Arkansas Blue Cross and Blue Shield

Providers' News

December 2006

Inside the December 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
and **www.fepblue.org**

The *Providers' News*

The Providers' News is a quarterly publication of Arkansas Blue Cross and Blue Shield. Please send your questions or comments about the Providers' News to:

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Arkansas BlueCross BlueShield
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Countdown to NPI!

Arkansas Blue Cross and Blue Shield needs your National Provider Identifier (NPI) to ensure our payment system is updated before the NPI deadline (May 23, 2007).

Please send a copy of the verification from the National Plan and Provider Enumeration System (NPPES) that indicates the provider and/or organization name and newly assigned NPI to the Provider Network Operations division of Arkansas Blue Cross and Blue Shield.

Simply submitting your NPI on a claim is not sufficient. Providers must register their NPI with Arkansas Blue Cross and Blue Shield by mailing, faxing, or emailing their NPI verification to:

Arkansas Blue Cross and Blue Shield
Provider Network Operations
P.O. Box 2181
Little Rock, Arkansas 72203-2181

Fax: 501-378-2465
E-mail: providernetwork@arkbluecross.com

Please attach the "Provider Change of Data" form (located under "Forms for Providers" on the "Provider" page of the Arkansas Blue Cross web site at www.arkbluecross.com) with the NPPES confirmation form. If the provider's demographics or payment information data has not changed, they should only complete the Provider #, Name, Email Address, NPI, Medical Records, Fax Number, and Practice Location Address information on the "Provider Change of Data" form.

For those providers with access to AHIN, the Advanced Health Information Network, a program has been created to notify Arkansas Blue Cross and Blue Shield about a provider's NPI assignment submitted through AHIN . All AHIN users can now select the "NPI Administration" button to submit their new NPI. Please check the AHIN bulletin board for instructions and additional information.

Providers who have not already applied for their NPI, please do so ASAP. HIPAA requires that all covered entities completing electronic claims transactions (such as providers, health-care clearinghouses, and large health plans) must use only the NPI to identify covered healthcare providers in all standard transactions by May 23, 2007.

For additional information on NPI, visit the CMS website at ***http://new.cms.hhs.gov/***. On the CMS home page, select the "Regulations & Guidance" link located under "CMS Programs & Information" and then the "National Provider Identifier Standard" link located under the "HIPAA Administrative Simplification" section. Providers can also click on the NPPES link or go directly to their web site and apply online at ***http://nppes.cms.hhs.gov***.

Arkansas Blue Cross and Blue Shield Implements NPI Functionality

On October 2, 2006, Arkansas Blue Cross and Blue Shield and our affiliated companies began utilizing the National Provider Identifier (NPI) for those providers who have registered their NPI with our organization. (Please note, due to a nationally-coordinated implementation schedule, the Federal Employees Program (FEP) will not begin NPI implementation until January, 2007.)

During October, providers began submitting their NPI on standard HIPAA transactions such as electronic claim transactions (ANSI 837). Providers may use their new NPI when communicating with Arkansas Blue Cross, including use of the Interactive Voice Response (IVR) unit, and will also begin receiving their NPI on correspondences. Please note that the 5-digit Arkansas Blue Cross provider number will still be required in the ANSI 837 REF segment through May 23, 2007.

Providers or Clearinghouses who process Electronic Remittance Advice (ANSI 835) transactions will begin receiving their NPI as the primary provider identifier beginning January, 2007. Please discuss this change with vendors to help ensure HIPAA-compliant transactions containing an NPI can be processed accurately.

The current CMS 1500 and UB-92 paper claim forms were not designed to accommodate the new NPI. New paper claim forms have been designed by NUCC and NUBC, respectively, which do accommodate the NPI. Providers may bill using their NPI on paper claim forms when the implementation period begins for each form. The current implementation start date for the new CMS 1500 Professional paper claim form is January 2, 2007 and the implementation start date for the UB-04 Institutional paper claim form is March 1, 2007.

This NPI implementation plan, which closely parallels the CMS Medicare implementation plan, should allow for a smooth transition towards HIPAA compliance by the deadline of May 23, 2007.

For additional information on NPI, visit the CMS website at ***http://new.cms.hhs.gov/***. On the CMS home page, select the "Regulations & Guidance" link located under "CMS Programs & Information" and then the "National Provider Identifier Standard" link located under the "HIPAA Administrative Simplification" section. Providers can also click on the NPPES link or go directly to their web site and apply online at ***http://nppes.cms.hhs.gov***.

Upon receipt of an NPI, please register the identifier with Arkansas Blue Cross through AHIN (the Advanced Health Information Network) by selecting the "NPI Administration" button or by faxing the NPPES verification form and the "Provider Change of Data" form to Provider Network Operations at 501-378-2465.

AHIN - Extended Hours of Operation

AHIN (Advanced Health Information Network) has extended hours of operation. Please note the updated hours of operation below:

Monday thru Saturday 6 am until midnight.

Summary of Arkansas Blue Cross and Blue Shield's NPI Guidelines

- **NPI must be used for providers of service and any other provider identification on May 23, 2007 per the HIPAA mandate or electronic claims and applicable electronic transactions will be rejected.**

- **NPI must be used for organizations (facilities, clinics, etc.) on May 23, 2007 per HIPAA mandate or electronic claims and applicable electronic transactions will be rejected.**

- **NPI for all providers of service and any other provider identification must be used on both CMS 1500 and UB-04 paper claim forms on May 23, 2007 or the claims will be rejected.**

- **All providers who file claims directly to Arkansas Blue Cross and Blue Shield must register their NPI with Arkansas Blue Cross and Blue Shield. Simply submitting the NPI on a claim is NOT enough. See Providers News articles on how to register your NPI with Arkansas Blue Cross.**

Arkansas Blue Cross and Blue Shield Gives Providers Two Easy Options For Patient Information

1. **AHIN access for patient eligibility and benefits available to your front office staff and your admissions office staff.** AHIN is **not** just for submitting claims! AHIN allows your front office staff and admission office the ability to retrieve patient eligibility and benefit information.

To access AHIN, go to the Arkansas Blue Cross and Blue Shield web site at www.arkbluecross.com, click on the Provider Page and Select the AHIN link. If your office, facility or hospital already uses AHIN, (ask your Office Manager), you can have immediate access to eligibility, claims and claim-status information.

