Arkansas Blue Cross and Blue Shield

Providers' News

June 2004

Inside the June 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.

We're on the Web!
www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com

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 BlueCross BlueShield
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CodeReview Edits for BlueAdvantage Administrators of Arkansas:

BlueAdvantage Administrators of Arkansas will begin using CodeReview edits when processing claims for all its business beginning August 1, 2004.

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.

New Member IDs for All Members of Health Advantage and BlueAdvantage Administrators of Arkansas:

In a continuing effort to protect the privacy of our members, Health Advantage and BlueAdvantage Administrators of Arkansas will reissue new ID cards for all members replacing the current social security-based member number with a new unique identifier.

By January 2005, all members of Health Advantage and BlueAdvantage will possess ID cards that do not utilize social security numbers as part of their member number. Member numbers will however continue to begin with a character prefix.

Beginning in May 2004, member ID cards will be replaced an employer group at a time. Due to the phased approach of this implementation, some members will have a social security number on their card until the end of the year.

Health Advantage will reissue membership ID cards in 2 phases. During May, Health Advantage tested the replacement process by issuing new ID cards for Arkansas Blue Cross and Blue Shield employees.

The remaining phase for reissuing membership cards for Health Advantage will be completed in late summer or early fall. BlueAdvantage, however, will reissue member cards in four phases: July, August, September and December, 2004.

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 ID card whenever healthcare services are requested.

Make sure to enter the member number on the claim exactly as it appears on the ID card and update your practice management system with the new member number. Health Advantage and BlueAdvantage will update the newly assigned member numbers within the Integrated Voice Response (IVR) system as well as our Customer Service areas.

If there is any question as to the correct member ID to use for claim filing, the Advanced Health Information Network (AHIN) workstation will always display the correct member number and eligibility information.

UPIN of the Referring Physician Required:

For all Arkansas Blue Cross and Blue Shield products, the correct Unique Physician Identification Numbers (UPIN) of the referring physician is required in the appropriate fields on both the 1500 and UB-92 claim forms. The ANSI format requires a qualifier of 1G in addition to the UPIN.

Claims filed with an invalid UPIN will deny or pay at the out-of-network benefit level. Using the correct UPIN is especially important on Health Advantage claims in order for the correct benefit level to be paid.

The UPIN is assigned to providers by Medicare. (Providers may fax the UPIN to 501-378-2465, call 501-210-7050, or email providernetwork@arkbluecross.com). If you do not have a UPIN or have problems with claims paying correctly and believe it could be related to the UPIN, please contact your network development representative.

In the meantime, providers may file claims using their Arkansas Blue Cross five-digit provider number. The five-digit provider number will help map the claim to the correct benefit level.

Faxing Implant Invoices:

Last year, Arkansas Blue Cross and Blue Shield and its affiliates, initiated a claim processing improvement to request Medical Records by FAX. This process has been received favorably by physicians and hospitals.

Starting August 4, 2004, Arkansas Blue Cross, along with Health Advantage, BlueAdvantage Administrator of Arkansas, and Federal Employee Program, is adding implant invoices to this process. Providers **DO NOT** need to send a copy of the invoice for the implant when submitting claims. This will allow providers to submit claims for implants electronically.

If an implant invoice is needed for adjudication of the claim, an implant invoice request letter will be faxed to the same FAX number as the Medical Record Requests. The implant invoice request letter will have the new bar-code and tracking number. Please return the implant invoice request letter first followed by the requested invoice for the implant.

The bar-coded letter will allow the information providers send to be tracked and processed faster. The bar-coded letter is unique for each implant invoice request and cannot be reused. Therefore, please **DO NOT** use the bar-coded letter for other patients.

Federal Employee Program (FEP) - Eligibility of FEP Members Now Available Through AHIN:

In order to receive a more timely response on your claims for Federal Employee Program (FEP) patients, please use the AHIN workstation through Blue Exchange to verify the name and eligibility of FEP patients.

A majority of FEP claims are pending due to the patient information on the claim not matching the patient information on the FEP system. (The most common problem is the name not matching.) Effective July 1, 2004, claims will be returned when the claim submitted does not match our records.

For those providers who have access to the AHIN workstation, to view FEP eligibility on a patient, please follow these steps:

- Organization Name: 999999 Other BCBS Plans
- Type of Coverage: Medical
- Required fields are:
  1. Member ID,
  2. Last name and First name or Initial* and
  3. Member's Birth date.

*Once you have entered and submitted the required information, even if you do not have the correct first name or correct initial, the system will display the correct information.

To find out more about AHIN workstation, please visit our website at www.ArkansasBlueCross.com. Click on the "Provider" link and then click "AHIN".

FEP — Beginning in August 2004, Durable Medical Equipment Claims for FEP Patients Automatically Being Received and Processed from Palmetto:

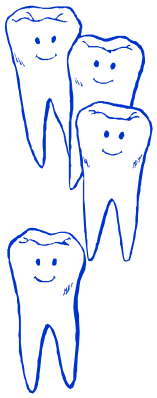
Beginning August 1, 2004, FEP will automatically receive and process the Medicare Durable Medical Equipment claims from Palmetto. Providers who file their Medicare DME claims with Palmetto should no longer submit paper claims to the FEP for secondary payment coordination.

