Arkansas Blue Cross and Blue Shield

Providers' News

September 2005

Inside the September Issue:

Please Note:

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield, a mutual insurance company, its wholly owned subsidiaries, and affiliates. The 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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True BLUE PPO - Our Newest Network:

As a result of the recent ruling of the Eighth U.S. Circuit Court of Appeals regarding the 1995 Arkansas Patient Protection Act (commonly known as the Any Willing Provider (AWP) law), Arkansas Blue Cross and Blue Shield is creating the new True Blue PPO network. The True Blue PPO network is being created to provide an AWP-compliant network option for USAble Corporation's current and future customers who are not self-funded groups exempt from AWP.

The Arkansas' FirstSource® PPO will continue to exist and the USAble Corporation will continue to administer the FirstSource network. However, Arkansas' FirstSource® PPO will be used exclusively for self-funded groups exempt from AWP. Reimbursement for the new True Blue PPO is the same as the current Arkansas' FirstSource® PPO reimbursement.

The True Blue PPO amendment was sent to all FirstSource participating providers in July 2005. This amendment will be effective on October 1, 2005. To remain in the FirstSource network as well as be included in the new True Blue PPO network, no action is required from providers. The contractual relationship simply continues under the terms of the amended contract, beginning October 1, 2005.

However, if a provider chooses not to accept the new amendment, they must send a letter to USAble Corporation giving notice of termination of their contract with USAble Corporation. The termination notice should be sent to:

USAble Corporation
Provider Network Operations
320 West Capitol
P.O. Box 2135
Little Rock , AR 72203-2135

Product lines using the new True Blue Network include Arkansas Blue Cross and Blue Shield fully insured PPO, Federal Employee Program (FEP), BlueCard, the Arkansas Comprehensive Health Insurance Pool (CHIP), and Workers' Compensation.

Please Note: Health Advantage will administer claims processing for their self-funded employer groups that may choose to have a limited network of participating facilities and other health care providers. Member ID cards will indicate claims administration by HMO Arkansas, the self-insured plan for Health Advantage if a limited network is applicable.

If you have any questions, please contact your region's Network Development Representative.

Network Access for BlueAdvantage Members:

BlueAdvantage Administrators of Arkansas employer members are self-funded group health plans exempt from Arkansas' Any Willing Provider (AWP) law. As such, BlueAdvantage employer groups may continue to access the Arkansas' FirstSource PPO® network or choose the new True Blue PPO network.

During the 4th quarter of 2005, BlueAdvantage will begin placing the appropriate network identifier, either the Arkansas' FirstSource or the True Blue logo, on member's ID cards. Until new ID cards are re-issued, providers can assume that if a BlueAdvantage member's ID card contains only the national BlueCard PPO suitcase logo the member participates in Arkansas' FirstSource PPO® network. The exception to this change is Wal-Mart which will continue their current network until further notice.

If you have questions about the network being accessed by your BlueAdvantage patients, providers can view member benefits through the AHIN workstation or call BlueAdvantage's customer service at 1-888-872-2531.

Arkansas Blue Cross and Blue Shield's Reimbursement Under AWP:

At Arkansas Blue Cross and Blue Shield, our goal in complying with the recent "any willing provider" court ruling is to be both fair to our providers of care and to create minimal disruption for our customers while complying with the law.

In accordance with these objectives, please be advised of the following modifications to our previous communications:

- The current Arkansas' FirstSource® PPO reimbursement remains unchanged for participating providers.
- The new AWP-compliant True Blue PPO network will be implemented as planned October 1, 2005 with reimbursement identical to Arkansas' FirstSource® PPO.
- All Arkansas' FirstSource providers will automatically participate in the new True Blue PPO beginning October 1, unless we are notified in writing of your termination.
- The current Health Advantage HMO reimbursement also remains unchanged for participating providers.
- The Notice of Payer Policies and Procedures and Terms and Conditions document previously received by some providers will still be implemented.
- The Arkansas Blue Cross Hospital Reimbursement Program (HRP) will not change October 1 as previously indicated.
- For current Arkansas' FirstSource PPO participating hospitals, reimbursement for the Arkansas' FirstSource PPO will remain unchanged.
- For current Arkansas' FirstSource PPO participating hospitals, True Blue PPO reimbursement will be identical to Arkansas' FirstSource reimbursement.
- Those hospitals not currently participating in Arkansas' FirstSource, who apply for participation in the new AWP-compliant True Blue PPO network will receive a separate communication regarding reimbursement upon meeting the terms and conditions of network participation
- Reimbursement for the current Health Advantage HMO participating hospitals will remain unchanged.
- Those hospitals not currently participating in Health Advantage will receive a separate communication regarding reimbursement upon meeting the terms and conditions of network participation

If you have any questions regarding the reimbursement, please contact your Regional Network Development Representative.

Intensity Modulated Radiation Therapy (IMRT)

Multiple codes are used to bill IMRT but CPT codes specific for this service are 77301 and 77418.

Many IMRT claims are filed with diagnoses that do not meet coverage criteria. Arkansas Blue Cross and Blue Shield intends to pay such claims as 3D-conformal therapy.

AWP Affects "Non-Contracted" Provider Types:

Arkansas Blue Cross and Blue Shield, its affiliate companies and subsidiaries have not traditionally had contracts available for all provider types. Some examples of provider types that have fallen into this "non-contracted" category are:

- Physical Therapists,
- Occupational Therapists,
- Speech Pathologists,
- Audiologists,
- Licensed Professional Counselors,
- Licensed Certified Social Workers, and
- Orthotics/Prosthetics suppliers.

Providers types such as physicians, hospitals, dentists, chiropractors, ambulatory surgery centers, and durable medical equipment vendors are not considered "non-contracted" as contracts have been available to those who met the qualifications.

In the past, non-contracted providers have reaped the benefits of in network providers although a signed agreement did not exist. For example, an individual physical therapist may have obtained an Arkansas Blue Cross provider number but a provider contract was not available for this provider type.

Usually in this scenario where agreements were not available, claims have been processed at an "in-network" benefit level and Arkansas Blue Cross has honored the assignment of benefits, which normally resulted in payment being sent directly to the provider. Non-contracted providers have also had the ability to balance-bill the Members.

The recent ruling of the Eighth U.S. Circuit Court of Appeals regarding the 1995 Arkansas Patient Protection Act (commonly known as the Any Willing Provider (AWP) law) will result in network participation agreements being offered to some of the provider types who are a part of the "non-contracted" category. Provider types specifically listed in the 1995 Patient Protection Act and subsequent Arkansas Acts 490 and 491, will now have contracts available for those providers who meet and agree to the terms and conditions of participation.

Providers who sign an Arkansas Blue Cross contract will be listed in the applicable provider directory (including the web-site directories) and will receive in-network benefits claims adjudication and direct payments.

The "non-contracted" providers who **do not** have signed participation agreements will not receive in network benefit claims adjudication. Further, payment for services rendered by a non-participating provider will be sent to the member. Arkansas Blue Cross, its affiliate companies and subsidiaries have begun implementing the requirements under the AWP ruling where applicable.

However, Arkansas Blue Cross believes that in the best interest of our members who have been utilizing "non-contracted" providers, the implementation of this change should be delayed until December 1, 2005. Therefore, "non-contracted" providers will continue to receive current claims adjudication processing and pricing of claims through November 30, 2005. This will allow additional time to process applications of new providers and prevent unnecessary disruptions in our networks.

Website Search Improvements:

Searching the Web sites of Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas is easier than ever. The search feature on these sites has been upgraded with a new engine powered by ***Google***, one of the most popular search sites on the Internet.

To find the search option click on the "Search" link on the home page of each site:

- www.ArkansasBlueCross.com,
- www.HealthAdvantage-hmo.com, or
- www.BlueAdvantageArkansas.com.

The "Search" link also is located in the top right corner of most internal pages.

Type a word or phrase into the text box provided on the "Web Site Search" page and hit the "search" button or use the keyboard "return" or "enter" key. The site search engine will search all Web pages and PDF's (printable documents in Adobe portable document format) contained on the site. Provider Manual pages, ***Providers' News*** archives, and informational pages for providers will also be searched.

The new site search engine will not search databases, such as the Provider Directory or Coverage Policy. These sections already have their own built-in search engines.

Also, the site search will not search pages that require a log-in ID and password. These pages contain personal information and are behind a secure firewall.

"Advanced Search" provides additional options to narrow a search, such as:

- Show a limited number of results (10, 20, 30, 50 or 100).
- Return pages that contain **all of the words** you enter ("and" search).
- Return pages that contain **an exact phrase**.
- Return pages with **any of the words** entered ("or" search).
- Return pages **without** certain words.
- Return results where the terms you enter occur either **anywhere on the page,** in the **page title,** or in the **page URL**.
- Sort by **relevance** or **date**.

The search results page displays the link, the URL, and a short text description of the section on the page that contains the keywords entered. Repetitious results are grouped at the end of the results as a link to click to see those additional results. The link to the advanced search appears just above the text field for the site search.

Can't find what you need? Go to the "Site Map" to search for a topic or click on the "E-Mail Customer Service" link at the bottom of any page to ask a question. Customer Service will respond to questions as quickly as possible.

Colonoscopy:

Because of the state law, which became effective August 1, 2005, regarding screening colonoscopy and other procedures, the following are billing and payment requirements for Arkansas Blue Cross and Blue Shield :

HCPCS Code G0104:

HCPCS Code G0104 (colorectal cancer screening; flexible sigmoidoscopy) is classified as RESTRICTED. HCPCS Code G0104 is a covered code but is restricted based on code definition, fragmentation, site-of-service, units-of-service, state mandate, and member benefit contract limitations.

It is restricted to patients who are 50 years of age or older and are not at high risk for colon cancer (high risk as defined by the American Cancer Society, 2005: personal history of colon cancer, a strong family history of colon cancer or polyps in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer), or polyps in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0104 is a fragmentation of CPT Codes 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45387, 45391, and 45392 and HCPCS Codes G0105 and G0121. All of these codes represent colonoscopy procedures and would include examination of the sigmoid colon.

Code G0104 is considered a component of CPT 45303, 45305, 45308, 45309, 45315, 45317, 45320, 45321, 45327, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, and 45345 as each of these codes represent “surgical sigmoidoscopy” and diagnostic endoscopy is included in surgical endoscopy, based on CPT coding instructions. HCPCS Code G0104 is limited to one unit-of-service and is subject to site-of-service payment differential. HCPCS Code G0104 is restricted to once every 5 years based on the Arkansas Act 2236.

The appropriate ICD-9 code for screening purposes is ICD-9 V76.51 (Special screening for malignant neoplasm; colon).

For screening sigmoidoscopy for members who are asymptomatic for colon disease, HCPCS Code G0104 should be reported. If “screening” sigmoidoscopy is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT Code 45330 and the appropriate diagnostic ICD-9 code should be reported if no disease is found on colonoscopy or if disease is found but no surgical endoscopy procedure is performed. If disease is found and an endoscopic surgical procedure performed (e.g., biopsy, snare, ablation), the code that represents the appropriate surgical sigmoidoscopy code should be reported.

