Providers' News

To: All Providers

From: Provider Network Operations

Date: December 2002

Please Note: This newsletter contains information pertaining to Arkansas Blue Cross and Blue Shield (ABCBS), a mutual insurance company, its wholly owned subsidiaries and affiliates. 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 2001 American Medical Association. All Rights Reserved."

Arkansas Blue Cross and Blue Shield Introduces Three New, More-Affordable Health Insurance Plans

Arkansas Blue Cross and Blue Shield has created three new, more-affordable health insurance plans, which will be available beginning January 1, 2003. The products are designed to offer more choices for the budget-conscious consumer. Arkansas Blue Cross and Blue Shield will begin issuing rate proposals on the new products on November 15, 2002, for a January 1, 2003, effective date.

"For more than 50 years, Arkansas Blue Cross and Blue Shield has been driven by the insurance needs of Arkansans," said Sharon Allen, president and chief operating officer of Arkansas Blue Cross and Blue Shield. "Understanding those needs requires listening to our customers — employers, members and agents. Employers have told us they need more predictability to be able to budget for health insurance, and our members

have told us they need more choices and more flexibility. Everyone wants more affordable health insurance coverage. These new products are a direct result of our being responsive to the marketplace and our customers."

The traditional approach to making health insurance premiums more affordable has been to increase co-pays, deductibles, and coinsurance. In an effort to offer employers and members more choices, the new products make use of additional benefit design features to reduce total premiums. Each product overview will describe some of these "new" features.

The new products consist of:

- **BasicBlue® and Group BasicBlue®**
- **MyChoice Blue®**
- **MSA Blue®**

BasicBlue® and Group BasicBlue®.

BasicBlue® and Group BasicBlue® are lower-cost health plans for individuals and groups. Both are designed to offer basic health insurance at a more affordable price and address the need for a lower cost product that provides basic inpatient and outpatient hospital coverage, including physician services, while in those settings.

Plan highlights include inpatient and outpatient care, physician services, catastrophic major medical coverage, and ambulance and emergency services. In addition, optional riders may be purchased that provide specified benefits for physician office visits and prescription medications.

Benefits:
Below is a summary outline of the basic plan benefits:

- Inpatient Hospital: After copayment, plan pays per-day benefit.
- Outpatient Hospital: After copayment, plan pays 100% of allowable charges.
- Inpatient/Outpatient Physician Services: Plan pays 100% of allowable charges up to annual dollar maximum.
- Catastrophic Major Medical: After $7,500 deductible, plan pays 80% with no annual out-of-pocket coinsurance maximum ($1 million lifetime maximum).
- Open Provider Network: Members can use any provider, but the members can save money by selecting a provider in the ***Blue Book***. For other providers, the member will be responsible for any amount over the predetermined fees.

(For some of the basic plan benefits listed above, the patient share of the allowable charges is applied to the catastrophic major medical deductible/benefit.)

Riders (Optional):
Physician offices services and prescription drugs are not covered under the base plan. Applicants have the option of purchasing a limited physician office rider and/or a limited prescription drug rider.

- Physician Office Visits: After copayment, plan pays 100% up to an annual dollar maximum.
- Prescription Drugs: After deductible, plan pays percentage per calendar year.

BasicBlue®
Arkansas Blue Cross and Blue Shield
An Independent Licensee of the Blue Cross and Blue Shield Association

Group BasicBlue®
Arkansas Blue Cross and Blue Shield
An Independent Licensee of the Blue Cross and Blue Shield Association

MyChoice Blue®:

MyChoice Blue® is a PPO product that is designed for employers of any size — from 2 to 2,000 employees — with a more predictable premium cost, while offering each employee the freedom to choose from among four separate benefit designs. Each employee can choose a different option, based on the benefits and cost that best fit his or her needs.

The four distinct plans all include a comprehensive Preferred Provider Organization (PPO) network, office visit co-payments for both primary care physicians and specialists, preventive care, prescription drug card, inpatient and outpatient services, full range of ancillary services, and treatment for emergency medical conditions at the in-network benefit level. Each plan has a different deductible and different benefit limits for select services.

