information. Scanning technology has improved greatly, but cannot always interpret hand-written information reliably.

Some additional tips to help us process your claims:

- Put your ABCBS provider number and your name on the claim and in the appropriate field. We cannot reimburse you if we don't know who you are.

- Put the member's group policy number and the member's alpha prefix/identification number in the appropriate field. We can't process the claim without it.

- Complete all required fields. Refer to your UB-92 manual for detailed instructions.

These guidelines have been printed in the past. It is very important to follow these guidelines closely to avoid delays or possibly having your claims returned.

Advantages to Electronic Claim Submission

There are major advantages to submitting electronic claims versus paper claims:

- You have better control and accuracy. Electronic claims are entered in the ABCBS's computer system just the way they leave your office. There is no need to worry about a claim being delayed or denied because it is not legible. You know when your claims are received because your office receives special reports detailing which claims were accepted and if there is a problem you can correct it before the claim is processed.

- You are able to reduce your overhead; electronically submitted claims can save hours of clerical time. You do not have to spend time typing, stapling, stamping, and mailing.

- Call Electronic Services today at 501-378-2419.

Arkansas State Employees changes to Fully-Insured with ABCBS and Health Advantage

Effective January 1, 2001 the Arkansas State Employee group changes from self-insured funding to a fully insured funding. **Because of this your *2000 dates of service* claims for Arkansas State employees must be filed to ABCBS or Health Advantage by May 31, 2001.** If you do not file by that date claims may not be processed by ABCBS or Health Advantage but will need to be mailed to the state employee benefit agency for adjudication. This is necessary due to the self funding program ending and to handle the claims "run-out".

Reminders from the Medical Review Area

Please remember to always:

1. Complete all questions on the Medical Facts letter regarding pre-existing conditions and answer all question on our form letters.

2. Utilize the appropriate diagnosis to procedure codes and try to avoid using vague diagnoses and V codes.

3. Use the appropriate E&M code for the service rendered and avoid upcoding.

4. Do not use the modifier 25 with office visit codes unless there is really a separate identifiable service provided.

5. Provide both operative reports if billing as co-surgery.

6. Provide the lab results with neutrophil count or a formula to calculate the neutrophil count when we request information for the use of Neupogen.

7. Psychiatrists and Psychologists office staff should enter the correct number of services on the claim depending on the service provided. Some Psych codes do not have time units and entering the incorrect number of services will result in incorrect payment.

Arkansas' FirstSource PPO

See page 7 for a list of Arkansas' FirstSource PPO Access Only Groups as of March 2001. **Claims for all Access Only groups may be filed electronically to Arkansas Blue Cross Blue Shield.**

Paper claims must be typed on red UB92 or red HCFA1500 claim forms. Anything handwritten on paper claims will cause a delay in processing.

Please do not include a prefix or suffix with the ID number when submitting claims for Access Only groups. It will cause your claim to reject and be returned.

Respiratory Health Education Program

The following information is being distributed to providers along with an informational brochure:

Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Administrators continue to develop community-based programs with a focus on our members — and your plan of care. As a part of this effort, we are pleased to introduce the Respiratory Health Education Program, the next in our series of Health Education Programs that will soon be available to our members.

Respiratory Health Education brochures will soon be mailed to members and their families who are at greater risk for serious complications of a respiratory infection — those 65 years of age and older, those who suffer from chronic diseases and those who suffer from lung conditions such as asthma, emphysema or bronchitis. Our community-based, disease-specific education programs emphasize self-management techniques, and include national and local health-education resources and assistance with member health-plan benefits.

In addition to the brochure, each member also will receive an enrollment form. The program starts when the member enrolls. When signed by the member, the enrollment form gives us permission to discuss the member's health information with providers and other health educators.

Program highlights include:
- A voluntary health survey.
- One-on-one contact with a regional registered-nurse case manager based on risk stratification.
- National and local health care resource lists.
- Tip sheets on measures for use at home to prevent respiratory infection, simple techniques to relieve symptoms and education to help the member understand the role of medications in the treatment of respiratory infection.

Please contact your local Arkansas Blue Cross or Health Advantage case manager if you treat a member who would benefit from this program. And please share any suggestions you have that may improve our community-based efforts. We look forward to working with you on behalf of our members — your patients.

Health Advantage EOP

Health Advantage, USAble Administrators and First Pyramid Life will be implementing in the very near future, a new version of the Explanation of Payment (EOP). In addition to the new "look" the EOP will be duplexed.