HCPCS Code G0105:

HCPCS Code G0105 (colorectal cancer screening, colonoscopy on an individual at high risk) is classified as RESTRICTED. This is a covered code but is restricted based on code definition, fragmentation, site-of-service, units-of-service, state mandate, and member benefit contract limitations.

HCPCS Code G0105 is restricted to patients who are asymptomatic for colon disease, and are at high risk for colon cancer (high risk as

defined by the American Cancer Society, 2005: personal history of colon cancer or adenomatous polyp, a strong family history of colon cancer or polyps, colon cancer in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0105 is a fragmentation of CPT Codes 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45387, 45391, and 45392. These codes represent "surgical" endoscopy codes, and surgical endoscopy codes include diagnostic endoscopy based on CPT coding instructions.

HCPCS Code G0105 is mutually exclusive with G0121 based on code descriptors. HCPCS Code G0105 is mutually exclusive with CPT Code 45378, as 45378 can also represent a screening colonoscopy. If HCPCS Code G0105 billed with CPT Code 45378, 45378 is denied as a fragmentation.

HCPCS Code G0105 is limited to one unit-of-service and is subject to site-of-service payment differential. The appropriate ICD-9 code for screening purposes is ICD-9 V76.51 (Special screening for malignant neoplasm; colon).

For screening colonoscopy for members who are asymptomatic for colon disease, HCPCS Code G0121 should be reported. For colonoscopy for patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT Code 45378 and the appropriate diagnostic ICD-9 code should be reported if no disease is found on colonoscopy. If disease is found and an endoscopic surgical procedure performed, the code that represents the appropriate surgical endoscopy code should be reported.

Screening for patients who are at high risk, as defined above, is covered once every 3 – 5 years for the individual with previous adenomatous polyp or previous personal colon cancer.

HCPCS Code G0106:

HCPCS code G0106 (Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema) is classified as NONCOVERED. HCPCS Code G0106 is for a screening barium enema for an asymptomatic individual as an alternative to sigmoidoscopy; the barium enema component of the code is identical to G0122.

HCPCS Code G0106 is covered under G0122, and must meet the following criteria established for G0122:

1) For screening barium enema for members who are asymptomatic for colon disease, HCPCS G0122 should be reported. If "screening" barium enema is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT 74280 and the appropriate diagnostic ICD-9 code should be reported.

2) The appropriate ICD-9 code for screening purposes is V76.51 (Special screening for malignant neoplasm; colon).

HCPCS Code G0120:

HCPCS Code G0120 (Colorectal cancer screening; alternative to HCPCS Code G0105, screening colonoscopy, barium enema) is classified as NONCOVERED. HCPCS Code G0120 is for a screening barium enema for an asymptomatic individual as an alternative to sigmoidoscopy; the barium enema component of the code is identical to G0122.

HCPCS Code G0120 is covered under Code G0122, and must meet the following criteria established for G0122:

(Continued on page 8)

(Continued from page 7)

1) For screening barium enema for members who are asymptomatic for colon disease, HCPCS Code G0122 should be reported. If "screening" barium enema is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT Code 74280 and the appropriate diagnostic ICD-9 code should be reported.

2) The appropriate ICD-9 code for screening purposes is ICD-9 Code V76.51 (Special screening for malignant neoplasm; colon).

HCPCS Code G0121:

HCPCS Code G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) is **RESTRICTED**. HCPCS Code G0121 is a covered code but is restricted based on code definition, fragmentation, site-of-service, units-of-service, state mandate, and member benefit contract limitations.

HCPCS Code G0121 is restricted to patients who are 50 years of age or older, and are not at high risk for colon cancer (high risk as defined by the American Cancer Society, 2005: personal history of colon cancer or polyp, a strong family history of colon cancer or polyps in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0121 is a fragmentation of CPT Codes 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45387, 45391, and 45392, as all of these codes represent "surgical" endoscopy codes, and surgical endoscopy codes include diagnostic endoscopy based on CPT coding instructions. HCPCS Code G0121 is mutually exclusive with Code G0105 based on code descriptors.

HCPCS Code G0121 is mutually exclusive with CPT Code 45378, as 45378 could also represent a screening colonoscopy. HCPCS Code G0121 is limited to one unit-of-service and is subject to site-of-service payment differential. Code G0121 is covered for screening for colon cancer for members whose age is 50 or greater who are asymptomatic for colon disease (once every 10 years if the colonoscopy is normal). The appropriate ICD-9 code for screening purposes is V76.51 (Special screening for malignant neoplasm; colon).

For screening colonoscopy for members who are asymptomatic for colon disease, less than 50 but at high risk for colon cancer (as defined above) G0105 should be reported. For "screening" colonoscopy for patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool) CPT 45378 and the appropriate diagnostic ICD-9 code should be reported if no disease is found on colonoscopy. If disease is found and a endoscopic surgical procedure performed, the code that represents the appropriate surgical endoscopy code should be reported.

HCPCS Code G0122:

HCPCS Code G0122 (Colorectal cancer screening; barium enema) is classified as RESTRICTED. HCPCS Code G0122 is restricted based on Coverage Policy #2002020 which considers virtual colonoscopy or CT colonography to be investigational.

HCPCS Code G0122 is allowed based on member benefit contract specific inclusion of coverage for colon cancer screening. Screening barium enema for colon cancer is included in Arkansas Act 2236 effective August 1, 2005. G0122 is restricted to:

1) Patients who are 50 years of age or older, and are not at high risk for colon cancer; and
2) Patients of any age at high risk for colon cancer (high risk as defined by the

American Cancer Society, 2005: personal history of colon cancer, a strong family history of colon cancer or polyps in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0122 has a total, professional and technical component. The total component is allowed only from site-of-service non-facility. Code G0122 is limited to one unit-of-service. The appropriate ICD-9 code for screening purposes is ICD-9 V76.51 (Special screening for malignant neoplasm; colon).

For screening barium enema for members who are asymptomatic for colon disease, HCPCS Code G0122 should be reported. If "screening" barium enema is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT code 74280 and the appropriate diagnostic ICD-9 code should be reported.

Coverage Policy Update:

Since June, 2005, the following policies have been added or revised in the Arkansas Blue Cross Blue Shield Medical Policy Coverage Manual:

- Radiofrequency Ablation of Renal Tumors;
- Infliximab for the Treatment of Ulcerative Colitis;
- Nesiritide (Natrecor);
- Infliximab (Remicade);
- Monochromatic Infrared Energy to Treat Cutaneous Ulcers, Diabetic Neuropathy, Miscellaneous Musculoskeletal Conditions;
- Genetic Testing for Inherited BRCA1 or BRCA2 Mutations;
- Preimplantation Genetic Diagnosis;
- Serum Holo-Transcobalamin as a Marker of Vitamin B12 (i.e., Cobalamin) Status;
- Measurement of Exhaled Nitric Oxide in the Diagnosis and Management of Asthma and Other Respiratory Disorders;
- Electrostimulation and Electromagnetic Therapy for the Treatment of Chronic Wounds;
- Iron Therapy, Parenteral;
- Sildenafil (Revatio) for Pulmonary Hypertension;
- Intensity Modulated Radiation Therapy (IMRT);
- Angioplasty, Renal Artery, Stenting, Percutaneous;
- Periurethral Bulking Agents for the Treatment of Incontinence;
- Radiofrequency Ablation of Bony Metastases;
- Spinal Manipulation Under General Anesthesia;
- Subconjunctival Retinal Prosthesis;
- Respiratory Assist Devices, BiPAP;
- Endovascular Stent Grafts for Thoracic Aortic Aneurysms or Dissections; and
- Atherectomy, Peripheral/Visceral, Percutaneous.

Sleep Apnea/Hypopnea:

Many who practice in sleep medicine are aware that there may be some variation in the degree of desaturation required to define a hypopnea. This variation produces confusion in literature review as well as clinical practice.

Arkansas Blue Cross and Blue Shield wishes to clarify the definition of hypopnea for quality assurance purposes for sleep testing as well as for the prescribing of nasal CPAP or other medical and/or surgical therapies. For Arkansas Blue Cross our members, providers should use of definitions published by Medicare:

> ***Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds associated with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation.***

Please apply this definition when diagnosing or treating Arkansas Blue Cross members and to derive such indices as the apnea/hypopnea index.

Pharmacy Update: Important Information Regarding Drug Coverage - Nexium® Replaces Protonix®:

Due to increased requests from members to add Nexium® to the drug formulary, effective August 1, 2005, Nexium® will replace Protonix® on the Arkansas Blue Cross and Blue Shield and Health Advantage drug formularies. The two **covered** proton pump inhibitor (PPI) drugs now will be Nexium® and Prevacid®.

Protonix will no longer be covered by Arkansas Blue Cross or Health Advantage. Please remind patients that Prilosec® OTC is available without a prescription in the 20 mg strength and will cost substantially less per month than a prescription copayment for PPI.

Arkansas Blue Cross and Health Advantage regrets any inconvenience this change might cause our providers and members. Arkansas Blue Cross and Health Advantage continues to strive to hold all formulary changes to a minimum to avoid any confusion and/or inconvenience.

If you have any questions, please contact Norman Canterbury, PD, Pharmacy Director for Arkansas Blue Cross and Blue Shield at (501) 378-3364.

Note: This pharmacy change does not apply to the Federal Employee Program (FEP). For FEP pharmacy information, please contact the Prescription Drug Program at 1-800-624-5060 or the Mail Service Prescription Drug Program at 1-800-262-7890.

New Patient Relationship Codes for Paper and Non-Compliant Claims:

On September 1, 2005, a change was made to the current patient relationship codes for paper and non-compliant claims. This change will affect both professional (CMS 1500) as well as institutional (UB 92) claims.

After September 1, 2005, any claims submitted with the old patient relation codes will be rejected. The old patient relation codes and the new patient relation codes are listed below. Please reference the ANSI X1 2837 Implementation Guide.

NEW CODES Effective 9/1/05

01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
G8	Other Relationship

DELETED CODES Prior to 9/1/05

01	Patient is Insured
02	Spouse
03	Natural Child/Insured Financial Resp.
04	Natural Child Insured does not have Financial Responsibility
05	Step Child
06	Foster Child
07	Ward of the Court
08	Employee
09	Unknown
10	Handicapped Dependent
11	Organ Donor
12	Cadaver Donor
13	Grandchild
14	Niece/Nephew
15	Injured Plaintiff
16	Sponsored Dependent
17	Minor Dependent of a Minor Dependent

Provider Service Number and My BlueLine:

(Reprint from the June 2005 issue of the Providers' News)

Arkansas Blue Cross and Blue Shield is happy to announce effective May 1, 2005 participating providers can now call ***My BlueLine*** at 1-800-827-4814 or 501-378-2307 for eligibility, claim status, and benefit information for members of Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas.

Note: Please continue using the existing telephone numbers for the following:

- Blue Card 1-800-880-0918
- Federal Employees Program (FEP) 501-378-2531 or 1-800-482-6655

Arkansas Blue Cross believes this will be a great enhancement for providers. Providers will no longer have to call multiple phone lines to get information on a member, depending upon whether the member's coverage is with Arkansas Blue Cross, BlueAdvantage, Health Advantage, or Medi-Pak .