Benefits:
The following services have benefit limits:

- Office visits co-payments.
- Outpatient and Office x-rays.
- Physical Therapy, Occupational Therapy and Speech Therapy.
- Home Health Visits.
- Durable Medical Equipment.
- Inpatient and Outpatient Mental Health and Substance Abuse.
- Adult Preventive Services are covered under all four plans. They are paid the same as services for illness and not as an enhanced benefit

Office visits are always a covered service. There are, however, limits on the number covered under the copay. Visits over the limit are subject to deductible and coinsurance.

The office visit copay will cover a visit to a PPO physician's office that includes a face-to-face exam/evaluation/consultation. In addition, laboratory, x-ray, diagnostic tests, and routine injections performed on that day and billed on the same claim, by the same provider, will be covered by the copay.

The office visit copay is not intended to cover the expensive treatments now available in a physician's office such as surgeries and chemotherapy. All other services will be subject to deductible and coinsurance. Services in the physician's office that are not accompanied by an exam will also be subject to coinsurance and deductible.

MyChoice Blue® will not make network exceptions for lack of geographic access, inability to get timely treatment, services performed at an in-network facility by an out-of-network provider, or for any other reason. To minimize the patient's out-of-pocket expense, it is very important that providers refer members to in-network providers whenever possible.

MSA Blue®:

MSA Blue® is a high deductible product that conforms to federal regulations allowing participants to set up tax-preferred Medical Savings Accounts (MSA). The medical savings account may be used to pay certain non-reimbursed medical expenses, and the amount in the fund can build up year to year.

This plan is a comprehensive major medical (CMM) plan not tied to the Arkansas' FirstSource PPO, and generally covers all services covered under a traditional CMM plan (check AHIN for additional benefit information). There are no wellness benefits, can be implemented without an office visit co-pays, and accidents are covered as any other illness (subject to deductible).

Beginning in 2003, these plans will have a $2,500 annual deductible for individual coverage and a $4,500 deductible for family coverage. The family deductible can be satisfied by one person or any combination of covered family members (this also applies to the stop-loss provision for family coverage).

Benefits:

- Pays covered medical and prescription claims at 80 percent,
- Employer-sponsored health plan,
- Offers deductibles of $2,500 (individual) and $4,500 (family),
- Receives the benefit of negotiated provider discounts with unrestricted choice of providers, and
- Offers a lower, more affordable premium.

Product Information:
To find out more about these three new products, contact the local Arkansas Blue Cross and Blue Shield office, an authorized insurance agent, or visit our Web site at www.ArkansasBlueCross.com.

Arkansas State Employees and Public School Employees (ASE/PSE):

Primary Care Physician Survey:

In September 2002, Enterprise Development Services conducted a survey, to measure Primary Care Physician (PCP) satisfaction with Health Advantage services. The following report details the approach and results.

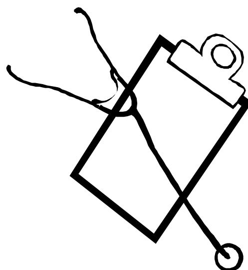
Survey Methodology

- 100% of the Health Advantage PCP network received the survey, including 787 individual and PCP clinics.
- Of the 787 PCPs surveyed, 365 (46.4%) responded.
- The survey contained five questions on Health Advantage services.

Results

Responses to all survey questions are favorable with each of the rated questions scoring a mean of at least 4.0.

- On a scale of 0 to 5, where 5 is very satisfied with Overall experience with Health Advantage, 96 percent of respondents gave Health Advantage a rating of 3 or higher.
- On a scale of 0 to 5, where 5 is very satisfied that claims were handled accurately by Health Advantage, 94 percent of respondents gave Health Advantage a rating of 3 or higher.
- On a scale of 0 to 5, where 5 is very satisfied that claims were handled timely by Health Advantage, 94 percent of respondents gave Health Advantage a rating of 3 or higher.
- On a scale of 0 to 5, where 5 is very satisfied that the answers provided by Health Advantage Customer Service were accurate, 95 percent of respondents gave Health Advantage a rating of 3 or higher.
- On a scale of 0 to 5, where 5 is very satisfied that the inquiries provided by Health Advantage Customer Service were handled promptly, 94 percent of respondents gave Health Advantage a rating of 3 or higher.



