Arkansas Blue Cross and Blue Shield

Providers' News

September 2006

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
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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Arkansas Blue Cross Needs Your NPI!

Providers who have already applied and received their National Provider Identifier (NPI), Arkansas Blue Cross and Blue Shield needs it 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.

Providers may mail, fax, or email 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.

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, healthcare 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***.

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.

Licensed Physical Therapy Assistants

Licensed Physical Therapy Assistants are not recognized providers by Arkansas Blue Cross and Blue Shield and do not have Arkansas Blue Cross provider numbers. If physical therapy is provided by a licensed physical therapy assistant and billed "incident-to" by a licensed physical therapist with an Arkansas Blue Cross provider number, the licensed physical therapist must be present with the physical therapy assistant for the physical therapy to be a covered benefit.

Arkansas Blue Cross and Blue Shield to Implement NPI Functionality

On October 2, 2006, Arkansas Blue Cross and Blue Shield and our affiliated companies will begin 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.)

Beginning October 2006, providers may submit 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.

Radiology Services Authorization Began September 1st

On Friday, September 1, 2006, the Radiology Utilization Management Authorization Program became effective. As a reminder, Arkansas Blue Cross and Blue Shield and Health Advantage are working with National Imaging Associates, Inc. (NIA) for outpatient imaging management services. Physicians who order high-tech scanning procedures **(PET scans, CT scans, MRI/MRA or Nuclear Cardiology)** for any individual or group member (except FEP, Medi-Pak®, or ARHealth [where Medicare is primary]) must obtain a prior authorization before the scan can be performed.

Since February 2006, physicians have been participating in a "soft authorization" process. Physicians (and their clinical staff) have been following the protocol of the authorization program; however, some requests have been deferred for "alternative clinical recommendation". As of September 1, 2006, "alternative clinical recommendations" are no longer issued and authorizations are either "issued" or "denied" based on the radiology coverage guidelines.

It is the **ordering physician's responsibility** to receive prior authorization before ordering one of these high-tech scanning procedures. It is also the rendering providers' financial responsibility if a scan is performed without prior authorization.

It is very important for physicians to note a member's ID card to determine if a prior authorization is needed for high-tech scanning procedures. Also, it is very important that coding for services is done correctly as there are consequences for incorrect coding.

Complete details are available through the:

- Clinical Guidelines for Radiology Procedures located on the National Imaging Associates web site at www.RadMD.com
- Bulletin board postings on AHIN (Click on Bulletin Board under "Provider News" for "Radiology Services Authorization begins September 1".)
- Arkansas Blue Cross and Health Advantage web sites (Click on the "Authorization Information for Radiological Services" link located on the "Provider" page)
- ***Providers' News*** (Additional information may also be found in the March and June 2006 issues of the *Providers' News*.)

CPT Code 90660: Influenza Virus Vaccine for Intranasal Use

Arkansas Blue Cross and Blue Shield has expanded coverage for CPT Code 90660 - Influenza virus vaccine for intranasal use - by allowing Average Wholesale Price of $22.02 for children and adolescents ages 5—18, and adults (who are otherwise well) ages 19—49. The member is not to be billed for any additional amount of co-insurance, co-payment, or deductible, as there is no additional payment required. There is no coverage for ages beyond the FDA approved indications listed.

High-Tech Radiology Billing Requirements

As of September 1, 2006, Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation (Arkansas' FirstSource® PPO and True Blue PPO) have changed billing requirements for High-Tech Radiology, defined as CT scans, magnetic resonance, PET scans or nuclear cardiology. This change does not affect hospitals billing for these services.

Imaging Centers should use their Arkansas Blue Cross provider number as the rendering provider when billing services for High-Tech Radiology on the standard electronic claims transactions. In most cases, these imaging center provider numbers were previously being used as the provider's clinic number.

Imaging Centers will likewise use this provider number in the appropriate block of the CMS 1500 claim form as the rendering provider for High-Tech Radiology (currently, the appropriate block for entering a provider number is Block 24K). Imaging Centers will also use their Arkansas Blue Cross provider number as the clinic billing number on electronic claims and CMS 1500 claim form (currently Block 33B).

Arkansas Blue Cross and its family of companies prefer that Imaging Centers do not submit claims for total component on one line for High-Tech Radiology services. Instead, the professional and technical services should be split and billed on two separate lines:

- **Technical Component**—billed using the Imaging Center's provider number; and
- **Professional Component**—billed using the physician's provider number.

However, Imaging Centers may bill "Total Component" on one line for the High-Tech Radiology services provided that the Imaging Center-based physician performing the supervision and interpretation meets the requirements described within the Imaging Center provider agreement.

All applicable modifiers should be used (e.g. Modifier 26 for Professional Component, TC for Technical Component). **Professional Component reimbursement for High-Tech Radiology will only be made to physicians**; therefore, payment will be made for the Professional Component only when submitted under a physician's provider number. Physicians billing with Modifier TC will receive a denial. Professional services billed with the Imaging Centers provider number and /or Modifier 26 will be denied. Imaging Center claims should be submitted with place of service "11".

This listing of specific claims filing requirements for Imaging Centers is not exclusive or comprehensive of all Arkansas Blue Cross claims filing or coding policies and procedures. These specific requirements are in addition to and not a substitute for other Arkansas Blue Cross claims filing and coding policies.

Contracting with Radiology Imaging Centers

Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation have added non-hospital imaging centers as contracted providers to their respective provider networks. Provider agreements were sent to non-hospital based providers who perform high-tech radiology services, defined as CT scans, magnetic resonance, PET scans or nuclear cardiology.

As of September 1, 2006, imaging centers that signed and returned their participation agreements are considered in-network providers (provided the Imaging Centers meet all contract requirements and applicable credentialing standards and network terms and conditions). Imaging Centers that have not signed network participation agreements will still be treated as out of network.

In-network Imaging Centers are currently displayed in the "Provider Directory" located on the Arkansas Blue Cross and Health Advantage web sites at www.ArkansasBlueCross.com and www.HealthAdvantage-hmo.com. Users can locate a imaging provider by selecting "Imaging Centers" in the "Specialty" drop-down box under the "Hospital and Facilities" selection.

A typographical error was made in some imaging center contracts. Under **Section II, "Imaging Center's Services and Compensation," sub-heading titled "Imaging Center-Based Physicians"**, the last sentence should read:

> "In the event of a Diagnostic Imaging Provider Assessment Program ("Program"), imaging center will not bill for nor collect reimbursement from Members, any professional services that are not performed by personnel who have ***not*** been approved by the Program to provide such services to Members."

Imaging centers were also notified of Provider Assessment Guidelines that must be met by January 1, 2009 in order to remain an in-network provider.

There has been one revision/correction made to the Provider Assessment Guidelines. Under "Computed Tomography (CT) and Magnetic Resonance Imaging (MR)," sub-section titled "Instrumentation Requirements," the last bullet now reads:

> "MR systems with field strength of less than 0.3 Telsa will be considered very low field systems and will not be covered."

Those providers performing and billing "Total" or "Technical Components" for high-tech radiology procedures who have not received a participation agreement should contact their regional Network Development Representative.

AHIN: Two Additional Tools Now Available

Providers have already seen how AHIN (Advanced Health Information Network) has increased their efficiency by providing eligibility, claims viewing and status, online filing and correcting, as well as other features. Now, two additional tools are available for providers and their staff:

1. Electronic Remittance Advice (ERA)
2. Electronic Funds Transfer (EFT)

Electronic Remittance Advice (ERA):

Quit the paper chase and have Remittance Advices delivered electronically. Providers can post payments without leafing through the stacks of paperwork that came in the past.

ERA's save providers time and filing space—while exceeding demands for accuracy and dependability. The electronic remittance advice system allows the provider's practice management system to operate at peak efficiency which adds to their bottom line and frees their staff to do other things.

If a paper copy is needed, providers can print any Remittance Advice. A history of a provider's Remittance Advice is maintained on-line and is always available for viewing.

Electronic Funds Transfer (EFT):

When do providers like to be paid? Today? Tomorrow? Two weeks from now? Why wait for the mailman? A payment can be deposited directly into a provider's bank account and the provider is notified when the payment has been made. Just like a personal on-line account, providers control their financial information and their privacy and confidentially are assured.

Getting Started is Easy:

Contact your Arkansas Blue Cross regional Network Development Representative who can provide more information and show providers the way to a more efficient, productive office.

At this time, Electronic Fund Transfer is not available for the Federal Employee Program (FEP) or Medi-Pak® Advantage .

Electronic Remittance Advice (ANSI 835's)

Effective January 1, 2007, Arkansas Blue Cross and Blue Shield will be making changes to the Electronic Remittance Advice (ANSI 835's). Arkansas Blue Cross will begin adjudicating claims at the line level. As a result of this change, Arkansas Blue Cross will be adding line level detail to the electronic RA's. This means all deductions will be taken at the line level instead of the claim level.

If providers are auto-posting from the 835's, they may have to modify their systems as a result of this change. The electronic remittance advice should still balance to the claim and line level summaries.

Arkansas Blue Cross and Blue Shield will be facilitating testing of the new line level remit between November 1 and December 31, 2006. Providers who would like to test the new format, please contact the Arkansas Blue Cross EDI Services Division at (501) 378-2419 or toll-free at (866) 582-3247.

This change does not affect the Electronic Remittance Advices for Health Advantage or BlueAdvantage Administrators of Arkansas.

Modifier 59 Billing Instructions

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

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

Arkansas Blue Cross has received a number of claims in which Modifier 59 has been inappropriately used, (e.g., in instances where only one procedure code is billed for a given date of service). Because Modifier 59 is intended to be used where there is a second or separate procedure performed on the same day, Modifier 59 should never be used when only one procedure code is billed for same date of service,

Modifier 59 is never appropriate for Evaluation and Management (E&M) codes. Modifier 25 is the appropriate modifier to bill when reported with an E&M service on the same day as a procedure code with a 0, 10, or 90-day global to identify a separate and distinct E&M service.

E&M services represent “daily services” and the relative value units for E&M services include some RVUs for the case in which the physician must see the patient more than once in a 24-hour day. In this case, the E&M code that best describes ALL the evaluation and management services provided on that day should be reported.

As a general rule for surgical procedures, if a surgery would be reimbursed based on multiple surgery guidelines without Modifier 59, no additional reimbursement would be warranted with Modifier 59 appended. The inappropriate appending of Modifier 59 will result in additional claim processing time and potential requests for clinical information.

Most billings of Modifier 59 will require the submission of medical records. The medical records should clearly support the distinct and independent status of the procedure to which Modifier 59 has been appended.

Review of Modifier 59:

- Modifier 59 is used to report distinct and separate procedures performed on the same day.
- Modifier 59 should be used with caution since this modifier affects the processing and reimbursement. Modifier 59 is not designed to provide reimbursement for separate procedures that are performed as an integral part of another procedure. Use of Modifier 59 will normally require submission of medical records.
- When a procedure is described in the CPT code descriptor as a "separate procedure" but is carried out independently or is unrelated to other services performed at the same session, the CPT code may be reported with Modifier 59.
- Modifier 59 should not be used when another, more descriptive modifier is available.
- Documentation needs to be specific to the distinct procedure or service clearly identified in the medical record.

There are modifiers available that describe the body location. (i.e., LT and RT, for left and right side. There are others to describe specific

digits, eyelids, etc.) If a modifier is available that specifically describes the body location, that modifier should be used INSTEAD of Modifier 59.

Clear Claim Connection (CCC):

The September 2004 issue of the ***Providers' News*** provided information on Clear Claim Connection (CCC), a new tool available to Arkansas Blue Cross providers via the Advanced Health Information Network (AHIN) website. This tool should be used to determine the appropriate use of Modifier 59.

The code combination being billed should be entered into CCC, without Modifier 59. If Modifier 51 applies to the secondary procedure, the reimbursement for covered services will be based on 50% of the allowance for the secondary procedure(s). In cases such as this (where CCC indicates that Modifier 59 should be used), Arkansas Blue Cross will not ordinarily request medical records. While providers may append Modifier 59 to any claim when warranted, they should be aware that doing so will ordinarily trigger a request for medical records, and thus may delay the processing of the claim.

If the secondary procedure would be denied based on CCC and it meets the conditions for billing Modifier 59, Modifier 59 should be appended AND Arkansas Blue Cross will require submission of medical records in MOST cases. When medical records are needed, they will be requested via the automated Medical Records Request system.

If CCC combines two procedures into one procedure that includes both of the services provided, providers should bill using the one procedure that includes both procedures. An example is CPT Codes 93501 & 93510 which are more accurately reported using CPT Code 93526.

Arkansas Blue Cross receives in excess of 7,500 line items per month with Modifier 59 appended. Arkansas Blue Cross has reviewed numerous claims submitted with Modifier 59. Listed below are examples of inappropriate billing of Modifier 59.

Modifier 59 is NEVER appropriate with:

- E&M codes (CPT Codes 99200-99499);
- Anesthesia Procedures (CPT Codes 00100 - 01999 [except 01967] and 99100 - 99140);
- Single procedure on the date of service;
- Administration codes corresponding to injection, immunization or vaccine (the administration is paid separately from the code for the drug without addition of Modifier 59);
- Injection codes with multiple units (Providers are expected to bill for the appropriate dosage. If the injection code is for 50 mg and 100 mg is given, providers should bill with 2 units of service. Modifier 59 is not necessary.);
- EVERY administration code on a claim;
- E&M, influenza vaccine, and administration (this combination is acceptable without a Modifier 25 on the E&M and/or without Modifier 59 on the administration code);
- Code Combination in CCC accessed via AHIN, allows all services;
- Code Combination in CCC accessed via AHIN appends Modifier 51 to the secondary procedure(s) (Modifier 59 may be included in situations where it is necessary to identify a different lesion, session, etc., not defined by a more specific modifier. Colonoscopy procedures discussed separately in this newsletter is an example.);
- Code Combination in CCC accessed via AHIN replaces the two codes with one code that describes both services (i.e., CPT Code 93501 + 93510 = 93526);
- One upper and one lower GI Endoscopy procedure (The two procedures address different areas of the body based on definition.);
- E&M plus radiology plus one surgical procedure (In this scenario, Modifier 59 is not appropriate on the surgical procedure. If the E&M code meets the conditions described by Modifier 25, then the

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appropriate coding is to add Modifier 25 to the E&M procedure.)