If at any point a caller needs to speak with a Customer Service Representative during regular business hours, simply say "Customer Service." At that time, the caller will be given an option of visiting with a Customer Service Representative with Arkansas Blue Cross, Health Advantage, or BlueAdvantage.

Please note that for BlueAdvantage, there are several phone lines handling self-insured employer groups. Therefore, it may become necessary to direct callers to a phone number on the member's ID card.

Also, Arkansas Blue Cross has streamlined the flow of calls once in the self-service interactive voice response system (***My BlueLine***). Callers will find easier access to get the important information on eligibility and claim status.

Arkansas Blue Cross truly hopes that this self-service option is utilized as much as possible for routine questions and status updates. This will keep Customer Service Representatives available for any questions that cannot be answered through the self-service ***My BlueLine***.

Arkansas Blue Cross also wants to remind providers that the same information is available through AHIN with additional detail for member eligibility, member benefits, claim status, and information on BlueCard for out-of-state Blue Plan coverage.

Note: This information and any benefit information provided is not a guarantee of payment or coverage and is only valid if all coverage criteria is verified when Arkansas Blue Cross receives the claim. Coverage criteria to be verified includes, but is not limited to, payment of premium, employment status under group plans, and dependent eligibility. No payment will be made for any services in connection with which there has been any negligent or intentional misrepresentation, or failure of disclosure, of any fact relevant to an eligibility or coverage determination.

Medicare and Arkansas Blue Cross and Blue Shield End HIPAA Contingency Plan for Electronic Claims:

On August 4, 2005, Centers for Medicare & Medicaid Services (CMS) announced in ***Medlearn Matters*** (MM3956) that Medicare would be ending its HIPAA Transactions and Code Sets (T&CS) contingency plan for claims on October 1, 2005. Arkansas Blue Cross and Blue Shield will follow the lead of Medicare and end its HIPAA contingency plan on the same date.

As the healthcare industry approached the extended HIPAA T&CS deadline of October 16, 2003, there were still some covered entities that had not been able to come into HIPAA compliance. CMS, as the HIPAA enforcement arm of the department Health and Human Services (HHS), did not want to disrupt the flow of healthcare information and the payment for that healthcare. Therefore, CMS established a contingency plan that allowed providers to continue submitting NSF formatted electronic claims to Medicare, if that provider was making good faith efforts to come into compliance.

Arkansas Blue Cross also wanted to keep the electronic transactions flowing and also implemented a similar HIPAA contingency plan. Today Arkansas Blue Cross has over 99.9% of our providers submitting HIPAA compliant transactions.

With the ending of the contingency plan, providers among this very large majority submitting HIPAA compliant claims will not see any change in claims filing procedure or payments. However effective October 1, 2005, claims from providers who still submit NSF formatted electronic claims directly to Arkansas Blue Cross will be rejected.

Providers still have options to come into HIPAA compliance. Providers may still have time to complete the systems changes and testing, by October 1, 2005.

Providers may also enlist the services of a healthcare clearinghouse to convert the NSF claims to the HIPAA required ANSI formats. There are several good clearinghouses in the industry. Arkansas Blue Cross offers the Advanced Health Information Network (AHIN) as a free clearinghouse service for claims being filed with:

- Arkansas Blue Cross,
- Health Advantage,
- BlueAdvantage Administrators of Arkansas,
- Medicaid,
- Arkansas Medicare Parts A and B, and
- Claims being routed to any other Blue plan.

However, there is a 10 cent per claim fee for any other commercial carrier claim handling.

For more information on selecting AHIN as a clearinghouse, or if to complete testing of HIPAA compliant claims, please contact the Arkansas Blue Cross EDI Services Division at (501) 378-2419 or toll-free at (866) 582-3247.

Respiratory Syncytial Virus (RSV) Season:

(Reprint from the September 2003 & September 2004 issues of the Providers' News.)

Benefits are available for coverage of Respiratory Syncytial Virus antibody, Accredo Novo Factor (Palivzumab), under certain clinical conditions during any six-month period beginning in the fall and ending in the spring.

Clinical conditions are as follows:

- Infants, less than two years of age, who have Bronchopulmonary Dysplasia which requires oxygen supplementation;
- Infants delivered at less than 28 weeks gestation, under twelve months at the time of hospital discharge, and discharged during RSV season **(any six month period beginning in fall and ending in spring)**;
- Infants delivered at 28-34 weeks gestation who have ongoing medical problems, less than six months of age at the time of hospital discharge, and discharged from the hospital during RSV season (November-April);
- High-risk infants, with non-respiratory problems, on an individual consideration basis (e.g., acyanotic cardiac lesions with left-to-right shunting, failure to thrive, immunodeficiency, neuro-muscular disease, severe congenital disorders).

Medical necessity documentation must be submitted for prior authorization through the Managed Pharmacy Division of Arkansas Blue Cross and Blue Shield at (501) 378-3392. Accredo Novo Factor injections can be supplied to provider offices for administration through the specialty medication network pharmacy, **Nova Factor**.

Nova Factor is Arkansas Blue Cross' preferred specialty medication network pharmacy provider offering Accredo Novo Factor with expert pharmaceutical care management services such as compliance and caregiver education. In addition, **Nova Factor** provides claims processing and claims assistance for the member so there is less paperwork for providers and their staff. **The member can maximize benefits by obtaining the Accredo Novo Factor through Nova Factor**.

Steps to Order Accredo Novo Factor:

1. Review the ***Coverage Criteria*** on the form mailed to your office.
2. Receive ***Prior Authorization*** at (501) 378-3392.
3. Complete the **Nova Factor** Patient Referral Form: Accredo Novo Factor (palivzumab).
4. Fax the completed form to (501) 378-6980.

Reminder:

If a member utilizes an out-of-network pharmacy provider, a substantial out-of-pocket responsibility for the member may result. Members are liable for amounts in excess of Arkansas Blue Cross and Blue Shield's Allowable Charge when billed by an out-of-network provider. The member may reference their ***Evidence of Coverage*** for more information or contact their local health plan Customer Service Department.

To Find out More:

For provider who have questions or need more information, please call the toll-free **Nova Factor** Customer Service line at 1(877) 482-5927. For your convenience, **Nova Factor** is available Monday through Friday, 7:30 a.m. - 7:00 p.m. Central Standard Time.

Important Information Regarding New Drug Administration Codes G0345-G0362:

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- Use of local anesthesia;
- IV start;
- Access to indwelling IV, subcutaneous catheter or port;
- Flush at conclusion of infusion; and
- Standard tubing, syringes and supplies.

If a **significant separately identifiable Evaluation and Management service is performed**, the appropriate E/M service code should be reported utilizing Modifier 25 in addition to the administration code(s). **This requirement will be monitored for compliance.**

The "initial" code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur. Only one "***initial"*** code may be billed for an encounter, unless protocol requires that two separate IV sites must be utilized.

If two separate IV sites must be utilized, Modifier 59 should be appended. Medical necessity of the separate IV site must be documented. Records may be required to document the additional port. The initial codes are G0345, G0347, G0353, G0357 and G0359.

Intravenous or intra-arterial push is defined as:

- An injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient; **OR**
- An infusion of 15 minutes or less;

HCPCS Code G0350 may only be billed **ONCE** per encounter. Records should document the drug(s) administered concurrently.

The subsequent hour codes may only be billed when the infusion time is greater than 30 minutes beyond the one hour increments:

- 91 – 150 Minutes = 1 unit of service
- 151 – 210 Minutes = 2 units of service
- 211 – 270 Minutes = 3 units of service
- 271 – 330 Minutes = 4 units of service
- 331 – 390 Minutes = 5 units of service
- 391 – 450 Minutes = 6 units of service
- 451 – 510 Minutes = 7 units of service
- 511 – 570 Minutes = 8 units of service

The HCPCS codes for the drugs given may be billed in addition to the administration codes. Each hydration code should be linked to at least one code for pre-packaged fluid and electrolytes. Each other administration code billed should be linked to at least one drug code.

Crosswalk from CPT to New 'G' Codes:
Hydration

CPT (Old)	HCPCS (New)	Description	Time (Minutes)	Type	Initial Codes
90780	**G0345**	Intravenous infusion, hydration; ***initial***, up to one hour	31-90	IV	
90781	**G0346**	Intravenous infusion, hydration; ***each additional hour***, up to eight (8) hours (List separately in addition to code for primary procedure)	91-150 = 1 unit; 151-210 = 2 units; 211-270 = 3 units; 271-330 = 4 units; 331-390 = 5 units; 391-450 = 6 units; 451-510 = 7 units; 511-570 = 8 units.	IV	**G0345 G0357 G0359**

Injections and Infusions (Non-chemotherapy; Other than hydration)

CPT (Old)	HCPCS (New)	Description	Time (Minutes)	Type	Initial Codes
90780	**G0347**	Intravenous infusion, for therapeutic/ diagnostic (Specify substance or drug); ***initial***, up to one hour	31-90	IV	
90781	**G0348**	Intravenous infusion, for therapeutic/ diagnostic (Specify substance or drug); ***each additional hour***, up to eight (8) hours (List separately in addition to code for primary procedure and report in conjunction with G0347)	91-150 = 1 unit 151-210 = 2 units 211-270 = 3 units 271-330 = 4 units 331-390 = 5 units 391-450 = 6 units 451-510 = 7 units 511-570 = 8 units	IV	**G0347 G0357 G0359**
N/A	**G0349**	***Additional sequential infusion***, up to one hour (List separately in addition to code for primary procedure)		IV (Additional Drug)	**G0347 G0357 G0359**
		Second and additional Non-Chemo drug infused after the conclusion of the infusion of the first drug			
N/A	**G0350**	***Concurrent infusion*** (List separately in addition to code for primary procedure report only ***once per substance/drug*** regardless of duration, report G0350 in conjunction with G0345	Not applicable **One Unit Per Day**	IV	**G0345 G0347 G0353 G0357 G0359**
		More than one Non-Chemo drug infused at the same time as the first drug			
90782	**G0351**	Therapeutic or diagnostic ***injection*** (Specify substance or drug); subcutaneous or intramuscular	Not applicable	IM, SubQ	
90784	**G0353**	***Intravenous push, single or initial*** substance/drug	15 or less	IV Push	
N/A	**G0354**	Intravenous push; ***each additional sequential intravenous push*** (List separately in addition to code for primary procedure)	15 or less	IV Push	**G0345 G0347 G0353 G0357**
		Second and additional Non-Chemo drug infused after the conclusion of the infusion of the first drug			

Crosswalk from CPT to New 'G' Codes (continued) :

Chemotherapy Administration

CPT (Old)	HCPCS (New)	Description	Time (Minutes)	Type	Initial Codes
96400	**G0355**	Chemotherapy administration, subcutaneous or intramuscular non-hormonal antineoplastic		IM, SubQ	
96400	**G0356**	Hormonal antineoplastic		IM, SubQ	
96408	**G0357**	Intravenous, push technique, single or initial substance/drug	15 or less	IV Push	
96408-96459	**G0358**	Intravenous, push technique, **each additional substance/drug** (List separately in addition to code for primary procedure)	15 or less	IV Push	**G0357 G0359**
96410	**G0359**	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug	31-90	IV	
96412	**G0360**	Chemotherapy administration, intravenous infusion technique;	91-150 = 1 unit 151-210 = 2 units	IV	**G0359**
96414	**G0361**	Initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump		IV	
96410-96459	**G0362**	Each additional sequential infusion (different substance/ drug), up to one hour (use with G0359)		IV	**G0359**
		Second and additional Chemotherapy drug infused after the conclusion of the infusion of the first drug			

Resources used for the coding and payment policies for codes G0345-G0362 include:

- Medicare Prescription Drug and Modernization Act of 2003;
- Current Procedural Terminology (CPT) Guidelines;
- American Society of Clinical Oncology, in a Frequently Asked Questions;
- Bulletin addressing the new G-codes for infusion, dated 23 Feb 05;
- *Federal Register,* Vol. 69, No. 219, November 15, 2004.