There are several new fields that have been added to the format:

- In the top right hand corner, Page # of #, Check Date, Number and Amount are shown.
- At the patient level, the Division# and the Division Name, representing the Subscriber's Employer information is shown.
- At a claim and service line level, the Coinsurance Amount is now being reported.

In addition, should there be interest included in your payment amount, this information will be shown at the individual service line, claim level and total of interest in the payment amount.

A sample of the new EOP follows on the next page.

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' FIRSTSOURCE PPO
ACCESS ONLY GROUPS – MARCH 2001

AALF'S MANUFACTURING, INC.
ACF INDUSTRIES, INC./AMERICAN RAILCAR
AMANA
AMERICAN FREIGHTWAYS
ANCHOR PACKAGING (HERMANN CO)
ARVEST BANK GROUP
ASSOCIATED WHOLESALE GROCERS
ATLANTIC RESEARCH
BALDWIN PIANO
BASLER
BEKAERT
BOAR'S HEAD PROVISIONS CO.
BRICK LAYERS UNION #5
BRYCE CORPORATION
BURLINGTON
CAMACO (MAGNA INTERNATIONAL)
CAVALIER/SPIRIT HOMES
COLUMBIA FOREST PRODUCTS
DARLING FIXTURES
DEFIANCE METALS
DIOCESE OF LITTLE ROCK
EASTERN OZARKS REG. HLTH CTR
EMERSON-KENNETT, MO.
EMERSON-PARAGOULD
EMERSON-ROGERS
EMERSON-US MOTORS, MENA
FEDERAL DATA CORP
FOAMEX
FRIENDSHIP COMMUNITY CARE
GREENFIELD INC., ROGER TOOL WORKERS
HARDING UNIVERSITY
HARPS FOOD STORES, INC
HOT SPRINGS COUNTY MED CENTER
HOWARD MEMORIAL HOSPITAL
HUNTCO STEEL
INNOVATION INDUSTRIES
JAMES HARDIE INDUSTRIES (USA) INC.
KEY ENERGY SERVICES
LABARGE
LEVI HOSPITAL EMPLOYEE BENEFIT PLAN
MAGNA RETIREES
MAGNOLIA HOSPITAL
MARSHALLTOWN TOOLS
MAVERICK TUBE CORP.
MERCANTILE BANK
MOTOR APPLIANCE CORP.
MUELLER INDUSTRIES
NEWPORT HOSPITAL
NORANDAL USA INC.
NORTH ARKANSAS MEDICAL CTR.
ODOM'S TENNESSEE PRIDE
PAT SALMON & SONS, INC.
PAXTON MEDIA GROUP
PETERSON MANUFACTURING
PILGRIM'S PRIDE
QUEBECOR WORLD
REGAL WARE
RURAL METRO
SHEET METAL WORKERS
SIEGEL-ROBERTS, INC.
SIPLAST INC.
SOUTHERN BAG CORP.
SOUTHERN PAINTERS WELFARE
ST. MICHAEL'S HOSPITAL
TOWN & COUNTRY PRICE CUTTERS
TOWNSEND FOOD
UNION PLANTERS CORP.
WABASH NATIONAL
WALLACE & OWENS
WAL-MART, INC.
WHEELING MACHINE PRODUCTS
WONDER STATE BOX DIVISION
UFCW

HOSPITAL CLAIMS ONLY
ALCOA
AMERICAN GREETINGS
BALL CORPORATION
HEALTHCARE BUSINESS SACS (CNA)
EMERSON MOTORS - WHITE RODGERS
LENNOX
REYNOLDS METAL
WHIRLPOOL CORPORATION

A Guide to
The HCFA - 1500
Claim Form Including Rule and Regulation 43 Information

for professional providers

Arkansas Blue Cross and Blue Shield

The Arkansas Insurance Department (AID) Rule and Regulation 43 recently was revised to help ensure the timely processing of health insurance claims-both to benefit health insurance companies and providers. Any claims received on or after January 1, 2001 will be subject to the revised regulation.

The revised regulation defines the number of days that insurance carriers have to process "clean claims" and "non-clean claims" or "Section 13" claims. Clean claims are claims submitted with all information necessary for payer adjudication and that does not require further investigation.

Section 13 claims are those that have been submitted, but must be suspended from processing until the insurance carrier receives more information. An insurance carrier must notify the claimant (provider or member), within 30 days of receiving a claim, what information is required to process the claim correctly.