AHIN is available for more than a million Arkansas Blue Cross, Health Advantage, BlueAdvantage Administrators of Arkansas and USAble Administrators members and former members. AHIN is updated nightly and available for Arkansas Blue Cross and out-of-state Blue Cross and Blue Shield plans, Health Advantage, BlueAdvantage Administrators, USAble Administrators and Medicaid (Texas and Arkansas).

The best news of all is that AHIN access is free of charge and is EASY to use. If you would like more information on setting up your front office staff or admissions staff to have this easy access to AHIN, please call **501-378-2336.** AHIN can limit access to only eligibility and benefit information.

2. **My BlueLine, Arkansas Blue Cross and Blue Shield's Provider Service line is available 24/7 (1-800-827-4814). Use your natural, conversational voice to ask for patient specific information.**

My BlueLine provides several choices:

- Eligibility and Benefits
- Claim Status
- Addresses

Just pick up the phone, dial 1-800-827-4814 and talk. With My BlueLine it really is that simple and during business hours, frees up our Customer Service Staff to answer your more complicated inquiries.

Please note that all eligibility or benefits information is conditional upon verification *when the claim is received and processed*, and should not be relied upon as assurance of payment of the claim. While Arkansas Blue Cross strives to provide the most current information via AHIN, My BlueLine and otherwise, Arkansas Blue Cross cannot guarantee that all information has been timely furnished to us, or that computer entries have been updated to the time of the inquiry.

All eligibility or benefits information given, via AHIN, My BlueLine or otherwise, is subject to the terms, conditions, exclusions, and limitations of the applicable member's health plan or insurance contract, and the participating provider agreement, which take precedence over any inconsistent or contrary oral or written representations

Note: This does not apply to the Federal Employee Program (FEP) at this time.

Black Claim Forms No Longer Acceptable

Beginning January 1, 2007, paper claims submitted on black claim forms will be returned to the provider. Paper claims should be submitted on standard CMS 1500 claim form with red "drop out" ink. These may be obtained through various vendors such as the American Medical Association or the U.S. Government Printing Office.

New UB-04 Claim Form

HEADS UP! Changes are coming to the UB form used to submit facility claims. Listed below is a summary of the changes as well as the effective dates for the changes.

Form locaters have been added and some are being relocated on the form. Please notify whoever files your claims that these changes are coming and be prepared.

UB-92 to UB-04 Core Changes

Additions to Form Locators:

Additions were made to better align the paper form with the electronic version:

1) Pay-to-name and address
2) Patient name – ID
3) Accident State
4) Page _ of _ Creation date
5) Identifiers
   - National Provider Identifier (NPI)
6) Diagnosis indicator field
   - To report if the diagnosis was present on admission
7) Patient Reason for Visit code
8) PPS code field

Form Locators Removed:

Deletions were made based on industry needs and input from users:

1) Patient marital status
2) Patient prior payments
3) Due from patient
4) Employment status code
5) Employer location
6) Provider representative signature
7) Date bill submitted
8) Various unlabeled fields

Modifications to Current Form Locators:

Modification of existing form locators were required to align the paper claim form to the electronic format and to prepare for future reporting.

1) Increase Type of Bill from 3 characters to 4
2) Increase field size for HCPCS/Rates/HIPPS Rate codes
   - Allows 2 additional modifiers
3) Added 3 Condition Code fields
4) Increased diagnosis code fields from 9 to 18
5) Expanded diagnosis code field to prepare for ICD-10-CM
6) Added additional Occurrence Span Code field

- Usage matrix created for Type of Bill
- Back of form modified to align language with current regulations and industry standards

Substitutions to Current Form Locators:

Various fields substituted or moved:

1) Covered Days – reported as Value Codes
2) Non-covered Days – reported as Value Codes
3) Coinsurance Days – reported as Value Codes
4) Lifetime Reserve Days – reported as Value Codes
5) Medical record number – moved
6) ICN/DCN – moved

New UB-04 Claim Form Implementation Schedule

Schedule/Date	Specification/Task	Responsible Industry User
June 2005	UB-04 form approved	NUBC
June 2005 — August 2006	Draft UB-04 Data Specifications Manual (Beta 1) and updates (available at www.nubc.org)	NUBC
September 2006 — May 2007	Final UB-04 Data Specifications Manual	NUBC
May 2006	OMB # Assigned	CMS
June 2005 — May 2007	Full color paper proofs of the UB-04 form available for mechanical, scanning, and other testing purposes	Health Plans, Providers, Information support vendors, and Government
March 1, 2007	Receivers of the UB-04 manual must be able to receive the revised form	Health Plans, Providers, Information support vendors, and Government
March 1, 2007 — May 22, 2007	UB-04 or UB-92 forms/data set specifications can be used	Providers
May 23, 2007	UB-92 form/data set is discontinued (based on claims submission date, not date of service)	Health Plans, Providers, Information support vendors, and Government

Medi-Pak® Advantage: Deeming Process

Medi-Pak® Advantage is a Medicare Advantage Private Fee-For-Service plan offered by Arkansas Blue Cross and Blue Shield. Medi-Pak® Advantage has been authorized by the Centers for Medicare & Medicaid Services, and is being offered to Medicare members in all 75 counties in Arkansas.

Private-fee-for-service plans, like Medi-Pak® Advantage, combine the benefits of Medicare Part A and B and includes additional services and programs not covered by Medicare. With a private-fee-for-service plan the member should not purchase a traditional Medicare supplement plan like Medi-Pak® offered by Arkansas Blue Cross. Medi-Pak® Advantage members receive benefits for covered services of any doctor, specialist or hospital that accepts Medi-Pak® Advantage's Terms and Conditions.

Except for pharmacies, Medi-Pak® Advantage members are not restricted to a particular provider network, do not need referrals for specialists or other services, and are covered for covered services of any willing provider in the U.S. who is eligible to be paid under Medicare rules. Arkansas Blue Cross and Blue Shield is working with a separate company known as "TMG Health", which will assist with any claim adjudication and other customer services for Medi-Pak® Advantage members.

Please note that Federal healthcare providers, including the Veterans Administration are not eligible for reimbursement under a Medicare private-fee-for-service plan except for urgent or emergency services.

Under federal CMS regulations, a deemed provider is a physician, hospital or other health care provider who has knowledge of a patient's enrollment in Medi-Pak® Advantage and files a claim for services. A physician, hospital or other health care provider is not required to render services to a Medi-Pak® Advantage member; a decision can be made on a patient-by-patient basis.