The change will result in a more timely processing of claims for secondary payment from FEP. Once this automated process is in place, continuing to file paper claims for secondary payments could result in overpayments.

Please allow 30 days for FEP to process your Medicare DME claims from the date that Palmetto has paid the claim.

FEP — Helpful Hints on Submitting Dental Claims for FEP Members:

1. Dental claims for FEP patients should be submitted to Arkansas Blue Cross and Blue Shield with the identification number beginning with an 'R' and followed by eight numeric digits.
2. Please ensure you have the correct identification number for the patient.
3. Dental claims must be filed on the paper dental claim forms. Dental claims are not accepted when they are submitted electronically.
4. Dentists who provide services through a dental clinic must indicate both the clinic number and performing provider number on the claim form.



HealthConnect BLUE

YOUR 24-HOUR HEALTH INFORMATION RESOURCE

Providers can now take advantage of the patient referral process for HealthConnect Blue – an innovative program that helps your patients acquire the knowledge they need to take an active role in their own health care.

The new HealthConnect Blue provides your Health Advantage patients with 24/7 telephone access to Health Coaches who provide unbiased, evidence-based health information and support specific to the individual patient condition. It's like having an extra clinician in your office to help with patient education and support.

Please call your regional office to refer a patient to the HealthConnect Blue program.

Note: Public School Employee groups with Health Advantage and Arkansas Blue Cross will be able to utilize HealthConnect Blue beginning in August 2004 and Arkansas State Employee groups by October 2004.

Got E-mail? Let's Bridge the Communication Gap!

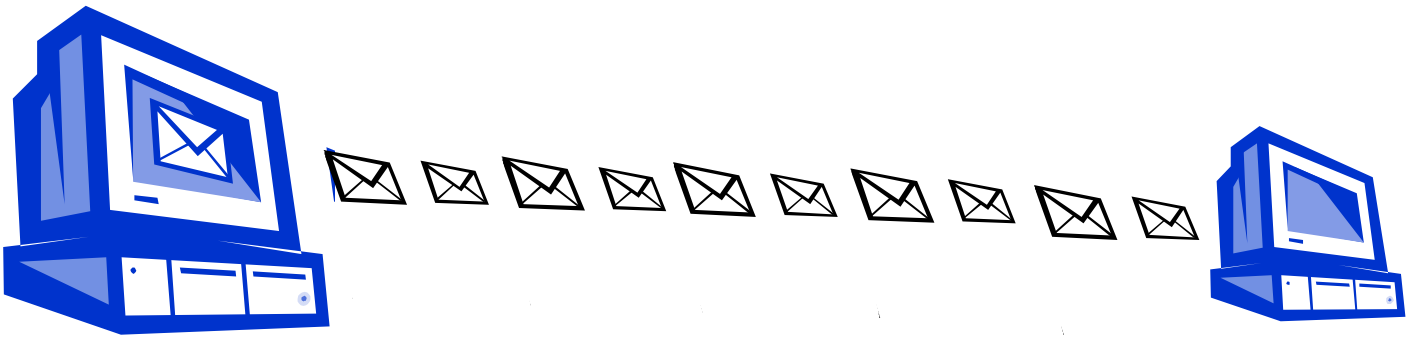
Let's face it: As artful as this periodical is, many of you don't read every word every time. Thus you miss periodic notifications that may be important to your patients and your practices. In addition, issues frequently arise that are specific to a particular specialty or specialties.

Arkansas Blue Cross and Blue Shield would like to begin sending specialty specific notifications by email allowing notification of noteworthy items sooner than is possible via the Providers' News.

Please send your e-mail address to: **providernetwork@arkbluecross.com.**

Be assured: This will be used for professional communication, and its use will be limited purely to business issues of importance to you and your office.

Everybody wins when communication improves, so let's take advantage of an increasingly "wired" community.



Modifier 24:

Arkansas Blue Cross and Blue Shield is seeing a misuse of modifier 24 such as:

- When there is a significant, separately identifiable service on the SAME day as the procedure or service, the appropriate modifier is '25'.
- When the procedure does not have a postoperative period (i.e., zero global days, zzz global days), this modifier is not appropriate.
- Routine use of the modifier for postoperative Evaluation & Management services related to the surgical procedure

CPT-4 defines Modifier 24 as: Unrelated Evaluation and Management Service by the same physician during a postoperative period: **The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier '24' to the appropriate level of E/M service.**

Use of Modifier 24 may require additional clinical information.

Modifier - 52:

Claims submitted for services with Modifier - 52 will be reimbursed at 67% of the usual allowance for the procedure. Per the CPT-4 manual, Modifier - 52 is used to indicate a reduced service was performed.

Based on analysis of claims data, Arkansas Blue Cross and Blue Shield believes this payment level for the reduced service is appropriate. These guidelines apply to Arkansas Blue Cross Regular Business, Arkansas Blue Cross subsidiaries ,and Blue Card claims.

