Arkansas Blue Cross and Blue Shield

Providers' News

December 2003

Inside the December Issue:

Please Note:

This newsletter contains information pertaining to Arkansas Blue Cross and Blue Shield, 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.

Fee Schedule Update:

Effective March 15, 2004, Arkansas Blue Cross and Blue Shield will convert to the 2004 Medicare Relative Value Units.

Effective December 15, 2003, the Arkansas Blue Cross and Blue Shield Fee Schedule, for codes that have relative value units, will be available on AHIN.

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Interactive Voice Response System — Your Questions Answered 24 Hours a Day, 7 Days Per Week:

Arkansas Blue Cross and Blue Shield, Arkansas' FirstSource, and Health Advantage are happy to announce the availability of the new Interactive Voice Response System (IVR).

The new IVR system recognizes common English to answer questions when you call the customer service telephone numbers. Please continue to call the Arkansas Blue Cross and Blue Shield or Health Advantage Customer Service phone number. When you call, the new IVR system will immediately answer.

By simply responding to the questions asked by the system — with no buttons to push — you can get questions answered quickly and easily without having to wait.

In order to access the IVR system, providers will need their 5-digit Arkansas Blue Cross and Blue Shield provider number. Please continue to call the Arkansas Blue Cross or Health Advantage Customer Service phone number.

The new IVR system will be able to help with questions about eligibility, benefits, and you can check on the status of a claim. During regular business hours, you can request — at any time during the telephone call — to speak to the next available customer service representative. The new IVR system is there when you need quick answers to simple questions and is available 24 hours a day, seven days a week.

Access to the IVR system using BlueAdvantage Administrators of Arkansas customer service lines will be available in early 2004.

Social Security Number — Based Member Identification to be Eliminated in 2004:

Due to escalating identity theft problems, several states have passed laws restricting the usage of Social Security numbers. Recognizing this as a local concern, Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas are currently making efforts to migrate away from ID cards that include members' Social Security numbers.

Arkansas Blue Cross, BlueAdvantage, and Health Advantage will begin the migration away from using Social Security numbers as part of the member number during 2004. All member ID numbers will continue to begin with a character prefix.

Please note that it is essential for prompt claim processing to submit the current member number located on the ID card. Always ask to see a member's card whenever healthcare services are requested and enter the ID number on the claim exactly as it appears on the card. We will also be utilizing the newly assigned member numbers within AHIN workstations, the Integrated Voice Response (IVR) system, as well as in our Customer Service areas.

This migration will be phased-in with various employer groups being impacted at different times. Additional communication will be forthcoming as we approach the first implementation phase of this migration.

Pharmacy - Raptiva®: Coverage Policy, and Claims Filing Policies and Procedures:

Genentech has recently introduced a new medication, Raptiva®, with FDA approval for use in treatment of moderate to severe plaque psoriasis in adults who are candidates for the systemic therapy.

The yearly treatment cost for the medication for one patient is approximately $18,000 (based on the listed average wholesale price). In order to help manage the cost of the new medication for our members, Arkansas Blue Cross and Blue Shield has established a preferred pharmacy relationship with Advance PCS Specialty RX.

Providers will bill Arkansas Blue Cross for only the administration of the medication. Under all Arkansas Blue Cross policies that include prescription drug benefits, prescription medications must be obtained from a participating pharmacy in order to be covered. Under the Preferred Payment Plan ("PPP") participation agreement, Arkansas Blue Cross has established an allowance for Raptiva® administered by physicians.

Blue Cross and Blue Shield has established the following specific Allowance and Coverage policy and specific claims filing policies and procedures for Raptiva®:

1. Prior approval of coverage is required. Call the prior authorization number, (501) 378-3392, for eligibility verification and to arrange the pharmacy contact for dispensing the medication.
2. Upon receipt of a prescription, AdvancePCS Specialty RX will dispense and ship the medication to the member prior to the scheduled administration.
3. AdvancePCS Specialty RX will bill Arkansas Blue Cross (or one of its affiliates, or by a self-funded group health plan accessing an affiliate's network) for the cost of the medication.

Please note:
The affiliates and subsidiaries of Arkansas Blue Cross and Blue Shield, specifically, Health Advantage, BlueAdvantage Administrators of Arkansas, and USAble Corporation have elected to receive the benefit of the Preferred Payment Plan agreement with respect to the allowance for Raptiva®, as well as the claims filing policies and procedures for Raptiva® outlined above.

Pharmacy - Proton Pump Inhibitor Changes:

The recent action regarding the FDA approval of Prilosec® 20 mg for over-the-counter use as Prilosec® OTC has resulted in changes of coverage for the PPI class of drugs by Arkansas Blue Cross, Health Advantage, and all other pharmacy plans managed by Arkansas Blue Cross and Blue Shield.