Necessary information includes the following:

- Information to determine if contract limit or exclusion applies
- Medical information to determine price of medical procedure
- Information to determine eligibility of claimant
- Information to determine if claim is covered by another carrier, government program, workers' compensation or third party
- Information to determine Coordination of Benefits (COB) obligation
- Information to determine if there is fraud or material misrepresentation
- Payment of premiums that were delinquent at the time of claimed services

The AID Rule and Regulation 43 requires that:

1. All clean claims must be processed (paid or denied with notification to provider or member) within 30 days. Clean claims submitted on paper must be processed within 45 days. A clean claim does not include claims on expenses incurred during a period of time when premiums were delinquent; or for benefits under a Medicare supplemental policy if the claim is not accompanied by an explanation of Medicare benefits or the Explanation of Medicare Benefits (EOMB) has not been otherwise received by the insurance carrier.
2. For Section 13 claims, the claim must be determined to be non-clean and returned to the provider or member within 30 days. After the correct information has been provided to the insurance carrier, the insurance carrier then has 30 days to process the claim.

If the insurance carrier does not process a clean claim within 60 days, the insurance carrier must then pay a penalty beginning on the 61st day after the claim was filed. The penalty is the amount of the claim multiplied by 12 percent per annum multiplied by the number of days delinquent divided by 365. The late processing penalty will be paid to the provider through an additional check from the insurance carrier.

If the insurance carrier does not process a Section 13 claim within 45 days of receipt of necessary information, the insurance carrier must then pay a penalty beginning on the 46th day after the correct information is received. The penalty is the amount of the claim multiplied by 12 percent per annum multiplied by the number of days delinquent divided by 365. The late processing penalty will be paid to the provider through an additional check from the insurance carrier.

For information and guidelines on filing the HCFA 1500 claim form and the HCFA 1500 anesthesia claim form, and for filing guidelines for wellness services, please read the following information.

NOTE: R&R43

*As in the past, this rule does **NOT** apply to the Federal Employee Program, Access Only Groups, and some groups administered by USAble Administrators.*

Medical Records Note: In order to comply with R&R 43, ABCBS will be decreasing the days allowed to obtain medical records. Currently we allow a 21 days period before the claim is denied no response, that will change to a 14 day limit beginning January 1, 2001.

ABCBS HCFA-1500- 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) – <u>DO NOT USE NICKNAMES</u>**

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.

The 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.** 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 be returned to the provider for the correct information.

When submitting claims for BlueCard® Out-of-Area Program (other Blue Cross and Blue Shield Plan members) patients, please be sure to use the three-letter prefix that appears on the identification card.

Block 2 Patient's name

Enter the patient's last name followed by a comma and the first name in all capital letters. **Please enter this name exactly as it appears on their card.** 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 in the following format (mm/dd/cc/yy) and sex. Date of Birth is required. (Remember for Health Advantage to use the Date of Birth on the ID card for all submissions).

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 any other health benefit plan including; Health Advantage, USAble or Arkansas BlueCross BlueShield, 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 including USAble, Health Advantage, or Arkansas Blue Cross and Blue Shield.
(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?

NOTE: Block 14 must be completed if YES indicated in any box.

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 or the claim will be returned to the provider for this information.

Block 11d Is there another health benefit plan?

Enter an "X" in the appropriate box. If yes, block 9 (a-d) must be completed.

Block 14 Date of current (illness. injury or pregnancy)

Note: If YES is indicated in block 10 and/or the diagnosis indicates accident or medical emergency, this field MUST be completed.

- Injury - Enter date the accident/injury occurred

- Illness - Enter for an acute medical emergency only and include onset date of Condition

- Pregnancy - Enter 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 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. 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.

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.

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 units of service rendered for the procedure. Anesthesia services and "special" procedure codes require time units format. If you need additional space on the claim form, you may run the information in this block into Block 24H.

Block 24K Reserved for local use

It is **required** 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. If this field is left blank, the claims will be returned to the provider for the needed information.

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 **required** that you provide us with the correct billing provider's number. Please follow the example listed below when you enter the provider identification number and the control letters in the GRP# field. If a clinic - enter the Group #. If a solo practitioner - enter the individual provider #. If this field is left blank, the claim will be returned to the provider for the needed information.