Cystourethroscopy - CPT Code 52351:

The CPT-4 Manual defines code 52351 as cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic. Under the subheading "Ureter and Pelvis" in the "Urinary System" section, the CPT-4 manual states:

> "Surgical cystourethroscopy always includes diagnostic cystourethroscopy. To report a diagnostic cystourethroscopy, use 52351. Do not report 52351 in conjunction with 52341-52346, 52352-52355."

CPT Code 52351 is considered a fragmentation if billed with CPT Code 52341, 52342, 52343, 52344, 52345, 52346, 52347, 52352, 52353, 52354, or 52355, unless the latter code(s) is billed with modifier '59' and 52351 is identified with the contra lateral LT or RT modifier that is the opposite of the LT or RT modifier billed with 52341-52346 and 52352-52355.

If code 52351 is billed with 52341-52346 or 52352-52355 and modifier '-59 and the HCPCS Level II LT or RT are not appended appropriately, CPT 52351 should be denied as incorrect CPT coding.

Coverage Policy Manual Revisions:

Where possible, Arkansas Blue Cross and Blue Shield develops written criteria (called coverage criteria) concerning services or supplies that it considers investigational. Arkansas Blue Cross base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments.

Arkansas Blue Cross puts these coverage criteria in policies available to the medical community and its members so that members and providers will know in advance, when possible, what is or is not considered investigational. A procedure that is deemed investigational is considered such based on the member's benefit contract definition of investigational.

If a service or supply is considered investigational according to one of its published medical criteria policies, Arkansas Blue Cross will not pay for it. Provider contracts state providers cannot collect any amount from members for experimental/ investigational services unless the provider obtained a signed waiver from the member prior to the service.

If the investigational nature of a service or supply is not addressed by one of its published medical criteria policies, Arkansas Blue Cross will consider it to be non-investigational only if all of the following apply:

1. The drug or device can be lawfully marketed only with approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has been announced to the public at the time the drug or device is furnished;
2. The drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, is not required to be reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law does not require such review and approval;
3. Reliable evidence shows that the drug, device or medical treatment or procedure is not the subject of on-going phase I, II or III clinical trials or is not otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;
4. Reliable evidence does not indicate that further studies or clinical trials are necessary to determine the maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.
5. Reliable evidence does not indicate that the treatment should not be used as a first line therapy for a particular condition or disease.

Since March, 2004, 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:

- External Infusion Pumps
- Photodynamic Therapy for Actinic Keratosis
- Transesophageal Endoscopic Therapy
- Immune Globulin, Intravenous
- Leuprolide
- Magnetoencephalography / Magnetic Source Imaging
- Wireless Capsule Endoscopy
- Gastric Restrictive Surgery
- Keratoplasty, Refractive
- Laser Treatment of Congenital Port Wine Stain Hemangiomas
- Mastectomy, Prophylactic
- Stereotactic Radiosurgery
- Auditory Brain Stem Implant
- Brachytherapy, Breast

Coverage Policy may be accessed on-line at www.ArkansasBlueCross.com or www.HealthAdvantage-hmo.com.

Arkansas' FirstSource PPO Access Only Groups: Groups Effective June 2004:

NOTE: Claims for Access Only groups may be submitted electronically to Arkansas Blue Cross and Blue Shield.

• Aalf's Manufacturing Inc / Midland's Choice	• Howard Memorial
• ACF Industries Inc / American Railcar	• James Hardie / Bryar Gypsum
• Anchor Packaging / Hermann Co.	• KLA Benefits / Klipsch LLC
• AR Carpenters Health & Welfare Fund	• LA Darling
• AR Sheet Metal Workers -Local #36-L	• Levi Hospital
• Arkansas State University Athletes	• Magnolia Hospital
• Arvest Bank	• Marshalltown Tools
• Ashley County Medical Center	• Maverick Tube Corp
• Atlantic Research	• Motor Appliance Corporation
• Basler Electric	• Nestle
• BEKAERT - Rogers, AR Location	• Newport Hospital
• BEKAERT - Van Buren, AR Location	• Odom's Tennessee Pride Sausage
• Boar's Head Provisions Co	• Paxton Media / Jonesboro Sun
• Brentwood Industries, Inc	• Peterson Manufacturing / Mission Plastics
• Bridgestone - Firestone	• REA Magnet Wire
• Bryce Corporation	• Siegel-Robert Inc
• Columbia Forest Products	• Siplast Inc
• Defiance Metals	• Southern Painters Welfare
• Diocese Of Little Rock / Christian Bro	• St. Michael Healthcare-Hospital
• FedEx Freight East, Inc / (American Freightways)	• St. Michael Healthcare-Rehab
	• Town & Country Grocers / Price Chopper
• Genmar - Ranger Boats	• Townsend Foods
• Harding University	• UFCW (Kroger & Consumer Market)
• Harps Food Stores	• Wabash National / Cloud Corp
• HealthScope Benefits - Employees	• Wallace & Owens
• Hot Spring County (HSC) Medical Center	• Whirlpool

Arkansas' FirstSource PPO Access Only Groups: Groups Terminated since Jan 2003:

Group Name	Termination Date	
• Alcoa	1/1/2004	
• American Greetings	1/1/2004	
• Ball Corp	1/1/2003	
• Bricklayers Union No. 5	8/1/2003	
• Camaco	7/1/2003	To Blue Advantage
• Emerson Motors - Rogers	1/1/2004	
• Emerson Electric, Kennett, MO	1/1/2004	
• Emerson Motor- Paragould	4/1/2003	To Blue Card
• Emerson Motors/US Elect Motors - Mena	1/1/2004	
• Emerson White Rogers - Batesville	10/1/2003	To Blue Card
• Emerson White Rogers - Harrison	10/1/2003	To Blue Card
• Eastern Ozark Regional Healthcare	1/1/2004	To Blue Card
• Foamex	9/1/2003	
• Friendship Community	11/1/2003	To Blue Advantage
• Greenfield Industries	1/1/2003	
• Hood Packaging	1/1/2003	
• Innovation Industries	11/1/2003	
• LaBarge Inc	11/1/2003	
• Lennox	1/1/2003	To Blue Card
• Magna International Retirees	5/1/2004	
• Norandal USA	1/1/2004	To Blue Card
• North AR Medical Center	7/1/2003	To Blue Advantage
• Pat Salmon and Sons	9/1/2003	
• Quebecor World	1/1/2004	To Blue Card
• Reynolds	1/1/2004	
• Wal-Mart	1/1/2004	To Blue Advantage
• Wheeling Machine Products	4/1/2003	
• Wonder State Box / So MO Container / SMC Packaging	1/1/2003	

Claims Payment Issues:

While one of Arkansas Blue Cross and Blue Shield's ongoing goals is to minimize the number of claims paid incorrectly, errors will occasionally be made. Some of these error conditions can affect 1099 earnings and/or patients' claim history, deductibles, and benefit limits. These situations can result in incorrect information being reported to the IRS and/or incorrect patient benefit determination.

Please note:

- Amounts of issued provider payee checks are recorded as increases to the 1099 earnings;
- Amounts of voided provider payee checks are recorded as decreases to the 1099 earnings;
- Amounts received from providers (claims refunds) are recorded as decreases to the 1099 earnings.
- 1099 earnings are accumulated under the Tax Identification Number (TIN) of the payee, as recorded in our files at the time of the transaction.
- Providers must notify Arkansas Blue Cross promptly if their TIN or name changes in order to ensure accurate reporting to the IRS. If the IRS sends Arkansas Blue Cross a "B-Notice" indicating that the Taxpayer Name and TIN filed does not match the IRS records, Arkansas Blue Cross will be required to withhold, and remit to the IRS, 28% of future amounts payable to the provider if corrected data is not received within the mandated time frame. Once withheld amounts are remitted to the IRS, they cannot be refunded to a provider, but will be reported on the provider's 1099 as Federal Income Tax Withheld.

Important Claims Filing Notes to Physicians:

- Paper Claims: As the provider of service, you should always enter your individual provider number in box # 24K of the HCFA1500 claim form. If you want a clinic to be the payee, you must enter the clinic's provider number in box # 33.
- NSF Electronic Claims: As the provider of service, you should always enter your individual provider number beginning in position 93 of field 23 on the FA0 record.
- Non-Medicare claims: Providers must enter the "pay to" provider number beginning in position 105 of field 14 on the BA0 record for non-Medicare claims.
- Medicare claims: The "pay to" provider number must be entered beginning in position 48 of field 9 on the BA0 record for Medicare claims.
- For ANSI 837, Version 4010A1 Electronic Claims: Please refer to the ANSI X12N 837 Implementation Guide for instructions regarding the use of Loop 2010AA, REF02 or Loop 2010AB, REF02 for the "pay to" provider and Loop 2310B, REF02 or Loop 2420A, REF02 for the rendering provider number.
- Deductibles, benefit limits, out-of-pocket maximums, and lifetime maximums are accumulated by individual member. If erroneous claims are not adjusted appropriately and promptly, subsequent claims may be incorrectly adjudicated.
- Please verify that the payee is correct on all checks that you receive prior to negotiating them.

Listed below are examples of some situations that can occur along with procedures recommended to facilitate correction of the data.

- If you receive payment for a claim for services that you did not provide: Please refund the amount paid in error. Even if you know to whom the payment should have been made, do not forward the amount to that party. Your 1099 can only be corrected if the money is returned so that the claim can be re-processed to the appropriate party.
- If the patient was paid and payment should have been made directly to you: Please advise the patient to return the check, or refund the amount paid, along with a request to re-process the payment to the provider. If you accept payment from the patient, Arkansas Blue Cross could subsequently discover the error and send a request for refund to him/her since records will reflect that he/she received the payment.
- If you were paid and payment should have been made to the patient: Please refund the payment to Arkansas Blue Cross (rather than to the patient) along with a request to re-process the payment to the patient. A provider's 1099 can only be corrected if the money is returned, so that the claim can be re-processed to the appropriate party.
- If a check is made payable to an individual physician but should have been made payable to the clinic: Please return the check to Arkansas Blue Cross (rather than depositing it in the clinic's account) with a request to re-process the payment to the appropriate

Claims Payment Issues (continued):

provider. A provider's 1099 can only be corrected if the money is returned, so that the claim can be re-processed to the appropriate party. NOTE: If the check is made payable to an individual physician, the 1099 will be generated in the physician's name, even if he/she is an employee of the clinic.