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Code Updates:

CPT Code 76950:

Effective April 1, 2003, the reimbursement for CPT 76950 (ultrasonic guidance for placement of radiation therapy fields), will be:

Total component - $99.67
Professional component - $44.82
Technical component - $54.85

Modifier – 59:

Modifier – 59 is used to indicate a distinct procedural service. Based on a recent review of claims it appears Modifier – 59 is being used inappropriately.

CPT describes Modifier - 59 as follows: "Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier - 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or service, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

However, ***when another already established modifier is appropriate, it should be used rather than Modifier - 59.*** Only if no more descriptive modifier is available, and the use of Modifier - 59 best explains the circumstances, should Modifier - 59 be used."

Modifier - 78:

Services submitted with Modifier - 78 will be reimbursed at 70% of the usual allowance for the procedure. Per the 2002 CPT manual, Modifier - 78 is used to indicate a service performed by returning to the operating room for a related procedure during the postoperative period. These guidelines apply to both ABCBS Regular Business and Blue Card claims.

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Current Perception Threshold Testing:

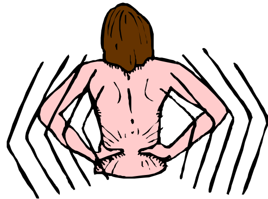
Some providers are performing *Current Perception Threshold* testing and billing the services with CPT codes from the 95900 – 95936 range. This is inappropriate billing as there is no specific CPT code for this testing.

Also, the new HCPCS code G0255 (current perception threshold/sensory nerve conduction test (sNCT), per limb, any nerve), will be denied as investigational based on the current ABCBS coverage policy.

Education Program – Low Back Pain:

Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas continue to develop community-based programs with a focus on our members—and your plan of care. As a part of this effort, the next in our series of Health Education Programs, the Low Back Pain Education Program is now available to our members.

This program is focused on members who have had medical claims submitted with diagnoses associated with acute low back pain who are at risk of progressing to chronic low back pain and members who have progressed to chronic low back pain but have not experienced surgical intervention.



Our community-based, disease-specific education programs emphasize self-management techniques, member communication with their physician, and include national and local health education resources and assistance with member health plan benefits.

The program starts when the member signs and returns the enrollment form which gives us permission to discuss the member's health information with you and other health educators.

Program highlights include:

- A voluntary telephone health survey with a customized report based on the member's response.
- One-on-one contact with a regional registered nurse case manager based on risk stratification.
- National health information resource list of website locations and toll-free numbers regarding back pain.
- Health Education information developed in collaboration with physicians addressing lifestyle changes with exercise, smoking cessation, weight management/nutrition and medication.
- Health Education information developed in collaboration with physicians regarding treating a back attack, risk factors for back pain, causes of and coping with back pain, good back habits, exercise for prevention and protection, strengthening the back, and protection of the back at work.
- A free gift to help in managing Low Back Pain.

Please contact your local case manager if you treat a member who would benefit from this program or if you have questions regarding the program. 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.

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Federal Employee Program (FEP):

Benefit Changes for FEP:

Effective for dates of service on or after January 1, 2003 the following benefit changes will be implemented for the Federal Employee Program:

- Preferred providers and participating providers will accept 100% of the Plan allowance as payment in full for covered services. This applies even when members have other coverage.

Cardiac Rehabilitation:

- Prior approval for cardiac rehabilitation services (Procedure code 93797 and 93798) will no longer be required under both Options as long as the care follows Medically Necessary guidelines for cardiac rehabilitation services.

Colonoscopies:

- Benefits for colonoscopies, for routine services, will now be provided.
- Colonscopies, billed with a preventive diagnosis code, will now be allowed as a surgical benefit when the following procedure codes are billed with a Preventive only diagnosis code.
  - Ø **Procedure codes:** 45355, 45378-45380, 45382-45385, 45387, G0105 or G0121.
  - Ø **Diagnosis codes:** V41, V41.0, V41.2, V62.0-V626, V65, V65.0-V65.4, V65.40, V65.41, V65.43-V65.45, V65.49, V65.5, V65.8, V65.9, V72, V72.0 or V72.1.

Barium Enemas:

- Double Contrast Barium Enema (DCBE) procedure code 74280 will be covered as a colorectal cancer screening under both options regardless of frequency diagnosis, or age when services are performed by a preferred provider or facility. The applicable co-payments will apply to the office visit/exam.