Example:

Provider Number - M12345

Enter on your form as: M12345

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	01

Beginning	Ending	NSF TYPE
J0000	J9999	09
K0000	K0048	12
K0000	K0048	18
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

Beginning	Ending	NSF TYPE
P0000	P9999	05
Q0035	Q0035	05
Q0068	Q0068	05
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	09
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
00100	01999	07
10000	69999	02
10000	69999	08
70010	77260	04
77261	77799	06
78000	79999	04
80048	85094	05
85095	85095	02
85096	88169	05

Beginning	Ending	NSF TYPE
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
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

Claims Filing Guidelines for Anesthesia - HCFA - 1500

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate a current and valid CPT/HCPCS anesthesia procedure code in field 24d of the HCFA 1500.

Time Units
Time units are determined on the basis of total minutes. Providers should always 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.
NOTE: Do not report base units in the units field (block 24g). The claims systems are programmed to include the base units in the overall payment calculations.

Physical Status Modifiers
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. These modifiers should be indicated in the modifier field in 24d following the CPT/HCPCS anesthesia code. The charges should be included in the overall charge for the anesthesia.

Claims Filing Guidelines for Wellness Services

Preventive Medicine Evaluation (Routine Physical) - Adults

Valid Procedures and Codes: (block 24d – HCFA 1500)

Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, new patient;

99385	age 18 thru 39 years
99386	age 40 thru 64 years
99387	age 65 years and over

Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, established patient;

99395	age 18 thru 39 years
99396	age 40 thru 64 years
99397	age 65 years and over

Diagnoses and Codes: (block 21 and corresponding pointer in 24e – HCFA 1500)

V70	General medical examination
V70.0	Routine general medical examination at a health care facility (excludes checkup of an infant or a child)
V70.9	Unspecified general medical examination

Annual Routine Gynecological Exam

Valid Procedures and Codes: (block 24d - HCFA 1500)

Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, new patient;

99384	age 12 thru 17 years
99385	age 18 thru 39 years
99386	age 40 thru 64 years
99387	age 65 years and over

Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, established patient;

99394	age 12 thru 17 years
99395	age 18 thru 39 years
99396	age 40 thru 64 years
99397	age 65 years and over

Diagnoses and Codes: (block 21 and corresponding pointer in 24e – HCFA 1500)

V72.3	Gynecological examination Papanicolaou smear as part of general gynecological examination. Pelvic examination (annual) (periodic)
V76.2	Special screening for malignant neoplasm; cervix
V76.10	Special screening for malignant neoplasms; breast screening, unspecified
V76.11	Special screening for malignant neoplasms; screening mammogram for high-risk patient
V76.12	Other screening mammogram
V76.19	Other screening breast exam

Routine Pap Smear

Code	Description
88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service)
88142	Cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	With manual screening and rescreening under physician supervision
88144	With manual screening and computer-assisted rescreening under physician supervision
88145	With manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88150	Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision
88153	With manual screening and rescreening under physician supervision
88154	With manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88155	with definitive hormonal evaluation (e.g., maturation index, karyopknotic index, estrogenic index) removed 88156-88157-88158

88164	Cytopathology, slides, cervical or vaginal, (the Bethesda System) ;manual screening under physician supervision
88165	With manual screening and rescreening under physician supervision
88166	With manual screening and computer-assisted rescreening under physician supervision
88167	With manual screening and computer-assisted rescreening using cell selection and review under physician supervision

Mammograms

Code	Description
76090	Mammography; unilateral
76091	bilateral
76092	Screening mammography, bilateral (two view film study of each breast)

A screening examination is performed when an individual does not have a sign or symptoms of disease. A diagnostic examination is performed when there are signs or symptoms of a disease.

If during the screening a problem is found, code the screening procedure on one line with the pointer code in 24 E to the screening diagnosis and the diagnostic procedure on a separate line with the pointer code to the appropriate diagnosis code.

Child Services

Preventative Medicine Evaluation and Normal Immunizations

Valid Procedures and Codes: (block 24d – HCFA 1500)

Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, new patient;

99381 age under 1 year
99382 age 1 thru 4 years
99383 age 5 thru 11 years
99384 age 12 thru 17 years

Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, a comprehensive examination, Counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures. established patient;

99391 age under 1 year
99392 age 1 thru 4 years
99393 age 5 thru 11 years
99394 age 12 thru 17 years

Valid Diagnosis and Code: (block 21 and corresponding pointer in 24e – HCFA 1500)

V20.2 Routine infant or child health check
Developmental testing of infant or child
Immunizations appropriate for age
Routine vision and hearing test