Notice of Payer Policies & Procedures and Terms & Conditions Applicable to all Individual Network Participants and Applicants for Arkansas' FirstSource® PPO, Health Advantage HMO, and True Blue PPO Networks:

As a result of the new "Any Willing Provider" (or "AWP") legislation and a significant increase in individuals participating in "Consumer Driven Products," USAble Corporation and Health Advantage are announcing clarifications and extensions of current Payer[1] Policies and Procedures and Terms and Conditions applicable to all qualified individual providers who participate in or seek admission to USAble's Arkansas' FirstSource® PPO and True Blue PPO networks or Health Advantage's HMO network (including those individuals who may contract through physician-hospital organizations and other group agreements).

With the significant number of new providers who will be participating in the FirstSource, True Blue and Health Advantage Networks when the AWP law is enforced, the following information should be very helpful in outlining the terms and conditions applicable to all network applicants and participants.

Even though the majority of the enclosed information covers policies that have been in place for several years, we encourage everyone to read the entire document to make sure you and your staff are aware of all "Payer Policies and Procedures" and terms and conditions for the networks. The following information contains additions and changes to the current network terms and conditions that are effective immediately[2].

I. Regional Network Administration

Participation in the networks is divided into regional service areas in which the applying/participating provider is located. Providers wishing to participate in the network for any given region must:

a) Maintain a practice location within the geographic limits of that region;
b) Meet all credentialing standards and terms and conditions for the networks generally; and
c) Be willing to accept the allowances, fee schedules, and payment policies for that specific region.

Additionally, should any provider furnish services for any reason to any Member outside the region in which the provider's practice is located, network participating providers must agree to be bound by and accept the allowances, fee schedules, and payment policies in effect for the region in which the provider is enrolled. The networks' regional service areas currently are based on seven regions, organized by counties and defined as

1. USAble Corporation is not an insurer or payer, but participates in this publication for purposes of network terms and conditions for its separate PPO networks, Arkansas' FirstSourceÒ PPO, which is utilized by self-funded health benefit plan payers, and True Blue PPO, which is utilized by, among others, Arkansas Blue Cross and Blue Shield for its PPO Members.

2. While these Payer Policies & Procedures and Terms & Conditions for network participants shall be deemed to be effective immediately (unless a later effective date is specifically referenced in the text of any specific policy, below), review for compliance & application of the policies/terms to individual providers will be conducted according to the following schedule:
   a) for new network applications, these new policies/terms will apply upon review for initial credentialing, and upon any subsequent recredentialing review;
   b) for current network participants, these new policies/terms will apply upon the earlier of
      (i) the next recredentialing review or
      (ii) any complaint or notice to the networks that a particular network participant fails to meet the requirements of these new policies/terms; or
      (iii) any other method (including but not limited to claims review, customer service calls or inquiries, newspaper or other media reports, etc.) by which alleged non-compliance is brought to the attention of the network-sponsoring companies, following the publication date of this document.

the Northwest, Northeast, West Central, Central, South Central, Southwest and Southeast Regions.

II. Re-Application after Termination from the Networks:

If a provider is terminated or excluded from the networks, such termination or exclusion may render the provider ineligible to re-apply or be considered again for network participation for certain specified periods, as referenced more specifically in the subsections, below. Additionally, a previously terminated or excluded provider may be subject to special conditions for re-admission, based on the history of past conduct or violations of contract terms or policies and procedures.

It should also be noted that USAble, Health Advantage and their parent entity, Arkansas Blue Cross and Blue Shield have determined that if a provider is removed from one of their separate networks (e.g., if Arkansas Blue Cross removes a provider from its Preferred Payment Plan network) based on a violation of that network's terms and conditions, the removed provider is rendered ineligible to participate in the remaining networks, i.e., once a provider joins any of the networks, the network sponsors (USAble, Health Advantage and Arkansas Blue Cross and Blue Shield) intend to require good standing with that network as an additional term and condition of participation in the other networks.

(a) Exclusion for Breach of Network Participation Agreement - If a participating provider is excluded from the network for any breach[3] of the network participation agreement, such excluded provider shall not be eligible to apply for re-admission for a minimum period of three years. Depending on the nature of the breach, the network-sponsoring companies further reserve the right to attach special conditions to any such re-admission after three years. By way of example (and without excluding any other possible special conditions), if a provider is excluded for failure to refund duplicate payments when requested, upon re-applying, such provider may be subject to the special condition of a percentage hold-back on claims payments, an interest charge for un-reimbursed duplicate payments, or other requirements to address the past history of contract violations.

NOTE: Exclusions for a contract breach that involve violations of utilization, claims or coding policies, Coverage Policy, refusal to recognize member health plan exclusions, or other written standards are subject to special re-application standards and waiting periods, as referenced in subpart (b), below.

If a payer or its agent has published a written policy that providers may or should file claims that are known to be excluded from coverage under applicable Coverage Policies whenever such a filing and denial are necessary because of the need to furnish proof of such denials to a secondary payer (under applicable coordination of benefits rules), the preceding standard would not be grounds for a provider's exclusion in such limited circumstances, provided that secondary payer requirements are in fact the basis for such claims filings. In addition, if a provider has fully complied with the member waiver requirements of the network participation agreement, prior to administering any services to a member that would not be covered under applicable payer Coverage Policies, then such provision of services shall not be grounds for exclusion from the networks, so long as provider does not bill the applicable payer for such services

(b) Exclusion for Violations of Utilization, Claims or Coding, Coverage Policy or other Written Standards - If a participating provider is excluded from the network for a failure or refusal to comply with the utilization standards, claims filing or coding policies, Coverage Policies or any other written standards of the network-sponsoring companies after provider receives written warning of non-compliance with such standards or policies, such excluded provider shall not be eligible to apply for re-admission until five years have elapsed following such exclusion.

(Continued on page 20)

3. Except for a breach that involves a "restricted" license, as defined in the Practitioner Credentialing Standards of USAble Corporation or Health Advantage; in such cases, the duration of a provider's ineligibility for network participation shall continue to be governed by the Practitioner Credentialing Standards, which generally apply an ineligibility period of the duration of the license restrictions or two years from the date of the initial restriction, whichever is longer.

(Continued from page 19)

Depending on the nature of the breach, the network-sponsoring companies further reserve the right to attach special conditions to any such re-admission after five years, including but not limited to any measure that, in the network-sponsoring company's judgment, is needed to address the history of past violations. Such measures may include but are not limited to reducing the allowance or fee schedule applicable to such re-admitted provider, or requiring such previously excluded provider to submit to pre-admission audit of random samples of medical records, patient files or insurance claims (such audits to be conducted as part of credentialing activity, which allows covered entity payers access to protected health information under applicable HIPAA Privacy rules) for the purpose of investigating whether the previous violations of standards have been corrected in the intervening five years. If the provider fails to fully cooperate in such an audit, or if ongoing violation of standards is found in any such pre-admission audit, the applying provider shall not be eligible for readmission to the networks.

(c) Exclusion for False or Misleading Claims - If a participating provider is excluded from the network for filing any false or misleading claim, or engaging in or assisting any other person or individual in the presentation of any false or misleading information (including but not limited to any claims data, medical background or records, employment history or status, or other coverage eligibility information) to any insurer, HMO or self-funded payer, such excluded provider shall not be eligible to apply for re-admission to the networks, and shall be permanently disqualified from participation.

NOTE: Providers are deemed responsible for all actions of any employee or agent of the provider, including but not limited to nursing or administrative staff, office managers or personnel, billing clerks, billing services, practice management agents or vendors, software vendors or others working on provider's behalf to file any claims data or to otherwise furnish any information to insurers, HMOs or other payers. If false or misleading claims (or any other data) are sent to any insurer, HMO or payer accessing the networks, participating providers may be excluded and permanently disqualified from network participation even though such providers contend or could show that participating provider was not personally aware of or involved in the presentation of such information. The networks can not conduct continual, full-scale audits of all claims or all providers, and must therefore be able to rely on providers to appropriately monitor their staff and vendors, and to take prompt corrective action if any problem is identified.

(d) Curing a Contract Breach Prior to Termination - Current network participation agreements recognize that a material breach of the contract may be cured to avoid immediate termination if the network-sponsoring company requests such cure, and if an offending provider fully cures the breach within five business days after written request from the network-sponsoring company. While this provision is not being changed, it should be noted that not all contract breaches are capable of being cured, and if a breach is one that cannot be fully cured then immediate termination cannot be avoided in such instances. For example, a provider who breaches the contract and network term that privileges must be maintained at a participating hospital, or that minimal malpractice coverage be maintained, could fully cure that breach, upon request of the network sponsor, by obtaining such privileges or malpractice coverage within five business days of written request from the network sponsor.

However, a provider who breaches the contract and network terms requiring compliance with applicable utilization standards, or coding or claims filing policies, or Coverage Policies, or medical records/ documentation standards (among other possible examples) will ordinarily not be able to fully cure such breaches because past actions cannot be erased or reversed completely (even if financial restitution is made). Likewise, a provider who knowingly files false or misleading claims or related data with any payer cannot fully cure such action. Accordingly, participating providers agree that only those contract breaches for which the network sponsor specifically requests cure within the five business day period will be eligible for cure to avoid termination.

III. Providers' News Notices and Articles:

Network participation agreements currently stipulate that participating providers may receive notices of policy changes via Providers' News (as well as through websites of applicable payers such as Arkansas Blue Cross and Blue Shield or Health Advantage). It is important for all participating providers to understand that the role of Providers' News will be further enhanced in the new AWP environment, as a source of notice concerning network terms and conditions. All participating providers are responsible for ensuring that such providers and their office staff monitor and pay regular and close attention to the notices and articles published in Providers' News, as it represents an efficient method of communication with network-participating providers on a state-wide basis.

Claims filed or other actions taken by a participating provider or their office staff or other representatives that fail to follow instructions published in Providers' News shall constitute grounds for exclusion from the networks, regardless of whether a participating provider has personally received or read the Providers' News publication, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring Providers' News. It should be noted that past editions of Providers' News are available on the website of Arkansas Blue Cross and Blue Shield, to which all participating providers have access via the internet.