The following proton pump inhibitor changes were effective Nov. 15, 2003:

- Aciphex® - Not covered
- Nexium® - Not covered
- omeprazole - Not covered
- Prevacid® - Covered (3rd Tier Copay)
- Prilosec® - Not covered
- Protonix® - Covered (3rd Tier Copay)

GI Endoscopy and Anesthesia:

American Gastroenterology Association guidelines for anesthesia during gastrointestinal endoscopy states:

> "The routine assistance of an anesthesiologist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted and is cost prohibitive."
>
> "Sedation-related risk factors, the depth of sedation, and the urgency of the endoscopic procedure all play important roles in determining whether or not the assistance of an anesthesiologist is needed. The sedation-related risk factors include: Significant medical conditions such as extremes of age, severe pulmonary, cardiac, renal or hepatic disease, pregnancy, the abuse of drugs or alcohol, uncooperative patients or potentially difficult airway of intubation."

The supervision of conscious sedation is included in the physician work of endoscopy. Thus, when this work is delegated to an anesthesiologist or CRNA, the reimbursement for the endoscopy will be reduced by $75.00.

Code Changes and Updates - CPT Code 94150:

CPT Code 94150, Vital capacity, total (separate procedure), will no longer be reimbursed.

Studies indicate that CPT code 94150 is being billed for vital capacity results obtained from peak flow meters and hand-held spirometers that do not provide a written record, and no official interpretation is provided (CPT-4 indicates that any pulmonary function test requires a written interpretation).

CPT Assistant indicates that studies done with peak flow meters are included in the E&M service provided that same day. If the testing is done with a device that measures a timed vital capacity and expiratory flow measurements, the procedure should be billed with CPT Code 94010.

Claims for Newborns:

Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas encourages its' members to enroll their newborn as quickly as possible to avoid delays in claims processing.

Before submitting claims for newborn services, please check AHIN for eligibility or call the appropriate customer service area for verification. If the newborn has not been added, please remind the baby's parent to submit an application through their employer or directly to Blue Cross if they are on an individual policy.

On fully-insured groups, Arkansas State law allows 90 days from the date of birth to enroll a newborn. However, for self-insured groups, enrollment requirements may vary by plan.

HITS — Code Additions and Deletions:

Since Home Infusion Therapy (HITS) contracts became effective in December 2002, several coding additions and deletions have been made to the fee schedule. An updated fee schedule for HITS providers can be located on pages 16 - 19. Please notice that this update is a mixtures of new codes and deleted codes, as well as codes that have been added to further clarify the coverage of the home infusion therapy services.

HIPAA: Most Frequent Claims Billing Errors:

Many providers, clearinghouses, and billing agents have successfully passed HIPAA claims testing with Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas. A large percentage of these have begun submitting production claims in the new HIPAA-standard electronic claims format.

However, if changes are made to the submitter's system, problems may still occur in production that were not experienced during testing or were corrected during testing. Unexpected consequences are being seen such as delays in claim processing, denials, or claims needing to be completely resubmitted.

The most common errors seen after a provider begins submitting HIPAA claims in production are:

1. Failing to include the rendering provider. The rendering provider (service provider) is required when it is different from the Billing or "Payto" provider. Most frequently, this problem occurs during submissions from a Group Practice or Clinic where no service provider is included on the claim. Failure to include the service provider from a Group Practice, except in certain instances, will cause claim denials.
2. Failing to include the "Payto" provider. The Group Practice or Clinic number (Payto provider) should be included on the claim in the 2010AA loop when the services are provided by an individual provider within that clinic.
3. Sending an incorrect qualifier. The EDI User's Guide will clarify proper submission.

The majority of these issues have been seen from billing agents and clearinghouses. Please relay this information to those vendors that handle claims processing for your organization.

Before systems changes are implemented, additional test files should be submitted to ensure the files will pass validation and processing edits. Also, please ensure these vendors are validating provider numbers prior to claims submission.

Consulting the current Arkansas Blue Cross EDI Users Guide and Companion Document will help avoid unnecessary delays. A copy of the guide is available at www.arkmedicare.com

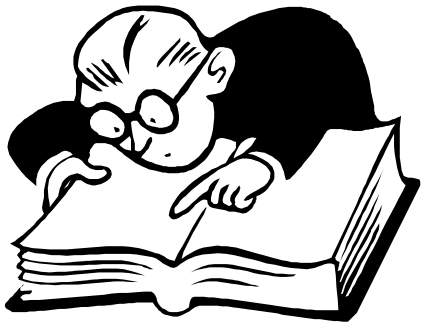
Coverage Policy Manual Revisions:

Over the past few months, Arkansas Blue Cross and Blue Shield has added new policies and /or made revisions to current policies in the "Coverage Policy Manual".

New / Updated policies include:

- High-dose chemotherapy & autologous stem &/or progenitor cell support for treatment of germ cell tumors
- Antithrombin III replacement
- Immune globulin, intravenous
- Iron therapy, parenteral
- Autologous chondrocyte implantation
- Cochlear implant
- Intradiscal electrothermal therapy
- Prophylactic oophorectomy

The purpose of the Coverage Policy Manual is to inform members and their physicians why certain medical procedures may or may not be covered under Arkansas Blue Cross and Blue Shield insurance contracts or health plans. Coverage Policies are currently available at ***www.ArkansasBlueCross.com***.