However, if care is given and the conditions below are met, the provider will be considered a deemed provider and paid according to the Medi-Pak® Advantage Reimbursement Methodology. All claims from a deemed provider are adjudicated on the basis that the provider is accepting assignment.

Except for pharmacies, Arkansas Blue Cross will not contract with physicians and providers for Medi-Pak® Advantage; rather, providers may choose to become a deemed provider.

Providers are considered deemed when:

1. Providers know before rendering services that a Medicare member is enrolled in Medi-Pak® Advantage. Medi-Pak® Advantage will provide members with an identification or enrollment card that they must show providers each time they receive care.
2. Providers have a reasonable opportunity to obtain Medi-Pak® Advantage Terms and Conditions for participation in the plan. The Terms and Conditions are also available through the Arkansas Blue Cross customer services toll-free number, 1-866-390-3369 and the Arkansas Blue Cross web site at www.ArkansasBlueCross.com.
3. Providers subsequently render services to that member and file a claim for services.

Providers rendering services to a Medi-Pak® Advantage member and subsequently filing a claim for the member for services to Arkansas Blue Cross, will have the claims adjudicated as a deemed provider. **Once a provider has submitted claims for a member, the provider will be considered deemed for all future claims submitted by the provider for that member.**

If a provider chooses not to accept the Terms and Conditions, they will only be paid if they treat Medi-Pak® Advantage members for urgent or emergency care and file a claim with Medi-

Pak® Advantage. Providers may only collect any applicable copayments or coinsurance from the member, and may not balance bill the member for any additional amounts. Nor may providers balance bill the member for emergency or urgent care.

Except for prescription drugs, the Medi-Pak® Advantage plan reimburses deemed providers as accepting assignment at 100 percent of the current Medicare allowable amount minus any member copayments or coinsurance for all services covered by Medi-Pak® Advantage.

All deemed providers will be reimbursed at 100% of the current Medicare allowable whether the provider is participating or non-participating with Medicare and whether the claim is assigned or not assigned.

Providers may collect only the applicable copayment or coinsurance amounts from Medi-Pak® Advantage members and may not otherwise charge or bill the members. Balance billing is prohibited by deemed providers who provide services to Medi-Pak® Advantage members.

Copayments or coinsurance should be collected from a member at the time of service. If a provider inadvertently collects more from a member than the designated copayment or coinsurance amount, the provider must refund the difference to the member.

Federal Health Care providers are not eligible for payment for services to Medi-Pak® Advantage members except for urgent or emergency care.

Providing non-emergency care for Medi-Pak® Advantage members when the provider does not accept the Terms and Conditions:

Providers who do not choose to be deemed for Medi-Pak® Advantage and who render non-emergency or non-urgent services should clearly advise the member that the member will be responsible for the services.

If the member chooses to request services with the knowledge that the provider is not accepting Medi-Pak® Advantage's Terms and Conditions, the provider should not file a claim for the member. The member can file a claim direct to Medi-Pak® Advantage and the claim will be adjudicated based on eligibility at the time of service and the provider's status with Medicare.

In addition, deemed providers must:

- Be licensed or certified by the state and be acting within the scope of that license or certification, if applicable.
- Not be sanctioned by Medicare or must not have opted out of Medicare.
- Comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to members, including inspections and audits.
- Not discriminate against the Medi-Pak® Advantage members based on their race, ethnicity, national origin, religion, sex, age, genetic information, mental or physical disability, sexual orientation, or source of payment.
- Have a Medicare billing number, NPI and (if an Arkansas Provider) an Arkansas Blue Cross provider billing number and submit claims as accepting assignment.
- Be certified to treat Medicare beneficiaries if the provider is an institutional provider.
- Follow the standards for confidentiality and patient privacy rights.
- Agree to comply with all Medi-Pak® Advantage appeal and grievance procedures.
- Agree to notify members of their potential liability for services not covered by Medi-Pak® Advantage.

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- Agree to collect from members only the cost-sharing amounts listed in the Summary of Benefits.
- Not balance bill a member.

Deemed providers agree to the guidelines below regarding claims:

- Medi-Pak® Advantage requires all claims be submitted within 365 days from the date of service. The plan will process claims following traditional Medicare billing rules, including prospective payment system requirements. Providers should submit claims using the same coding rules as the traditional Medicare. Providers should send all claims to Arkansas Blue Cross.
- Agree that in no event, including, but not limited to nonpayment by Medi-Pak® Advantage, Medi-Pak® Advantage insolvency or breach of this Agreement, shall you or your assignees and/or subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members of Medi-Pak® Advantage or persons other than Medi-Pak® Advantage acting on their behalf, for covered services provided to members by you.

This provision shall not prohibit collection of payments for any non-covered services or member cost-share amounts set forth above. You further agree that:

(i) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between you and a member or persons acting on their behalf and

(ii) this provision shall apply to all of your employees, agents, trustees, assignees and subcontractors, and you shall obtain from such persons specific agreement to this provision.

In order to ensure that Medi-Pak Advantage pays claims correctly and timely, Critical Access Hospitals and Rural Health Clinics should send a photocopy of your Medicare payment rate letter anytime you receive an update from Medicare. Please forward to the following address:

Arkansas Blue Cross and Blue Shield
Attention: Medi-Pak Advantage
P. O. Box 2181
Little Rock, Arkansas 72203-2181

Providers Not Currently Participating with Medicare:

Furnishing services to Medi-Pak® Advantage members as a deemed provider requires that the non-participating Medicare provider knows the patient is in the Medi-Pak® Advantage program and has reasonable access to the plan's Terms and Conditions, which includes payment and claims submission within these Terms and Conditions information. Deemed non-participating providers with Medicare will be reimbursed as assigned at 100% of the Medicare fee schedule minus any member cost sharing amounts.

Emergency Situations:

For providers who do not participate with Medicare, the limiting charge may be applied in emergency or urgent care situations, when the patient is not able to inform the provider they were Medi-Pak® Advantage members and/or the provider could not access the Terms and Conditions.

In these instances, Arkansas Blue Cross will pay the limiting charge and the Medicare approved amount, minus any applicable member cost-sharing amount.

Deemed Non-participating providers with Medicare will be reimbursed as assigned at 100% of the Medicare feel schedule minus any member cost sharing amounts.

Effect of Eligibility Inquiry Responses:

Each deemed provider agrees that any "verification of benefits" or other eligibility inquiries made prior to, at or after admission or provision of any services to Medi-Pak® Advantage members are not a guarantee of payment. While Arkansas Blue Cross and Blue Shield will endeavor in good faith to report such members' eligibility information available to Arkansas Blue Cross and Blue Shield within its records or computer systems at the time of admission or provision of services, deemed providers acknowledge and agree that it is not possible to guarantee accuracy of such records or computer entries.