- Double Contract Barium Enema (DCBE) – covered as Preventive Adult Care when services are provided by a Participating or Non-participating provider under Standard Option:
    - Ø DCBE procedure code 74280 as a Preventive benefit for member's age 50 or greater once every 5 years.

Fasting Lipoprotein Profile

- Preventive benefits for fasting lipoprotein, (total cholesterol, LDL, HDL, and triglycerides) when performed by a Preferred provider or any independent laboratory as part of a routine physical examination will now be provided.

FEP:
Blue Quality Center for Transplant (BQCT):

Effective January 1, 2003, Blue Quality Centers for Transplant (BQCT) (a national network of credential hospitals providing services for a select group of transplant types) will be included as part of the FEP Preferred Provider Organization (PPO).

Benefits will be provided at the Preferred benefit level for all BQCT transplant services regardless of the BQCT contract status with the Blue Cross and Blue Shield Plan. This change is limited to covered transplant services rendered on and after January 1, 2003, when FEP is paying as the Primary Carrier. However, there is not a BQCT in the state of Arkansas.

For additional information contact Stephenie Beene, R.N., C.C.M., FEP Case Management Coordinator at (501) 378-2074.

FEP:
Cardiac Rehabilitation Services:

For FEP, Cardiac Rehabilitation Services are considered medically necessary for the following:

- Acute myocardial infarction (AMI-Heart Attack)
- Coronary artery by bypass draft (CABG) surgery
- Percutaneous transluminal coronary angioplasty (PTCA)
- Heart valve surgery
- Heart transplantation
- Stable angina pectoris
- Compensated heart failure
- Procedures that meet certain criteria based on clinical review by the case manager and clinical information from the referring physician.

FEP:
Directory Update: Dental Fee Schedule:

In the recent FEP 2002-2003 Service Benefit Plan Directory of Network Providers (pages 78 & 79) and Supplement (pages 14 & 15), an error was made in the Standard Option Preferred Dental Network Fee Schedule and Maximum Allowable Charges – 2003. The correct MAC (Maximum Allowable Charges) amounts for the dental codes are listed below.

Dental Code	MAC
D1203	$13.00
D1204	$15.50
D1205	$40.00
D9220	$300.00

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FirstSource PPO Group:
Wellness Benefits:

For the FirstSource PPO Group, effective for dates of service November 1, 2002 and after, Wellness benefit services provided by a PPO provider filed with one of the diagnosis listed below will be paid at 100% up to $500 per calendar year. Services provided by a non-PPO provider with one of the diagnosis listed will pay at 80% and apply toward the same $500 maximum.

Diagnosis Codes:

V03.3	V25.1 - V25.2	V72.3
V03.5 - V03.89	V25.4 - V25.8	V72.5
V04.0 - V04.6	V45.5 - V45.52	V72.6
V04.8	V64.0	V76.1 - V76.44
V05.3 - V05.8	V65.4 - V65.49	V76.47
V06.1	V70	V76.51
V06.3 - V06.5	V70.0	V76.52
V20.2	V72.0	V77.0 - V77.7
V25.0 - V25.02	V72.1	V77.9 - V77.91

Health Advantage:
Open Access POS Plans

Remember that if a member has "Open Access" on their ID card, they may see any participating provider without a referral from their Primary Care Physician (PCP). The "Open Access" product allows a member to seek services from a specialist without obtaining a referral from their PCP as long as the specialist is an in-network provider.

With "Open Access", members do not have to choose a PCP. Even if members have a PCP listed on their ID card, they may see any participating PCP.

HIPAA:

Due to Arkansas Blue Cross and Blue Shield's effort to meet HIPAA compliance, future dates of service are no longer allowed (i.e. a span of dates that exceed the current date) on a claim. ABCBS will reject the claim. Providers will be required to refile at the end of the date range for the services.

HIPAA Compliant Claims Software:

ABCBS will be offering a new HIPAA compliant HCFA 1500 electronic claims software package (QIKCLAIM) sometime in April 2003.

QIKCLAIM will have three integrated modules.

- The first module allows for Medicare Part B electronic claims submission and will be offered at a one-time fee of $25.
- The second module will allow for the electronic transmission of ABCBS, Health Advantage, Blue Advantage, First Source (Access Only Groups), Federal Employee Program, and Blue Card claims at a one-time fee of $200.
- The third module allows for the electronic transmission of Arkansas Medicaid claims at a one-time fee of $200.