- ALL clinical laboratory services billed on one day;
- Line items billed separately with RT and LT modifiers (These modifiers distinguish the different sites without using Modifier 59.);
- E&M and surgery on the same day (If the E&M service meets the conditions of Modifier 25, Modifier 25 should be appended to the E&M service. It is never appropriate to also bill Modifier 59 with the surgical procedure.); and
- Outpatient facility claims where only one surgical procedure was performed. (All ancillary, lab and radiology services will be combined with the surgical procedure and reimbursed based on the outpatient surgery fee schedule.)

Display of Adjustments on BlueCard Remittance Advice

As of August 16, 2006, adjustments that do not affect the current net payment are now segregated from other claims and adjustments on the BlueCard Remittance Advice.

New claims and adjustments that result in additional payments (the correction claim payment amount is greater than the reversal claim payment amount) are displayed first in patient name and claim number order. A correction claim is then displayed immediately following the corresponding reversal claim. However, if the spelling of the patient name is different, a correction claim may appear elsewhere.

After all new claims and additional payment adjustments are listed, a "**TOTAL CLAIMS**" line is displayed. Any amounts being offset/ withheld to recover prior overpayments are now listed next under a heading of "**OFFSET DETAILS**". These will be followed by a "**NET PAYMENT**" line, which show the net dollar amount of the current check or EFT (the same amount that is displayed in the box in the upper right corner of each page).

If adjustments are processed that do not affect the current net payment, they are reported on a new page under "**CLAIM ADJUSTMENTS, EXCLUDING ADDITIONAL PAYMENTS**". These adjustments include statistical adjustments for which the claim payment did not change as well as overpayment adjustments for which the payment amount on the corrected claim is less than on the reversal claim.

Providers now receive refund request letters for the overpayment adjustments under separate cover, unless the adjustment was processed as a result of an unsolicited refund from a provider. Please note that even though these adjustments are not needed to balance to the current payment, they contain important information that should be noted in a patient's account records (such as changes in patient liability, provider discounts, etc.).

For providers who have any claims with a reject status, these claims are reported on a new page under **"CLAIMS WITH REJECTED STATUS".**

Arkansas Blue Cross and Blue Shield hopes these changes facilitate our provider's posting and balancing process. Provider who have questions should contact BlueCard Customer Service at 501-378-2127 or 1-800-880-0918.

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.

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 system-wide 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.

Qualifications For Designation Of Pain Management Subspecialty

Pain medicine is the medical discipline concerned with the diagnosis and treatment of the entire range of painful disorders. Because of the vast scope of the field, pain medicine is a multidisciplinary subspecialty, and the expertise of several disciplines is brought together in an effort to provide the maximum benefit to each patient.

The following standards for a designation as a network pain management subspecialist are being implemented by Arkansas Blue Cross and Blue Shield, USAble Corporation, and Health Advantage.

For providers who are currently practicing as a pain medicine specialist and would like to be designated as such in the separate networks referenced above, please review the following pathways which define the requirements that must be met to qualify for designation as a pain medicine specialist in the networks.

Certification pathways:

March 1998, the American Board of Psychiatry and Neurology (ABPN) and the American Board of Physical Medicine and Rehabilitation (ABPMR) joined the American Board of Anesthesiology (ABA) in their recognition of pain medicine as an interdisciplinary subspecialty. The respective Boards have agreed on a **single standard of certification**. The ABA administers a computer-based examination covering the various content areas of pain medicine.

Diplomates from ABPN, as well as diplomates from other American Board of Medical Specialties who have appropriate training in pain medicine, may apply to the ABPN for admission to the certifying process. Diplomates of the ABA and ABPMR are required to apply for certification through their respective Boards.

Candidates from the ABPN, ABPMR, ABA, and from other American Board of Medical Specialties who have appropriate training in pain medicine and have successfully passed the certifying examination, receive Certification in the Subspecialty of Pain Medicine, valid for 10 years.

The American Board of Interventional Pain Physicians (ABIPP):

The ABIPP is a Specialty Board providing:

1) Board Certification in Interventional Pain Management,
2) Competency Certification in Controlled Substance Management, and
3) Competency Certification in Coding, Compliance and Practice Management.

The ABIPP Competency Certification is not “Board Certification” which is clearly stated by the ABIPP. ABIPP promotes the importance of Board Certification in Interventional Pain Management and had developed specific Board Certification requirements to be a Diplomate of the ABIPP. The requirements are as follows:

1) Completion of an Accreditation Council for Graduate Medical Education approved fellowship; or interventional pain management practice experience for four years.
2) Completion of 200 hours of interventional pain Continuing Medical Education (CME) of which 50 hours is hands on CME with cadaver training.
3) Fulfill unrestricted licensure requirements to practice medicine in the United States.
4) Satisfactory professional standing with the ABIPP.
5) Diplomate status of a primary specialty approved by the American Board of Medical Specialties (ABMS).

6) Successful completion of the ABMS subspecialty examination in pain medicine with Certification in the Subspecialty of Pain Medicine offered by the ABA, ABPMR, and/or the ABPN.

And

The completion of Competency Certification in Coding, Compliance, and Practice Management and Competency Certification in Controlled Substance Management.

The ABIPP offers a second pathway to Board Certification as a Diplomate. This second pathway includes completion of ABIPP Part I – Theoretical Examination **AND** completion of Part II – Practical Examination. Completion of the Fellow of Interventional Pain Practice (FIPP) exam offered by the World Institute of Pain can substitute for Part 1 and Part 2 of the ABIPP exam requirements.

Designation as Subspecialist in Pain Medicine by the Respective Networks of Arkansas Blue Cross, USAble and Health Advantage:

The designation of sub-specialist in pain medicine by the networks can be fulfilled by several pathways:

Pathway 1:

- Satisfactory completion of 12 months fellowship training in pain medicine approved by the Accreditation Council for Graduate Medical Education (ACGME). Training must be completed by June 30 of the year of the examination.

And

- Satisfaction of all licensure requirements for certification in the subspecialty of pain management (as established by the ABMS, and the ABPN, ABPMR, and ABA).

And

- Successful completion of the ABMS Certification Examination in Subspecialty of Pain Medicine.

Note: If a candidate meets all licensure requirements for certification in subspecialty of pain management (as established by the ABMS, and the ABPN, ABPMR, and ABA), and successfully completed the ABMS Certification Examination in the Subspecialty of Pain Medicine *prior to the ABMS requirement* of a 12 month fellowship, then the candidate meets the requirements for designation as a subspecialist in pain management in the networks.

OR

Pathway 2:

Through the 2006 examination only, by fulfilling the following temporary criteria:

- Satisfactory completion of residency training for primary certification by ABMS member Board prior to September 1, 2004, and satisfactory completion of 12 months of fellowship training in pain medicine by June 30 of the year of the examination. **After the 2006 examination, all candidates applying or reapplying for certification in pain medicine must complete 12 months of ACGME accredited training in pain medicine.**

And

- Satisfaction of all licensure requirements for certification in the sub-specialty of pain management (as established by the ABMS, and the ABPN, ABPMR, and ABA).

And

- Successful completion of the ABMS Certification Examination in Subspecialty of Pain Medicine.

Note: If a candidate meets all licensure requirements for certification in subspecialty of pain management (as established by the ABMS, and the ABPN, ABPMR, and ABA), and successfully completed the ABMS Certification Examination in the Subspecialty of Pain Medicine *prior to the ABMS requirement* of a 12 month fellowship, then the candidate meets the requirements for designation as a subspecialist in pain management in the networks.

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OR

Pathway 3:

Satisfactory completion of the specific Board Certification requirements to be a Diplomate of the ABIPP by satisfactory completion of the following:

- Completion of ACGME approved fellowship in pain medicine, **and**
- Unrestricted licensure to practice medicine in the United States, **and**
- Satisfactory professional standing with the ABIPP, **and**
- Diplomate of primary specialty approved by the ABMS, **and**
- Successful completion of the ABMS Certification Examination in the Subspecialty of Pain Medicine.

OR

Pathway 4:

- Completion of ABIPP Part I – Theoretical Examination, **AND**
- Completion of ABIPP Part II – Practical Examination, or Completion of the Fellow of Interventional Pain Practice credentialing process and certifying exam by the World Institute of Pain.

OR

Pathway 5:

- Practice of Pain Management for at least four years, including evaluating, diagnosing, and providing treatment and consultative services to patients requiring pain management,

And

- Performance of procedures which are routine to the basic practice of pain management including, but not necessarily limited to:
  - A broad range of peripheral nerve block procedures;
  - Epidural and subarachnoid injections;
  - Joint and bursal sac injections;
  - Prior therapeutic techniques; and
  - Epidural, subarachnoid and peripheral neurolysis;

And

- Submission of evidence of the extensive training and supervised experience in the field of Pain Management,

And

- An average of twenty hours continuing medical education units per year in pain management for at least four years.

Applicants who wish to apply for designation using **Pathway 5** will be allowed to apply until January 1, 2008. After January 1, 2008, all applicants will need certification following Pathways 1, 2, 3, or 4.

An applicant's request for designation of subspecialty certification in pain management will be reviewed by the Medical Director(s) engaged by the network to provide consultation services for this purpose. The network Medical Director(s) will evaluate the documentation contained in the application and determine, based on the preceding standard, if the applicant qualifies to be designated as a pain management specialist in the respective networks of Arkansas Blue Cross, USAble Corporation, or Health Advantage. Applicants who do not meet the preceding standard shall not be entitled to recognition by the respective networks as pain management specialist or subspecialist.

For providers who meet the requirements through one of the pathways and wish to change their specialty designation to pain medicine, please submit a request to:

Provider Network Administrator
PO Box 2181
Little Rock, AR 72203-2181

Please specify the pathway and include documentation verifying each criterion outlined in the pathway that has been completed.

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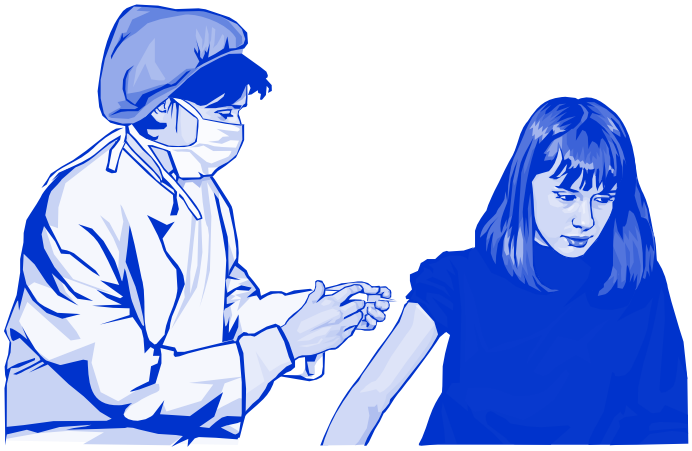
Providers who are unsure of how their specialty is listed in the network directories, please access the online directories available on the Arkansas Blue Shield and Blue Shield web site at www.ArkanssBlueCross.com. Click on the "Provider Directory" icon located on the home page and select the appropriate network from the network listings. This will allow users to access a provider's network profile and specialty designation. Providers who do not have internet access should contact their Network Development Representative for assistance.

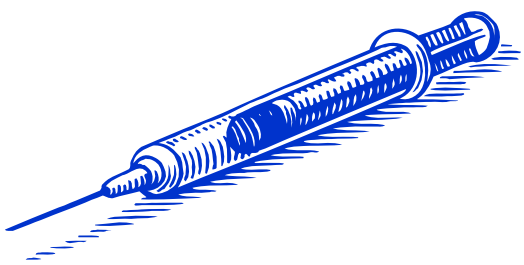
Rotavirus and HPV Vaccine



The Rotavirus and HPV vaccines have been FDA approved this year. Coverage for children insured by Arkansas Blue Cross and Blue Shield and Health Advantage are consistent with guidelines proposed by the Advisory Committee on Immunization Practices (ACIP).

Rotavirus (Rota Teq®) CPT Code 90680:

Immunization is covered for 3 doses of RV (Rota Teq®) administered orally at 2, 4, and 6 months of age. The recommended dosing schedule is for the first dose to be administered between 6-12 weeks of age with subsequent doses administered at 4 to 10 week intervals, and all 3 doses of vaccine completed by 32 weeks of age.



Human Papilloma Virus (HPV) (Gardasil) CPT Code 90649:

The immunization is covered for a 3-dose series for the quadrivalent HPV vaccine as recommended for females at age 11 to 12 years old with the following schedule:

- 1st dose: at elected date
- 2nd dose**:** 2months after the first dose
- 3rd dose: 6 months after the first dose

The Gardasil HPV vaccine is also covered for girls 9-10 and 13-18 years of age.

Intervals for HPV vaccine

Minimum Age	Dose 1 - 2	Dose 2 - 3
9 years old	4 weeks	12 weeks

The Gardasil HPV vaccine is covered for women 19-26 years of age whose benefit contract includes the Wellness Benefit.

Coverage for BlueAdvantage Administrators of Arkansas members may vary and depends on the specific terms of such members' self-funded employee health benefit plan, as outlined in the self-funded plan's Summary Plan Description. BlueAdvantage does not provider coverage, but serves as a third party administrator for self-funded plan customers.

Provider Workshops

Conway

Wednesday, November 29, 2006

Session 1 - 9:00 am & Session 2 - 1:00 pm

UCA - Brewer-Hegeman Conference Center

El Dorado

Wednesday, November 8, 2006 at 1:00 p.m.

Warner Brown Building

460 West Oak Street

Fort Smith

Friday, December 8, 2006 at 9:00 a.m.

Spark's Regional Medical Center

Shuffield Education Center

Hot Springs

Tuesday, November 14, 2006 at 1:00 p.m.

St. Joe's Mercy Health Center

Mercy-McAuley Room

Jonesboro

Thursday, November 2, 2006 at 8:00 a.m.