Deemed providers understand and agree that the eligibility of Medi-Pak® Advantage members and coverage for any services shall be governed by the terms, conditions and limitations of the member's benefit certificate, which shall take precedence over any inconsistent or contrary oral or written representations. If, following any in-patient treatment or other services, it is discovered that premiums had not been paid for a member's coverage, or that coverage had lapsed or terminated, or was not otherwise available for any reason, no reimbursement shall be due from Arkansas Blue Cross and Blue Shield for such services.

Medi-Pak® Advantage: Health Professional Shortage Area (HPSA)

Medi-Pak® Advantage deemed physicians who provide covered professional services in a Health Professional Shortage Area (HPSA) are entitled to an incentive bonus payment of 10% of the Medi-Pak® Advantage payments received. This incentive bonus payment is only applicable for physician's professional services provided in the Medicare designated HPSA areas and is paid as accepting assignment.

The incentive bonus payment is issued on a per claim basis and will be reflected on the Remittance Advice. The payment is based on the actual Medi-Pak® Advantage paid amount, not the Medi-Pak® Advantage allowed amount.

For a current listing of HPSAs, providers should refer to the Medicare newsletters or the web site. Physicians who qualify for the HPSA payment should follow all Medicare billing guidelines, i.e., applicable place of service and the AQ modifier when billing the claim to Arkansas Blue Cross and Blue Shield.

Submission of Claims: Electronic Claims for Medi-Pak® Advantage (Correction)

The following is a correction to September 2006 issue of the *Providers' News*. The original article was located on page 28 titled "Submission of Claims: Electronic Claims"

Electronic Claims:
All claims for Medi-Pak® Advantage should be submitted as Blue Cross claims, **not Medicare**, but should follow Medicare billing guidelines and data requirements. To ensure proper routing of the claims, providers/facilities must submit Medi-Pak® Advantage claims (both professional and institutional) with the following values populated in the ANSI 837 format:

Subscriber Information:
Loop: **2000B**
Segment: **SBR**
Element: **09 (Claim Filing Indicator) – value must = BL**

Payer Name
Loop: **2010BB**
Segment: **NM1**
Element: **08 (ID Code Qualifier) – value must = PI**
Element: **09 (ID Code) – value must = 00520**

Please check with your electronic filing support to make sure you can bill these properly.

Medi-Pak® Advantage: Offsets and Overpayments

Offsets
An offset occurs when a provider has an overpayment. There is no need to routinely submit a refund check. Medi-Pak® Advantage will offset the amount owed from the total amount paid on the provider's next Remittance Advice (RA). Arkansas Blue Cross and Blue Shield will not offset the amount from a certain claim or service.

Some providers have asked how to identify for which patient and for which date of service the overpayment occurred since the "reductions/ recovery" section on the RA carries only the Health Insurance Claim Number and the offset amount. By keeping a copy of all RA's, providers will have an easier time matching overpayments with offset amounts.

Overpayments
An overpayment is money that Medi-Pak® Advantage paid a provider beyond what he or she should have received. Overpayment is often due to the following:

- Duplicate submission of the same service or claim;
- Payment to the incorrect payee;
- Payment for excluded or for medically unnecessary services;
- Payment made as primary payer when Medicare should have paid as secondary payer.

When claims are submitted incorrectly, a provider may receive payment they should not have received. The adjustment to correct the overpayment will be reflected on the provider's next Remittance Advice (RA).

If a provider disagrees with the overpayment determination they may request a review.

Keep a copy of all RAs for your records. This will allow easier reference to the patient specific information should an offset occur.

Medi-Pak® Advantage: Physician Scarcity Areas

Medi-Pak® Advantage deemed physicians in a designated Medicare physician scarcity area will receive a five percent bonus payment. This payment will be made on a per claim basis and will be reflected on the Remittance Advice. A single service may be eligible for both the new physician scarcity bonus as well as the current HPSA bonus payment.

Payment will be based on the zip code of where the service was performed. Physicians who qualify for this type of payment should follow all Medicare billing guidelines when billing the claim to Arkansas Blue Cross and Blue Shield.

Medi-Pak® Advantage: Voluntary Over-payment Refund

The Centers for Medicare & Medicaid Services (CMS), along with the Office of Inspector General (OIG) and the Department of Justice, supports two initiatives that helps combat health care fraud and abuse and encourages providers to comply with the rules and regulations of Federal health care programs.

The two initiatives are (1) Compliance Program Guidances and (2) Corporate Integrity Agreements (CIAs). In accordance with these two initiatives, CMS requests providers to furnish specific, pertinent information when returning voluntary refund checks so that monies can be credited timely and accurately.

The Compliance Program Guidances are voluntary while the CIAs are mandatory (through the OIG). Providers who are under the CIAs have entered into an agreement with the OIG as part of a global settlement of a fraud investigation. The providers affected by the CIA arrangement must complete the entire Overpayment Refund form that the OIG will send them.

Every voluntary refund check to Medi-Pak® Advantage should include the following important information:

1) Provider/Physician/Supplier Name
2) Address
3) Provider/Physician/Supplier Number
4) Check Number
5) Contact Person and Phone Number
6) Amount of Check
7) Check Date

For each claim included in the refund check, provide the following information:

1) Patient Name
2) Medicare Claim Number (HIC Number)
3) Medi-Pak® Advantage Claim Number
4) Claim Amount Refunded
5) Reason for Claim Adjustment

Note: This does not apply to the Federal Employee Program (FEP) at this time.

Observation Bed Place of Service Code – Physician Services

There is not a specific place of service code defined for the observation bed setting. Either the inpatient (21) or outpatient (22) place of service code is acceptable.

The prior authorization requirement for high tech radiology procedures is waived for services provided to patients in an observation bed setting. Unfortunately, when these services are billed with place of service 22, there is no way to identify that the patient was in an observation bed. Consequently, these claims are being denied for no authorization and must be resubmitted for adjustment.

Please use the inpatient place of service (21) for PHYSICIAN services (billed on the CMS 1500 claim form or by use of the 837P electronic transaction) provided to patients in an observation bed setting. Since either place of service code is acceptable, providers may use the inpatient place of service code for ALL physician services provided to patients in an observation bed setting.