Once QIKCLAIM is ready for distribution, a form will be available on our web sites www.ArkansasBlueCross.com and www.arkmedicare.com. Providers must complete and submit the online order form then print and mail the completed form to:

Arkansas Blue Cross Blue Shield
EDI Department
Attn: Helen Hall
P.O. Box 2181
Little Rock AR 72203-2181

Current AHIN users are not required to obtain and use QIKCLAIM. AHIN Direct Data Entry (DDE) users may want to utilize QIKCLAIM for batch claims submission and continue to use AHIN for claims correction, claims status, and eligibility.

If you have questions, please contact the EDI Department of Arkansas Blue Cross and Blue Shield at (501) 378-2419 or toll-free at (866) 582-3247.

Home Infusion Therapy - New Contracts:

Arkansas Blue Cross and Blue Shield, Arkansas' FirstSource PPO, and Health Advantage have made changes to their home infusion therapy services (HITS) network as of December 1, 2002.

The following HITS providers are PPP, PPO and HMO network participants effective December 1, 2002:

- Advanced Home IV
- Christus St Michael Ambulatory Care Pharmacy
- American Home Patient
- Baptist Medical Towers Pharmacy
- Health Way of Searcy, Inc
- Home IV Specialists, Inc
- LinCare United Medical IV Pharmacy
- Vital Care Infusion Specialists

If a patient is receiving care from a HITS provider who is no longer in network, this care needs to be transitioned to an in network provider. Please contact your region's case management department to establish a transition plan.

The new contract requires the usage of a new coding structure, primarily using S codes. Beginning January 1, 2003, ABCBS will be rejecting all local codes that have been associated with our HITS contracts in the past. If you have any HITS claims for dates prior to December 1, 2002, they need to be filed before January 1, 2003 or those local codes will be rejected.

As of December 1, 2002, all HITS claims require the use of the new coding structure. These coding changes are necessary as we strive to meet HIPAA regulations.

If you have any questions, please contact Provider Network Operations at 501-378-2006

Marvin Named Associate Medical Director

Peter M. Marvin, M.D., *F.C.C.P., a pulmonary medicine physician from North Little Rock, has been named as associate medical director for the Arkansas Blue Cross and Blue Shield enterprise.

As associate medical director, Marvin will assist the medical director in providing professional and technical counsel designed to promote effective operation of existing and future services. The associate medical director also contributes to improved services for members and health care providers. Marvin will review and advise on coverage policies, provider profiling methodology, quality and outcome measurement, and provider communication issues.

Prior to joining Arkansas Blue Cross in August, Marvin was in private practice in Pulmonary Medicine in North Pulaski County. At Baptist Health North Little Rock (formerly Baptist Memorial Medical Center), he served as medical director for the Intensive Care Unit, the Respiratory Therapy Department, Clinical Effectiveness and Sleep Laboratory; served as co-director of Nutritional Support Services; as a member of the Ethics Committee; and as chief of staff. Marvin also is a former chest clinician with the Arkansas Department of Health.

A native of Arkansas, Marvin received his bachelor's degree from Brown University in Providence, Rhode Island and a master's degree in Pharmacology from the University of Arkansas for Medical Sciences. Marvin completed his medical degree and internship in General Medicine at UAMS. He completed his residency in Internal Medicine at UAMS and the John McClellan Veterans Hospital in Little Rock. He completed a fellowship in Pulmonary and Critical Care Medicine at UAMS and the VA.

Marvin is certified in Internal Medicine with a subspecialty certification in Pulmonary Disease. He is a member of the Alpha Omega Alpha Medical Honor Society, a fellow of the American College of Chest Physicians, a member of the Arkansas Medical Society, the Southern Medical Association, and American Academy of Sleep Medicine. Marvin and his wife, Lori, have five children.

**PLEASE NOTE: Fellow of the College of Chest Physicians (F.C.C.P.) — granted by the American College of Chest Physicians to recognize research, teaching and practice contributions.*

Physician Fee Schedule Available on AHIN:

In an effort to provide more information to our participating physicians, we are happy to announce that the ABCBS Physician Fee Schedule is now available on AHIN (Advanced Health Information Network).