St. Bernard's Regional Medical Center

Auditorium

Mountain Home

Tuesday, October 17, 2006 at 8:00 a.m.

Baxter Regional Medical Center

Cafeteria Conference Room

North Little Rock

Thursday, November 30, 2006

Session 1 - 9:00 a.m. & Session 2 - 1:00 p.m.

Wyndham Hotel — Riverfront

Pine Bluff

Thursday, November 16, 2006 at 1:00 p.m.

South East Arkansas College

McGeorge Hall — 1900 Hazel Street

Springdale

Wednesday, October 18, 2006 at 9:00 a.m.

Holiday Inn - Northwest Arkansas

Main Ballroom

Texarkana

Thursday, November 9, 2006 at 9:00 a.m.

Christus St. Michaels Hospital

Conference Room (North entry)

For additional information regarding provider workshops in your area, contact your regional Network Development Representative

Coverage Policy Manual Updates

The following policies were revised or added to the Arkansas Blue Cross and Blue Shield Coverage Policy Manual:

- Bone Mineral Density Testing;
- Chemodenervation (Botulinum Toxin);
- Cochlear Implant;
- Digitization: Computer Enhanced X– Ray Analysis for Spinal Evaluation;
- Electrical Impedance Scanning of the Breast;
- Food and Chemical Sensitivity Testing;
- Genetic Testing, Long QT Syndrome;
- Genetic Testing, NOTCH3 for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts & Leukoencephalopathy (CADASIL);
- HDC & Allogeneic Stem &/or Progenitor Cell Support – Myelodysplasia;
- HDC & Allogeneic Stem &/or Progenitor Cell Support – Hodgkin's Disease;
- HDC & Autologous Stem &/or Progenitor Cell Support – Ewing's Sarcoma;
- Magnetic Resonance Imaging (MRI), Very Low Field (<0.3 T (Tesla));
- Microwave Thermotherapy for Breast Cancer;
- Osteochondral Allograft for Osteochondral Defects of the Knee;
- Total Artificial Heart;
- Vacuum Assisted Closure Device;
- Vagus Nerve Stimulation for the Treatment of Seizures; and
- Wireless Capsule Endoscopy in the Evaluation of Esophageal Disorders.

Radiological Supervision and Interpretation for Diskography (CPT Codes 72285 & 72295)

CPT Codes 72285: Diskography, cervical or thoracic, radiological supervision and interpretation; and 72295: Diskography, lumbar, radiological supervision and interpretation.

CPT Codes 72285 and 72295 are limited to one (1) unit of service per day, regardless of the number of levels injected and billed using CPT Codes 62290 and 62291.

When CPT Codes 72285 and 72295 are provided in a physician's office, reimbursement will be made based on one unit of the total component allowance. When CPT Codes 72285 and 72295 are provided in a facility, the physician will be reimbursed based on one unit of the professional component allowance. No additional reimbursement is made to facilities for CPT Codes 72285 and 72295.

Reimbursement for the radiological procedure is included in the facility reimbursement for the surgical procedure provided in the outpatient department of the hospital or in the Ambulatory Surgery Facility. If provided as part of an inpatient stay, the reimbursement for the radiological procedure is included in the DRG.

Homocysteine Measurement, CPT Code 83090

CPT Code 83090 (Homocysteine) was introduced in 2001. Utilization of CPT code 83090 has increased significantly over the past five years. It appears from claims data that the utilization of homocysteine measurement is primarily done as part of screening of patients with elevated lipid levels, and is done by a small number of physicians.

Recently, three large, prospective trials that were initiated over the last five years have reported the results of lowering serum homocysteine concentrations with the use of folic acid, vitamin B-12, and vitamin B-6. Unfortunately, these trials showed no significant effect on the risk of recurrent myocardial infarction, stroke, or sudden death from AMI. The value of routinely measuring serum or plasma homocysteine levels has been brought into question (Annals of Internal Medicine, 2006; 145:226-227 and New England Journal of Medicine, 2006; 354:1629-1632).

The American Heart Association has had a position paper in place since 1999 recommending against routine screening for homocysteine. Arkansas Blue Cross and Blue Shield member benefit contracts exclude services for screening (with certain exceptions mandated by Arkansas law).

Coverage policy 2006028, which describes limited coverage for measurement of serum or plasma homocysteine, has been established and is available on the Arkansas Blue Cross web site at www.ArkansasBlueCross.com.

Medicare Advantage PFFS

Arkansas Blue Cross and Blue Shield submitted an application and was approved by the U.S. Government's Centers for Medicare and Medicaid Services (CMS) to become a Medicare Advantage Private Fee-For-Service (PFFS) plan sponsor. With CMS's approval, Arkansas Blue Cross will begin enrolling Medicare beneficiaries in its new PFFS plan – known as Medi-Pak® Advantage – on November 15, 2006. The first possible effective date for any Medi-Pak® Advantage policyholder would be January 1, 2007.

Medi-Pak® Advantage is a comprehensive, private fee-for-service Medicare Advantage product that combines the benefits of traditional Medicare and supplemental coverage as well as prescription drug benefits into one health care coverage plan.

Since Medi-Pak® Advantage is a non-network private fee-for-service plan, members receive full benefits for covered services from any provider that is Medicare eligible and is willing to accept Medi-Pak® Advantage members and the plan's Terms and Conditions. No formal contract with the Medicare eligible provider is required.

Prior to providing services to a Medi-Pak® Advantage member, providers must agree to the Terms and Conditions of the Plan Payment. When providers choose to extend services to a Medi-Pak® Advantage member, they are acknowledging their agreement and are "deemed" by CMS regulations to have a contract with Arkansas Blue Cross

When providing services to a Medi-Pak® Advantage member, providers automatically agree to accept the approved amount as payment in full. Payment for covered services will generally be the Medicare allowable, less any member cost-sharing amounts.

Medi-Pak® Advantage: Deeming Process and Terms and Conditions of Provider Participation

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 can obtain services from any willing provider in the U.S. who is eligible to be paid under Medicare rules. Arkansas Blue Cross 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

Providers who do not agree to accept these Terms and Conditions may not provide services to a Medi-Pak® Advantage member unless the services are extended on an urgent or emergency basis.

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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 Medi-Pak® Advantage members based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, 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.
- 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.

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Providers Not 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.

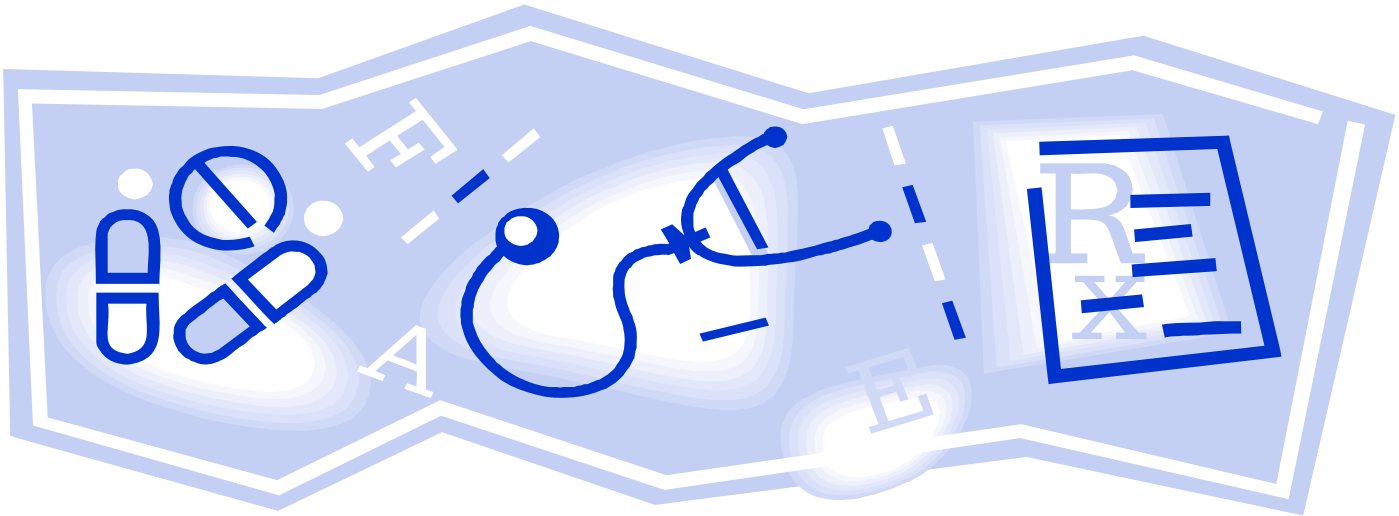
In these instances, Arkansas Blue Cross will pay the limiting charge and the Medicare approved amount, minus any applicable member cost-sharing amount.

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: Reimbursement Methodology

The information located on the following pages is intended to summarize the reimbursement methodologies for Medi-Pak® Advantage:

Medi-Pak® Advantage reimburses eligible services to deemed providers based on the Medicare fee schedules, Prospective Payment Systems (PPS), and the estimated Medicare payment amounts. Payment methodologies are reviewed by the Centers for Medicare and Medicaid Services (CMS) for accuracy. Payment rates will not be less than under traditional Medicare (Medicare fee-for-service) in accordance with 42 CFR 422.114. Details regarding Medicare reimbursement methodologies can be located on the CMS web site located at http://cms.hhs.gov.

If there is a conflict between the information provided on the following pages and the information published by CMS, the information published by CMS will prevail.

Providers have a right to appeal under Medi-Pak® Advantage. If a provider has information that traditional Medicare would pay more for a service, documentation (e.g. copy of a remittance advise or other official notice of payment for the same service from the Medicare Fiscal Intermediary or Carrier as proof of Medicare payment) may be submitted for review, verification, and payment adjustment if appropriate to:

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

Facility or Service	Medi-Pak® Advantage Reimbursement Methodology
Acute Care Hospital: Inpatient Services	Reimbursement is based on the Medicare Prospective Payment System (PPS), under Diagnosis Related Groups (DRG) methodology. Reimbursement for these services includes any appropriate capital disproportionate share hospital (DSH) and capital indirect medical education (IME) payments. Operating IME costs and graduate medical education (GME) payments are fully carved out. Organ acquisitions are reimbursed on a cost basis at an approved transplant facility.
Acute Care Hospital: Outpatient Services	Reimbursement is based on the Medicare Outpatient Prospective Payment System (OPPS), under the Ambulatory Payment Classifications (APCs) methodology. Services excluded from OPPS are reimbursed based on their respective fee schedule. Payment for pass-through services will be made based on information received from CMS. Add-on for TOPS payment if applicable.
Acute Long-Term Care: Inpatient Services	Reimbursement is based, as of 10/01/02, on the Medicare LTCH PPS (DRGs) blend unless the facility elected to be paid immediately at the 100 percent of the Federal PPS rate.
Acute Long-Term Care: Outpatient Services	Reimbursement is based on Medicare Outpatient Prospective Payment System (OPPS), under the Ambulatory Payment Classifications (APC) methodology. Services excluded from OPPS are reimbursed based on their respective fee schedule.

Facility or Service	Medi-Pak® Advantage Reimbursement Methodology
Ambulance: Independent and Provider based	Reimbursement is based on the current Medicare Ambulance Fee Schedule.
Anesthesia: Physician Performed	Reimbursement is based on the Medicare anesthesia dollar conversion factor by locality, times the sum of the uniform base units, plus the time units.
Anesthesia: Physician Medical Direction of Two or More Nurse Anesthetists Concurrently	Reimbursement is based on the Medicare anesthesia conversion factor by locality, times the sum of uniform base units, plus the time units, reduced by the application of the appropriate modifier.
Ambulatory Surgical Centers (ASC)	Reimbursement is based on the Medicare ASC fee schedule, adjusted by the appropriate wage index.
Assistant at Surgery: Physicians	Reimbursement is based on 16 percent of the Medicare fee schedule amount for the global surgery.
Assistant at Surgery: Physicians Assistant	Reimbursement is based on 16 percent of 85 percent of the Medicare fee schedule amount for the global surgery, not to exceed 10.4 percent of the global amount.
Blood	Reimbursement is based on the Medicare OPPS for hospital outpatient services.
Certified Registered Nurse: Anesthetist (CRNA)	Reimbursement is based on the Medicare anesthesia dollar conversion factor by locality, times the sum of uniform base units, plus the time units, reduced by the application of the appropriate modifier.
Children's Hospitals: Inpatient Services	These services are exempt from the inpatient PPS, and reimbursement is cost-based on Medicare cost report data.
Children's Hospitals: Outpatient Services	Reimbursement is based on Medicare OPPS, under APC methodology.
Clinical Nurse Specialist (CNS)	Reimbursement is based on 85 percent of the Medicare physician fee schedule.
Clinical Psychologist (CP)	Reimbursement is based on the Medicare physician fee schedule.
Clinical Social Workers (CSW)	Reimbursement is based on 75 percent of the Medicare physician fee schedule.
Clinical Trial Services	Traditional Medicare directly reimburses all approved clinical trial services provided to a Medi-Pak® Advantage plan enrollee according to appropriate Medicare fee-for-service methodology.
Community Mental Health Centers (CMHC)	Reimbursement is based on the Medicare OPPS.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Reimbursement is based on the Medicare physician fee schedule. Vaccines are reimbursed under the Medicare OPPS.
Co-Surgeons	Reimbursement is based on each co-surgeon receiving 62.5 percent of the global surgery under the Medicare physician fee schedule.
Co-Surgeons / Team Surgery	Team surgery is reimbursed "by report" and based on the Medicare physician fee schedule.