This instruction DOES NOT change the facility billing for observation bed services. **Note:** This does not apply to the Federal Employee Program (FEP) at this time.

Data Required on Facility Claims Submitted for Secondary Payment

Arkansas Blue Cross and Blue Shield and its affiliated companies will no longer be able to manually process facility claims submitted on paper with incorrect or incomplete information in the payor fields (boxes 50 and 51) and the patient fields (boxes 58,59, and 60).

Any time providers are filing for secondary payment, complete and correct information about the payor from whom the provider received primary payment is required in line "A" in each of these fields, with the secondary payor information for the payor from whom the provider is requesting secondary payment in line "B" in each of these fields.

If Arkansas Blue Cross does not receive complete and accurate information in these fields, the claim will be returned to the provider. **Medigap payor information should never be placed in line "A", and Arkansas Blue Cross cannot accept claims for secondary payment without line "A" being accurately and completely populated.**

Arkansas Blue Cross is able to accept electronic submissions for secondary payment and would prefer that claims be sent in this medium. Providers are encouraged to submit claims electronically for all Arkansas Blue Cross lines of business.

With the implementation of the national coordination of benefits process for Medicare, it is unnecessary to submit claims to Arkansas Blue Cross for secondary payment for Medicare primary claims. Arkansas Blue Cross asks that providers not send paper claims for payment secondary to Medicare until at least 30 days after the primary payment was made by Medicare.

If after 30 days a secondary payment has not been received from Arkansas Blue Cross, providers can confirm that Arkansas Blue Cross has received the crossover in the AHIN system. If providers see the claim in AHIN, there is no need to file paper for secondary payment.

Note: This does not apply to the Federal Employee Program (FEP) at this time.

Bandage Lens

The appropriate HCPCS code to use for a "Bandage Lens" is S0515, Scleral lens, liquid bandage device, per lens. Billings for a "bandage lens" using any other procedure codes will be denied as "inappropriate coding".

DME Procedure Codes

The following DME procedure codes are routinely rented on a daily basis. For these procedures, please indicate the number of days rented in the units of service column.

If the rental if for a full month, 30 units of service should be used. Please note the maximum reimbursement for HCPCS Code E0935 is 21 days.

- E0781 - Ambulatory Infusion Pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient.
- E0935 - Continuous passive motion exercise device for use on knee only (Maximum rental = 21 days)
- E2402 Negative pressure wound therapy electrical pump, stationary or portable. (Note: this item is a contract exclusion in most member contracts.)

Intermediate Layered Closure

This is a reiteration of current payment guidelines. The payment policy of Arkansas Blue Cross and Blue Shield for specific codes is available on the AHIN system under CSCI (Code Specific Coding Instructions).

Intermediate closure is not separately billable if reported with an excision code for lesion excision when the excised diameter of the lesion and margin is:

- ≤ 0.5 cm for lesions on the face, ears, eyelids, nose, lips, mucous membrane;
- ≤ 1.0 cm for lesions on the scalp, neck, hands, feet, and genitalia; for lesion(s) on the trunk, arms or legs.

Intermediate closure of these smaller wounds resulting from excision of benign or malignant lesions is considered a fragmentation of the excision. If a claim is classified as "fragmented" or a "fragmentation" of a single code or service, Arkansas Blue Cross and Blue Shield will not pay for the fragmented claim or service but will pay only for the code and service of which the fragmented claim is considered an integral part, i.e., Arkansas Blue Cross will deny payment for breakdown or itemization of a single service into inappropriate or artificial, discrete parts, and will pay only for one, unitary service or code unit.

The average intraservice time for CPT Codes 12031, 12041, and 12051 reported at the time the work relative value units for these codes were developed by the Harvard Hsiao committee was 24 minutes, 27 minutes, and 24 minutes, respectively.

The work relative value units developed for CPT Codes 12031, 12041, and 12051 are 2.15, 2.37, and 2.47, respectively. For reference, the work RVU for CPT Code 99215, the most complex return office visit code, is 2.0 (2007 MFS). Any claim reporting CPT Codes 12031, 12041, or 12051 with CPT Codes 11400, 11401, 11420, 11421, 11440 11600, 11601, 11620, 11621, or 11640 requires a letter of explanation and description of the procedure. Procedures which describe minimal work of the layered closure are considered a fragmentation of the excision procedure.

FEP Benefit Changes for 2007

Federal Employees Program (FEP) members enrolled in the Standard Option receive some benefits for covered services from any covered provider, whether Preferred or not. However, members will receive the highest level of benefits when services are rendered by a Preferred provider.

Enrollment codes for Standard Option Plan:
104 Standard Option - Self Only
105 Standard Option - Self and Family

FEP members enrolled in the Basic Option must use a Preferred provider to receive benefits. If members receive care from a non-Preferred provider, members will not receive reimbursement for treatment.

Enrollment codes for the Basic Option Plan:
111 Basic Option - Self Only
112 Basic Option - Self and Family

FEP 2007 Benefit changes:

Changes for the Standard Option only:

- 12 chiropractic manipulations are available per calendar year when provided by licensed chiropractors.
- Ambulance transport services are now paid in full for ambulance transport services related to a medical emergency after the members pay a $50 copayment per trip (no deductible).
- The FEP program clarified how they determine when a treatment plan for outpatient psychotherapy visits must be submitted.

Changes to the Basic Option only:

- The FEP program now provides benefits in full for diagnostic or psychological tests billed for by the outpatient department of a Preferred, Member, or Non-member facility when related to the treatment of a mental health or substance abuse condition. Previously, these services were subject to a $40 copayment.

Changes to both the Standard and Basic Options:

- Preventive care benefits for Herpes Zoster (shingles) and Human Papillomavirus (HPV) vaccines is available as licensed by the U.S. Food and Drug Administration for adults. In addition, the FEP program now provides preventive care benefits for children who receive Rotavirus vaccines and Human Papillomavirus (HPV) vaccines.
- Ultrasound tests as provided as part of obstetrical care are now available.
- Surgically implanted penile prostheses to treat erectile dysfunction regardless of its physiological cause is now available.
- Additional surgical gastric procedures to treat morbid obesity is now available.
- Additional diagnosis is now covered for organ/tissue transplants.
- Therapeutically equivalent generic drugs that become available, the FEP program may classify the brand-name product as a non-formulary brand-name drug.
- Clotting factors and anti-inhibitor complexes to treat hemophilia is available through the prescription drug benefits.