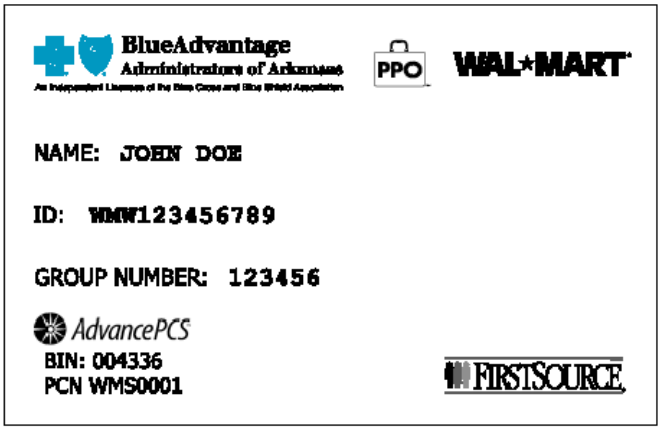
BlueAdvantage Administrators of Arkansas to Begin Processing Wal-Mart Claims in 2004:

Effective January 1, 2004, BlueAdvantage Administrators of Arkansas will assume third-party administration responsibility for Wal-Mart associates in Arkansas, Missouri and Kansas. In August 2003, BlueAdvantage began processing claims for Wal-Mart associates in Oklahoma.

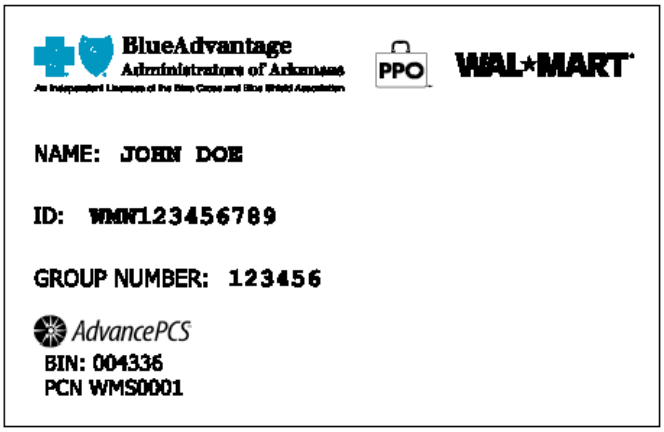
Wal-Mart has contracted with BlueAdvantage to administer the medical plans of Wal-Mart associates by providing network access, handling claims administration and offering customer service.

Wal-Mart associates have two medical plan options:

- **The Network Dollar Saver Plan** – On this plan, associates commit to using only PPO providers and facilities. Eligible claims are paid at 80 percent. If out-of-network providers are used, eligible claims are paid at 60 percent. Associates on the Network Dollar Saver Plan will have the Arkansas' FirstSource PPO logo on their ID card (as shown below).



- **The Network Plan** – If network hospitals are used, eligible claims are paid at 80 percent. When out-of-network providers are used, claims are processed at regular levels. However, expenses that exceed the network allowed amount will be the responsibility of the associate. The Network Plan includes PPO facilities and any physician from the Blue Book. The ID card for Wal-Mart associates with the Network Plan is shown below.



BlueAdvantage will be using CodeReview edits when processing claims for Wal-Mart associates. As a reminder, CodeReview is a system that assists the claims processor in evaluating the accuracy of submitted CPT codes by using its clinical knowledge base to detect, correct, and document coding inaccuracies on CPT-4 coded claims. CodeReview is based upon the American Medical Association (AMA) CPT-4 guidelines. CodeReview was described in greater detail in the March 23, 1998, edition of *Providers' News.*

Please submit all claims incurred during 2003 through your current process. Beginning January 1, 2004, all Wal-Mart claims will be processed by BlueAdvantage. To reach BlueAdvantage call toll-free 1-(866)-823-3790, or by mail at:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203-1460

FluMist — Coverage Guidelines:

Effective January 1, 2004, the Arkansas Blue Cross and Blue Shield insurance policies, Health Advantage evidences of coverage and some self-insured group health plans administered by BlueAdvantage Administrators of Arkansas, which provide coverage for the influenza vaccination, will be amended to provide coverage for intranasally administered influenza vaccine, popularly know as “FluMist.”

The contracted benefit for FluMist is subject to an annual limitation of $15, the cost of a preservative-free intramuscular injection of influenza vaccine. For members who use this benefit, please remember that your physician may “balance-bill” you. That means that members will be responsible for any amount in excess of the reimbursement by their health plan.

FluMist is a nasal-inhaled flu vaccine. There is no evidence that FluMist has more or less benefit than the injectable flu vaccine. The decision to use this drug is between the member and their care provider.