Valid Immunization and Codes

Code	Description
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90645	Hemophilus, influenza b vaccine (Hib) HbOC conjugate (4 dose schedule) for intramuscular use
90646	Hemophilus, influenza b vaccine (hib) PRP-D conjugate, for booster use only, for intramuscular use
90647	Hemophilus influenza b vaccine (Hhib) PRP-OMP conjugate (3 dose schedule) for intramuscular use
90648	Hemophilus influenza b vaccine (Hib) PTP-T conjugate (4 dose schedule) for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DtaP), for intramuscular use
90701	diphtheria and tetanus toxoids and whole cell pertussis vaccine (DPT), fpr intramuscular use
90702	diphtheria and tetanus toxoids (DT) adsorbed for use in individuals younger than seven years, for intramuscular use
90703	tetanus toxoid adsorbed, for intramuscular or jet injection use
90704	mumps virus vaccine, live, for subcutaneous or jet injection use
90705	measles virus vaccine, live, for subcutaneous or jet injection use
90706	rubella virus vaccine, live, for subcutaneous or jet injection use
90707	measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use
90708	measles and rubella virus vaccine, live, for subcutaneous or jet injection use
90709	rubella and mumps virus vaccine, live for subcutaneous use
90710	measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90712	poliovirus vaccine,(any type(s), (OPV), live, for oral use
90713	poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90716	varicella virus (chicken pox)vaccine, live, for subcutaneous use
90718	tetanus and diphtheria toxoids (Td) absorbed, for use in individuals seven years or older, for intramuscular or jet injection use
90719	diphtheria toxoid, use, for intramuscular use
90720	diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DPT-HIB), for intramuscular use
90721	diphtheria, tetanus toxoids, and acellular pertussis vaccine) and Hemophilus influenza B vaccine (DtaP HIB), for intramuscular use

90744	Hepatitis B vaccine; pediatric/adolescent dosage (3 dose schedule), for intramuscular use

Valid Diagnostic Test and Codes:

Lab Urinalysis

Code	Description
81000	Urinalysis, by dip stick or table reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen
81002	non Automated, without microscopy
81003	automated, without microscopy

Hemoglobin/Hematocrit

85021	hemogram, automated (RBC, WBC, Hgb, Hct and indices only)

A screening examination is performed when an individual does not have any signs or symptoms of disease. A diagnostic examination is performed when there are signs or symptoms of a disease.

If during the screening a problem is found, code the screening procedure on one line with the pointer code in 24E to the screening diagnosis and the diagnostic procedure on a separate line with the pointer code to the appropriate diagnosis code.

2001 Deleted CPT Codes with Cross Reference

DELETED CPT CODE	CROSS REFERENCE
52335	52351
52336	52352
52337	52353
52338	52354
52339	52355
52340	52400
70541	70554-70546, 70547-70549
71036	76003
76365	76360
76934	32000, 76942
76938	76942
76960	76950
82251	82247, 82248
87060	87070, 87081
87072	87076, 87077
87082	87081
87083	87081
87085	87086
87087	87088
87117	87015
87145	
87151	87147
87155	87147
87163	87076, 87077
87174	
87175	
87192	87181, 87184, 87186, 87187, 87188
87208	
87211	87177
97770	97532, 97533

2001 HCPCS Codes

HCPCS CODE	TOTAL or Purchase	PROF COMP or Rental	TECH COMP or Used	TOTAL or Purchase SOS	PROF COMP or Rental SOS	TECH COMP or Used SOS
A0425	BR			BR		
A0426	BR			BR		
A0427	BR			BR		
A0428	BR			BR		
A0429	BR			BR		
A0430	BR			BR		
A0431	BR			BR		
A0432	BR			BR		
A0433	BR			BR		
A0434	BR			BR		
A0435	BR			BR		
A0436	BR			BR		
A4290	BR			BR		
A4319	$6.04			$6.04		
A4324	$2.07			$2.07		
A4325	$1.72			$1.72		
A4331	$3.04			$3.04		
A4332	$0.12			$0.12		
A4333	$2.10			$2.10		
A4334	$4.71			$4.71		
A4348	$26.55			$26.55		
A4396	$38.61			$38.61		
A4464	BR			BR		
A4561	$18.32			$18.32		
A4562	$45.57			$45.57		
A4608	$58.32			$58.32		
A6021	$21.04			$21.04		
A6022	$20.05			$20.05		
A6023	$181.51			$181.51		
A6024	$5.90			$5.90		
A6231	$4.46			$4.46		
A6232	$6.57			$6.57		
A6233	$18.30			$18.30		
A7018	$0.31			$0.31		
A7019	$0.33			$0.33		
A7020	$2.63			$2.63		
A7501	$100.18			$100.18		
A7502	$47.61			$47.61		
A7503	$10.81			$10.81		
A7504	$0.64			$0.64		
A7505	$4.46			$4.46		
A7506	$0.32			$0.32		
A7507	$2.37			$2.37		
A7508	$2.74			$2.74		
A7509	$1.34			$1.34		
A9508	BR			BR		