Standard Option Mail Order Program:

For the Standard Option, members have a choice when filling prescriptions of using either the Mail Order Program or their local retail pharmacy. It is usually more cost-effective for members to use the Mail Order Program.

Physicians may call 1-800-378-5697 for more information on the Mail Order Program (the fax line for physicians is 1-866-278-7770).

For the Basic Option, members only have benefits at their local Retail Pharmacy. Basic Option members do not have the Mail Order Programs benefits.

For a complete list of benefit changes, please refer to the FEP website at ***www.fepblue.org***.

Federal Employee Program (FEP): Dental Claims Update

Helpful hints on how to submit dental claims for Federal Employee Program (FEP) members: When dental services for FEP members are rendered in the state of Arkansas, claims should be sent to Arkansas Blue Cross and Blue Shield for processing. Please submit FEP dental claims to:

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

Note: To ensure proper payment of claims, obtain the FEP ID number from the member identification card. The FEP identification number begins with an R followed by 8 digits. (Example R12345678)

Cancer of the mouth: When treating patients with cancer of the mouth, please submit the dental claim with the cancer related diagnosis code on the claim form. Cancer related IDC-9 diagnosis codes are 140-208.99 or 230-239.99. Please refer to the ICD-9 diagnosis code book for the year the services were rendered for the exact diagnosis code. Please place the diagnosis code in field 35 on the 2006 ADA dental claim form.

When Filing FEP Dental claims as a Clinic prior to May 23, 2007, please follow these guidelines when not using the 2006 ADA dental claim form and an NPI number has not been obtained: In the field labeled "Provider ID" or "ARK B/C Provider Number" is where both the performing provider number and clinic number should be entered. Enter the 5-digit Arkansas Blue Cross provider number for the performing provider followed by a slash (59999/) and then enter the 5-digit Arkansas Blue Cross dental clinic number (5C999).

New billing requirements for FEP Dental claims effective May 23, 2007: Submit all dental claims using the 2006 American Dental Association Claim Form. More information on how to obtain the new dental claim form can be found at the ADA website at www.ada.org.

All providers must file claims using their National Provider Identifier (NPI) beginning May 23, 2007. Please visit the CMS web site for additional information regarding NPI at www.cms.hhs.gov/HIPAAGenInfo/. Claims received without an NPI will be returned.

Providers can submit claims using their 5 digit Arkansas Blue Cross provider number AND/OR their NPI number until the May 23, 2007 deadline.

Filing dental claims as a CLINIC using the 2006 ADA claim form using and NPI:

- Field 48 - Under "Billing Dentist or Dental Entity" enter the clinic name and address;
- Field 49 - Enter the clinic NPI number;
- Field 52A - Enter the 5 digit Arkansas Blue Cross clinic provider number;
- Field 54 - Under "Treating Dentist and Treatment Location Information", enter the NPI of the provider performing the services;
- Field 58 - Enter the 5 digit Arkansas Blue Cross provider ID for the provider performing the service under "Additional Provider ID".

Filing dental claims as the PERFORMING PROVIDER (not part of a clinic) when using the 2006 ADA claim form and NPI:

- Field 48 - Under "Billing Dentist or Dental Entity", enter the provider's name & address.
- Field 49 - Enter the dentist's NPI;
- Field 52A - Enter the provider's 5 digit Arkansas Blue Cross provider number;
- Field 54 - Under "Treating Dentist and Treatment Location Information", enter the NPI of the provider performing the services;
- Field 58 - Enter the 5 digit Arkansas Blue Cross provider ID for the provider performing the service under "Additional Provider ID".

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID / Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

Breast Cancer Follow-up

The American Society of Clinical Oncology (ASCO) recently published guidelines for surveillance of women who received adjuvant chemotherapy for early-stage breast cancer. Arkansas Blue Cross and Blue Shield believes these guidelines are reasonable and will reimburse for the recommended services when all other coverage criteria of a member's health plan are met. The recommended services include:

- A history and physical exam should be performed every 3-6 months for the first 3 years after primary therapy; every 6-12 months for years 4 and 5; then annually. These evaluations should include teaching and reinforcement about the symptoms of recurrence and the reporting to a physician.
- Mammography 1 year after the initial study that resulted in the diagnosis but at least 6 months after completion of definitive radiotherapy. Subsequent mammograms should be done as indicated for surveillance of abnormalities. Women should be instructed in the technique and the need for monthly self-breast exams.

The following forms of breast cancer surveillance testing were NOT recommended by ASCO, at least in otherwise asymptomatic women with no specific findings on clinical examination, and, accordingly, will NOT be covered in such circumstances

- Routine blood tests such as CBC or liver function tests;
- Tumor markers including CA 15-3, CA 27-29, CEA;

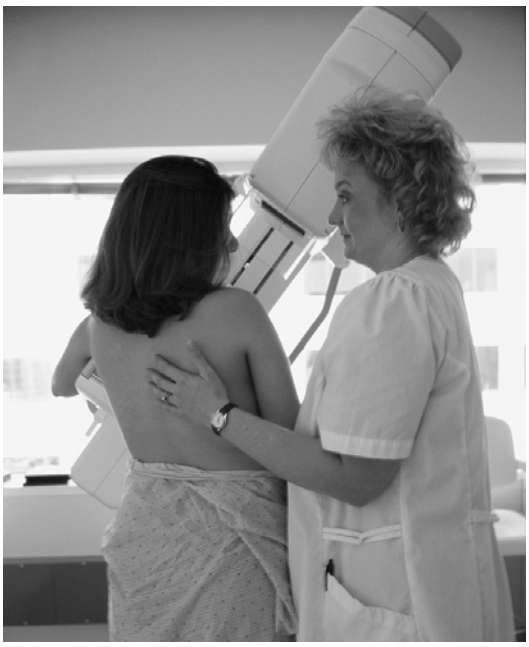
Imaging studies that include chest x-ray, bone scan, CT scans, ultrasound of the liver, FDG-PET scans, and MRI breast. NIA will use the same guidelines for imaging requiring prior authorization.

Mammography

The current procedure codes for screening mammography are CPT Codes 76092 and HCPCS Code G0202. The procedure codes for diagnostic mammography are CPT Codes 76090 and 76091 and HCPCS Codes G0204 and G0206.

These CPT codes will be changing January 2007. The corresponding new codes are noted in parenthesis. The procedure codes for screening mammography are CPT Codes 76092 **(77057)** and HCPCS Code G0202.

The procedure codes for diagnostic mammography are CPT Codes 76090 **(77055)** and 76091 **(77056)** and HCPCS Codes G0204 and G0206.