Federal Employee Program (FEP):

CMS 1500 Physician Claim Form:

In order to process your CMS 1500 claim successfully please follow the guidelines below:

- Block 2 Patient's name (Last name, First name). Make sure the patient’s name is completed accurately and enter the name exactly as given by the authorized person, patient or member. Do not use nicknames. Effective January 1, 2004, we will no longer correct this field.
- Block 3 Patient's date of birth. Please enter this information exactly as stated by the authorized person patient or member. Effective January 1, 2004, we will no longer correct this field.
- Block 4 - Insured's name (Last name, First name). Make sure the Insured’s name is completed accurately. Please enter the name exactly as it appears on the member’s card. Please do not use the terms "same" or "self" if the insured's name is the same as the patient's name.
- Blocks 10 and 14 — should be completed when patients are seen in the clinic due to an accident.
- Blocks 24D — use valid current procedure codes and modifiers
- Block 24K — provide the performing provider's number assigned by Arkansas Blue Cross and Blue Shield.
- Block 33 — provide the billing provider's number in the GRP# field.

Claims are returned when incorrect information is submitted.

Federal Employee Program (FEP):

CMS 1450 Hospital Claim Form:

Please follow the guidelines below in order to process your CMS 1450 claim successfully:

- Use a **Red** CMS 1450 or UB-92 claim form.
- Use the correct *Type of Bill*.
- Do not hand write or put comments on claims.
- All data must be contained within its defined area.
- Block 12 Patient's name (Last name, First name). Please make sure the patient's name field is completed accurately. Please enter this name exactly as given by the authorized person, patient or member. Do not use nicknames. Effective January 1, 2004, we will no longer correct this field.
- Block 14 Patient's date of birth. Please enter this information exactly as stated by the member. Effective January 1, 2004, we will no longer correct this field.
- Block 32 occurrence code and date when patients are seen in the outpatient facility due to an accident.
- Block 46: inpatient and outpatient claims must have the number of units listed for each revenue code.
- Block 51: provide the Arkansas Blue Cross and Blue Shield provider number.
- Block 58 Insured's name (Last name, First name). Make sure the Insured's name is completed accurately. Please enter the name exactly as it appears on the card. Please do not use the terms "same" or "self" if the insured's name is the same as the patient's name.

The UB-92 manual (available from the Arkansas Hospital Association) is our guide for completing the CMS 1450 claim form.

Claims are returned when incorrect information is submitted.

Pre-Service Review:

There has been some confusion regarding pre-service versus prior approval. FEP does not give pre-service. However there are some required prior approval services listed in the Service Benefit Plan brochure.

For 2004 benefits, prior approval is still required for Home Hospice or Organ/Tissue Transplant. For more information regarding Home Hospice or Organ/Tissue Transplant, please refer to the September 2002 *Providers' News*.

Services other than Home Hospice or Organ/ Tissue Transplant do not require prior approval and are considered Pre-Service Review. When FEP receives a request for Pre-Service review, we will respond by stating:

"We do not give pre-service review. We do give prior approval for Home Hospice or Organ/Tissue transplant. Since this claim is not for services that require prior approval, the claim will be reviewed for benefits and medical necessity after the services have been rendered."

Federal Employee Program (FEP):

Dental Claims:

When dental services for FEP members are rendered in the state of Arkansas, claims for processing should be sent to:

Arkansas Blue Cross and Blue Shield
Attention: FEP
P. O. Box 2181
Little Rock, AR 72203

FEP does not use United Concordia to process dental claims.

To ensure your dental claim processes successfully, please make sure all fields on the claim are completed accurately.

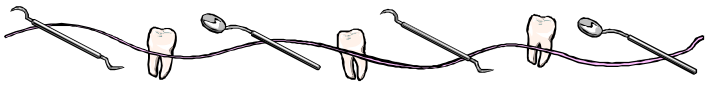
- Patient's name (First name, Last name). Please enter this name exactly as given by the authorized person, patient, or member. Do not use nicknames. Effective January 1, 2004, we will no longer correct this field.
- Patient's date of birth. Please enter this information exactly as stated by the authorized person patient or member. Effective January 1, 2004, we will no longer correct this field.
- Employee/insured name. Please enter the name exactly as it appears on the members' card. Please do not use the terms "same" or "self" if the insured's name is the same as the patient's name.
- Employee identification number. The FEP identification number begins with an "R" followed by 8 digits (Example R12345678).
- Individual provider number. Please use the Arkansas Blue Cross and Blue Shield 5-digit provider number assigned each dentist.
- Use valid current CDT procedure codes.

FEP Standard Option - The FEP Dental fee schedule allowance is not intended to be payment in full, but a benefit to offset the provider's charge. Providers who sign a participating agreement with Arkansas Blue Cross and Blue Shield, agree to accept the Arkansas Blue Cross and Blue Shield Dental Fee schedule. (Note: This is the FEP Maximum Allowable charge.) You can bill the members the difference between our fee schedule and the Maximum Allowable Charge. Please refer to the attached FEP Dental Fee Schedule for Standard Option effective March 1, 2003.

FEP Basic Option - Only Preferred providers will be eligible for benefits under Basic Option. If you are a participating dentist for Arkansas Blue Cross and Blue Shield, you are considered a Preferred provider for preventive dental Basic Option services. The member pays a $20 copayment for each evaluation, and we pay any balances up to the Maximum Allowable Charge. Please refer to the FEP Dental Fee Schedule for Basic Option effective March 1, 2003.