IV. Provider Manuals:

All participating providers have been and will continue to be subject to the terms and conditions set forth in Provider Manuals of payers such as Arkansas Blue Cross and Blue Shield and Health Advantage, as well as any separate Provider Manual of non-payer networks such as USAble Corporation/BlueAdvantage Administrators of Arkansas ("BAAA") or True Blue PPO. The Provider Manual is an operational handbook and set of guidelines furnished for the convenience and guidance of providers and their office staff. The Provider Manual serves as a resource for answers to common provider questions about health plan coverage policies and procedures, as well as an outline of some basic required administrative procedures for proper processing of claims and participation as a participating provider.

The current version of the Arkansas Blue Cross and Blue Shield Provider Manual is posted to the Arkansas Blue Cross and Blue Shield website. Updated Provider Manuals for Health Advantage and USAble Corporation (BAAA) are expected to be published on their respective websites within several months. Applying providers must agree, as a term and condition of participation, to abide by the Provider Manuals of applicable payers and all participating providers must follow the guidelines, procedures and policies set forth in such Provider Manuals, if they are to remain eligible for network participation.

Until the publication of updated Provider Manuals for Health Advantage and USAble Corporation/BAAA, participating providers in the Arkansas' FirstSource® PPO, True Blue PPO, and Health Advantage HMO networks shall be obligated to follow the general provisions and guidelines of the Provider Manual of Arkansas Blue Cross and Blue Shield, including, when published, the updated version of the Arkansas Blue Cross and Blue Shield Provider Manual, which is expected to be posted to the Arkansas Blue Cross and Blue Shield website in the next several weeks. Failure to accept or follow any term or condition of the Provider Manual shall constitute grounds for exclusion from the networks, regardless of whether a participating provider has personally received or read the Provider Manual, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring Provider Manuals.

Participating providers who lack internet access may request a hard copy of the Provider Manuals, but in doing so must recognize that updates may be posted at any time to the website version, and hard copy updates will not be provided, except upon specific follow-up request from such provider. As a term and condition of network participation, providers are expected to make their own arrangements for internet access so as to have and maintain ready access to posted materials, including the Provider Manuals. (Written notice of changes to the Provider Manual ordinarily will also be published in Providers' News, although a complete new edition of a Provider Manual ordinarily will not be issued or published in that manner.)

(Continued on page 22)

(Continued from page 21)

V. Coverage Policies:

Network-participating providers must, in order to be eligible for continuing network participation, agree to accept and abide by the Coverage Policy of the insurer, HMO or self-funded payer for whose members' benefit the network is operated. Coverage Policies for payers such as Arkansas Blue Cross and Blue Shield (accessing the True Blue PPO network for some of its members) and Health Advantage have been established with active input from practicing physicians across the state of Arkansas who serve on various regional committees organized, in part , for that purpose.

Coverage Policies are written to reflect evidence-based medical care as reflected in peer-reviewed medical literature and to reflect concurrence with the Primary Coverage Criteria, which is a coverage standard incorporated into many health plans or insurance contracts for Members of Arkansas Blue Cross and Blue Shield or Health Advantage. Coverage Policies and the rationale for such policies are publicly accessible on the websites of Arkansas Blue Cross and Blue Shield and Health Advantage. The rationales are based on the evidence listed in each separate Coverage Policy. Appeal mechanisms are available to both the affected Member and provider when they disagree with the application of a particular Coverage Policy to a specific claim.

Coverage Policies may change (either to broaden or restrict coverage) based on new information that meets the Primary Coverage Criteria or other required standards of a Member's health benefit plan or insurance contract. Requests for changes in Coverage Policies are welcome, if the requesting party presents supporting data from multicenter randomized trials, adequately populated prospective controlled trials, or expert opinion, as such expert opinion is defined in the Primary Coverage Criteria or other provisions of a Member's health benefit plan or insurance contract. Coverage Policies specific to self-funded payer health benefit plans (if any) may also be posted to the BlueAdvantage Administrators website of USAble Corporation. Compliance with such Coverage Policies is a specific condition of the written network participation agreement, so this policy/term is not new; however, the following supplements the formal contract provision to provide additional details and requirements:

(a) Individual Provider Responsibility for Compliance - Participating providers are responsible for making sure that claims filed with any insurer, HMO or self-funded payer accessing the networks comply with applicable Coverage Policies as posted to the websites, regardless of whether a participating provider has personally accessed the websites, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring the websites. Participating providers who lack internet access may request a hard copy of specific Coverage Policies, but in doing so must recognize that updates may be posted at any time to the website version, and hard copy updates will not be provided, except upon specific follow-up request from such provider. As a term and condition of network participation, providers are expected to make their own arrangements for internet access so as to have and maintain ready access to posted materials, including the Coverage Policies (however, it should be noted that changes to Coverage Policies will also ordinarily be published by notice in Providers' News.)

(b) Noncompliance is grounds for network exclusion - A provider who receives written notice directed specifically to such provider of a violation of published Coverage Policies of a payer accessing the networks, and who thereafter fails or refuses to accept and follow the Coverage Policies of such payer, as posted to the websites (or as otherwise published to providers generally through Providers' News or specific correspondence of any payer or its agent to providers) shall be subject to exclusion from the networks. Providers who disagree with such Coverage Policies shall remain free to follow any course of practice or treatment they deem appropriate with respect to patients, and such providers may choose to challenge a reimbursement decision based on a Coverage Policy by internal appeals, external review, arbitration or any other avenue otherwise open to such provider for administrative or legal challenge; however, if an internal appeal within the insurer, HMO or self-funded payer is denied, or if provider loses any external review, arbitration or other administrative or legal challenge, or if provider fails to pursue any internal appeal or administrative or legal challenge, participating providers who thereafter

persist in refusing to accept or follow Coverage Policies, after receiving written warning from the applicable payer or its agent, shall not be eligible for continued network participation, and shall be excluded from participation on that basis.

If a payer or its agent has published a written policy that providers may or should file claims that are known to be excluded from coverage under applicable Coverage Policies whenever such a filing and denial are necessary because of the need to furnish proof of such denials to a secondary payer (under applicable coordination of benefits rules), the preceding standard would not be grounds for a provider's exclusion in such limited circumstances, provided that secondary payer requirements are in fact the basis for such claims filings. In addition, if a provider has fully complied with the member waiver requirements of the network participation agreement, prior to administering any services to a member that would not be covered under applicable payer Coverage Policies, then such provision of services shall not be grounds for exclusion from the networks, so long as provider does not bill the applicable payer for such services.

NOTE: Even if a provider wins an external review, arbitration or other administrative or legal challenge, if the provider thereafter refuses to comply with the challenged Coverage Policy, such provider may still be excluded from the network unless the insurer, HMO or self-funded payer whose Coverage Policy was challenged changes the policy as a result of the external review, arbitration or other administrative or legal challenge. In other words, merely because an external reviewer, arbitrator, agency or court requires payment to a provider on a particular claim or set of claims does not mean the provider can ignore the Coverage Policy adopted by payers accessing the network, if provider wishes to continue to be a network participant.

(Of course, if a final, binding court decision invalidates and enjoins enforcement of the Coverage Policy, or mandates its modification, payers will be obligated to comply, but in the absence of any such decision, providers cannot circumvent the network participation terms and conditions merely by winning a claims payment dispute with the payer). Providers in such circumstances, are choosing to disqualify and exclude themselves from participation if they persist in rejecting applicable Coverage Policy.

VI. Utilization Standards:

Network participation agreements currently require compliance by participating providers with applicable utilization policies and programs of the networks or payers utilizing the networks. The network-sponsoring companies or payers utilizing the networks may establish utilization standards, including but not limited to ratings of a participating provider in comparison to a designated peer group of other participating providers, or to state or national statistical averages, or the recommendations of any independent source such as medical research or analysis organizations, Medicare or other government programs. Participating providers must cooperate fully in all such utilization programs (including but not limited to furnishing of all claims or practice data needed to evaluate participating provider's compliance with utilization criteria), and must comply with such standards, as a term and condition of continuing network participation.

Failure to accept and meet all utilization standards shall be grounds for exclusion from the networks. Prior to implementation of new utilization standards not currently in use, USAble Corporation and Health Advantage intend to review such new standards with a representative group of practicing physicians to solicit and obtain their input, and may also elect to have such new utilization standards reviewed by an external organization having expertise in clinical or practice guidelines and standards.

Network sponsors or payers may elect to refer any perceived utilization issue of a participating provider to an external reviewer or external review organization. Participating providers must fully cooperate with any such external review in responding to inquiries and furnishing any requested information. Failure to fully cooperate shall be grounds for exclusion from the networks.

NOTE: Providers with identified utilization issues or outlier status may be subject to probationary status and special conditions for continued participation, or other measures

(Continued on page 24)

(Continued from page 23)

short of network termination, including by way of example, and not to exclusion of any other conditions, requirement to submit medical records with all claims or percentage hold-backs on claims payments. If a participating provider under review for utilization issues refers patients to another provider, or otherwise takes any steps to hide over-utilization, the utilization on such referrals may be attributed to such participating provider.

VII. Publication of Utilization, Quality and Other Practice Data:

As a term and condition of network participation, all participating providers are asked to agree, and in the absence of a negative response sent by certified letter, are deemed to authorize insurers, HMOs or self-funded payers whose members utilize the networks, to publish to such members, customers and to the public generally (subject, of course, to applicable member confidentiality requirements and HIPAA Privacy standards) any data regarding the rates of utilization or performance of services by such participating provider, any data regarding quality of services provided to members, any data (again, subject to protection of member identification/ confidentiality) regarding member complaints, any data regarding malpractice claims, including but not limited to the filing of such claims, settlement of any such claims, insurance payments made as to such claims, judgments or awards made as to such claims, any data regarding complaints to the State Medical Board or other regulatory or disciplinary authorities regarding such participating provider, any data regarding provider's education, professional training, practice history, prior locations and licensure in any jurisdiction, and any other data concerning participating provider and provider's professional qualifications, competency or practice that may be useful and informative to such members, customers and the public generally.

As a term and condition of network participation, participating providers agree to release the insurer, HMO or self-funded payer and their agents or representatives from any claims or liabilities related to the publication of any provider data to members, customers or the public generally, so long as such publication is not deliberately and maliciously false.

Providers who refuse to release any data for purposes of publication as referenced herein, or who decline to release insurers, HMOs or self-funded payers and their agents and representatives from all claims or liabilities (except for a deliberate and malicious falsehood) shall be subject to the following procedure: the network sponsor will publish to its members, in any manner or medium the network sponsor decides is appropriate, including but not limited to provider directories, websites or specific written notices or verbal statements the fact that the provider has declined to grant permission for such provider's utilization and practice data to be released to members.

Providers will be given a copy of the utilization and practice data that the network sponsor proposes to publish, and shall have a period of 30 days in which to review it before any publication to members is made. Providers who do not agree to authorize release of their utilization and practice data to members must send written notice to USAble Corporation and Health Advantage, by certified mail, within 30 days after receipt of a copy of the proposed utilization and practice data publication. Providers who fail to send written notice, in the time and manner specified, of denial of permission to publish their utilization and practice data shall be deemed to authorize such publication, and shall be subject to publication without further notice or express authorization.