Facility or Service	Medi-Pak® Advantage Reimbursement Methodology
Critical Access Hospital (CAH) Inpatient/Outpatient/Swing Beds	Critical Access Hospitals are asked to provide Medi-Pak Advantage with their interim rate letter from Medicare for reimbursement of covered services. Please send to: Arkansas Blue Cross Blue Shield Attn: Medi-Pak Advantage - Critical Access Hospital P O Box 2181 Little Rock, AR 72201
Drugs (Part B)	Reimbursement is based on the drug fee schedule which is 106% of the "average sales price" (ASP). Exceptions include blood, drugs delivered through durable medical equipment (DME), influenza, pneumococcal and hepatitis B vaccines and certain new drugs which are still paid based on 95 % of the average wholesale price (AWP).
Epoetin (EPO)	Reimbursement is based on 95 percent of the median average wholesale price in the Drug Topics Red Book if administered by a physician to a home patient. If furnished by an end stage renal disease (ESRD) supplier or ESRD facility, payment is made at the rate of $10 per 1,000 units rounded to the nearest 10 units.
ESRD Facility	The reimbursement rate is the Medicare composite rate based on the facility location, metropolitan statistical area (MSA) or non-MSA, and whether the facility is provider-based or independent. Non routine services (covered outside of the composite rate) are paid based on the appropriate Medicare fee schedule. Non routine drugs are paid according to the drug methodology outlined above.
Federally Qualified Health Center (FQHC): Independent and Provider Based	Reimbursement is based on the lesser of the current all-inclusive Medicare rate or the current Medicare national per-visit limit.
Health Professional Shortage Area (HPSA)	100 percent of the MFS + 10 percent.
Hemophilia Clotting Factors Billed by Provider (ex. Hospital, Skilled Nursing Facility, Home Health Agency)	Reimbursement for inpatient care is an add-on payment to the Medicare PPS. In an outpatient setting, reimbursement is on a cost basis. All other settings [skilled nursing facility (SNF), home health agency (HHA)] are paid 95 percent of Drug Topics Red Book average wholesale price.
Hemophilia Clotting Factors Billed by Supplier (e.g. DME, supplier, independent pharmacy, Red Cross	These services are reimbursed at 95 percent of the average wholesale price in the Drug Topics Red Book.
Home Health Agencies: Independent and Provider Based	Reimbursement is based on the Medicare PPS, under home health resource groups (HHRGs) methodology. Providers are reimbursed per 60-day episode of care via submission of a request for accelerated payment (RAP) and the claim. Reimbursement includes adjustments for low utilization payment adjustment (LUPA), significant change in condition (SCIC), partial episode payment (PEP), therapies and outliers. Limited services are reimbursed under OPPS. DME is reimbursed based on the DMEPOS fee schedule.

Facility or Service	Medi-Pak® Advantage Reimbursement Methodology
Hospital Outliers	Section 1886(d) (5) (A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers). The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.
Immunosuppressive Drugs, Transplant	Reimbursement is based on the Medicare OPPS if the beneficiary is in the OP department of a Medicare participating hospital. In all other settings, reimbursement is 85% of the average wholesale price (AWP).
Indian Health Service Facility (IHS): Inpatient Services	Reimbursement is based on Medicare PPS, under DRG methodology.
Indian Health Service Facility (IHS): Outpatient Services	Reimbursement is based on an all-inclusive rate. Medicare Outpatient professional services are reimbursed based on their respective fee schedules.
Injections	Specific injection services are reimbursed separately if the physician doesn't render other services at the time of the injection. Chemotherapy injections are paid in addition to the office visit for the same date of service. Reimbursement is based on the applicable fee schedule.
Laboratory	The reimbursement rate is 100% of Medicare laboratory fee schedule.
Mammography Screening	The reimbursement rate is 100% of Medicare physician fee schedule.
Medical Nutrition Therapy	The reimbursement rate is 100% of Medicare physician fee schedule.
Medicare Dependent Hospital Inpatient Services	Reimbursement is based on the Medicare PPS, under the DRG methodology. The PPS rate equals the greater of the federal rate or the applicable hospital specific rate (based on cost-report data). Reimbursement includes capital IME and DSH payments where appropriate.
Medicare Dependent Hospital Outpatient Services	These services are reimbursed subject to the Medicare OPPS, under the APC methodology. Services excluded from OPPS are reimbursed based on their respective fee schedule.
Nurse Practitioner	The reimbursement rate is 85% of the Medicare physician fee schedule.
Oral Anti-Cancer Drugs	Reimbursement is based on the appropriate Medicare national fee schedule.
Oral Anti-Nausea	Reimbursement is based on the appropriate Medicare national fee schedule.
Physical Therapy/Occupational Therapy/ Speech Therapy	Reimbursement is based on 100 percent of the Medicare physician fee schedule, up to the Medicare annual limit.
Physician (MD)	Reimbursement is based on 100% of Medicare physician fee schedule.

Facility or Service	Medi-Pak® Advantage Reimbursement Methodology
Physician (DO)	Reimbursement is based on 100% of Medicare physician fee schedule.
Physician (Podiatrist)	Reimbursement is based on 100% of Medicare physician fee schedule.
Physician (Chiropractor)	Reimbursement is based on 100% of Medicare physician fee schedule for covered services.
Physician (Optometrist)	Reimbursement is based on 100% of Medicare physician fee schedule.
Physician (Dentist)	Reimbursement is based on 100% of Medicare physician fee schedule.
Physician Scarcity Area (PSA)	100 percent MFS plus an add-on bonus of 5 percent.
Physician Assistant	Reimbursement is based on 85% of Medicare physician fee schedule.
Psychiatric Hospital: Inpatient Services	These services are exempt from the inpatient PPS. Reimbursement is cost-based and paid on a per-day basis for routine and ancillary services. Reimbursement is applicable only to Medicare-approved services.
Psychiatric Hospital: Outpatient Services	These services are subject to the OPPS, under APC methodology. Services excluded from OPPS are reimbursed based on their respective fee schedules.
Radiology	100% of the Medicare physician fee schedule.
Registered Dietician	Reimbursement is based on 85 percent of Medicare physician fee schedule.
Rehab Hospital: Inpatient Services	Reimbursement is based on PPS, based on Case-Mix Group methodology. Payment is based on discharge rates, incorporating facility-level and case-level adjustments.
Rehab Hospital: Outpatient Services	Reimbursement is based on Medicare OPPS, under APC methodology. Services excluded from OPPS are reimbursed based on their respective fee schedules.
Religious Non-Medical Health Care Institutions	Reimbursement is based on Medicare cost basis for covered services.
Rural Health Clinic (RHC): Independent and Provider Based	Reimbursement is based on 80 percent of the current per-visit payment limit plus 20% of total charges of covered services. Provider are asked to submit applicable Medicare reports for reimbursement with per-visit rate stated. Please send to: Arkansas Blue Cross Blue Shield Attn: Medi-Pak Advantage - Rural Health Clinic P. O. Box 2181 Little Rock, AR 72201
Skilled Nursing Facilities: Independent and Provider Based	Reimbursement is based on the Medicare PPS, under related utilization groups (RUG) methodology.
Sole Community Hosp: Inpatient Services	Reimbursement is based on Medicare PPS, under DRG methodology.
Swing Beds	Reimbursement is based on SNF PPS effective July 1, 2002. CAH swing beds are exempt from SNF PPS and are reimbursed under the CAH method.
VA Hospitals	In general, federal providers are excluded from participation in the Medicare program. Like other non-participating hospitals, Federal Hospitals may be paid for emergency inpatient and outpatient hospital services at an applicable Medicare reimbursement.

Medi-Pak® Advantage Eligibility Inquiries and Claims Submission Guidelines

Eligibility:

1. Before rendering services, providers should request to see the patient's Medi-Pak® Advantage identification card.
2. Providers may obtain available information concerning Medi-Pak® Advantage members' eligibility by calling Medi-Pak® Advantage customer service at 1-866-390-3369, Monday – Friday, 8 a.m. – 8 p.m. CST.
3. Arkansas providers may also obtain available information concerning Medi-Pak® Advantage members' eligibility by accessing AHIN by utilizing the electronic gateway which is operational 24 hours a day, 7 days a week.

Effect of Eligibility Responses:

Please see reference to eligibility inquiries in the "Terms and Conditions" section of these Medi-Pak® Advantage materials for an explanation of the limitations on eligibility responses, which should not be relied upon as a guarantee of eligibility of payment.

Claims Submission:

Claims for Medi-Pak® Advantage members should be sent to Arkansas Blue Cross and Blue Shield and not to any Medicare carrier or fiscal intermediary. The only exception is for hospice services, which continue to be paid by traditional Medicare. Please send all claims for hospice services to your Medicare carrier or fiscal intermediary.

Submission of Claims:

All providers should submit claims as soon as possible after a service is provided using the standard CMS-1500, CMS-1450, UB-92, or UB-04 claim form. All Medicare billing guidelines must be followed when submitting Medi-Pak® Advantage claims. Services billed beyond 365 days from date of service are not eligible for reimbursement.

Electronic claims:

If providers are currently submitting claims through AHIN, providers can submit Medi-Pak® Advantage claims using the following:

- Source of Payment Medi-Pak® Advantage – Arkansas Blue Cross Private Business
  - Facility = MA
  - Professional = MB
- Payer ID:
  - Facility = a
  - Professional = b

Please check your electronic filing support to make sure that you can bill and accept the new source of payment changes. Do not use the Medicare Source of payment code.

Paper Claims:

Paper claims should be submitted to Arkansas Blue Cross at the following address:

Medi-Pak® Advantage
Arkansas Blue Cross Blue Shield
PO Box 2181
Little Rock, AR 72203-2181

Paper Claim Forms:

- Bill facility paper claims on a UB-92 or UB-04 claim form. Form must be in red ink.
- Bill professional claims on a CMS-1500 claim form. Form must be in red ink.

Important claims information:

Be sure to include the following on the Medi-Pak® Advantage claims:

- Arkansas Blue Cross Provider Number, Arkansas Blue Cross Clinic Number (if applicable), National Provider Identification Number (NPI), Medicare Provider Number and Federal Tax identification number
- Medi-Pak® Advantage member ID number

Laboratories:

Providers need to send laboratory claims directly to Arkansas Blue Cross and use the CLIA number.

Facilities:
When submitting claims on a CMS-1450, UB-92 or UB-04 , include the six-digit Medicare number (NPI) in Field 51 (PROVIDER NO.).

Providers Outside of Arkansas:
All providers outside of Arkansas should submit claims to the local Blue Cross plan, using the alpha prefix **XCX**.

Coordination of Benefits:
If a member has primary coverage with another plan, please submit a claim for payment to the primary plan first. The amount payable by Medi-Pak® Advantage will be governed by the Medicare allowed amount and amount paid by the primary plan and the coordination of benefits policies.

Advanced Beneficiary Notification (ABN):
ABN's are not required for Medi-Pak® Advantage members. Providers must inform a PFFS member in advance of the service that will not be covered. A provider's notification can be verbal or in writing but providers are encouraged to document the discussion.

Notices of Discharge and Non-Coverage:
Arkansas Blue Cross and Blue Shield delegates to providers the responsibility for issuing Notices of Discharge and Medicare Appeal Rights (NODMAR) and Notices of Non-Coverage (NOMNC) in accordance with applicable Medicare regulations.

Claims Payment:
Medi-Pak® Advantage processes claims by following the traditional Medicare billing rules including the prospective payment system requirements. Submit claims by using the same coding rules as traditional Medicare and by using CPT codes and defined modifiers. Bill diagnosis codes to the highest level of specificity. Remember to use the CMS-approved HCPCS codes and CMS-approved modifiers.

Facilities should also be filing a zero dollar claim with CMS to register the Medi-Pak® Advantage member's services at their facility for cost settlement reporting.

Providers should inform Medi-Pak® Advantage if they believe a facility claim qualifies for an outlier payment. Medi-Pak® Advantage follows Medicare's methodology in reimbursing outlier payments according to the appropriate prospective payment methodology. Notification to the plan can be made either on the claim, on an attachment, or by phoning Provider Services if the claim has already been paid.

CMS requires that 95% of all clean claims be processed within 30 days from receipt. In the event that a clean claim is not processed within the 30 day timeframe, Arkansas Blue Cross will comply with Medicare's prompt payment of claims requirements for all clean claims.

Claims Appeals:
Except for pharmacies, if the payment amount a provider receives from Medi-Pak® Advantage (including the member cost sharing collected) is less than the provider would have received under traditional Medicare for the service; the provider can appeal the payment amount. To appeal the payment amount, the provider must provide reasonable documentation to the plan of the traditional Medicare payment amount that applies to the service. For example, a remittance advice from a Medicare carrier would be considered as documentation.

If providers have questions about a claim payment, please call the Medi-Pak® Advantage Customer Service at 1-866-390-3369, Monday-Friday, 8 a.m.— 8 p.m. CST. When calling, please have the following information available for the representative:

- Arkansas Blue Cross and Medicare provider billing number assigned by CMS or NPI;
- Member's name;
- Member's date of birth;
- Member's Medi-Pak® Advantage ID number listed on the member's ID card;
- Claim number in question;
- Date of service;

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- Issue wanting reviewed;
- Additional information if necessary; and
- Copy of claim (if available).

Appeals should be sent to:

Medi-Pak Advantage
Arkansas Blue Cross Blue Shield
Grievance and Appeal Management
P. O. Box 2181
Little Rock, AR 72203-2181

If providers demonstrate that they have not received proper payment, Medi-Pak® Advantage will then pay the difference between what was received and what would have been received under traditional Medicare.

Providers may appeal for application of the limiting charge only one time per patient. Once a patient is known as a Medi-Pak® Advantage member, the providers will for that member's future services have access to the Terms and Conditions of Medi-Pak® Advantage.

Record Retention and Audit:

- In accordance with federal law, all records will be retained for 10 years.
- Arkansas Blue Cross and Blue Shield and the U.S. Department of Health and Human Services, the U.S. Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of a provider involving transactions related to the provider's treatment of any Medi-Pak® Advantage member. This right to inspect, evaluate, and audit remains in effect for the time period established by Medicare regulations and providers must retain relevant documents accordingly.
- Arkansas Blue Cross will conduct retrospective audit review using National Coverage Determinations, Local Coverage Determinations, Arkansas Blue Cross Coverage Policy, and Durable Medical Equipment Regional Carrier guidelines.

Medi-Pak® Advantage: Frequently Asked Questions

General Information:

What Medicare Advantage product is Arkansas Blue Cross Blue Shield offering? Arkansas Blue Cross and Blue Shield has been approved by the Centers for Medicare and Medicaid Services (CMS) to begin offering a Medicare Advantage Private Fee-For-Service product: Medi-Pak® Advantage.