The Federal Employee Program Standard and Basic Option also covers treatment for the following services as a medical condition as long as medical necessity guidelines are met:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary;
- Surgery needed to correct accidental injuries to jaws , cheeks, lips, tongue roof and floor of mouth (within 12 months of the injury);
- Excision of exostoses of jaws and hard palate;
- Incision and drainage of abscesses and cellulitis;
- Incision and surgical treatment of accessory sinuses, salivary glands , or ducts, reduction of dislocations and excision of temporomandibular joints;
- Removal of impacted teeth.



Federal Employee Program (FEP):

Standard Option Now Covers Physical or Occupational Therapy Billed From a Chiropractor:

Under Standard Option (104 or 105), benefits have been changed beginning with dates of service January 1, 2002 to allow claims from Chiropractors billing for Physical or Occupational Therapy services.

- Physical Therapy services are limited to 50 visits per person per year. **Benefits are eligible based on your provider status with Arkansas Blue Cross and Blue Shield**
- Occupational Therapy and Speech Therapy services are limited to 25 visits per person per year or a combination of both. **Benefits are eligible based on your provider status with Arkansas Blue Cross and Blue Shield**

Prior to the benefit change, all claims from chiropractors for physical and occupational therapy services were denied. The FEP claims system has now been updated to allow physical and occupational therapy procedures billed from a chiropractor.

If you have a FEP Standard Option patient that had physical or occupational therapy services in 2002 or 2003, please resubmit the claims as a regular claim by December 31, 2004. (Do not submit a corrected claim form). **Any other service billed by a chiropractor other than the physical therapy and occupational procedure codes listed below remain non-covered under Standard Option.**

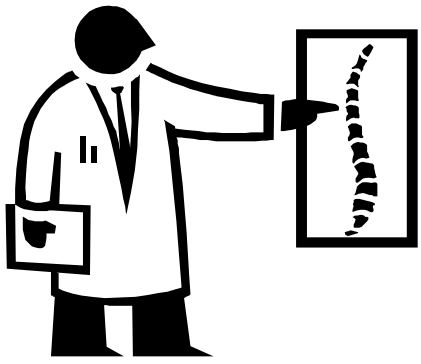
- Arkansas FirstSource Providers are paid at 90% of our allowance subject to the $250.00 calendar year deductible.
- Arkansas Blue Cross and Blue Shield Participating providers are paid at 75% of our allowance subject to the $250.00 calendar year deductible.
- Non-Participating providers are paid at 75% of our allowance subject to the $250.00 calendar year deductible. The member would owe the difference between our allowance and the billed amount.

Covered Physical Therapy Procedure Codes:

97001	97002
Q0086	S9106
S9131	S8901-S8910
S9102-S9104	

Covered, Combined Physical and Occupational Therapy Procedure Codes:

97010	97034	97504
97012	97035	97520
97014	97036	97530
97016	97039	97532
97018	97110	97533
97020	97112	97542
97022	97113	97545
97024	97116	97546
97026	97124	97703
97028	97139	97750
97032	97140	97799
97033	97150	S9091



Federal Employee Program (FEP):

Basic Option Now Covers Physical Therapy or Occupational Therapy Billed From an Arkansas' FirstSource Preferred Chiropractor:

Under Basic Option (111 or 112), benefits have been changed beginning with dates of service January 1, 2002 to allow claims from Preferred Chiropractors billing for Physical Therapy or Occupational services.

- Therapy benefits are limited to 50 visits per person per calendar year for physical, occupational, or speech therapy or a combination of all three. **Benefits are eligible based on your provider status with Arkansas Blue Cross and Blue Shield**

Prior to the benefit change, all claims from chiropractors for physical and occupational therapy services were denied. The FEP claims system has now been updated to allow physical and occupational therapy procedures billed from a chiropractor.

If you are a Preferred Chiropractor and you had a FEP Basic Option patient who had physical therapy or occupational services in 2002 or 2003, please resubmit the claims as a regular claim by December 31, 2004. (Do not submit a corrected claim form).

Participating or Non-Participating chiropractors billing for physical therapy or occupational services are not eligible for benefits. Basic Option providers must be Arkansas FirstSource Preferred Providers to be eligible for benefits.

FEP Basic Option also covers office visits, x-rays, and up to 20 spinal manipulations performed by an Arkansas FirstSource Preferred Chiropractor. Benefits are subject to a $20 copayment.

Covered Physical Therapy Procedure Codes:

97001	97002
Q0086	S9106
S9131	S8901-S8910
S9102-S9104	

Covered, Combined Physical and Occupational Therapy Procedure Codes:

97010	97034	97504
97012	97035	97520
97014	97036	97530
97016	97039	97532
97018	97110	97533
97020	97112	97542
97022	97113	97545
97024	97116	97546
97026	97124	97703
97028	97139	97750
97032	97140	97799
97033	97150	S9091

Federal Employee Program (FEP):

2004 FEP Benefit Changes — Both Standard (104 or 105) and Basic Option (111 or 112):

1. Clinical Trials — The Clinical Trials benefit will be expanded to include autologous bone marrow or peripheral blood stem cell transplants for the following autoimmune diseases: Systemic Sclerosis (SSc), Systemic Lupus Erythematosus (SLE), and Multiple Sclerosis (MS), when performed in specific National Institute of Health (NIH) funded, randomized, multi-center, comparative trials. The definition of Cancer Research Facility will be changed to include NIH-funded clinical trials for the diseases shown above.