Arkansas Blue Cross and Blue Shield recommends providers endorse and deposit all checks as soon as possible after confirming that the payee is correct. Most of our checks have a pre-printed stale date message indicating that the check will be void if not cashed within a specific time frame (usually six months). After that time, the check must be re-issued or, in some cases, the claim must be re-processed.

As a deterrent to fraud and to enhance the quality of copies of cleared checks that might be requested in the future, Arkansas Blue Cross also recommends that endorsements be made in black ink and include the bank account number into which the deposit is being made.

To minimize the time required to process a claim refund and to ensure that a provider's 1099 earnings are adjusted accurately:

- When sending a requested refund: Please return the remittance copy of the refund request letter along with your check.
- When sending an unrequested refund: It is not necessary to return the original check and the entire remittance advice/explanation of payment if just one or two patient claims are paid incorrectly. Please enclose copies of the remittance advice/explanation of payment pages with the claims paid in error high-lighted and a notation of the reason for the refund or enclose the following information for each claim paid in error:
  (1) Reason for the refund,
  (2) Patient name,
  (3) Patient ID number,
  (4) Date of service,
  (5) Amount
  (6) Provider name (pay to)
  (7) Provider number (pay to), and
  (8) TIN (pay to).

A separate refund check for each claim is preferred, if you are not returning the original check.

A provider's 1099 earnings can only be corrected if Arkansas Blue Cross has the specific provider name, number, and TIN. If a provider uses the services of a third party for these financial transactions, please instruct the third party administrator to provide this information on each refund.

Please do not combine refunds for Arkansas Blue Cross Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, USAble Administrators, USAble Life Group Health, or Medicare. Please do not issue refund checks to Arkansas First Source. The check should be payable to the original claim payer with a copy of the remittance advice/explanation of payment.

Note: Federal Employee Program (patient ID# begins with "R") refunds should not be combined with others to Arkansas Blue Cross and Blue Shield in order to comply with new timeliness standards even though the refunds are sent to the same processing location.

The following are the correct addresses to use for claims refund:

Arkansas Blue Cross Blue Shield
P.O. Box 2099
Little Rock, AR 72203 - 2099

ABCBS/Federal Employee Program
P.O. Box 2099
Little Rock, AR 72203 - 2099

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

Health Advantage
P.O. Box 8069
Little Rock, AR 72203 - 8069

USAble Administrators
P.O. Box 1460
Little Rock, AR 72203 - 1460

USAble Life Group Health
P.O. Box 1151
Little Rock, AR 72203 - 1151

Medicare (part A or B)
P.O. Box 8075
Little Rock, AR 72203 - 8075

Area Providers Reap Benefits From ABCBS' Online Service — By Worth Sparkman of Northwest Arkansas Business Journal

Typos used to make health care providers sick. If a wrong procedure code or someone's nickname was entered on a claim, it could take weeks to get the right information on the form, mail it back and forth, and get the insurance company to pay.

That was before electronic claims and Arkansas Blue Cross Blue Shield's Advanced Health Insurance Network (AHIN). AHIN is a Web-based network that allows providers to instantaneously file claims, check patients' coverage and eligibility, and determine the out-of-pocket expense a patient should pay while in the office.

Warren McDonald, northwest regional provider network manager for Arkansas Blue Cross, said errors on claims made by a provider are now usually identified and correctable within 15 minutes. The system points out fields where errors have occurred — name, address or that a male patient should not be treated for pregnancy — and alerts the health care provider. The provider can then check its files for the information without having to mail a letter and wait for a reply.

Jerry Bradshaw, president of AHIN and executive director of Arkansas Blue Cross' Health Information Network, said 75.5 percent of Arkansas Blue Cross' 4.5 million monthly claims come through the AHIN system. That calculates out to about 3.4 million claims per month, or 113,250 claims a day during most months.

McDonald hesitates to speculate how much money the system saves health care providers. The answer, he said, lies in the fact that denied claims are creeping downward. The statewide clinic denial rate for Arkansas Blue Cross and Health Advantage was 17 percent in 2002 and 16.6 percent in 2003, or a 2.4 percent decrease in denied claims. That means in 2003, 83.4 percent of claims were accepted upon their first submission.

Statewide hospital denial rates in 2002 were 23 percent compared with 21.6 percent in 2003, a 6.1 percent decrease. The numbers do not indicate self-funded accounts such as Wal-Mart Stores Inc. claims, McDonald said, but are a sample that's representative of about one-third of Arkansas Blue Cross' claims.

For the remaining rejected claims, he said, many are duplicates or coding issues. McDonald said the AHIN system helps providers identify those issues and make internal adjustments.

Bradshaw said the average clock speed on "clean" claims is 1.2 days from the time they are entered in the system until the time a check is cut. Many providers report checks in-hand within 14 days, but internal Arkansas Blue Cross data said average statewide claims are through the system in 6.7 days.