BlueCard®: Medicare Claims New Crossover Consolidation Process

How do providers submit Medicare primary/ Blue Plan secondary claims? For members with Medicare primary coverage and "Blue Plan" secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier. When submitting the claim, it is essential that the provider enter the correct "Blue Plan" name as the secondary carrier. This may be different from the local Arkansas Blue Cross and Blue Shield plan. (All Blue Plans are licensees of the Blue Cross and Blue Shield Association, but each Blue Plan licensee is a separate, independent company from other Blue Plan licensees.)

Check the member's ID card for additional verification. The member's ID card will include the alpha prefix in the first three positions**.** The alpha prefix is critical for confirming membership and coverage, and is key to facilitating prompt payments.

When providers receive the remittance advice from the Medicare intermediary, was the claim automatically forwarded (crossed over) to the Blue Plan? If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to Arkansas Blue Cross and Blue Shield. If the remittance indicates that the claim was not crossed over, submit the claim to Arkansas Blue Cross with the Medicare remittance advice.

What is Medicare crossover consolidation and how does it affect a provider's claim processing? To simplify and streamline claim submission, CMS (the Centers for Medicare and Medicaid Services) is now consolidating its claim crossover process under the special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA). Under this program, the COBC will automatically forward most Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Blue Plans are now implementing the Medicare crossover consolidation process for all BlueCard transactions and will continue over the next few months. Once the consolidated crossover process is fully implemented, providers should experience an increased level of "one-stop" billing for the Medicare primary claims.

Can this change affect the timing of the secondary payment from the Blue Plan? The claims providers submit to the Medicare intermediary will be crossed over to the Blue Plan only after the claims have been processed by the Medicare intermediary. This process may take up to 14 business days which means the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time providers receive the Medicare remittance advice. As a result, it may take an additional 14-30 business days for providers to receive payment from the Blue Plan.

What should providers do in the meantime? If a provider has submitted the claim to the Medicare intermediary/carrier and the provider has not received a response to their initial claim submission, **don't** automatically submit another claim. Instead, providers should:

- Wait 30 days; and
- Check claims status before resubmitting.

Sending another claim or having a billing agency resubmit claims automatically actually slows down the claim payment process and creates confusion for the member.

Who do providers contact if they have any questions? If the claim did cross over to the secondary "Blue Plan", providers must contact that Plan directly. If the claim did not cross over and a paper claim was filed with Arkansas Blue Cross with an EOMB attached, contact BlueCard Customer Service at 1-800-880-0918.

Arkansas Blue Cross and Blue Shield Adopts RBRVS for 2007

Effective April 1, 2007, Arkansas Blue Cross and Blue Shield will adopt the 2007 Resource Based Relative Value System (RBRVS) Relative Value Units (RVUs) which were published in the December 1, 2006 Federal Register Final Rule for most services.

The April 1, 2006 pricing update will also include the following:

- A 25% reduction in the technical portion of multiple radiology procedures in the same family of procedures will also be implemented. The reduction will apply to the lesser valued procedure(s) when multiple procedures in the same diagnostic family (as defined my CMS) are performed during the same patient encounter.
- The practice expense conversion factor for MRI and CT's will be increased from $38.61 to $40.00.

A new Arkansas Blue Cross and Blue Shield fee schedule using the 2007 RBRVS will be available on the AHIN website bulletin board beginning January 1, 2007.

Pharmacy: 2007 Formulary Changes

The following medications will move to the third tier effective January 1, 2007 and will have a higher copayment thereafter. If a member is currently taking one of these medications, the member may choose to pay the higher copayment or the member may change to a comparable medication in the first or second copayment tier.

Tier changes include the following:

Alrex
Caduet
Cardatrol
Celontin
Detrol
Detrol LA
Dibenzyline
Elidel
Femhrt
Kytril
Lipitor
Lotemax
Lumigan
Precose
Prefest
Qvar
Trusopt
Univasc
Uroxatral
Valtrex

This change applies to Arkansas Blue Cross and its affiliate and subsidiary companies.

A list of preferred or second-tier medications can be found on the following web sites:

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

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.

Arkansas State & Public School Employee Plan — Dental Information

The Arkansas State Employees and Retirees, and the Arkansas Public School Employees and Retirees have a preventive rider on their medical contract. This rider covers the 17 preventive dental codes listed below. Members will not have a separate dental identification card. Provider should use the ARHealth/Health Advantage ID card and member number for the claims submitted to United Concordia, Inc.

Previously, providers were informed that this rider would pay secondary to any group dental plan. The State of Arkansas has changed their view of the coordination of benefits clause and now will pay primary to all other dental coverage.

Code	Description	ASE/ PSE Benefit Guidelines
0120	Periodic oral evaluation	Two periodic exams per member per year.
0140	Limited oral evaluation – problem focused	Limited oral exam when done in conjunction with a procedure at the same visit is considered part of the definitive procedure and a separate fee may not be charged.
0150	Comprehensive oral evaluation	Includes a thorough examination and recording of the extraoral and intraoral hard and soft tissues.
0210	Intraoral X-rays – Periapical – first film	A full mouth series is covered once every 3-5 years.
0220	Intraoral X-rays – Periapical – each additional film	Routine working and final treatment x-rays are part of a complete procedure and are not a separate benefit. A maximum of 8-10 films are allowed on the same date of service.
0230	Intraoral X-rays – Periapical each additional film	
0240	Intraoral X-rays – Occlusal film	Two occlusal films per 12 month period.
0250	Extraoral – first film	
0260	Extraoral – each additional film	
0270	Bitewing – a film	One series of bitewing x-rays (2 or 4) allowed per calendar year.
0272	Bitewing – 2 films	
0274	Bitewing – 4 films	
0330	Panoramic film	1 of either D0210 or D0330 in a 5 year period.
1110	Prophylaxis – Adult	
1120	Prophylaxis – Child	
1203	Topical application of fluoride – child (prophylaxis not included)	Two topical applications of fluoride allowed per calendar year for covered dependents up to their 19th birthday.
1351	Sealant – to age 10 on 1st molars, age 15 on 2nd molars	1 per tooth in a 3 year period.