VIII. Criminal Investigations, Charges or Convictions, or Government Programs Investigations:

Any provider who is charged with commission of a crime may be excluded from the networks, regardless of whether the crime is a misdemeanor[4] or a felony, and regardless of whether a trial has been held, a conviction is

4. Not all misdemeanors shall be grounds for network exclusion. For example, in most circumstances, minor traffic violations, speeding tickets, etc. would not be considered relevant (although a pattern of repeat offenses, especially if others are injured by such violations, might be deemed appropriate grounds for network action). The intention is to consider primarily those misdemeanors that indicate either possible danger to or indifference to the well being of patients or other individuals (e.g., a misdemeanor involving physical violence or threats or abusive conduct) or fraudulent or disreputable claims or business practices or other egregious misconduct reflecting negatively on personal reliability and professional or business reputation.

obtained, or the charges are later withdrawn, settled or otherwise dismissed or resolved. The network sponsors and payers shall have the right to take all circumstances into account in consideration of their member's safety and the general business reputations of the network sponsors and payers.

In appropriate cases, the network sponsors or payers shall be entitled to exclude providers under investigation by any criminal law enforcement agency or process (including but not limited to grand juries or prosecuting attorneys), or by any government program (including but not limited to Medicare, Medicaid, state attorneys general or the U.S. Office of Inspector General).

NOTE: While the preceding addresses possible exclusion for criminal charges or investigations prior to conviction, it remains a network credentialing standard that any felony conviction is grounds for network exclusion, the only exception being in specified circumstances involving a government executive pardon.

IX. Malpractice Claims:

The networks' credentialing standards have always taken malpractice claims into account in evaluating providers for initial and ongoing credentialing for participation in the networks. Providers have been and will continue to be subject to exclusion based on their malpractice history. In looking at malpractice history, the networks reserve the right to exclude a provider based on the number of cases filed against a provider, the types of cases filed, the amount of any settlement made on behalf of the provider, as well as any combination of the preceding factors or any other factors that appear relevant to evaluating the provider's degree of culpability or responsibility for alleged harm to a patient.

The networks shall be entitled to exclude a provider based on their assessment of the provider's malpractice background, regardless of whether some or all claims have been dismissed, withdrawn, settled or resolved at trial, i.e., the networks reserve the right to make an independent judgment regarding whether the provider's conduct, as questioned in the malpractice allegations, was negligent or otherwise culpable so as to disqualify the provider from network participation.

While most malpractice activity is of such a nature that it must be evaluated on a case-by-case basis, the networks have determined that it is necessary to set some minimal standards of disqualification, regardless of any other factors or circumstances. These minimal standards[5] include the following:

(a) Any provider who has more than 10 malpractice lawsuits filed against the provider in the most recent ten year period prior to the date of application or credentialing/recredentialing review is disqualified and shall be excluded from the networks on that basis alone, irrespective of any other factors, including but not limited to the fact that any of the lawsuits might have been dismissed or withdrawn, or resulted in a trial verdict in favor of the provider.

(b) Any provider who has moved practice locations[6] three or more times in the most recent ten year period prior to the date of application or credentialing/ recredentialing review, and who also had three or more malpractice lawsuits filed against the provider during the same ten year period, is disqualified and shall be excluded from the networks on that basis alone, irrespective of any other factors, including but not limited to the fact that any of the lawsuits might have been dismissed or withdrawn, or resulted in a trial verdict in favor of the provider. Any provider who moves to Arkansas from another state or jurisdiction and whose malpractice history reflects that more than five malpractice lawsuits were filed against the provider is disqualified for a minimum period of three years on that basis alone, irrespective of any other factors, including but not limited to the fact that any of the lawsuits might have been dismissed or withdrawn, or resulted in a trial verdict in favor of the provider.

(Continued on page 26)

5. NOTE: The fact that a provider's malpractice history falls within these minimal standards does NOT mean that such provider is exempt from exclusion based on malpractice history. For example, a provider who has 7 malpractice lawsuits filed against him in the past 10 years could still be excluded because of the nature of those lawsuits, the amount of the settlements or judgments, or other related circumstances. The minimal standards are merely for purposes of setting a standard, below which the networks will decline to look at alleged extenuating circumstances or explanations, and will mechanically apply the minimal standards without further inquiry or evaluation.

6. A move of practice locations, for purposes of these policies/terms is defined in the "Moving Practice Locations" section.

(Continued from page 25)

(c) Any provider who has had five or more malpractice lawsuits filed against the provider, and who also has received any form of discipline, probation, warning, reprimand, censure, admonition, educational requirement, fine, penalty or other adverse action ("Sanction") from any state medical board or similar state or federal disciplinary authority or agency is disqualified for a minimum period of three years on that basis alone, irrespective of any other factors, including but not limited to the fact that any of the law-suits might have been dismissed or withdrawn, or resulted in a trial verdict in favor of the provider, or the fact that the medical board or other disciplinary authority or agency may have withdrawn, modified, stayed or suspended its original Sanction at the time of Provider's initial credentialing or recredentialing review.

NOTE: The minimum three-year disqualification period referenced in subsections (b) and (c) above, shall begin upon the date of the credentialing or recredentialing decision that first follows the publication date of this Notice, except that if the affected provider appeals the credentialing or recredentialing decision, the minimum three-year disqualification period shall begin upon the date of any adverse Appeals Committee decision on such appeal. The minimum three-year disqualification period may be extended based on the number of malpractice claims, the nature of such claims, the amount of any settlement(s), or the number or nature of any Sanctions.

X. Moving Practice Locations:

Because providers with competency, quality or other problems arising in one location sometimes move to another, the networks reserve the right to take into account how often a provider has moved practice location, and may, in some circumstances, exclude a provider from network participation based on the number or nature of such moves. For purpose of these policies/ terms, the phrase "moving" or "moved" in reference to "practice locations" means and includes the following two-part definition (a and b):

(a) changing the physical location at which the provider spends the majority of the provider's weekly work activities from one country to another country, from one state to another state, from one city to another city, or from one county to another county; or

(b) Time spent in the military or medical school or a residency or fellowship program shall not count as a "practice location" except in the following circumstances:

(i) any resident who begins a residency program and fails to satisfactorily complete that residency in the original location shall be deemed to have moved practice locations upon entering into any subsequent residency program in a different country, state or city; and

(ii) any discharge, termination or other cessation of a military medical position that is involuntary or dishonorable shall be deemed a move of practice location (and may also independently disqualify such provider from participation in the networks, depending on the nature of the discharge, termination or other cessation of a military medical position).

While review of practice location moves will generally be conducted on a case-by-case basis, taking the relevant circumstances into account, the networks have established the following minimal standards[7] of disqualification, regardless of any other factors or circumstances. These minimal standards include the following:

(1) A provider who has moved practice locations between states 6 times or more during the most recent past 10 year period is disqualified and shall be excluded from the networks on that basis alone, irrespective of any other factors.

(2) A provider who has moved practice locations between cities, or between counties, or between a combination

7. NOTE: The fact that a provider's history of moving practice locations falls within these minimal standards does NOT mean that such provider is exempt from exclusion based on moving practice locations. For example, a provider who has moved practice locations between states 5 times in the past 10 years could still be excluded because of the nature of or reasons for those moves, or other related circumstances. The minimal standards are merely for purposes of setting a standard, below which the networks will decline to look at alleged extenuating circumstances or explanations, and will mechanically apply the minimal standards without further inquiry or evaluation

of cities and counties, 10 times or more during the most recent past 6 year period is disqualified and shall be excluded from the networks on that basis alone, irrespective of any other factors.

(3) A provider who has moved practice locations between countries 3 times or more during the most recent past 5 year period is disqualified and shall be excluded from the networks on that basis alone, irrespective of any other factors.

XI. Claims Filing and Coding Policies:

Network-participating providers must, in order to be eligible for continuing network participation, agree to accept and abide by the claims filing and coding policies of the insurer, HMO or self-funded payer for whose members' benefit the network is operated. (Access to coding information is available to providers through the Advanced Health Information Network ("AHIN"), an on-line claims filing and data service offered free of charge to all providers participating in the separate networks of Arkansas Blue Cross and Blue Shield, USAble Corporation and Health Advantage.

For additional guidelines and sources on coding policies, code-specific coding information ("CSCI") and coding combinations are available to providers via AHIN's CSCI functionality, as well as via the "Clear Claim Connection" software program that may be accessed via links on AHIN). Compliance with such claims filing and coding policies is a specific condition of the written network participation agreement, so this policy/term is not new; however, the following supplements the formal contract provision to provide additional details and requirements:

(a) Individual Provider Responsibility for Compliance
Participating providers are responsible for making sure that claims filed with any insurer, HMO or self-funded payer accessing the networks comply with applicable claims filing and coding policies as established by the insurer, HMO or self-funded payer and announced to participating providers by any form of written communication, including but not limited to remittance advices, Providers' News articles, individual letters or email, or postings to websites of Arkansas Blue Cross and Blue Shield, Health Advantage or BlueAdvantage Administrators of Arkansas. Participating providers are responsible for compliance with all claims filing and coding policies regardless of whether a participating provider has personally accessed the websites, or has personally read any Providers' News article, email, letter or remittance advice, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring the websites, Providers' News, emails, letters or remittance advices.

(b) Noncompliance is grounds for network exclusion:
A provider who receives written notice directed specifically to such provider of a violation of claims filing and coding policies of a payer accessing the networks, and who thereafter fails or refuses to accept and follow such policies shall be subject to exclusion from the networks. Providers who disagree with such policies/ terms may choose to challenge a particular claims decision or determination by internal appeals, external review, arbitration or any other avenue otherwise open to such provider for administrative or legal challenge; however, if an internal appeal within the insurer, HMO or self-funded payer is denied, or if provider loses any external review, arbitration or other administrative or legal challenge, or if provider fails to pursue any internal appeal, or administrative or legal challenge, participating providers who thereafter persist in refusing to accept or follow claims filing or coding policies/terms shall not be eligible for continued network participation, and shall be excluded from participation on that basis.

NOTE: Even if a provider wins an external review, arbitration or other administrative or legal challenge, if the provider thereafter refuses to comply with the challenged claims filing and coding policy or term, such provider may still be excluded from the network unless the network or the insurer, HMO or self-funded payer whose claims filing or coding policy or term was challenged changes the policy or term as a result of the external review, arbitration or other administrative or legal challenge. In other words, merely because an external reviewer, arbitrator, agency or court requires payment to a provider on a particular claim or set of claims does not mean the provider can ignore the claims filing or coding policies or terms adopted

(Continued on page 28)

by the network or by payers accessing the network, if provider wishes to continue to be a network participant.

(Of course, if a final, binding court decision invalidates and enjoins enforcement of the claims filing or coding policy or term, or mandates its modification, the networks and payers will be obligated to comply, but in the absence of any such decision, providers cannot circumvent the network participation terms and conditions merely by winning a claims payment dispute with the payer). Providers in such circumstances are choosing to disqualify and exclude themselves from participation if they persist in rejecting applicable claims filing or coding policies or terms.