McDonald said that number is good even though 15 percent of Arkansas Blue Cross claims are still made with old-fashioned paper, which is significantly slower.

"[AHIN] allows them to know before they even leave for that day whether these claims are going to be denied or not," McDonald said. "Believe you me, that is worth a lot to a clinic manager to know that what they sent off — if they sent off $100,000 in claims — that they're likely to be successful claims."

How It Works

AHIN is a Web-based application that allows providers protected access on Arkansas Blue Cross computers, McDonald said. Any health care provider in the state who accepts Arkansas Blue Cross can sign up for the service, which is free. The provider simply applies online, then an Arkansas Blue Cross representative contacts them about specifics.

McDonald said the biggest obstacle in getting providers to sign up for AHIN, is lack of Internet access. He said many providers operate on internal networks that don't have an out-bound connection. Once logged in, a provider has options to view and register patients and view insurance claims, eligibility functions and other database-driven information about patients in the Arkansas Blue Cross network.

AHIN grew out of a need to link all seven regional offices of Arkansas Blue Cross. "It's a system that does not require [health care providers] to replace their internal systems; basically it's an integration effort," Bradshaw said. The company developed AHIN for two years, starting in 1996, then rolled out a beta version. In 2000,

Area Providers Reap Benefits From ABCBS' Online Service (continued):

the network was opened up statewide. "Of course since that time, we've been steadily modifying and enhancing it," Bradshaw said.

Arkansas Blue Cross and Blue Shield made a multimillion investment in the network and spends "a little over $1 million a year to operate, enhance and maintain it."

HIPAA, HIPAA, Hooray

HIPAA, the Health Insurance Portability & Accountability Act of 1996, couldn't have passed at a better time for AHIN.

"HIPAA came into being back when we were doing the original development on this," Bradshaw said. "We really built this system to be a HIPAA-compliant system."

According to a document published by the District of Columbia Health Department, "This law ensures continuity of health care coverage for individuals changing jobs; includes a provision that impacts on the management of health information; seeks to simplify the administration of health insurance; and aims to combat waste, fraud, and abuse in health insurance and health care."

The HIPAA regulations became mandatory on April 14, 2003. Basically, the HIPAA regulations protect patient privacy and cause provider gridlock.

Bradshaw said all claims going into or out of Arkansas Blue Cross are converted to HIPAA-compliant status automatically. "That has saved this organization literally millions and millions of dollars because we already had this on hand and didn't have to build something specifically for HIPAA."

AHIN is a separate LLC but is 62 percent owned by Arkansas Blue Cross. This allows the company to operate as a clearinghouse to make claims HIPAA-compliant before providers send them to other insurance companies. Bradshaw said AHIN charges nothing to Arkansas Blue Cross to convert claims and charges only 10 cents a claim as a clearinghouse to other firms. The going rate through other clearinghouses is about 35 cents a claim.

The Acid Testimonials

Medical Services of Northwest Arkansas operates nine clinics, including the Northwest Arkansas Pediatric Clinic and FirstCare Family Doctor Clinics. Claim information is captured at each clinic, but the actual claim process is centralized at the business office.

"I think AHIN has been a good thing for our practice and I think for our patients as well," said Larry Shackelford, CEO of Medical Services. The system gives his company real-time data and allows it to accurately collect out-of-pocket money from its clients at the time services are rendered and cut back on refunds as well as billing for uncollected co-pays.

Shackelford said it's impossible to put a dollar figure to the benefits his company experiences with AHIN. The system has helped improve the overall efficiency of Medical Services.

McDonald said Mercy Health Systems Clinics of Northwest Arkansas is the single largest claim filer with Arkansas Blue Cross' Northwest regional office.

Donna Price, insurance billing supervisor of Mercy Medical Clinics, said her four-person group files about 31,000 claims a month, or 1,000 a day on average, with a majority of those going through the AHIN system. She has been using the system since it became available in 2000. "It's fantastic," she said. "Without it, we would be lost."

Price said a denied claim could take up to a month to correct through the regular mail, but the AHIN system allows her to correct an issue in as little as five minutes. She said her company's computers collect claims data at the end of the day, then send them to AHIN. When she and her staff arrive in the morning, there is a list of denied claims in an "in box."

The system points out exactly what's awry with each claim. Her staff researches the defunct claims, sometimes through the AHIN database; makes corrections; and resubmits the file. Price said the average pay time from ABCBS for Mercy's 14 clinics is about 14 days.

"It saves us all money," said Bradshaw. It saves the provider from having to make a phone call and the staff at Arkansas Blue Cross from having to answer that call — often many calls for each claim. "It's one of those unique situations where everybody wins."

Article by Worth Sparkman of ***Northwest Arkansas Business Journal***, Vol. 8, No 5, Pages 1 & 16.