HCPCS CODE	TOTAL or Purchase	PROF COMP or Rental	TECH COMP or Used	TOTAL or Purchase SOS	PROF COMP or Rental SOS	TECH COMP or Used SOS
A9510	BR			BR		
A9700	BR			BR		
G0173	BR			BR		
G0174	BR			BR		
G0175	BR			BR		
G0176	BR			BR		
G0177	BR			BR		
G0178	BR			BR		
G0179	BR			BR		
G0180	BR			BR		
G0181	BR			BR		
G0182	BR			BR		
G0183	BR			BR		
G0184	BR			BR		
G0185	BR			BR		
G0186	BR			BR		
G0187	BR			BR		
G0188	BR	BR	BR	BR	BR	BR
G0190	BR			BR		
G0191	BR			BR		
G0192	BR			BR		
G0193	BR			BR		
G0194	BR			BR		
G0195	BR			BR		
G0196	BR			BR		
G0197	BR			BR		
G0198	BR			BR		
G0199	BR			BR		
G0200	BR			BR		
G0201	BR			BR		
G9001	BR			BR		
G9002	BR			BR		
G9003	BR			BR		
G9004	BR			BR		
G9005	BR			BR		
G9006	BR			BR		
G9007	BR			BR		
G9008	BR			BR		
G9016	BR			BR		
H0001	BR			BR		
H0002	BR			BR		
H0003	BR			BR		
H0004	BR			BR		
H0005	BR			BR		
H0006	BR			BR		
H0007	BR			BR		
H0008	BR			BR		

HCPCS CODE	TOTAL or Purchase	PROF COMP or Rental	TECH COMP or Used	TOTAL or Purchase SOS	PROF COMP or Rental SOS	TECH COMP or Used SOS
H0009	BR			BR		
H0010	BR			BR		
H0011	BR			BR		
H0012	BR			BR		
H0013	BR			BR		
H0014	BR			BR		
H0015	BR			BR		
H0016	BR			BR		
H0017	BR			BR		
H0018	BR			BR		
H0019	BR			BR		
H0020	BR			BR		
H0021	BR			BR		
H0022	BR			BR		
H0023	BR			BR		
H0024	BR			BR		
H0025	BR			BR		
H0026	BR			BR		
H0027	BR			BR		
H0028	BR			BR		
H0029	BR			BR		
H0030	BR			BR		
P9031	BR			BR		
P9032	BR			BR		
P9033	BR			BR		
P9034	BR			BR		
P9035	BR			BR		
P9036	BR			BR		
P9037	BR			BR		
P9038	BR			BR		
P9039	BR			BR		
P9040	BR			BR		
P9041	BR			BR		
P9042	BR			BR		
P9043	BR			BR		
P9044	BR			BR		
V2790	BR			BR		

2001 CPT Codes

CPT CODE	Total Office	Prof Office	Tech Office	Total SOS	Prof SOS	Tech SOS
15342	$209.23			$126.47		
15343	$36.13			$25.64		
16036	$135.21			$135.21		
19102	$388.14			$163.77		
19103	$773.96			$192.91		
19295	$152.69			$55.37		
21199	$1,604.45			$1,604.45		
22520	$801.35			$801.35		
22521	$751.81			$751.81		
22522	$262.26			$262.26		
30465	$1,257.68			$1,257.68		
33141	$431.85			$431.85		
34800	$1,862.63			$1,862.63		
34802	$2,055.54			$2,055.54		
34804	$2,055.54			$2,055.54		
34808	$353.76			$353.76		
34812	$579.30			$579.30		
34813	$411.46			$411.46		
34820	$836.32			$836.32		
34825	$1,112.57			$1,112.57		
34826	$353.76			$353.76		
34830	$2,898.85			$2,898.85		
34831	$3,133.72			$3,133.72		
34832	$3,133.72			$3,133.72		
35600	$435.35			$435.35		
36540	BR					
36870	$2,111.48			$470.32		
43231	$359.59			$359.59		
43232	$417.87			$417.87		
43240	$634.67			$634.67		
43242	$456.33			$456.33		
43256	$359.59			$359.59		
44370	$358.42			$358.42		
44379	$585.13			$585.13		
44383	$199.90			$199.90		
44397	$374.74			$374.74		
45327	$140.45			$140.45		
45341	$312.38			$312.38		
45342	$360.17			$360.17		
45345	$241.28			$241.28		
45387	$488.97			$488.97		
50545	$2,052.62			$2,052.62		
50947	$2,212.31			$2,212.31		
50948	$2,022.90			$2,022.90		
52341	$509.37			$509.37		
52342	$551.33			$551.33		