2. Maternity Care — Maternity benefits will be available for tocolytic therapy and related services when provided and billed by a Home Infusion Therapy company or a Home Health Care Agency (home uterine monitoring device). Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations for home nursing. Oral tocolytic agents are not covered under the maternity benefit. Previously, benefits for these services were provided under the home infusion therapy benefit and were subject to deductible and coinsurance amounts under the Standard Option and copayments and coinsurance amounts under the Basic Option.

3. Acupuncture — Benefits will no longer be available for acupuncture performed by a physical therapist. These services are not within the scope of licensure for a physical therapist. The 2004 Service Benefit Plan brochure will contain exclusion for "Services you receive from a provider that are outside the scope of the provider's licensure or certification." Benefits will continue to be available for acupuncture provided by a physician for pain control or as a physical therapy modality. Acupuncture as part of anesthesia service may be provided by a physician.

2004 FEP Benefit Changes — Basic Option (111 or 112) Benefit Changes:

- **Preventive Care — Children:**
  Benefits will be provided in full for covered preventive care that children receive from Preferred providers. Previously, these services were subject to either the $20 or $30 copayment.

Federal Employee Program (FEP):

2004 FEP Benefit Changes — Standard Option (104 or 105) Benefit Changes:

1. **Ambulance —** The benefits for covered ambulance transport services, not related to an accidental injury, will be paid at 90% of the Plan allowance, not subject to the calendar year deductible, regardless of the contracting status of the ambulance. The member is responsible for 10% of the Plan allowance and, for non-contracting providers, any difference between the Plan's allowance and the billed charge. Previously, benefits for these services were subject to the calendar year deductible and then paid at 90% or 75%, depending on the contracting status of the provider.

2. **Pharmacotherapy (CPT Code 90862) —** When provided by a Preferred provider, benefits for outpatient pharmacotherapy (medication management) will be provided in full after a $15 copayment. Previously, benefits for these services were paid at 90% of the Plan allowance after the calendar year deductible was satisfied.

3. **Mental Health / Substance Abuse —** Claims submitted with a mental health or substance abuse diagnosis for office visits (no psychotherapy) made to a primary care physician (family practitioners, general practitioners, pediatricians or obstetricians/ gynecologists) will no longer count toward the eight visits allowed prior to obtaining an approved treatment plan. For preferred benefits, prior approval is required before the ninth visit. Call Magellan Health at 1-800-367-0406. Previously, all office visits with a mental health or substance abuse diagnosis counted toward the treatment plan requirement.

4. **Mental Health / Substance Abuse —** Prior approval is no longer required for partial hospitalization or intensive outpatient treatment provided by Non-preferred providers.

Guidelines: How to Bill Same Procedure When Billed Multiple Times on Same Day:

When the same procedure billed with the same charge is done multiple times on the same day, you have a choice on how you can bill the claim.

- Combine like procedures and bill with the correct number of units.

Or

- Use modifier 76 or 77 as applicable. (You can also use any other modifier as needed. Example: procedure code then 26-76.)

Revised Standard Option Dental Fee Schedule:

Due to the deletion of codes by the American Dental Association, attached are the covered Standard Option Dental Fee Schedule. Please be aware the MAC allowances will change in March 2004.

Federal Employee Program (FEP):

FEP Dental Network Fee Schedule & Arkansas Blue Cross and Blue Shield Maximum Allowable Charges (MAC) - March 2003