A Private Fee-For-Service (PFFS) Medicare Advantage product offers enrollees full benefits for covered services from any physician or provider eligible to participate in Medicare and willing to accept the plan's Terms and Conditions of payment (see pages 19-30).

A plan may offer a Network or a Non-Network PFFS product. Arkansas Blue Cross began marketing Medi-Pak® Advantage to Medicare beneficiaries on October 1, 2006 with an effective date of January 1, 2007.

Which PFFS network option has Arkansas Blue Cross selected? Arkansas Blue Cross has chosen to offer a **Non-Network** PFFS product. Payment for covered services will generally be the Medicare allowable, less any member cost-sharing amounts.

In accordance with CMS guidelines, if a provider is aware the member is covered by a Medicare Advantage PFFS product,

has reasonable access to the Terms and Conditions of payment, and chooses to render services to the Medicare Advantage PFFS enrollee, then the provider is bound by the plan's Terms and Conditions of payment.

A provider is not required to render services to a Medicare Advantage PFFS enrollee. A provider's decision can be made on a patient-by-patient basis.

What is Medi-Pak® Advantage? Medi-Pak® Advantage combines the benefits of Medicare Part A and B and includes additional services not covered by traditional Medicare.

A Medi-Pak® Advantage member is free to choose any doctor, specialist or facility that accepts the Medi-Pak® Advantage Terms and Conditions of plan payment. The Benefit Summary is available on the Arkansas Blue Cross and Blue Shield web site and AHIN. Also, providers may call 1-866-390-3369 for benefit and eligibility information.

How do providers identify a patient with Medi-Pak® Advantage? Providers can obtain eligibility information by contacting 1-866-390-3369 and providing the member ID number. Eligibility information will also be available on AHIN for Arkansas providers. Note that responses to eligibility inquiries are not a guarantee of eligibility or payment and are subject to limitations (See "Effect of Eligibility Inquiry Responses" in "Terms and Conditions" for Med-Pak® Advantage, outlined at pages 19-30 of this newsletter).

How can an Arkansas Provider participate in the Medi-Pak® Advantage Program? Arkansas Blue Cross has chosen to offer a **Non-Network** PFFS product. Since this is a non-network product, providers do not need to enter into a PFFS contract with Arkansas Blue Cross. To be eligible to furnish care to a PFFS member, physicians, or other healthcare providers must be state licensed and have a Medicare billing number or be eligible to obtain one.

Institutional providers treating PFFS members, such as hospitals and skilled nursing facilities, must be certified to treat Medicare beneficiaries. The provider must also agree to the plan's Terms and Conditions of payment.

Where do providers find the Terms and Conditions of Payment? For a copy of the Medi-Pak® Advantage Terms and Conditions of payment, go to the Arkansas Blue Cross web site at www.ArkansasBlueCross.com, select the "Provider" page and click on the "Medicare" link or call Medi-Pak® Advantage Provider Service at 1-866-390-3369.

What networks are attached to Medi-Pak® Advantage? Arkansas Blue Cross has decided to offer a Non-Network PFFS Medicare Advantage product so there is no network. A member has full benefits for covered services by any qualified* provider that agrees to accept the Medi-Pak® Advantage Terms and Conditions of Plan Payment.

*(Please refer to the Deeming Process and the Terms and Conditions outlined on pages 19-30 of this newsletter for more explanation of the applicable program Terms and Conditions.)

Are there contracted laboratories? Medi-Pak® Advantage is a Non-Network PFFS plan. Members have full benefits for covered lab work performed at any Medicare-approved lab that is willing to accept the Medi-Pak® Advantage Terms and Conditions.

What is a deemed provider? Any provider furnishing health services to an Arkansas Blue Cross Medi-Pak® Advantage member, except for emergency services furnished in a hospital, is deemed to have a contract with Arkansas Blue Cross for purposes of services to Medi-Pak® Advantage members if:

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1. Services are covered by the plan;
2. The member is an enrollee of Medi-Pak® Advantage;
3. The provider is aware the member is a Medi-Pak® Advantage enrollee prior to rendering services to the Member; and
4. Providers know the Medi-Pak® Advantage Terms and Conditions of payment or have reasonable access to the terms and conditions of payment.

If a facility is considered deemed, then Arkansas Blue Cross will consider any facility-based provider as deemed.

Does the provider have a responsibility to somehow notify the plan that he or she is deemed? No, there are no contracts to sign and no paperwork required to participate. The provider simply needs to see the member's ID card to identify the individual as a Medi-Pak® Advantage member and file a claim for services. The provider should review the Terms and Conditions of payment referenced on pages 19-30 of this newsletter and available on the Arkansas Blue Cross and Blue Shield web site at www.ArkansasBlueCross.com

If the provider renders care to the member and files a claim, that provider is deemed. A provider may choose to provide care to Medi-Pak® Advantage enrollees on a patient-by-patient basis and may stop scheduling appointments with enrollees at their discretion.

What if a provider does not want to accept Medi-Pak® Advantage? A physician or other health care professional may decide on a patient-by-patient basis to accept Medi-Pak® Advantage. If a provider chooses not to be deemed and not to accept the Terms and Conditions of payment, that provider must not provide services to the Medi-Pak® Advantage member unless services are on an urgent or emergency basis. In such cases, claims should be filed to Arkansas Blue Cross (Arkansas providers) or the providers' local Blue plan (out of state providers).

How will providers know when Terms and Conditions change? Any changes to the Terms and Conditions are posted on the Arkansas Blue Cross web site. Providers will be notified of changes through the ***Providers' News***. Providers can also receive information on the Terms and Conditions by calling Medi-Pak® Advantage Provider Service at 1-866-390-3369. Arkansas Blue Cross and Blue Shield can provide information by phone, by mail, or by fax.

Is it the responsibility of the physician/ health care provider to check the Terms and Conditions? While Arkansas Blue Cross does not anticipate frequent changes to the Terms and Conditions, it is the provider's responsibility to understand the Terms and Conditions. Providers should check the Terms and Conditions as frequently as necessary.

Under the traditional Medicare, hospital patients must fill out a MSP (Medicare Secondary Payer) questionnaire. Should hospitals implement this process for Medi-Pak® Advantage members? Yes, hospitals should have their patients fill out the MSP. Arkansas Blue Cross reimburses physicians or other health care providers and attempts to recover the money from any third party that might be liable after the fact.

Benefits:

What are the benefits of the Medi-Pak® Advantage products? Medi-Pak® Advantage benefits include convenient copayments and no deductibles.

In the Benefit Summary section, under Diagnostic tests, x-rays and lab services, it mentions the member being responsible for a copayment for each service. Does that mean that if a patient is seen for an office visit, chest x-ray, and a lab test, the member will be charged three copayments for the one visit? No, only one copayment per visit. If a member just has lab drawn, they will be responsible for the applicable laboratory copay.

Please note: If a "facility location" (hospital lab), the member is responsible for the applicable coinsurance.

Please explain the pharmacy formulary and tiers? Medi-Pak® Advantage has a 4-tier drug formulary: generic, preferred brand, non-preferred brand, and specialty. Information on these drugs is available on the Arkansas Blue Cross website.

Is there a grace period for the beneficiary to move from non-formulary drugs to formulary? New members will have a 60-day grace period to switch to a drug on the formulary.

Does the Arkansas Blue Cross website allow Medicare beneficiaries to check to see if their current medications are covered on the formulary and at what tier (co-pay)? The full formulary is available on the Arkansas Blue Cross web site or call the PharmaCare Service number 1-800-698-8397.

Will a provider be able to obtain prior authorization on Medicare Part D drugs online through Arkansas Blue Cross web site, by telephone or paper process? For Prior authorizations, providers can call PharmaCare at 1-800-311-0594.

Claims:

How are emergencies treated? Claims for emergency services furnished in a hospital pursuant to 48 CFR 489.24 will be processed as filed (accepting or not accepting Medicare assignment).

Providers who accept assignment will be paid the Medicare allowable less the member's cost-share amounts. Providers who do not accept assignment will be paid the Medicare limiting charge less the member's cost-share amounts.

Where should Arkansas providers submit their Medi-Pak® Advantage claims? Medi-Pak® Advantage claims for members covered by **any** BlueCross BlueShield Plan should be submitted to Arkansas Blue Cross. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Where should out-of-state providers submit Medi-Pak® Advantage claims? Providers outside of Arkansas should file their Medi-Pak® Advantage claims to their local Blue Plan in their normal manner. Do not bill Medicare directly for any services rendered to a Medi-Pak® Advantage member.

What coverage guidelines does Medi-Pak® Advantage use? Medi-Pak® Advantage uses the same National Coverage Determinations (NCDs) as traditional Medicare along with Arkansas Blue Cross and Blue Shield Coverage Policy. Arkansas Blue Cross may use the Local Coverage Determinations (LCD) in effect for the area where care is rendered.

Providers may call Medi-Pak® Advantage Provider Service area at 1-866-390-3369 with specific questions about LCDs. LCDs can be found by going to **http://www.cms.hhs.gov/coverage/default.asp** or **www.arkmedicare.com/provider/medpol/default.htm** and selecting the search function.

What format does Arkansas Blue Cross and Blue Shield require for claims? Arkansas providers should submit claims for Medi-Pak® Advantage members as follows:

- Nine-digit Arkansas Blue Cross provider number if provider linked to clinic*
- Five-digit Arkansas Blue Cross provider number if solo practitioner*
- Five-digit Arkansas Blue Cross provider number if ancillary provider*
- Five-digit Arkansas Blue Cross provider number if facility*

*Use matching NPI number when appropriate.

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If a Provider currently submits their claims electronically to Arkansas Blue Cross Private Business, they may submit their Medi-Pak® Advantage claims using the same process. Please refer to the Terms and Conditions for further details.

Paper claims may be mailed to:

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

Providers do not need to sign Block 31 of the CMS 1500 since the provider's signature is already on file with Arkansas Blue Cross or their provider's local carrier if out of state.

Providers outside of Arkansas should file claims to their local Blue Plan in their normal manner. Claims for Medi-Pak® Advantage members should be filed using the same CMS billing guidelines, forms, and codes as traditional Medicare.

Will payment also come back on the regular Blue Cross Remittance Advice or on another Remittance Advice? Payment will be on a separate Blue Cross Remittance Advice and will be available for Arkansas providers on AHIN. Also, 835's will be prepared.

Are claims filed through AHIN? Arkansas provider claims come through AHIN – Medi-Pak® Advantage doesn't change how a provider is filing today. Out-of-state providers should file through their local Blue Plan.

For Arkansas providers, AHIN will have the Remittance Advice and 835 online. At this time, Electronic Fund Transfer is not available for Medi-Pak® Advantage.

Can providers use vendors other than AHIN for claims? Yes, the payment source code that providers will use for this product is Arkansas Blue Cross Private Business (not Medicare).

What is the claims payment timeliness standard for Medi-Pak® Advantage? As a Medicare Advantage Organization (MAO) under contract with the CMS, Arkansas Blue Cross must follow Medicare Advantage regulations. These contain provider protections, including a requirement for prompt payment to health care providers. Under this provision, a MAO must pay 95 percent of clean claims within 30 days of receipt for services rendered as deemed.

What is the timely filing provision for Medi-Pak® Advantage? 365 days from the date of service is the timely filing period.

Are Medicare ID numbers required on claims submitted? No, Arkansas provider claims should be submitted using their Arkansas Blue Cross provider number and NPI where applicable.

Do providers have to have a Medicare number to submit a claim for a Medi-Pak® Advantage member? To be eligible to furnish care to a PFFS member, physicians or other health care providers must be state licensed and be a Medicare eligible provider.

Can Arkansas physicians or health care providers go online to review their claims status or obtain information on patient eligibility? Providers can check benefits and eligibility online using AHIN. See "Effect of Eligibility Inquiry Responses" in the "Terms and Conditions" located on pages 19-30 for limitations applicable to eligibility inquiry responses.

For providers who do not presently have AHIN may obtain access by following the directions below:

- Download the AHIN Setup Document and Agreements (82 KB PDF)
- Complete, sign and mail the documents to:
  Advanced Health Information Network
  601 S. Gaines Street
  P.O. Box 1489
  Little Rock, Arkansas 72203-1489

An AHIN Customer Support Representative will notify the contact person listed on the AHIN setup document when all testing is complete and provide the assigned user names and password.

Ancillary Issues:

What are the criteria for patient eligibility for home health care? Medi-Pak® Advantage uses the same home health criteria that are in place for traditional Medicare.

Are payments for home healthcare the same as the Medicare Prospective Payment System (PPS)? Yes, Arkansas Blue Cross uses home health PPS. Claims are submitted for individual services. Four services or less during a 60 day period are paid at the individual service rate with the Low Utilization Payment Adjustment (LUPA).

Is there an initial and final payment for home health care, as with traditional Medicare, or is there one payment per 60-day episode? Arkansas Blue Cross pays the same way as traditional Medicare with an initial and final payment. However, home health agencies may request reimbursement per 60-day episode of care by submitting a Request for Accelerated Payment (RAP).

Disputed Payment Amounts:

What recourse do providers have to dispute payments? Physicians and other providers have the right to dispute payments by notifying Arkansas Blue Cross. If a physician or other provider has information that traditional Medicare would pay more for a service, the provider can submit documentation to Arkansas Blue Cross for review, verification, and payment adjustment, if appropriate.

Reimbursement:

Which fee schedule does Arkansas Blue Cross use to determine the physician payment rate? As with traditional Medicare, the fee schedule for the locality where the service is rendered is used to reimburse physicians and other providers.

What services are subject to the annual deductible? Medi-Pak® Advantage does not have inpatient or outpatient deductibles.

What happens if a member disenrolls from Medi-Pak® Advantage and goes back to traditional Medicare? How are the member's cost-shares calculated? If a member disenrolls from Medi-Pak® Advantage and returns to the traditional Medicare, then traditional Medicare cost-sharing provisions apply.