CPT CODE	Total Office	Prof Office	Tech Office	Total SOS	Prof SOS	Tech SOS
52343	$610.77			$610.77		
52344	$652.74			$652.74		
52345	$695.86			$695.86		
52346	$782.70			$782.70		
52351	$519.86			$519.86		
52352	$643.41			$643.41		
52353	$745.40			$745.40		
52354	$652.15			$652.15		
52355	$765.80			$765.80		
52400	$910.92			$910.92		
54512	$813.01			$813.01		
54522	$924.32			$924.32		
55873	$1,688.37			$1,688.37		
57022	$250.60			$250.60		
57023	$250.60			$250.60		
57287	$1,070.60			$1,070.60		
58353	$344.43			$344.43		
61697	$5,119.90			$5,119.90		
61698	$4,928.16			$4,928.16		
62252	$127.05	$61.78	$65.27	$127.05	$61.78	$65.27
64614	$333.94			$184.75		
66982	$1,348.60			$1,348.60		
67221	$519.27			$379.40		
69714	$1,380.07			$1,380.07		
69715	$1,747.82			$1,747.82		
69717	$1,421.45			$1,421.45		
69718	$1,768.80			$1,768.80		
70496	$582.80	$146.28	$436.52	$582.80	$146.28	$436.52
70498	$582.80	$146.28	$436.52	$582.80	$146.28	$436.52
70542	$895.18	$95.00	$800.18	$895.18	$95.00	$800.18
70543	$1,609.11	$128.22	$1,480.89	$1,609.11	$128.22	$1,480.89
70544	$776.29	$99.08	$677.21	$776.29	$99.08	$677.21
70545	$776.29	$99.08	$677.21	$776.29	$99.08	$677.21
70546	$1,471.57	$146.28	$1,325.29	$1,471.57	$146.28	$1,325.29
70547	$776.29	$99.08	$677.21	$776.29	$99.08	$677.21
70548	$776.29	$99.08	$677.21	$776.29	$99.08	$677.21
70549	$1,471.57	$146.28	$1,325.29	$1,471.57	$146.28	$1,325.29
71275	$631.17	$100.82	$530.35	$631.17	$100.82	$530.35
71551	$908.00	$105.49	$802.52	$908.00	$105.49	$802.52
71552	$1,610.86	$138.12	$1,472.74	$1,610.86	$138.12	$1,472.74
72191	$610.77	$100.82	$509.95	$610.77	$100.82	$509.95
72195	$759.39	$89.17	$670.22	$759.39	$89.17	$670.22
72197	$1,623.68	$139.29	$1,484.39	$1,623.68	$139.29	$1,484.39
73206	$549.00	$100.82	$448.17	$549.00	$100.82	$448.17
73218	$747.15	$79.84	$667.31	$747.15	$79.84	$667.31
73219	$895.18	$95.00	$800.18	$895.18	$95.00	$800.18
73222	$895.18	$95.00	$800.18	$895.18	$95.00	$800.18
73223	$1,609.11	$128.22	$1,480.89	$1,609.11	$128.22	$1,480.89