Dental Code	Service	FEP Fee Schedule Amount Up to Age 13	Age 13 and Over	MAC
	Clinical oral evaluations			
D0120	Periodic oral evaluation*	$ 12.00	$ 8.00	$ 25.00
D0140	Limited oral evaluation	$ 14.00	$ 9.00	$ 33.00
D0150	Comprehensive oral evaluation	$ 14.00	$ 9.00	$ 36.00
D0160	Detailed and extensive oral evaluation	$ 14.00	$ 9.00	I.C.
	Radiographs			
D0210	Intraoral complete	$ 36.00	$ 22.00	$ 70.00
D0220	Intraoral periapical-single first film	$ 7.00	$ 5.00	$ 16.00
D0230	Intraoral periapical-each additional film	$ 4.00	$ 3.00	$ 14.00
D0240	Intraoral -occlusal film	$ 12.00	$ 7.00	$ 19.00
D0250	Extraoral-single film	$ 16.00	$ 10.00	$ 19.00
D0260	Extraoral-each additional film	$ 6.00	$ 4.00	$ 15.00
D0270	Bitewing-first film	$ 9.00	$ 6.00	$ 16.00
D0272	Bitewing-two film	$ 14.00	$ 9.00	$ 26.00
D0274	Bitewing-four film	$ 19.00	$ 12.00	$ 35.00
D0277	Bitewings-vertical-seven or eight films	$ 12.00	$ 7.00	$ 40.00
D0290	Posterior-anterior or lateral skull & facial bone survey film	$ 45.00	$ 28.00	$ 50.00
D0330	Panoramic film	$ 36.00	$ 23.00	$ 60.00
	Tests and laboratory exams			
D0460	Pulp vitality tests	$ 11.00	$ 7.00	$ 20.00
	Palliative treatment			
D9110	Palliative (emergency) treatment of dental pain minor procedures	$ 24.00	$ 15.00	$ 42.00
D2940	Fillings(sedatives)	$ 24.00	$ 15.00	$ 33.00
	Preventive			
D1120	Prophylaxis-Child *	$ 22.00	$ 14.00	$ 30.00
D1110	Prophylaxis-Adult*	$ -	$ 16.00	$ 46.00
D1201	Topical application of fluoride (including prophylaxis) child*	$ 35.00	$ 22.00	$ 43.00
D1203	Topical application of fluoride (excluding prophylaxis) child	$ 13.00	$ 8.00	$ 13.00
D1205	Topical application of fluoride (including prophylaxis) adult*	$ -	$ 24.00	$ 59.00
D1204	Topical application of fluoride (excluding prophylaxis) adult	$ -	$ 8.00	$ 13.00
	Space maintenance (passive appliances)			
D1510	Space maintainer-fixed-unilateral	$ 94.00	$ 59.00	$ 160.00
D1515	Space maintainer-fixed-bilateral	$ 139.00	$ 87.00	$ 160.00
D1520	Space maintainer-removable-unilateral	$ 94.00	$ 59.00	$ 160.00
D1525	Space maintainer-removable-bilateral	$ 139.00	$ 87.00	$ 160.00
D1550	Space maintainer-recementation of space maintainer	$ 22.00	$ 14.00	$ 30.00

*** Limited to two per person per calendar year**

Federal Employee Program (FEP):

FEP Dental Network Fee Schedule & Arkansas Blue Cross and Blue Shield Maximum Allowable Charges (MAC) - March 2003

Dental Code	Service	FEP Fee Schedule Amount: Up to Age 13	FEP Fee Schedule Amount: Age 13 & Over	MAC
	Amalgam restorations (including polishing)			
D2140	Amalgam-one surface, primary or permanent	$ 25.00	$ 16.00	$ 61.00
D2150	Amalgam-two surfaces, primary or permanent	$ 37.00	$ 23.00	$ 77.00
D2160	Amalgam-three surfaces, primary or permanent	$ 50.00	$ 31.00	$ 90.00
D2161	Amalgam-four surfaces, primary or permanent	$ 56.00	$ 35.00	$ 110.00
	Filled or unfilled resin restorations			
D2330	Resin--one surface, anterior	$ 25.00	$ 16.00	$ 73.00
D2331	Resin--two surfaces, anterior	$ 37.00	$ 23.00	$ 92.00
D2332	Resin-three surfaces, anterior	$ 50.00	$ 31.00	$ 108.00
D2335	Resin--four or more surfaces or involving the incisal angle	$ 56.00	$ 35.00	$ 138.00
D2391	Resin Based Composite - one surface posterior	$ 25.00	$ 16.00	$ 85.00
D2392	Resin Based Composite - two surfaces posterior	$ 37.00	$ 23.00	$ 115.00
D2393	Resin Based Composite - Three surfaces posterior	$ 50.00	$ 31.00	$ 136.00
D2394	Resin Based Composite - Four or more surfaces posterior	$ 50.00	$ 31.00	$ 160.00
	Inlay restorations			
D2510	Inlay--metallic--one surface, permanent	$ 25.00	$ 16.00	$ 275.00
D2520	Inlay--metallic--two surfaces, permanent	$ 37.00	$ 23.00	$ 350.00
D2530	Inlay--metallic--three surfaces, permanent	$ 50.00	$ 31.00	$ 415.00
D2610	Inlay--porcelain/ceramic--one surface	$ 25.00	$ 16.00	$ 320.00
D2620	Inlay--porcelain/ceramic--two surfaces	$ 37.00	$ 23.00	$ 400.00
D2630	Inlay--porcelain/ceramic--three surfaces	$ 50.00	$ 31.00	$ 440.00
D2650	Inlay--composite/resin--one surface	$ 25.00	$ 16.00	$ 275.00
D2651	Inlay--composite/resin--two surfaces	$ 37.00	$ 23.00	$ 405.00
D2652	Inlay--composite/resin--three surfaces	$ 50.00	$ 31.00	$ 450.00
	Other restorative services			
D2951	Pin Retention--per tooth, in addition to restoration	$ 13.00	$ 8.00	$ 30.00
	Extractions- includes local anesthesia and routine post-operative care			
D7140	Extraction Erupted Tooth or Exposed Root	$ 30.00	$ 19.00	$ 75.00
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth	$ 43.00	$ 27.00	$ 140.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$ 71.00	$ 45.00	$ 174.00
D9220	General Anesthesia in connection with covered extractions	$ 43.00	$ 27.00	$ 250.00

*** Limited to two per person per calendar year**

FEP Fee Schedule Amount----the amount Standard Option Pays toward a covered dental service.