Fee Schedule Updates:

Effective March 15, 2004, the following codes have been updated in the Arkansas Blue Cross and Blue Shield Fee Schedule:

Code	Total/ Purchase	Prof/ Rental	Technical	Total/ Purchase	Prof/Rental SOS	Technical SOS
54150	$ 433.02			$ 174.26		
54160	$ 410.29			$ 220.30		
93005	$ 27.39	$ -	$ 27.39	$ -	$ -	$ 27.39
93041	$ 9.32	$ -	$ 9.32	$ -	$ -	$ 9.32
93501	$ -			$ 254.10		
93503	$ -			$ 220.30		
93505	$ -			$ 369.50		
93508	$ -			$ 374.74		
93510	$ -			$ 394.56		
93511	$ -			$ 453.42		
93514	$ -			$ 619.52		
93524	$ -			$ 615.44		
93526	$ -			$ 534.43		
93527	$ -			$ 644.58		
93528	$ -			$ 793.19		
93529	$ -			$ 430.11		
93530	$ -			$ 375.91		
93531	$ -			$ 727.33		
93532	$ -			$ 867.79		
93533	$ -			$ 583.97		
93555	$ -			$ 68.19		
93556	$ -			$ 69.94		
93561	$ -			$ 39.63		
93562	$ -			$ 12.82		
93571	$ -			$ 152.11		
93572	$ -			$ 125.30		
97014	$ 18.58	$ -	$ -	$ -	$ -	$ -

Fee Schedule Updates:

Effective April 14, 2004, the following changes were made to the Arkansas Blue Cross and Blue Shield Fee Schedule:

Code	Total/ Purchase	Prof/ Rental	Technical	Total/ Purchase	Prof/Rental SOS	Technical SOS
B4034	$ 2.14			$ 2.14		
B4035	$ 19.43			$ 19.43		
B4036	$ 9.38			$ 9.38		
B4081	$ 33.20			$ 33.20		
B4082	$ 24.94			$ 24.94		
B4083	$ 24.94			$ 24.94		
B4086	$ 46.10			$ 46.10		
B9000	$ 1,112.50	$ 111.25		$ 1,112.50	$ 111.25	

Effective April 15, 2004, the following changes were made to the Arkansas Blue Cross Fee Schedule:

Code	Total/ Purchase	Prof/ Rental	Technical	Total/ Purchase	Prof/Rental SOS	Technical SOS
S2130	$ 687.70			$ 687.70		

Effective May 12, 2004, the following changes were made to the Arkansas Blue Cross Fee Schedule:

Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
82017	$ 170.00	$ 11.90	$ 158.10	$ 170.00	$ 11.90	$ 158.10
90710	$ -			$ -		
95120	$ -			$ -		
95125	$ -			$ -		
95130	$ -			$ -		
95131	$ -			$ -		
95132	$ -			$ -		
95133	$ -			$ -		
95134	$ -			$ -		
96115	$ 113.65			$ 111.90		
96117	$ 113.65			$ 111.90		
99600	$ 95.00			$ 95.00		
S2113	$ -			$ 975.02		

Fee Schedule Updates:

Effective June 9, 2004, the following codes have been updated in the Arkansas Blue Cross and Blue Shield Fee Schedule:

- The allowance for J7330 has been changed to $0.00.

Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
52332	$ 1,049.62			$ 238.95		
54162	$ 322.87			$ 305.89		
76496	BR	BR	BR	BR	BR	BR

Myocardial Perfusion Study Add On (CPT Codes 78478 & 78480):

Effective May 19, 2004, the allowance for CPT Codes 78478 and 78480 was reduced on the Arkansas Blue Cross and Blue Shield Fee Schedule.

Claims review indicates these two procedures are most often performed together as part of the same evaluation. Determination of the ejection fraction is an automated, microprocessor driven calculation, requiring only modest additional time or cost when performed with the wall motion. The two studies will be valued together and priced as indicated.

Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
78478	$ 94.47	$ 32.49	$ 61.98	$ -	$ 32.49	$ -
78480	$ 94.47	$ 32.49	$ 61.98	$ -	$ 32.49	$ -

CPT Code 99195—Phlebotomy:

Phlebotomy, CPT code 99195, is only covered for the following diagnoses:

- 238.4 (polycythemia vera),
- 289.0 (polycythemia, secondary) or
- 275.0 and 285.0 (hemochromatosis).

Timely Filing:

When a patient covered by Arkansas Blue Cross and Blue Shield or an affiliate does not provide their provider with proof of coverage until after the 180 day timely filing has expired, that patient is responsible for the services and the provider should not bill Arkansas Blue Cross. The 180 day timely filing provision is applicable for both providers and members.

Arkansas Blue Cross does extend the timely filing requirements to include 180 days after the primary insurer adjudicates the claim. Timely deadline for secondary claims is 180 days from the date processed by the primary carrier.

Arkansas Blue Cross encourages providers to have their patients complete insurance coverage update forms at each time of service giving the patient every opportunity to provide insurance information.

If there is a question on coverage, refer to AHIN (Advance Health Information Network) for member eligibility and claims status or call *TheBlueLine*, our voice activated response service available 24 hours a day 7 days a week.

Correct Claim Form & Timely Filing Submission:

If you have a claim being resubmitted with information attached that reflects that the claim had been submitted previously then subsequently denied for not meeting timely filing requirements, please attach a "CORRECTED CLAIM FORM" and mail claims to Arkansas Blue Cross and Blue Shield, Health Advantage, or BlueAdministrators of Arkansas.