CPT CODE	Total Office	Prof Office	Tech Office	Total SOS	Prof SOS	Tech SOS
73706	$549.00	$100.82	$448.17	$549.00	$100.82	$448.17
73718	$747.15	$79.84	$667.31	$747.15	$79.84	$667.31
73719	$895.18	$95.00	$800.18	$895.18	$95.00	$800.18
73722	$895.18	$95.00	$800.18	$895.18	$95.00	$800.18
73723	$1,609.11	$128.22	$1,480.89	$1,609.11	$128.22	$1,480.89
74175	$610.77	$100.82	$509.95	$610.77	$100.82	$509.95
74182	$908.00	$105.49	$802.52	$908.00	$105.49	$802.52
74183	$1,623.68	$139.29	$1,484.39	$1,623.68	$139.29	$1,484.39
75635	$667.31	$157.36	$509.95	$667.31	$157.36	$509.95
75952	$366.00			$366.00		
75953	$150.36			$150.36		
76012	$169.01			$169.01		
76013	$138.71			$138.71		
76393	$797.27	$121.81	$675.47	$797.27	$121.81	$675.47
76819	$150.36	$52.45	$97.91	$150.36	$52.45	$97.91
80157	$20.61	$1.44	$19.17	$20.61	$1.44	$19.17
80173	$30.18	$2.11	$28.07	$30.18	$2.11	$28.07
82373	$14.93	$1.04	$13.88	$14.93	$1.04	$13.88
82945	$8.13	$0.57	$7.56	$8.13	$0.57	$7.56
83090	$34.97	$2.45	$32.52	$34.97	$2.45	$32.52
83663	$19.61	$1.37	$18.23	$19.61	$1.37	$18.23
83664	$9.80	$0.69	$9.11	$9.80	$0.69	$9.11
83921	$34.13	$2.39	$31.74	$34.13	$2.39	$31.74
84152	$38.13	$2.67	$35.46	$38.13	$2.67	$35.46
84591	$22.16	$1.55	$20.60	$22.16	$1.55	$20.60
85307	$31.77	$2.22	$29.55	$31.77	$2.22	$29.55
85536	$13.43	$0.94	$12.49	$13.43	$0.94	$12.49
86001	$10.83	$0.76	$10.07	$10.83	$0.76	$10.07
86146	$52.74	$3.69	$49.05	$52.74	$3.69	$49.05
86300	$43.14	$3.02	$40.12	$43.14	$3.02	$40.12
86301	$43.14	$3.02	$40.12	$43.14	$3.02	$40.12
86304	$43.14	$3.02	$40.12	$43.14	$3.02	$40.12
86611	$21.09	$1.48	$19.61	$21.09	$1.48	$19.61
86666	$21.09	$1.48	$19.61	$21.09	$1.48	$19.61
86683	$5.25	$0.37	$4.88	$5.25	$0.37	$4.88
86696	$40.13	$2.81	$37.32	$40.13	$2.81	$37.32
86757	$40.13	$2.81	$37.32	$40.13	$2.81	$37.32
87046	$4.89	$0.34	$4.55	$4.89	$0.34	$4.55
87071	$9.78	$0.68	$9.10	$9.78	$0.68	$9.10
87073	$9.78	$0.68	$9.10	$9.78	$0.68	$9.10
87077	$16.74	$1.17	$15.57	$16.74	$1.17	$15.57
87107	$16.98	$1.19	$15.79	$16.98	$1.19	$15.79
87149	$41.57	$2.91	$38.66	$41.57	$2.91	$38.66
87152	$10.85	$0.76	$10.09	$10.85	$0.76	$10.09
87168	$8.85	$0.62	$8.23	$8.85	$0.62	$8.23
87169	$8.85	$0.62	$8.23	$8.85	$0.62	$8.23
87172	$8.85	$0.62	$8.23	$8.85	$0.62	$8.23
87185	$9.84	$0.69	$9.15	$9.84	$0.69	$9.15

CPT CODE	Total Office	Prof Office	Tech Office	Total SOS	Prof SOS	Tech SOS
87254	$10.14	$0.71	$9.43	$10.14	$0.71	$9.43
87273	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87275	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87277	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87279	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87281	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87283	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87300	$9.35	$0.65	$8.69	$9.35	$0.65	$8.69
87327	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87336	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87337	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87339	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87341	$21.41	$1.50	$19.91	$21.41	$1.50	$19.91
87400	$9.35	$0.65	$8.69	$9.35	$0.65	$8.69
87427	$18.68	$1.31	$17.37	$18.68	$1.31	$17.37
87451	$9.51	$0.67	$8.84	$9.51	$0.67	$8.84
87800	$41.57	$2.91	$38.66	$41.57	$2.91	$38.66
87801	$72.75	$5.09	$67.66	$72.75	$5.09	$67.66
87901	$533.67	$37.36	$496.31	$533.67	$37.36	$496.31
87903	$1,012.94	$70.91	$942.03	$1,012.94	$70.91	$942.03
87904	$54.03	$3.78	$50.25	$54.03	$3.78	$50.25
88400	$5.21	$0.36	$4.84	$5.21	$0.36	$4.84
89321	$24.99	$1.75	$23.24	$24.99	$1.75	$23.24
92586	$114.23			$114.23		
93662	$477.31	$240.70	$236.62	$477.31	$240.70	$236.62
93668	$0.58			$0.58		
97532	$33.25			$25.91		
97533	$36.18			$25.91		
97601	$50.36			$30.80		