Access Only PPO Customers of USAble Cooperation Effective January 1, 2007

Group Name	Comments
Aalf's Manufacturing Inc / Midland's Choice	Arkansas' FirstSource PPO
Anchor Packaging / Hermann Co.	True Blue PPO—Effective 1/1/06
Ark Sheet Metal Workers -Local #36-L	Arkansas' FirstSource PPO
Arkansas Carpenters Health & Welfare Fund	Arkansas' FirstSource PPO
Arkansas Pipe Trades Health & Welfare	True Blue PPO— Effective 01/01/07
Arkansas State University Athletes	Arkansas' FirstSource PPO
Arvest Bank	True Blue PPO—Effective 1/1/06
Ashley County Medical Center	Arkansas' FirstSource PPO
BEKAERT - Rogers, AR Location	Arkansas' FirstSource PPO
BEKAERT - Van Buren, AR Location	Arkansas' FirstSource PPO
Boar's Head Provisions Co	Arkansas' FirstSource PPO
Brentwood Industries, Inc	Arkansas' FirstSource PPO
Bridgestone - Firestone	Arkansas' FirstSource PPO
Bryce Corporation	True Blue PPO—Effective 11/01/06
Columbia Forest Products	True Blue PPO—Effective 01/01/06
Defiance Metals	Arkansas' FirstSource PPO
Diocese Of Little Rock / Christian Brothers	Arkansas' FirstSource PPO
Franklin Electric	Arkansas' FirstSource PPO
Harps Food Stores	True Blue PPO Effective 06/01/06
Iberia Bank	True Blue PPO—Effective 02/01/07
KLA Benefits/Klipsch LLC	Arkansas' FirstSource PPO
LA Darling	True Blue PPO—Effective 01/01/06
Levi Hospital	Arkansas' FirstSource PPO

Group Name	Comments
Magnolia Hospital	Arkansas' FirstSource PPO
Marshalltown Company	Arkansas' FirstSource PPO
Maverick Tube Corp	True Blue PPO Effective 08/01/06
Motor Appliance Corporation	Arkansas' FirstSource PPO
Nestle USA	True Blue PPO—Effective 08/01/06
Odom's Tennessee Pride Sausage	True Blue PPO—Effective 01/01/07
Peterson Manufacturing / Mission Plas	Arkansas' FirstSource PPO
Rea Magnet Wire Co	Arkansas' FirstSource PPO
Siplast Inc	Arkansas' FirstSource PPO
Southern Painters Welfare	Arkansas' FirstSource PPO
Stephens Media Group	True Blue PPO—Effective 01/01/06
St. Michael Healthcare - Cobra	Arkansas' FirstSource PPO
St. Michael Healthcare-Hosp	Arkansas' FirstSource PPO
St. Michael Healthcare-Rehab	Arkansas' FirstSource PPO
St. Michael CH Wilkerson - Texarkana	Arkansas' FirstSource PPO
Town & Country Grocers / Price Chopper	Arkansas' FirstSource PPO
Townsend Foods	True Blue PPO—Effective 01/01/06
UFCW (Kroger & Consumer Market)	True Blue PPO—Effective 10/01/05
Wabash National / Cloud Corp	Arkansas' FirstSource PPO

Groups Terminated Since January 1, 2006	Termination Date
FedEx Freight East, Inc (Formerly American Freightways)	Term Effective 12/31/06
Genmar - Ranger Boats	Term Effective 12/31/06
Harding University	Term Effective 12/31/06 Changing to Blue Advantage
Wallace & Owens	Moved to BlueCard 08/01/06

Fee Schedule Updates

The following CPT4 and/or HCPCS Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT/ HCPCS Code	Total/ Purchase	Professional/ Rental	Technical/ Used	Total SOS	Professional SOS	Technical SOS
32201	$1,481.41	$0.00	$0.00	$327.82	$0.00	$0.00
50382	$1,795.00	$0.00	$0.00	$421.00	$0.00	$0.00
50384	$1,727.58	$0.00	$0.00	$383.18	$0.00	$0.00
83890	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83891	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83892	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83893	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83894	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83896	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83897	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83898	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83900	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83901	$46.84	$0.00	$46.84	$0.00	$0.00	$0.00
83902	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83903	$29.75	$0.00	$29.75	$0.00	$0.00	$0.00
83904	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83905	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83906	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83907	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83908	$18.66	$0.00	$18.66	$0.00	$0.00	$0.00
83909	$23.42	$0.00	$23.42	$0.00	$0.00	$0.00
83912	$23.42	$23.42	$0.00	$23.42	$23.42	$0.00
90375	$76.68	$0.00	$0.00	$0.00	$0.00	$0.00
90378	$661.83	$0.00	$0.00	$0.00	$0.00	$0.00
90660	$22.02	$0.00	$0.00	$0.00	$0.00	$0.00
90665	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
90669	$73.25	$0.00	$0.00	$0.00	$0.00	$0.00
90675	$157.25	$0.00	$0.00	$0.00	$0.00	$0.00
90698	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

CPT/ HCPCS Code	Total/ Purchase	Professional/ Rental	Technical/ Used	Total SOS	Professional SOS	Technical SOS
90701	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
90710	$115.00	$0.00	$0.00	$0.00	$0.00	$0.00
90720	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
90736	$152.88	$0.00	$0.00	$0.00	$0.00	$0.00
99500	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99501	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99502	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99503	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99504	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99505	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99506	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99507	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99509	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99510	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99511	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99512	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
99600	$115.00	$0.00	$0.00	$115.00	$0.00	$0.00
A7043	$27.00			$0.00	$0.00	$0.00
E0781	$0.00	$8.83	$0.00	$0.00	$0.00	$0.00
E0935	$0.00	$21.32	$0.00	$0.00	$0.00	$0.00
E1238	$1,638.73	$163.87	$1,229.05	$0.00	$0.00	$0.00
E2402	$0.00	$57.22	$0.00	$0.00	$0.00	$0.00
E2620	$547.70	$54.77	$410.79	$0.00	$0.00	$0.00
E2621	$574.76	$57.47	$431.08	$0.00	$0.00	$0.00
J0696	$3.50	$0.00	$0.00	$0.00	$0.00	$0.00
L2232	$78.20			$0.00	$0.00	$0.00
L3260	$19.07	$0.00	$0.00	$0.00	$0.00	$0.00
L8689	BR	$0.00	$0.00	$0.00	$0.00	$0.00
S9122	$15.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9123	$28.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9124	$25.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9131	$101.00	$0.00	$0.00	$0.00	$0.00	$0.00

CPT Code 90375 has been updated in the Arkansas Blue Cross and Blue Shield Fee Schedule to allow $76.68.

Providers' News

Arkansas Blue Cross and Blue Shield
P. O. Box 2181

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