How are payments for outpatient hospital services determined? Similar to traditional Medicare, reimbursement is determined by Ambulatory Payment Classification (APC) codes. However, under traditional Medicare, the APC code payment methodology often includes a high beneficiary cost-share; this is not the case under Medi-Pak® Advantage.

Arkansas Blue Cross and Blue Shield pays the Medicare-allowed amount, minus the member's Medi-Pak® Advantage copayment. Outpatient copayments are based on the type of facility where care is rendered.

How does inpatient reimbursement work? Inpatient services are reimbursed at the full Diagnostic Related Group (DRG) allowable amount, minus the Medi-Pak® Advantage member copayment for inpatient services.

Will the reimbursement rates change? Reimbursement rates are tied to Medicare fee schedules and only change if Medicare rates change. Under Arkansas Blue Cross' Terms and Conditions, Arkansas Blue Cross continues to pay at least the Medicare reimbursement rate.

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If a Medi-Pak® Advantage member transfers from an acute inpatient facility to an acute rehabilitation facility, does the member's copayment per day apply at the acute rehabilitation facility in addition to the acute inpatient facility? If a member is discharged and readmitted; or, discharged and admitted to a different type of facility, the copayment for that facility will apply.

What is the copayment for infusion patients in a home health care setting? There is no member copayment for Medicare covered home health visits. There is member coinsurance.

What grouper is used for DRG's? The DRG grouper software used is the same as CMS grouping and pricing.

What grouper is used for APC's? The APC grouper software used is the same as CMS grouping and pricing.

Is reimbursement for home health care from Home Health Resource Group (HHRG) codes and for a 60-day episode of care? Yes, reimbursement is the same as traditional Medicare.

What is the coverage for medical supplies under the home health benefit? Medical supplies are covered the same as traditional Medicare.

What is the limit on Durable Medical Equipment (DME) rentals? As with traditional Medicare, there is a 15-month limit on most DME rentals. Arkansas Blue Cross reimburses equipment rental for up to 15 months as long as it does not exceed the purchase price of that equipment.

What is the reimbursement for a deemed provider, versus a non-deemed provider? 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.

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

- Providers may collect only 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 the 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.

Will Medi-Pak® Advantage pay at the par or non-par Medicare rate for deemed non-participating providers with Medicare? If a deemed provider is non-participating with Medicare, Medi-Pak Advantage will reimburse at the participating Medicare rate and payment will go to provider. Member cannot be balanced billed. Limiting charge will not apply.

If there is no contract or agreement with the physician, what recourse does Medi-Pak® Advantage have if the provider does not follow their guidelines? Will they fall back on the Medicare regulations? How does that apply to the Medicare non-participating provider? This falls under the Deeming Guidelines and Terms and Conditions. Once a provider files a claim they are considered deemed and based on Terms and Conditions are agreeing to accept the Medicare allowable as outlined.

What if a beneficiary won't pay copayments at time of service? Can providers remove beneficiary from their practice, as providers could with commercial products, (i.e., for not paying their copayments at the time of service or not at all)? It's a cost savings for a clinic to not have to bill the beneficiary for the copayment. The provider can choose to be deemed or non-deemed at the time of each service. If a member will not pay copayments up front, providers can choose to be non-deemed and not offer services to the member.

Is a copayment assessed only on E/M codes or for each encounter regardless of the provided service? One copayment per visit applies regardless of the service.

Is there a $15 or $25 copayment for each lab, x-ray, diagnostic test performed or a maximum of 20% coinsurance for each test? Why does it state any payment due from the patient when lab is paid at 100%? Amounts vary by type of provider and place of service. PCPs in their office have $15 copayment; specialist in their office $25; services rendered in outpatient facilities 20%. Advanced imaging will always have a 20% coinsurance regardless of who performs them or where.

Utilization Management:

Are authorizations or referrals required for Medi-Pak® Advantage? Authorizations and referrals are not currently required for Medi-Pak® Advantage.

Do additional documentation requirements (ADR) apply to this plan? The same ADR requirements apply as do for traditional Medicare.

Out of State:

Where do providers submit out-of-state Medi-Pak® Advantage claims? Arkansas providers should submit claims to Arkansas Blue Cross. Do not bill Medicare directly for any services rendered to a Medi-Pak® Advantage member. Payment is made directly by a Blue Plan.

Based upon CMS regulations, if a provider accepts Medicare assignment and renders services to a Medi-Pak® Advantage member from another Blue Plan, providers will be reimbursed the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than the charge amount.

CMS regulations state that the Medicare allowable amount is considered payment in full. Other than the applicable member cost sharing amounts, reimbursement is made directly by the Blue Plan. Providers may collect only the applicable cost sharing (i.e. co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Providers can make claim status inquiries through Arkansas Blue Cross.

For Questions, Contact Us At the Medi-Pak® Advantage Provider Service Line, 1-866-390-3369 (Monday-Friday 8 a.m. to 8 p.m. CST)

Observation Beds

Coverage for an Observation Bed will be available as indicated below:

1. Observation bed charges will be recognized from general acute care hospitals only.
2. Reimbursement for observation bed charges will be limited to one day's semi-private room allowance or the PPO per diem, as applicable. There will be an upper limit of the inpatient DRG reimbursement amount for all services billed in conjunction with observation beds.
3. Hospital outpatient surgery fee schedule amount (global allowance) will encompass observation bed charges and related services.
4. Observation bed services which occur within 24 hours of a hospital admission will be considered part of the inpatient hospital billing. The admission date will be the day that the patient is first considered an inpatient. For purposes of precertification (if applicable), the admission will be treated as an emergency so that the 48 hours prior notice requirement will not have to be met. The Managed Care Company following the admission will post the actual admission date to their records.

Physician services related to an observation bed setting will have the same billing rules as Medicare:

Day 1 – Patient is placed in an observation bed. Physician bills the appropriate observation bed code.

Day 2 – Patient is admitted to the hospital. The physician bills the appropriate admission code.

Day 3 – Patient is discharged. Physician bills the discharge code.

All evaluation and management services provided by the physician on the same date as initial observation care (99218 – 99220) are inclusive in the initial observation service code billed. No additional benefits will be allowed for office visits, ER visits, follow-up observation visits, etc. on the same date.

Since coverage for observation is limited to 24 hours or less, and because the initial observation care codes include all E&M services on the same date, the code for observation discharge services (CPT Code 99217) is not eligible for benefits because coverage for observation is limited to 24 hours.

Examples of Covered and Non-Covered Observation Services:

Non-covered uses of the observation bed include but not limited to:

- Preparation for and/or monitoring after diagnostic tests.
- Care of an acutely or critically ill patient for which hospital admission is more suitable.
- Care of non-acute/custodial conditions that could be adequately treated on an out-patient basis.
- Care of patients who could have been adequately treated and released from the emergency room without extended monitoring.

Covered uses of Observation bed include but not limited to:

- Administering IV fluids for the treatment of mild to moderate dehydration.
- Monitoring patients following head trauma not associated with prolonged loss of consciousness.
- Monitoring patients during chemotherapy or transfusions.

Arkansas State and Public School: Insurance Board Increases Benefits for Arkansas Public School Employees

Arkansas State and Public School Employees Life and Health Insurance Board has approved changes for the Public School Employees benefit plan that will result in parity between Public School Plan and the Arkansas State Employees Plan.

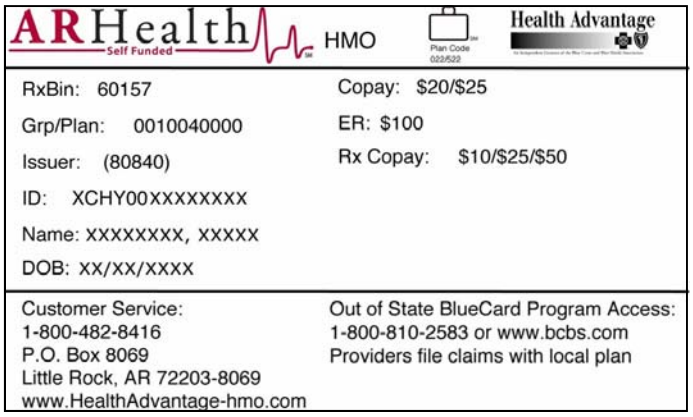
Health Advantage providers will recognize a reduction in the Primary Care Physician (PCP) copayment from $25 to $20, specialist copayments reduced from $35 to $25 per visit, and most coinsurance amounts reduced from 20% to 10%. Additionally, the in-patient admission copayment has been reduced to $250 per admission.

Public School Employees enrolled in a POS Plan are no longer required to obtain a referral from a PCP to obtain services from an in-network specialist (M.D or D.O.).

Public School Employees enrolled in a Health Advantage HMO or POS Plan now have one preventive eye exam every 24 months and preventive dental care every 6 months. Dental codes (listed on page 42) are the approved preventive services.

The Public School Employees enrolled with Arkansas Blue Cross and Blue Shield will still have a $500 deductible, but the maximum out-of-pocket has been reduced to $2000 per calendar year. Benefits will be paid at 80% of the Arkansas Blue Cross allowable amount.

For general benefits, visit the Health Advantage web site at www.HealthAdvantage-hmo.com and click on Public School Employees to access a summary sheet or call 800-482-8416 for assistance.


AR Health Self Funded HMO Health Advantage

RxBin: 60157
Grp/Plan: 0010040000
Issuer: (80840)
ID: XCHY00XXXXXXXX
Name: XXXXXXXX, XXXXX
DOB: XX/XX/XXXX

Copay: $20/$25
ER: $100
Rx Copay: $10/$25/$50

Customer Service:
1-800-482-8416
P.O. Box 8069
Little Rock, AR 72203-8069
www.HealthAdvantage-hmo.com

Out of State BlueCard Program Access:
1-800-810-2583 or www.bcbs.com
Providers file claims with local plan

Arkansas State and Public School Employees Preventive Benefits — Update

The Employee Benefit Division has approved additional Preventive Benefits for members and dependents of the Arkansas State Employees and Public School Employees benefit plans. Please note on the charts located on pages 40 & 41, the Human Papilloma Virus vaccine has been approved for females ages 9 to 26 and the Rotavirus vaccine has been approved for children between 2 and 6 months of age.

Coinsurance or copayments are not applicable for preventative services. Additionally, please note on the chart the clarification for billing computer-aided detection codes with non-digital mammograms.

Effective October 1 2006, Public School Employees enrolled in Health Advantage POS Plan will have "**open access"** to specialist providers (M.D. or D.O.) The open access is not noted on the new ID cards for PSE members. The new ID card were created and mailed by the Employee Benefits Division.

Members are still required to select a Primary Care Physician (PCP), but the PCP name will not appear on the ID card.

Providers should call 1-800-482-8416 to verify benefits and check claims status for ASE/PSE members.

ASE /PSE Preventative Benefits

New Patient - Well Baby Visits:

CPT Codes	Ages	Diagnosis Code Required
99381	Under 1 year	Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99382	Age 1-4	Early Childhood -- Must be billed with diagnosis code V20.2
99383	Age 5-11	Late Childhood -- Must be billed with diagnosis code V20.2
99384	Age 12-17	Adolescent -- Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Over 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99385	Age 18-39	Must be billed with diagnosis codes: V72.3, V70, V70.0, V7231, V7232, or V7612.
99386	Age 40-64	
99387	Age 65+	

Established Patient - Well Baby Visits (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99391	Under 1 Year	Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99392	Age 1-4	Early Childhood -- Must be billed with diagnosis code V20.2
99393	Age 5-11	Late Childhood -- Must be billed with diagnosis code V20.2
99394	Age 12-17	Adolescent -- Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Over 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99395	Age 18-39	Must be billed with diagnosis codes: V72.3, V70, V70.0, V7612, V7231, or V7232.
99396	Age 40-64	
99397	Age 65+	

Newborn Care -Well Baby Visits (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99432	Under 1 Year	Must be billed with diagnosis code V20.2

Preventive Care—Adult (members age 18 and over):

Description	CPT Codes	Ages	Diagnosis Code Required
Annual Physical		Age 18+	Must be billed with Diagnosis codes: V72.3, V70, V70.0, V7612, V7231, or V7232.
Office Visit	99385 & 99395	Age 18-39	
Office Visit	99386 & 99396	Age 40-64	
Office Visit	99387 & 99397	Age 65 +	
Laboratory Services	81000-81005, 80051, 80053, 80061, 85018, 85014, 85025, or 85027	Age 18+	

- Screening Mammogram (including breast exam)

Description	CPT Codes	Ages	Diagnosis Code Required
Mammogram, unilateral - with computer-aided detection	76082 with 76090 or 76091; 76083 with 76092	Age 40 +	Allowable with any diagnosis code.
Digital Mammogram, unilateral (Ineligible if billed w/computer-aided detection codes.)	G0202, G0204, G0206 or Revenue code 403		

- Pap Smear

CPT Codes	Ages	Diagnosis Code Required
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174-88175, G0101, Q0091	Age 18+	Allowable with any diagnosis code.

- Prostate Specific Antigen (PSA)

CPT Codes	Ages	Diagnosis Code Required
84152, 84153, 84154, G0102, G0103	Age 40 +	Allowable with any diag code.

- Colorectal Cancer Screening (Choice of the following beginning at age 50)

Description	CPT Codes	Age /Frequency	Diagnosis Code Required
Fecal occult blood test and one of the following:	82270, 82274, G0107	Annually	Allowable with any diagnosis code.
- Flexible sigmoidoscopy	45330—45339, G0104	Every 5 years	
- Colonoscopy	45378—45385, G0105 or G0121	Once every 10 yrs	
- Double contrast barium enema	74280, G0106	Once every 5 yrs	

- Cholesterol and HDL Screening

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Males Age 35+	82465, 83718-83721	Once every 5 yrs	Allowable with any diagnosis code.
Females Age 45+	82465, 83718-83721	Once every 5 yrs	

Immunizations – Adult (members age 18 and over):

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Diphtheria	90719	Every 10 years	Allowable with any diagnosis code.
Diphtheria and Tetanus toxoid (Td) ages over 7	90718	Every 10 years	
Hepatitis B (Hep B)	90740, 90747, 90746	Once Per Lifetime	
Human papilloma virus (HPV) 3-dose series	Gardasil 90649	Age 19 - 26	
Influenza	90658	Annually	
Pneumococcal Conjugate	90732	Adults over 55 or immunosuppressed	

Preventative Care—Child:

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
All childhood immunizations	Mandated services	Under age 18	Allowable with any diagnosis code.
Human papilloma virus (HPV) 3-dose series	Gardasil 90649	Age 9 - 18	
Rotavirus	Rota Technique 90680	2 - 6 months	

Arkansas State and Public School Employees: Preventive Dental

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.