(c) Abusive or Deceptive Claims Practices - Network-participating providers must be aware and agree that payers who receive claims from such providers are relying on the completeness and accuracy of the data submitted on the claim form, whether the form is submitted electronically or otherwise. Each data entry is critical to the correct processing of the claim. Participating providers who use the American Medical Association's CPT Manual, ICD-9 procedure codes, HCPCS codes, or the successor or updated versions of any of these established coding conventions to file claims with payers are deemed to make an affirmative representation of fact to the payer that the services or procedures performed are, in fact, the services or procedures described in the code the provider selected and used from the CPT Manual or ICD-9 or HCPCS publications, as reflected on the claim submitted.

Submission of a claim that uses an incorrect CPT, ICD-9 or HCPCS code shall be deemed to be an abusive and deceptive practice (and may even constitute fraud) unless clearly accidental and limited to a single source of error (e.g., multiple claims submitted at the same time due to one human or computer error). Any participating provider who, after receiving written notice of incorrect or inaccurate coding or other incorrect or inaccurate claims submission practices, submits any claim under an incorrect code, or uses a code that does not, in fact, describe the service performed, or who submits other inaccurate or misleading information in connection with a claim, shall be subject to exclusion from the network on that basis.

Furthermore, even if submission of incorrect claims was accidental and limited to a single source of error, if the error is repeated after being brought to the attention of participating provider, such provider shall be subject to network exclusion on that basis alone, regardless of whether the inaccuracy was done knowingly, and regardless of the reasons for the repeat error because the network-sponsoring companies must be able to rely on participating providers to diligently correct any claims submission errors and problems to avoid repetition, particularly where such problems have been brought to participating provider's attention. (NOTE If it is found that a provider had actual knowledge of submitting a false or inaccurate claim, such provider may be subject to network exclusion without first receiving a written notice of the deliberately inaccurate or false submission, i.e., if actual knowledge of false submission is shown, a second chance after notice/ warning need not be given).

(i) Billing Services or Agents Do Not Excuse Non-Compliance: The fact that the participating provider uses a billing service, practice management company, or other third party, or a software program created or managed by any such third party, or that any current or former employee, office staff, office manager or other personnel or agents of participating provider ("Agents") may be partly or wholly responsible for the submission of participating provider's claims, or that participating provider can show that provider had no actual knowledge of the actions or representations of such Agents, shall NOT constitute grounds for avoiding responsibility or network exclusion for submission of incorrect claims, or any abusive or deceptive claims practices. The network-sponsoring companies and payers cannot constantly audit all participating providers on a day-to-day basis, and must therefore rely on participating provider for assurances that billing services, employees, and agents of any kind who assist participating provider in the submission of claims will comply with all applicable claims filing and coding policies/terms, and will accurately represent the services performed.

(ii) Specific Examples of Abusive/Fraudulent Claims or Coding Practices: Specific examples of other claims filing or coding practices that are deemed to be abusive or fraudulent may be found in past or future editions of Providers' News, or in the Provider Manual or websites of Arkansas Blue Cross and Blue Shield, Health Advantage or USAble Corporation (BlueAdvantage Administrators of Arkansas), and all participating providers in the Arkansas' FirstSource® PPO, True Blue PPO and Health Advantage HMO networks shall be held accountable for such specific examples (in addition to the general standards outlined here), where previously published, or, for updated Provider Manuals, immediately upon publication to the respective websites of updated Provider Manuals (anticipated to be completed in the next several weeks for Arkansas Blue Cross and Blue Shield, and within the next several months for Health Advantage and USAble Corporation).

XII. Review and Use of Claims Data:

Network participation agreements for Arkansas' FirstSource®, True Blue PPO, and Health Advantage already recognize and agree that USAble and Health Advantage may conduct utilization studies or programs, including physician profiling, using the claims data that participating providers submit to either USAble or Health Advantage or to any affiliated companies of either. Participating providers must therefore understand and agree, as a term and condition of participation, that claims submitted to Arkansas Blue Cross and Blue Shield, which is the parent organization of USAble Corporation and of Health Advantage, may be subject to review and use in utilization studies or practice profiles of USAble Corporation or Health Advantage, and vice versa.

The claim utilization pattern or rate of a participating provider in Arkansas' FirstSource® PPO (or True Blue PPO or Health Advantage HMO) may thus be derived from a combination of the claims data submitted to any of these independent but affiliated companies. Refusal of any participating provider to authorize the release to and use of any claims data for utilization programs, studies or practice profiles of the three affiliated companies shall be grounds for exclusion from the networks.

XIII. Medical Records/Documentation of Services Provided:

Current participation agreements require maintenance of contemporaneous medical records to document the services performed. Providers are further subject, under current credentialing standards, to on-site audit of medical records and claims documentation, using an established set of audit measurements for accuracy, completeness and appropriateness of medical records and documentation of services. While it is long-established practice, not only for Medicare, but also for most private payers, to require that providers submit claims using Current Procedural Terminology codes and related standards, as published by the American Medical Association, and while virtually all providers submitting claims to both government and private payers commonly use such CPT codes and related standards, the network-sponsoring companies wish to make it explicit that where the CPT Manual calls for documentation to support a given code or claim utilizing that code, such documentation standards from the CPT Manual shall constitute the minimal documentation requirements for network participation.

The networks or payers utilizing the networks may adopt and publish additional or modified standards for medical records and related documentation, but in the absence of such specific standards, participating providers should understand and must agree that the CPT Manual's documentation provisions apply to all claims submitted, and establish the threshold for evaluating adequacy of claim documentation. Audit criteria currently in use for network participation shall continue to apply, but the networks additionally wish to clarify and make explicit a fact that has been present impliedly all along, i.e., that claims submitted using CPT codes should be supported, at a minimum, by the documentation referenced in the CPT Manual for such codes.

XIV. Hospital Privileges:

Maintenance of staff privileges at a network-participating hospital has always been a requirement for network participation in USAble's PPO networks and Health Advantage's HMO network. However, in recent years

(Continued on page 30)

(Continued from page 29)

such privileges have included a level of hospital privileges less demanding or intense than full admitting privileges (e.g., some hospitals have implemented reduced levels or degrees of privileges, below the level of full admitting privileges, such as "courtesy privileges" or the like). USAble and Health Advantage will no longer accept such reduced levels or degrees of hospital privileges, and instead will now require (except in specific instances outlined below) as a term and condition of network participation that participating providers must have and maintain at a participating hospital no more than 35 miles from their primary practice location hospital privileges that equate to the highest level or degree of full admitting privileges recognized or utilized by such hospital.

Exceptions to this "highest level of full admitting privileges" standard may include one or more of the following, as applicable to a given provider:

(1) Temporary hospital privileges may be accepted in the sole discretion of the network sponsoring company and the Credentialing Committee, provided, at a minimum, that the applicable hospital's review procedures and standards for granting temporary staff privileges are equivalent in scope to the review procedures and standards for full, active staff privileges at the highest level or degree of such privileges.

(2) The network-sponsoring companies may, in their sole discretion, grant exceptions to the staff privileges standard for the following specialist categories: Allergy, Dermatology, Pathology, Radiology or other physicians who are hospital-based and are employed by the participating hospital, provided, however, that even within these categories, no exceptions will be permitted for physicians who perform or intend to perform any type of invasive procedure not appropriate for an office setting.

(3) Primary Care Physicians (considered to be General Practice, Family Practice, Internal Medicine and Pediatric physicians), whose medical practice is exclusively office-based, and who therefore do not wish to obtain hospital privileges ("Applicants") may apply for exemption from the hospital privileges requirement, and may be exempted in the sole discretion of the network-sponsoring company, if all of the following requirements are met:

(i) Three letters of recommendation from other participating physicians in good standing who are not part of the Applicant's practice group or clinic must be furnished; and

(ii) A written plan must be submitted outlining in detail how the Applicant's patients will gain admission to a participating hospital in the event of need for inpatient treatment; and

(iii) The written plan must include specific identification of other participating providers who will act to provide coverage for the Applicant to admit the Applicant's patients to a participating hospital; and

(iv) The identified covering physicians must sign and submit a written statement affirming that they have agreed to provide coverage for the Applicant, as described.

Arkansas Blue Cross Fee Schedule Updates:

The following updates were made to Arkansas Blue Cross and Blue Shield Fee Schedule effective June 22, 2005.

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
G0279	$ 0.00	$ 0.00	$ 0.00	$596.95	$ 0.00	$ 0.00
G0281	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
G0282	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
G0283	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
90715	$35.25	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
J7042	$1.87	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

The following fee schedule updates were effective July 1, 2005.

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
90714	$17.50	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

The following fee schedule updates were effective July 5, 2005.

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
G0173	$ 0.00	$ 0.00	$ 0.00	$10,500.00	$ 0.00	$ 0.00
G0242	$ 0.00	$ 0.00	$ 0.00	$2,900.00	$ 0.00	$ 0.00
G0243	$ 0.00	$ 0.00	$ 0.00	$10,500.00	$ 0.00	$ 0.00
G0338	$ 0.00	$ 0.00	$ 0.00	$2,900.00	$ 0.00	$ 0.00

The following fee schedule updates were effective August 10, 2005.

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
90718	$16.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
90720	$7.91	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
90734	$82.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

The following fee schedule updates were effective August 31, 2005.

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
92605	$77.40	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
92606	$62.55	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
86921	BR	$12.50	BR	BR	$12.50	BR
86922	BR	$12.50	BR	BR	$12.50	BR

Arkansas Blue Cross Fee Schedule Updates:

The following HCPCS Codes were updated on the Arkansas Blue Cross and Blue Shield Fee Schedule effective August 24, 2005.