I.C. -----Individual Consideration

MAC (Maximum Allowable Charge) -----the maximum amount Preferred network dentists will charge you for a covered dental service.

Home Infusion Therapy Services (HITS) Coding Additions and Deletions

2004 HCPCS	Nomenclature	Pricing	Claims Filing/ Coding Policies
	Nursing Services		
99601	Home Infusion/Specialty drug administration, per visit (up to 2 hours)	$95.00 per visit	Do not bill with S9802. Limit to 3 visits per 24-hour period unless approved by Case Manager. Code Effective 1-1-04
99602	Home Infusion/ Specialty drug administration, each additional hour (list separately in addition to code for primary procedure.	$30.00 per hour	Billed only with 99601. Do not bill with S9802 or S9803. Limit to 3 visits per 24-hour period unless approved by Case Manager. Code Effective 1-1-04
S5108 through S5116	Home care training	Not covered under HITS	Deny Codes Effective 1-1-03
S9381	Delivery or service to high risk areas requiring escort or extra protection; per visit	Not covered under HITS	Deny - Code added for clarification 1-1-03
S9460	Nursing visit	Not covered under HITS	Deny Code added for clarification
S9524	Nursing Services related to Home IV Therapy, Per Diem		DELETED 4-1-03
99506	Home Visit for IM	Service should be included in infusion visit	Deny if bill separately Code added for clarification 1-1-03
S9800	Home therapy, provision of infusion, specialty drug administration and/or associated nursing services and procedures, by highly technical RN, per hour (do not use with code S9524)		DELETED 1- 1- 03
S9802	Home infusion/specialty drug administration, nursing services; per visit (up to two hours)	$ 95 per visit	Limit to 3 visits per 24-hour period unless approved by Case Manager. Do not bill with 99601 or 99602. Code effective 1-1-03

Home Infusion Therapy Services (HITS) Coding Additions and Deletions

2004 HCPCS	Nomenclature	Pricing	Claims Filing/ Coding Policies
	Nursing Services (continued)		
S9803	Each additional hour (after TWO hours - list separately in addition to code S9802)	$ 30 per hour	Must bill S9802 to use this code. Limit to 3 visits per 24-hour period unless approved by Case Manager. Do not bill with 99601 or 99602. Code effective 1-1-03.
S9806	RN services in the suite of the IV therapy provider per visit	Not covered under HITS	Deny Code effective 1-1-03
S9810	Home therapy: professional pharmacy service for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified per hour 9 do not use this code with any per diem code).	Rx covered under drug code. Nursing and supplies covered under nursing visit code. Therefore this code will not be reimbursed.	Deny Added for clarification.
	TPN		
S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment includes standard TPN formula, (lipids, specialty amino acid formulas. Drugs and nursing visits coded separately,) per diem.	Rx covered under drug code. Nursing and supplies covered under nursing visit code. Therefore, this code will not be reimbursed.	Deny Added for clarification

Home Infusion Therapy Services (HITS) Coding Additions and Deletions

2004 HCPCS	Nomenclature	Pricing	Claims Filing/ Coding Policies
	Chemotherapy		
S9329	Home Infusion Therapy; Chemotherapy Infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem- do not use with S9330 or S9331.	$0.00	Deny- do not use this "dump" code. Added for clarification
	Intermittent Home Infusion Therapy Injection, IM, SubQ , IV Push Therapies		
S9379	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment per diem (Drugs and nursing visits coded separately.)	Rx covered under Drug code Nursing and supplies covered under Nursing visit code. Therefore this code will not be reimbursed.	Deny Added for clarification
S9490	Home infusion therapy, corticosteriod infusion ; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment per diem (Drugs and nursing visits coded separately.)	Rx covered under Drug code Nursing and supplies covered under Nursing visit code. Therefore this code will not be reimbursed.	Deny Code effective 1-1-03
S9349	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drug and nursing visits coded separately), per diem.		Must meet specific coverage policy to qualify for coverage- not covered in most cases. Added for clarification.

Home Infusion Therapy Services (HITS) Coding Additions and Deletions

2004 HCPCS	Nomenclature	Pricing	Claims Filing/ Coding Policies
Catheter Care Supplies			
S5517	Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting		Do not pay – drugs covered under nursing visit. Do not bill member. Added for clarification.
S5518	Home infusion therapy, all supplies necessary for catheter repair		Do not pay. Do not bill member. Added for clarification.
S5520	Home infusion therapy, all supplies (including catheter) necessary for a PIC venous catheter (PICC) line insertion		Deny when billed under HITS. Added for clarification.
S5522	Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC) line, nursing services only (no catheter or supplies included)	AR nurse may not perform in home setting without x-ray confirmation of placement. Not covered under HITS.	Deny when billed under HITS. Added for clarification.
S5035	Home infusion therapy, routine service of infusion device (e.g. pump maintenance)	Not covered under HITS	Do not pay - included in per diem Added for clarification.
S5036	Home infusion therapy, repair of infusion device (e.g. pump repair)	Not covered under HITS	Do not pay - included in per diem Added for clarification.

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