Federal Employee Program (FEP) Reminders:

Precertification for Federal Employee Plan (FEP) Service Benefit Plan members:

In-patient hospital medical admissions:

- **Primary Payer:** When FEP Service Benefit Plan is the Primary payer, precertification is required. When precertification rules are not followed and the claim meets medical necessity guidelines, a member's liability will include a $500 penalty.
- **Medical Admissions:** Precertification is required for FEP members before being admitted to the hospital for inpatient care or within two business days following an emergency admission. To precertify a Medical Admission or to give a clinical update on an existing admission, call (800) 451-7302 and choose Option 2 twice.
- **Medicare Part A:** When a patient's Medicare Part A hospital benefits are exhausted and the FEP Service Benefit Plan is the primary payer, precertification is required.
- **Observation Room:** When a patient is in an observation room, precertification is not required. However, when the patient is admitted to the hospital, precertification is required.
- **Maternity Admission:** When a patient has a maternity admission for a routine delivery, precertification is not required. An admission for a routine delivery is defined as 48 hours for vaginal delivery and 96 hours for a cesarean section.
  - When the admission is longer than stated above, precertification is required for additional days.
  - If the baby stays after the mother has been discharged, precertification is required for additional days for the baby.

Precertification is not required:

- When the patient has another group health insurance policy that is the primary payer for the hospital stay.
- When the patient has Medicare Part A as the primary payer for the hospital stay.
- When the medical services will be done in an outpatient setting.

Behavioral Health:

Arkansas Blue Cross and Blue Shield has contracted with ***Magellan Behavioral Health*** to provide managed behavioral health services and a network of behavioral health providers for the FEP Service Benefit Plan members in Arkansas. Providers interested in contracting or with questions concerning the credentialing process should call Magellan Behavioral Health at 1-800-430-0535 and Option #4.

Please remember that all benefits are subject to the definitions, limitations, and exclusions in the 2006 Blue Cross Blue Shield FEP Service Benefit Plan Brochure (RI 71-005) and are payable only when medically necessary.

What this means for providers and their members? Members with the Service Benefit Plan coverage choose either Standard Option (enrollment code 104 or 105) or Basic Option (enrollment code 111 or 112). The member ID card includes a Mental Health and Substance Abuse toll-free number (1-800-367-0406) for members and providers to call with questions regarding: treatment plans, prior approval, or pre-certification.

Providers with questions regarding benefits, claims status, and payments should call 1-800-482-6655 or 501-378-2531.

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To maximize MHSA benefits, providers must follow these rules:

- **Standard Option (enrollment code 104 or 105)** Treatment plans must be submitted and approved prior to the member's ninth visit. Treatment plans should be submitted to Magellan Behavioral Health.
- **Basic Option (enrollment code 111 or 112)** Treatment plans must be submitted prior to the members 1st visit.
- **Standard and Basic Option:** Prior approval must be obtained for partial hospitalization or intensive outpatient therapy.
- **Standard and Basic Option:** Pre-certification must be obtained for inpatient hospital services. When precertification rules are not followed and the claim meets medical necessity guidelines, the members' liability will include a $500 penalty.

When FEP Standard Option members seek care from Magellan Health Preferred mental health or substance abuse professionals for covered services, the visit limit and other day maximums are waived and the member's out of pocket costs will be lower.

Revised Timeline for the NEW 1500 Health Insurance Paper Claim Form

The National Uniform Claim Committee (NUCC) announced the release of the new timeline for the 1500 Health Insurance Claim Form (version 08/05) that accommodates the reporting of the National Provider Identifier (NPI). This new version will update the existing 1500 Claim Form (version 12/90), often referred to as the HCFA 1500 or CMS 1500.

The revised CMS-1500 claim form has been approved by the Office of Management and Budget (OMB) for use with federal programs, such as Medicare. The revised form is currently available for testing and transition preparation purposes only. The revised CMS-1500 claim form is not to be used for the official purpose of claims submission at this time.

Arkansas Blue Cross and Blue Shield will follow the revised Medicare timeline below for the CMS-1500 claim form:

- **January 1, 2007:** Health plans, clearing-houses, & other information support vendors should be ready to handle and accept the revised (08/05) CMS-1500 claim form.
- **January 1 – March 31, 2007:** Providers can use either the current (12/90) version or the revised (08/05) version of the CMS-1500 claim form. **Submitters must continue to include the five-digit Arkansas Blue Cross number on all paper claims submissions during this time.**
- **April 1, 2007:** The current (12/90) version of the CMS-1500 claim form will be discontinued; only the revised (08/05) form will be used. All rebilling of claims should use the revised (08/05) form from this date forward, even though earlier submissions may have been on the current (12/90) form.

An additional point of clarification is needed regarding the revised CMS-1500 claim form received prior to January 2, 2007. Since the system changes will not be implemented until January 2, 2007, contractors are required to manually return all revised CMS-1500 claim forms received prior to January 2, 2007. Because Arkansas Blue Cross and Blue Shield will follow the revised Medicare timelines and guidelines, claims received prior to January 2, 2007 that are submitted on the revised CMS-1500 claim form will be returned.

The timeline for the implementation of the

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UB-04 **did not** change:

- Effective Start for UB-04 – 3/1/07
- Effective Stop for UB-92 -- 5/23/07

NUCC began revisions to the CMS-1500 claim form in June 2004 by identifying how to best accommodate the NPI with minimal changes to the current form. Two public comment periods were held to solicit feedback on the proposed changes to the form. All of the revisions made to the form were either NPI related or a significant need for the change was identified.

Form Availability:

Documents related to the release of the new version of the CMS-1500 claim form, including the revised form, new reference instruction manual, log of changes to the current form, and the recommended transition timeline are available at www.nucc.org.

The revised CMS-1500 claim form available on the NUCC website can not be printed to its exact specifications unless a special printer programmed to print forms is used. To receive copies of the revised form with the printing specifications needed for testing purposes, please email the TFP Data Systems at JRMagdaleno@tfpdata.com.

Instruction Manual:

In addition to revising the CMS-1500 claim form, the NUCC has drafted a new reference and instruction manual detailing how to complete the updated form. The purpose of this manual is to help standardize nationally the manner in which the form is being completed. A copy of the instruction manual is also available on the NUCC website.

Included in this newsletter is the reference and instruction manual prepared by Arkansas Blue Cross with important details on how paper claims need to be submitted to expedite claims processing. **It is important to note that the instructions from Arkansas Blue Cross and NUCC may vary because of imaging the requirements.** A detailed guide for the new CMS-1500 claim form (08/05) follows.

Please note: As released, the CR 4293 is to be implemented on October 1, 2006. However, the delay in the implementation of the shared system changes for the revised CR 5060, from October 1, 2006, to January 2, 2007, has created confusion among the contractors and also a potential compliance issue for the contractors implementing CR 4293. In order to clarify, Centers for Medicare and Medicaid Services (CMS) expects that the coding and testing for CR 4293 be completed by October 1, 2006, but that those business requirements are now not required to be effective until January 2, 2007.

Guide to CMS - 1500 Paper Claim Form For Professional Providers Revised August, 2006

These guidelines will help providers prepare claims for Optical Character Recognition (OCR) scanning when filing paper claims for Arkansas Blue Cross and Blue Shield, Health Advantage, and Blue Advantage Administrators.

Align the Form:

Please align the claim form carefully so that all data falls within the blocks on the claim form. The provider will be able to keep the form aligned if they center an "X" in the boxes at the top right and left corners of the claim. Please be sure that all line-item information appears on the same horizontal line.

Dates:

Use an 8-digit format for all dates on the claim. For example, enter June 1, 2006 as 06012006. All dates must be valid dates. Some fields require an entry such as DOS, while others are optional.

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Dollars and Cents:
Please do not use dollar signs ($) in any block. Separate dollars and cents with a blank space. For example, enter $1,322.00 as 1332 00.

Forms:
Please don't fold, staple, or tape claims. Please separate all forms carefully.

For providers using bursting equipment, adjust the splitters to precisely remove the pin feed edges. Claims must be submitted on the 08/05 version of the CMS-1500 claim form printed with red "drop out" ink.

Providers may obtain copies of the CMS-1500 claim form through various vendors such as the American Medical Association or the U.S. Government Printing Office.

Keep It clean:
Don't print, write, or stamp extra data on the claim form. When correcting errors, use white correction tape only, not correction fluid.

Lines of Service (block 24):
Limit the lines of service to six lines on each claim filed. Placing information in the shaded areas as shown on the NUCC site should be as "FYI" only since the data may not image properly. Arkansas Blue Cross and Blue Shield does not recommend the use of this free form line. However, if it is used, it is critical that the right qualifiers be used.

Names:
For all blocks requiring names, please omit any titles, such as Mr. or Mrs. **Enter the last name first, followed by a comma, and then the first name - Last Name, First Name. (For example: DOE, JAMES).**

Print quality:
Providers can help ensure that paper claims are accurately processed by checking the quality of the print carefully. Faint printing can cause scanning problems. Please replace printer ribbons or toner regularly and be sure to use the highest quality print setting available.

Ribbons and Fonts:
Use only **black** ribbons in typewriters or printers and change the ribbons frequently. Although claims can be accepted using a 12-pitch setting, please use a 10-pitch setting. If software supports fonts, please use Courier 12 Monospace font.

Time:
Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in Block 24G of the CMS-1500 claim form. If no units are indicated on the claim, the claim will be denied.

UPPERCASE:
Use only UPPERCASE letters for alphabetical entries. Don't mix fonts or use italics, script, percent signs, question marks, or parentheses.

By following these guidelines, providers will assist Arkansas Blue Cross and Blue Shield in meeting its goal of efficient, accurate claims processing.

CMS - 1500 Claims Guide: Step-by-Step Instructions

The following information is designed to help providers complete the **new** CMS-1500 claim form which is mandated by the National Uniform Claim Committee (NUCC) to meet the requirement for all providers to have a NPI number. Only submit paper claims if electronic claim submission isn't possible.

NOTE: Effective January 1, 2007, all fields indicated as REQUIRED in the following guide must be completed or the claim will be returned to the provider.

Block 1A - Insured's I.D. # (REQUIRED): Enter the patient's current identification number exactly as it appears on their identification card, including the appropriate three letter alpha prefix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in the processing or denial of the claim.

Block 2 - Patient's Name (REQUIRED): Enter the patient's last name followed by a comma and the first name in all capital letters. An entry in this block is required. Do not include any apostrophes, hyphens, suffixes (like Jr. or Sr.), or titles (such as Mr. or Mrs.) any other marks of punctuation besides the comma. For example, enter Mrs. Mary O'Hara as "OHARA, MARY."

Block 3 - Patient's Date of Birth and Sex (REQUIRED): Enter the patient's birth date (MM/DD/CCYY) and sex. **Entry in both the date of birth and sex is required.**

Block 4 - Insured's Name (REQUIRED): Enter the last name of the policyholder or subscriber, followed by a comma and the first name. Please enter this name exactly as it appears on their card**.** Do not include any apostrophes, hyphens, suffixes (like Jr. or Sr.), or titles (such as Mr. or Mrs.) any other marks of punctuation besides the comma. For example, enter Mary O'Hara as "OHARA, MARY." The terms "same" or "self" may result in a claim being rejected.

Block 5 - Patient's Address: Fill out this block only if the patient's address is different from the insured's address, in Block 7, and please enter no more than 28 characters in this field.

Block 6 - Patient's Relationship to Insured (REQUIRED): Check the appropriate box for patient's relationship to the insured. Enter an "X" in one of the following boxes:

- **Self** - the patient is the subscriber or insured
- **Spouse** - the husband or wife or qualified partner as defined by the insured's Plan.
- **Child** - minor dependent as defined by the insured's Plan.
- **Other** - stepchildren, student dependents, handicapped children, & domestic partners.

Block 7 - Insured's Address and Telephone: Enter the Insured's address and telephone number.

Block 9(A-D) - Other insured's Name & Other Information (REQUIRED): **I**f the patient is covered under another health benefit plan including Arkansas Blue Cross, BlueAdvantage, or Health Advantage, please enter the full name of the policyholder and include all the following information in Blocks 9 (A) - (D).

- Other Insured's Policy or Group Number (Note: Do not use a hyphen or space within the policy or group number.);
- Other Insured's Date of Birth and Sex;
- Employer's Name or School Name; and
- Insurance Plan or Program Name.

Block 10 (a-c)-Patient's condition related to? For each category (employment, auto accident, other), insert an "**X**" in either the YES or NO fields.

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If any "**YES**" fields are selected, Block 14 must be populated with the accident date. The appropriate postal abbreviation for the STATE must be supplied if an AUTO ACCIDENT.

Block 11 - Insured's Policy, Group, or FECA Number (REQUIRED): Enter the insured's current identification number exactly as it appears on their identification card, including the appropriate three-letter alpha prefix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in processing or denial of the claim.

Block 11A - Insured's Date of Birth, Sex (REQUIRED): Enter the 8-digit date of birth (MM/DD/CCYY) of the insured and an "**X**" to indicate the sex of the insured.

Block 11D - Is there another health benefit plan? Enter an "**X**" in the appropriate box. If marked "**Yes**", complete 9 and 9A-D.

Block 14 - Date of Current Illness, injury or Pregnancy:

- Injury - Enter date the accident occurred; if any YES fields are marked with an "**X**" in Block 10 (a-c) then Block 14 must populated with the accident date.
- Illness - Enter for acute medical emergency only and include onset date of condition;
- Pregnancy - Enter date of the last menstrual period (LMP) as the first date.