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
A6407	$ 1.88			$ 0.00	$ 0.00	$ 0.00
A6441	$ 0.67			$ 0.00	$ 0.00	$ 0.00
A6442	$ 0.17			$ 0.00	$ 0.00	$ 0.00
A6443	$ 0.29			$ 0.00	$ 0.00	$ 0.00
A6444	$ 0.56			$ 0.00	$ 0.00	$ 0.00
A6445	$ 0.32			$ 0.00	$ 0.00	$ 0.00
A6446	$ 0.41			$ 0.00	$ 0.00	$ 0.00
A6447	$ 0.67			$ 0.00	$ 0.00	$ 0.00
A6448	$ 1.16			$ 0.00	$ 0.00	$ 0.00
A6449	$ 1.75			$ 0.00	$ 0.00	$ 0.00
A6452	$ 5.91			$ 0.00	$ 0.00	$ 0.00
A6453	$ 0.61			$ 0.00	$ 0.00	$ 0.00
A6454	$ 0.77			$ 0.00	$ 0.00	$ 0.00
A6455	$ 1.39			$ 0.00	$ 0.00	$ 0.00
A6456	$ 1.28			$ 0.00	$ 0.00	$ 0.00
A7045	$19.47	$ 1.95	$14.60	$ 0.00	$ 0.00	$ 0.00
A7527	$ 3.58			$ 0.00	$ 0.00	$ 0.00
B4149	$ 1.53			$ 0.00	$ 0.00	$ 0.00
B4150	$ 0.65			$ 0.00	$ 0.00	$ 0.00
B4152	$ 0.55			$ 0.00	$ 0.00	$ 0.00
B4153	$ 1.86			$ 0.00	$ 0.00	$ 0.00
B4154	$ 1.19			$ 0.00	$ 0.00	$ 0.00
B4155	$ 0.93			$ 0.00	$ 0.00	$ 0.00
B4164	$16.08			$ 0.00	$ 0.00	$ 0.00
B4168	$23.42			$ 0.00	$ 0.00	$ 0.00
B4176	$45.33			$ 0.00	$ 0.00	$ 0.00
B4178	$54.42			$ 0.00	$ 0.00	$ 0.00
B4180	$23.05			$ 0.00	$ 0.00	$ 0.00
B4184	$75.55			$ 0.00	$ 0.00	$ 0.00
B4186	$100.75			$ 0.00	$ 0.00	$ 0.00
B4189	$168.11			$ 0.00	$ 0.00	$ 0.00
B4193	$217.24			$ 0.00	$ 0.00	$ 0.00
B4197	$264.47			$ 0.00	$ 0.00	$ 0.00

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
B4199	$302.21			$ 0.00	$ 0.00	$ 0.00
B4216	$ 7.31			$ 0.00	$ 0.00	$ 0.00
B4220	$ 7.57			$ 0.00	$ 0.00	$ 0.00
B4222	$ 9.34			$ 0.00	$ 0.00	$ 0.00
B4224	$23.66			$ 0.00	$ 0.00	$ 0.00
B5000	$11.24			$ 0.00	$ 0.00	$ 0.00
B5100	$ 4.40			$ 0.00	$ 0.00	$ 0.00
B9004	$2,386.38	$377.79	$1,789.79	$ 0.00	$ 0.00	$ 0.00
B9006	$2,386.38	$377.79	$1,789.79	$ 0.00	$ 0.00	$ 0.00
E0463		$1,406.38		$ 0.00	$ 0.00	$ 0.00
E0464		$1,406.38		$ 0.00	$ 0.00	$ 0.00
E1010	$1,143.79	$114.38	$857.86	$ 0.00	$ 0.00	$ 0.00
E1039		$22.65		$ 0.00	$ 0.00	$ 0.00
E1841		$453.00		$ 0.00	$ 0.00	$ 0.00
E2368	$516.57	$51.67	$387.44	$ 0.00	$ 0.00	$ 0.00
E2369	$449.94	$45.00	$337.45	$ 0.00	$ 0.00	$ 0.00
E2370	$802.84	$80.29	$602.12	$ 0.00	$ 0.00	$ 0.00
E2500	$391.06	$39.11	$293.29	$ 0.00	$ 0.00	$ 0.00
E2502	$1,195.80	$119.59	$896.86	$ 0.00	$ 0.00	$ 0.00
E2504	$1,577.42	$157.76	$1,183.05	$ 0.00	$ 0.00	$ 0.00
E2506	$2,312.96	$231.29	$1,734.69	$ 0.00	$ 0.00	$ 0.00
E2508	$3,576.61	$357.67	$2,682.47	$ 0.00	$ 0.00	$ 0.00
E2510	$6,768.25	$676.82	$5,076.18	$ 0.00	$ 0.00	$ 0.00
E2601	$88.65	$ 8.86	$66.49	$ 0.00	$ 0.00	$ 0.00
E2602	$161.88	$16.20	$121.43	$ 0.00	$ 0.00	$ 0.00
E2603	$223.04	$22.31	$167.28	$ 0.00	$ 0.00	$ 0.00
E2604	$315.76	$31.56	$236.83	$ 0.00	$ 0.00	$ 0.00
E2605	$321.69	$32.19	$241.29	$ 0.00	$ 0.00	$ 0.00
E2606	$436.07	$43.61	$327.06	$ 0.00	$ 0.00	$ 0.00
E2607	$295.60	$29.56	$221.70	$ 0.00	$ 0.00	$ 0.00
E2608	$354.00	$35.42	$265.51	$ 0.00	$ 0.00	$ 0.00
E2611	$312.35	$31.23	$234.29	$ 0.00	$ 0.00	$ 0.00
E2612	$422.54	$42.25	$316.89	$ 0.00	$ 0.00	$ 0.00
E2613	$393.04	$39.31	$294.78	$ 0.00	$ 0.00	$ 0.00
E2614	$543.93	$54.40	$407.97	$ 0.00	$ 0.00	$ 0.00
E2615	$452.32	$45.24	$339.23	$ 0.00	$ 0.00	$ 0.00
E2616	$608.58	$60.86	$456.45	$ 0.00	$ 0.00	$ 0.00
E2618	$153.68	$15.37	$115.25	$ 0.00	$ 0.00	$ 0.00
E2619	$51.32	$ 5.13	$38.51	$ 0.00	$ 0.00	$ 0.00
E2620	$574.76	$57.47	$431.08	$ 0.00	$ 0.00	$ 0.00
E2621	$547.70	$54.77	$410.79	$ 0.00	$ 0.00	$ 0.00

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
K0618	$621.58			$ 0.00	$ 0.00	$ 0.00
K0620	$ 1.14			$ 0.00	$ 0.00	$ 0.00
K0671		$32.07		$ 0.00	$ 0.00	$ 0.00
K0731	$52.45			$ 0.00	$ 0.00	$ 0.00
K0732	$130.75			$ 0.00	$ 0.00	$ 0.00
L0430	$1,228.75			$ 0.00	$ 0.00	$ 0.00
L1932	$722.22			$ 0.00	$ 0.00	$ 0.00
L2005	$2,913.34			$ 0.00	$ 0.00	$ 0.00
L3001	$107.04			$ 0.00	$ 0.00	$ 0.00
L3002	$130.71			$ 0.00	$ 0.00	$ 0.00
L3003	$141.02			$ 0.00	$ 0.00	$ 0.00
L3010	$141.02			$ 0.00	$ 0.00	$ 0.00
L3020	$160.57			$ 0.00	$ 0.00	$ 0.00
L3030	$61.75			$ 0.00	$ 0.00	$ 0.00
L3040	$38.08			$ 0.00	$ 0.00	$ 0.00
L3050	$38.08			$ 0.00	$ 0.00	$ 0.00
L3060	$59.69			$ 0.00	$ 0.00	$ 0.00
L3070	$25.73			$ 0.00	$ 0.00	$ 0.00
L3080	$25.73			$ 0.00	$ 0.00	$ 0.00
L3090	$32.95			$ 0.00	$ 0.00	$ 0.00
L3100	$34.99			$ 0.00	$ 0.00	$ 0.00
L3140	$72.06			$ 0.00	$ 0.00	$ 0.00
L3150	$65.87			$ 0.00	$ 0.00	$ 0.00
L3170	$41.18			$ 0.00	$ 0.00	$ 0.00
L3300	$42.20			$ 0.00	$ 0.00	$ 0.00
L3310	$65.87			$ 0.00	$ 0.00	$ 0.00
L3330	$458.05			$ 0.00	$ 0.00	$ 0.00
L3332	$59.69			$ 0.00	$ 0.00	$ 0.00
L3334	$30.88			$ 0.00	$ 0.00	$ 0.00
L3340	$68.97			$ 0.00	$ 0.00	$ 0.00
L3350	$18.51			$ 0.00	$ 0.00	$ 0.00
L3360	$28.82			$ 0.00	$ 0.00	$ 0.00
L3370	$40.13			$ 0.00	$ 0.00	$ 0.00
L3380	$40.13			$ 0.00	$ 0.00	$ 0.00
L3390	$40.13			$ 0.00	$ 0.00	$ 0.00
L3400	$32.95			$ 0.00	$ 0.00	$ 0.00
L3410	$75.16			$ 0.00	$ 0.00	$ 0.00
L3420	$44.25			$ 0.00	$ 0.00	$ 0.00
L3430	$129.70			$ 0.00	$ 0.00	$ 0.00

HCPCS/ CPT CODE	Purchase/ Total	Rental/ Prof	Used/ Tech	Purchase/ Total SOS	Rental/ Prof SOS	Used/ Tech SOS
L3440	$61.75			$ 0.00	$ 0.00	$ 0.00
L3450	$85.42			$ 0.00	$ 0.00	$ 0.00
L3455	$32.95			$ 0.00	$ 0.00	$ 0.00
L3460	$27.78			$ 0.00	$ 0.00	$ 0.00
L3465	$47.34			$ 0.00	$ 0.00	$ 0.00
L3470	$50.43			$ 0.00	$ 0.00	$ 0.00
L3480	$50.43			$ 0.00	$ 0.00	$ 0.00
L3500	$23.69			$ 0.00	$ 0.00	$ 0.00
L3510	$23.69			$ 0.00	$ 0.00	$ 0.00
L3520	$25.73			$ 0.00	$ 0.00	$ 0.00
L3530	$25.73			$ 0.00	$ 0.00	$ 0.00
L3540	$41.18			$ 0.00	$ 0.00	$ 0.00
L3550	$ 7.22			$ 0.00	$ 0.00	$ 0.00
L3560	$18.51			$ 0.00	$ 0.00	$ 0.00
L3570	$68.97			$ 0.00	$ 0.00	$ 0.00
L3580	$52.49			$ 0.00	$ 0.00	$ 0.00
L3590	$43.23			$ 0.00	$ 0.00	$ 0.00
L3595	$33.95			$ 0.00	$ 0.00	$ 0.00
L3600	$61.75			$ 0.00	$ 0.00	$ 0.00
L3610	$81.32			$ 0.00	$ 0.00	$ 0.00
L3620	$61.75			$ 0.00	$ 0.00	$ 0.00
L3630	$81.32			$ 0.00	$ 0.00	$ 0.00
L3640	$34.99			$ 0.00	$ 0.00	$ 0.00
L3965	$842.44	$84.26	$631.83	$ 0.00	$ 0.00	$ 0.00
L3966	$746.64	$74.67	$559.98	$ 0.00	$ 0.00	$ 0.00
L3968	$944.86	$94.48	$708.65	$ 0.00	$ 0.00	$ 0.00
L3974	$121.17	$12.13	$90.87	$ 0.00	$ 0.00	$ 0.00
L5857	$6,907.59			$ 0.00	$ 0.00	$ 0.00
L5990	$1,471.18			$ 0.00	$ 0.00	$ 0.00
L8110	$43.27			$ 0.00	$ 0.00	$ 0.00
L8120	$60.96			$ 0.00	$ 0.00	$ 0.00
L8515	$51.19			$ 0.00	$ 0.00	$ 0.00
L8615	$365.74			$ 0.00	$ 0.00	$ 0.00
L8616	$85.19			$ 0.00	$ 0.00	$ 0.00
L8617	$74.40			$ 0.00	$ 0.00	$ 0.00
L8618	$21.25			$ 0.00	$ 0.00	$ 0.00
L8620	$113.28			$ 0.00	$ 0.00	$ 0.00
L8621	$ 0.50			$ 0.00	$ 0.00	$ 0.00
L8622	$ 0.27			$ 0.00	$ 0.00	$ 0.00

Providers' News

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