Please note that this fee schedule is not new and does not represent a change in the ABCBS physician fee schedule. This document merely makes available the ABCBS physician fee schedule as of November 2002. Fee schedule amounts and/or procedure codes can change without notice. An attempt will be made to update this document as changes occur. However, updates will continue to be published in "Providers' News."

After you have logged onto AHIN, just click on "Bulletin Boards" and then on "Fee Schedule." You can search for a particular code on AHIN by using the binocular icon in the toolbar. Once you click the icon, a dialog box will appear. Type in the procedure code for which you wish to search, and click the Find button. If the code is listed in this document, you will automatically be taken to the section of the document containing the code and the code will be highlighted. If the code is not listed, the application will indicate "not found".

Pages of the fee schedule can be printed using the printer icon in the tool bar. **Be sure to indicate which page(s) you want to print or the entire fee schedule will print.**

The physician fee schedule is also available on CD in an Excel format for $125. Please note that this CD will not contain updates made after November 2002. Updates will continue to be published in "Providers' News."

If you would like to order a copy, please send a written request, make your check payable to Arkansas Blue Cross and Blue Shield, and mail to:

Provider Network Operations Division
P. O. Box 2181
Little Rock, AR 72203

Please be advised that existence of a procedure code or fee schedule amount does not mean, nor intend to convey, that a service is covered, payment will be made, or that a particular amount will be allowed.

If you don't have access to AHIN, please call 501-378-2419 or toll free at 1-866-582-3247 for information.

Platelet Derived Growth Factors

Arkansas Blue Cross Blue Shield has recently seen a number of claims for treatment of chronic wounds with autologous platelet derived growth factors.

Claims for this service have been billed with the following CPT codes:

- Ø 15000: Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100-sq. cm or one percent of body area of infants and children.
- Ø 20926: Tissue grafts, other (eg, paratenon, fat, and dermis).

AMA CPT Information Services was queried about the correct billing for autologous platelet grafting for wound care with receipt of the following information: "There is not a specific CPT code that accurately describes autologous platelet grafting for chronic wound care."

Therefore, the unlisted code 17999 (unlisted procedure, skin, mucous membrane, and subcutaneous tissue), should be reported. The use of an unlisted code does require the submission of a procedure note. However, the use of autologous platelet derived wound healing formulas is considered investigational and is not a covered service.

Timely Filing Reminder:

Under the new Provider agreements, claims must be filed within 180 days of the date of service to be eligible for payment. Services not filed timely will be denied and the non-allowed amount may not be billed to the member.

USAble Administrators: Adopts New "Blue" Name:

To better identify USAble Administrators as a Blue Cross and Blue Shield affiliated company that provides third-party administrative services to Arkansas companies and their employees, the company changed its name effective November 19, 2002 to BlueAdvantage Administrators of Arkansas.

Only the name is changing. Everything else – customer service, staffing, addresses, phone and fax numbers – will remain the same. Replacement I.D. cards bearing the new name and logo will be reissued to members later this year and in early 2003.

Effective November 19, 2002, the USAble Administrators Web site, www.USAbleAdminArkansas.com, has been changed to www.BlueAdvantageArkansas.com. The new address will take you to many helpful services found on the Web site.

BlueAdvantage Administrators is Arkansas' largest third-party administrator, serving more than 120,000 employees and their family members. The company processes claims and administers enrollment, as well as, benefits for self-funded groups. Each self-funded group provides the funds from which its employees' claims are paid. The company is an independent licensee of the Blue Cross and Blue Shield Association and is licensed to offer administrative services in all 75 counties in Arkansas.

BlueAdvantage
Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

USAble Life: Assumption of First Pyramid Life Business

As of 10/01/02, the Texas Department of Insurance has approved the assignment of all existing First Pyramid Life Insurance Company of America policies in Texas to USAble Life. This assignment will not affect the group health insurance benefits in any way. The same terms and conditions will apply to the policy.

ABCBS is currently in the process of issuing new Identification Cards to all members. During this transition, however, you may see members with cards displaying either USAble Life or First Pyramid Life logos on their ID Cards.

AHIN will not be effected by this change. Providers will continue to file claims through the same process and access patient eligibility information in the same fashion. For assistance, contact the Customer Service division at (800) 470-9621 or (870) 773-2584.

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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