Change Claim Submission For CPT Code 59400 :

CPT Code 59400 — routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care.

The 2004 Relative Value Units (RVU) does not have an allowable for CPT Code 59400 when submitted with place of service "11". The new RVU's require the place of service to be "21" instead of "11".

Arkansas Blue Cross and Blue Shield and Health Advantage require claims for CPT Code 59400 be submitted with place of service "21". Claims submitted for CPT Code 59400 with place of service 11 will no longer be accepted.

Also, CPT Code 59400 should not be billed until after the delivery and postpartum care is completed.

Radiopharmaceutical Diagnostic and Therapeutic Imaging Agents:

Radiopharmaceutical diagnostic and therapeutic imaging agents, represented by HCPCS codes A4642, A9500-A9524 and A9526-A9605, will be paid based on 95% of the average wholesale price listed in the RedBook. The units submitted should be determined based on the dosage described by the HCPCS code. The PPO discount will apply.

If there is a situation where this does not cover your cost, you may resubmit your claim with a copy of the manufacturer's invoice to you for reconsideration. This change will be effective October 1, 2004.

Arkansas Blue Cross and Blue Shield will no longer accept procedure code 78990 (Provision of diagnostic radiopharmaceuticals). If you are using a radiopharmaceutical that is not addressed in codes A9500-A9524 and A9526-A9605, you should use the unlisted HCPCS radiopharmaceutical codes, A4641 (Diagnostic); A9699 (Therapeutic). A copy of the manufacturer's invoice to you will be required for these claims.

Code	Description
A4641	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified
A4642	Supply of satumomab pendetide, radiopharmaceutical diagnostic imaging agent, per dose
A9500	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m sestamibi, per dose
A9502	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin, per unit dose
A9503	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m, medronate, up to 30 mci
A9504	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m apcitide
A9505	Supply of radiopharmaceutical diagnostic imaging agent, thallous chloride TL 201, per mci
A9507	Supply of radiopharmaceutical diagnostic imaging agent, Indium in 111 capromab pendetide, per dose
A9508	Supply of radiopharmaceutical diagnostic imaging agent, Iobenguane sulfate I-131, per 0.5 mci
A9510	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc99m disofenin, per vial
A9511	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m, depreotide, per mci
A9512	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m pertechnetate, per mci
A9513	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m mebrofenin, per mci

Code	Description
A9514	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m pyrophosphate, per mci
A9515	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m pentetate, per mci
A9516	Supply of radiopharmaceutical diagnostic imaging agent, I-123 sodium iodide capsule, per 100 uci
A9517	Supply of radiopharmaceutical therapeutic imaging agent, I-123 sodium iodide capsule, per mci
A9519	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m macroaggregated albumin, per mci
A9520	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m sulfur colloid, per mci
A9521	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m exametazine, per dose
A9522	Supply of radiopharmaceutical diagnostic imaging agent, Indium-111 ibritumomab tiuxetan, per mci
A9523	Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per mci
A9524	Supply of radiopharmaceutical diagnostic imaging agent, iodinated I-131 serum albumin, 5 microcuries
A9525	Supply of low or iso-osmolar contrast material, 10 mg of iodine
A9526	Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, per dose
A9528	Supply of radiopharmaceutical diagnostic agent, I-131 sodium iodide capsule, per millicurie
A9529	Supply of radiopharmaceutical diagnostic agent, I-131 sodium iodide solution, per millicurie
A9530	Supply of radiopharmaceutical therapeutic agent, I-131 sodium iodide solution, per millicurie
A9531	Supply of radiopharmaceutical diagnostic agent, I-131 sodium iodide, per microcurie (up to 100 microcuries)
A9532	Supply of radiopharmaceutical therapeutic agent, iodinated I-125, serum albumin, 5 microcuries
A9533	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per millicurie
A9534	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per millicurie
A9600	Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per mci
A9605	Supply of therapeutic radiopharmaceutical, samarium Sm 153 lexidronamm, 50 mci

View EOB's on www.ArkansasBlueCross.com:

Arkansas Blue Cross and Blue Shield members now have online access to their Explanation of Benefits (EOB) statements.

An EOB is a notification Arkansas Blue Cross mails to members after processing their claims. This form lists date and type of service, total amount billed, amount paid, who was paid and member's minimum financial responsibility. The EOB also shows the amount of coinsurance or deductible applied to the member's out-of-pocket maximum.

To view their EOB's, members must log in to My Blueprint, an online self-service center. On the My Blueprint "Welcome" page, the member should select "View claims status or history" and then select a member and timeframe.

On the "Claims Summary" page, the member may click on Complete under Status to view a PDF (portable document format) of the EOB for thatclaim. EOB's created since January 1, 2004, will be available.

To view a PDF, the member will need to download the free Adobe Acrobat Reader. A link to download Reader is available on the "Claims Summary" page. EOB's also are available for Health Advantage (www.HealthAdvantage-hmo.com) and BlueAdvantage Administrators of Arkansas (www.BlueAdvantageArkansas.com) members through My Blueprint. EOB's are not available on line at this time for Medi-Pak members but will be added later.

Providers' News

Arkansas Blue Cross and Blue Shield
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