Block 17- Name of Referring Physician or Other Source: Enter the name (First Name, Middle Initial, and Last Name) and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim. Do not use periods or commas within the name.

Block 17A - Other ID Number: If the name of the referring physician is provided in Block 17, it is **REQUIRED** that 17A reflect the proper two-digit qualifier (1B = Arkansas Blue Cross Provider number or 1G = Provider UPIN) along with the appropriate provider number for the referring physician.

Block 17B - National Provider Identifier: Enter the National Provider Identifier (NPI) of the referring provider, ordering provider, or other source in 17B. **NOTE: Required for claims filed May 23, 2007 or later.**

Block 18 - Hospitalization Dates Related to Current Services: Enter admission and discharge dates for inpatient hospitalization related services.

Block 19 - Reserved for local use.

Block 20 - Outside lab charges: If laboratory work was performed outside a provider's office, enter the laboratory's actual charge to the provider. If the laboratory bills Arkansas Blue Cross directly, enter an "**X**" in the "**NO"** box.

Block 21(1-4) - Diagnosis and/or Nature of Illness or Injury (REQUIRED): Enter the appropriate ICD-9 diagnosis code (up to five digits) for the services performed. **Do NOT use any punctuation such as a decimal.**

Block 22 – Medicaid only.

Block 23 - Prior Authorization Number: Enter any of the following as assigned by the payer for the current service:

- Prior authorization number,
- Referral number, or
- Mammography pre-certification number.

Block 24 - Supplemental Information: The following are types of supplemental information that can be entered in the shaded areas of Item Number 24.

National Drug Codes (NDC) for drugs – must have N4 qualifier followed by 11 digit NDC code – do not put a space between the qualifier and code; do not use hyphens in the code.

Placing the following information in the shaded areas as shown on the NUCC site should be as "FYI" only since the data may not image properly. Arkansas Blue Cross does not recommend the use of this free form line.

However, if it is used, it is critical that the right qualifiers be used.

Narrative description of unspecified codes must have a "**ZZ**" qualifier followed by the code description – do not put a space between the qualifier and the code.

From the NUCC website:

"To enter supplemental information, begin at Block 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/ code/information. Do not enter hyphens or spaces within the number/code."

Block 24A-Date(s) of Service (REQUIRED): Enter date(s) of service, from and to. If only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is only allowed for services on consecutive days. The number of days must correspond to the number of units in 24G.

Block 24B - Place of Service (POS) Code (REQUIRED): Enter the appropriate two-digit code from the "Place of Service" list from the CMS web site for each item used or service performed. The "Place of Service" identifies the location where the service was rendered.

Block 24C - EMG Emergency Indicator: Enter "**N**" for NO and "**Y**" for YES in the bottom, unshaded area of this field.

Block 24D-Procedures, Services or Supplies (REQUIRED): Enter the CPT/HCPCS code(s) and applicable modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description unless it is an 'unlisted' procedure code. If 'unlisted' an NDC or description must be shown in the shaded area for that line.

Block 24E - Diagnosis Pointer (REQUIRED): Enter the line-item diagnosis code pointer(s) referencing the appropriate diagnosis code(s) reported in Block 24D. Do not use a range, list primary diagnosis for the service line first. (1, 2, 3 not 1-3).

Block 24F - Charges (REQUIRED): Enter the charge for each listed service.

Block 24G - Days or Units (REQUIRED): Enter the units of service rendered for the procedure. Anesthesia services and "special" procedure codes require time units format. **NOTE: Must be whole number.**

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in block 24G of the CMS-1500 claim form. If no units are indicated on the claim, the claim will be denied.

Block 24I - ID Qualifier: Enter the 1B qualifier for the five-digit Arkansas Blue Cross provider number in the shaded area. (1B = Arkansas Blue Cross Provider Number — **Required through May 23, 2007)**)

Block 24J - Rendering Provider ID Number (REQUIRED): The individual provider rendering the service should be reported in Block 24J. The original fields for Block 24J and 24K have been combined and re-numbered as Block 24J. Enter the five-digit Arkansas Blue Cross provider number in the shaded area of the field. **This number is required through May 23, 2007 or the claim will be rejected.** Enter the NPI number in the un-shaded area of the field. **NOTE: NPI is required on claims filed on May 23, 2007 or later.**

Block 25 - Federal Tax ID Number: Enter the provider of service's or supplier's federal tax ID (employer identification number) or Social Security number. Enter "**X**" in the appropriate box to indicate which number is being reported.

(Continued on page 50)

(Continued from page 49)

Only one box can be marked.

Block 26 - Patient's Account Number: Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Block 27- Accept Assignment?(REQUIRED): Enter an "**X**" in the correct box. Only one box can be marked. "Accept Assignment" indicates the provider agrees to accept assignment under the terms of the Medicare Program.

Block 28 - Total charge (REQUIRED): Enter the sum of all line charges.

Block 29 - Amount Paid: Enter the total amount the patient or other payers paid on the covered services only. Attach a copy of the other insurer's explanation of benefits (EOB) and complete Block 9.

Please note: If Arkansas Blue Cross is the secondary payer, providers should not submit a claim until payment is received from the primary payer.

Block 31 - Signature of Physician / Supplier: Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter the 8-digit date (MM/DD/CCYY), or alpha-numeric date (e.g. January 1, 2006) the form was signed.

Block 32 Service Facility Location: Enter the name, address, city, state, and zip code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, zip code, and state when billing for purchased diagnostic tests. When more than one supplier is used, a separate CMS-1500 claim form should be used for each supplier.

Block 32A National Provider Identifier (NPI): Enter the National Provider Identifier (NPI) number of the service facility. **NOTE: NPI is required for claims filed on May 23, 2007 or later.**

Block 32B - Other ID Numbers: Enter the two-digit qualifier identifying the five digit Arkansas Blue Cross number followed by the ID number. Do not enter spaces, hyphens, or other separators between the qualifier and number. (1B = Arkansas Blue Cross Provider number)

Block 33 - Physician's or Supplier's Billing Name, Address, and Phone: Enter the provider's or supplier's billing name, address, zip, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

1st line – Name
2nd line – Address
3rd line – City, State, and Zip Code

33A - National Provider Identifier (NPI): Enter the "pay to" National Provider Identifier (NPI) number of the billing provider in Block 33A. **NOTE: The NPI is required for claims filed May 23, 2007 or later. Must also include the five-digit Arkansas Blue Cross number through May 23, 2007.**

33B - Other ID Numbers: Enter the two digit qualifier identifying the five digit Arkansas Blue Cross number followed by the ID number. Do not enter spaces, hyphens, or other separators between the qualifier and the number.

Important Things To Know:

- The NPI number was mandated by NUCC to process claims after May 23, 2007;
- The five digit Arkansas Blue Cross provider number must appear on all claims through May 23, 2007;
- Claims submitted on the revised CMS-1500 claim form prior to January 2, 2007 will be returned per Medicare guidelines;
- Providers must register their NPI with each insurance payer / carrier, including Medicare.
- The fastest method of claims processing and reimbursement is electronically. Only submit paper claims if electronic claim submission isn't possible.

New BlueChoice® Policy Now Available

Arkansas Blue Cross and Blue Shield recently added a new health insurance plan to its portfolio for individuals and families that offers policyholders the ability to select benefit features that fit their unique needs and budget. BlueChoice® provides deductible, coinsurance and copayment options from which to choose. BlueChoice® utilizes the True Blue PPO network.

Wellness benefits, children's preventive care, and hospitalization are standard with BlueChoice®. Policyholders will have "open access" to health-care providers, which means they are not required to receive a referral to see a physician, but will save more money by staying in-network. BlueChoice® provides up to $2 million in lifetime benefits for each covered family member.

"BlueChoice® is *all about* choice," said Ron DeBerry, senior vice president of Statewide Business. "Arkansas Blue Cross and Blue Shield believes this new health insurance plan will appeal especially to individuals or families who need insurance coverage, but may not need all the bells and whistles. BlueChoice® also is a great plan for early retirees, those without group health insurance, or students looking for their first job."

Policyholders may select maternity coverage and may select from two prescription drug benefit options. Policyholders may enhance their benefits by adding critical illness coverage or term life insurance. With BlueChoice®, policyholders may even apply for Arkansas Blue Cross's separate BlueCare® Dental coverage. Whatever their needs and budget require, BlueChoice® provides the options to tailor their insurance plan.

BlueChoice® is for individuals under the age of 65 and not on Medicare who do not have employer-sponsored health coverage. As with all of our individual health insurance plans, medical underwriting is required for this new insurance policy; however, it is a bit more flexible because of the higher deductibles associated with the plan structure.

"For those who currently do not have health insurance and may think they cannot afford it, Arkansas Blue Cross thinks BlueChoice® can provide options to meet people's needs both with price and benefit." said DeBerry. "We believe BlueChoice® is a great product for making that first step toward insurance coverage, BlueChoice® is an exciting offer we believe can reach a segment of the market we've not been able to reach before."

Note: BlueChoice® doesn't provide coverage for mental health services, including treatment for alcoholism, drug addiction, and psychiatric conditions. There are also limits on home health care, outpatient therapy, occupational therapy, respiratory therapy and speech therapy.

Preexisting Condition Exclusion Period: Treatment of preexisting conditions or diseases, until this policy has been in effect continuously for twelve (12) months, are not covered. This means a condition or disease which causes symptoms, before the effective date, that would have caused an ordinarily prudent person to seek diagnosis, care or treatment. This also applies to aggravations of such conditions or diseases.

Charts on the following pages contain an overview of benefit options available as well as copayments, co-insurance, and deductibles. For additional information on BlueChoice®, visit the Arkansas Blue Cross and Blue Shield web site at www.ArkansasBlueCross.com.

	BlueChoice®					
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Calendar Year Deductible						
✦No more than 2 covered family members must satisfy individual deductible ✦3 months of carryover deductible for amnts accumulated in Oct, Nov, & Dec	$500	$1,000	$1,000	$2,000	$2,500	$5,000
Coinsurance Option 1	80%	60%	80%	60%	80%	60%
Calendar Year Coinsurance Max Opt 1	$10,000	$20,000	$10,000	$20,000	$10,000	$20,000
Coinsurance Option 2	80%	60%	80%	60%	100%	80%
Calendar Year Coinsurance Max Opt 2	$5,000	$10,000	$5,000	$10,000	$0	Unlimited
Lifetime Maximum	$2,000,000					
Copay applies where indicated: otherwise deductible must be satisfied & then plan benefits will be paid as follows:						
Physicians Services						
Primary Care Physician Office Visits						
Option 1	$30 copay	60%	$30 copay	60%	$30 copay	60% or 80%
Option 2	n/a	n/a	n/a	n/a	n/a	n/a
Specialist Office Visit (includes routine services)						
Option 1	$50 copay	60%	$50 copay	60%	$50 copay	60% or 80%
Option 2	n/a	n/a	n/a	n/a	n/a	n/a
Other specialist services	80%	60%	80%	60%	80% or 100%	60% or 80%
Wellness (not subject to deductible)	80%	60%	80%	60%	80% or 100%	60% or 80%
	$500 annual max		$500 annual max		$500 annual max	
Physical/Occupational	50%	50%	50%	50%	50%	50%
	45 visit annual max		45 visit annual max		45 visit annual max	
Speech Therapy	50%	50%	50%	50%	50%	50%
	25 visit annual max		25 visit annual max		25 visit annual max	
Other physician services	80%	60%	80%	60%	80% or 100%	60% or 80%
Hospital Services						
Inpatient - semi-private room, ICU, ancillary charges	80%	60%	80%	60%	80% or 100%	60% or 80%
Emergency Room	$200 copay	60%	$200 copay	60%	$200 copay	60% or 80%
Outpatient	80%	60%	80%	60%	80% or 100%	60% or 80%
Home Health Visits	50%	50%	50%	50%	50%	50%
	40 visit annual max		40 visit annual max		40 visit annual max	
Durable Medical Equipment	50%	50%	50%	50%	50%	50%
	($5,000 annual max)		($5,000 annual max)		($5,000 annual max)	
Mental Illness (psychiatric treatment), Alcohol and Drug Treatment	Not Covered		Not Covered		Not Covered	
Ambulance	80%	60%	80%	60%	80% or 100%	60% or 80%
	($1,000 Annual Max)		($1,000 Annual Max)		($1,000 Annual Max)	
Other Covered Services	80%	60%	80%	60%	80% or 100%	60% or 80%

	BlueChoice®					
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Calendar Year Deductible						
✦No more than 2 covered family members must satisfy individual deductible ✦3 months of carryover deductible for amnts accumulated in Oct, Nov, & Dec	$5,000	$10,000	$10,000	$20,000	$25,000	$50,000
Coinsurance Option 1	100%	80%	100%	80%	100%	80%
Calendar Year Coinsurance Max Opt 1	$0	Unlimited	$0	Unlimited	$0	Unlimited
Coinsurance Option 2	n/a	n/a	n/a	n/a	n/a	n/a
Calendar Year Coinsurance Max Opt 2	n/a	n/a	n/a	n/a	n/a	n/a
Lifetime Maximum	$2,000,000					
Copay applies where indicated: otherwise deductible must be satisfied & then plan benefits will be paid as follows:						
Physicians Services						
Primary Care Physician Office Visits						
Option 1	$30 copay	60% or 80%	$30 copay	80%	$30 copay	60% or 80%
Option 2	100%	80%	100%	80%	100%	80%
Specialist Office Visit (includes routine services)						
Option 1	$50 copay	60% or 80%	$50 copay	80%	$50 copay	80%
Option 2	100%	80%	100%	80%	100%	80%
Other specialist services	100%	80%	100%	80%	100%	80%
Wellness (not subject to deductible)	100%	80%	100%	80%	100%	80%
	$500 annual max		$500 annual max		$500 annual max	
Physical/Occupational	50%	50%	50%	50%	50%	50%
	45 visit annual max		45 visit annual max		45 visit annual max	
Speech Therapy	50%	50%	50%	50%	50%	50%
	25 visit annual max		25 visit annual max		25 visit annual max	
Other physician services	100%	80%	100%	80%	100%	80%
Hospital Services						
Inpatient - semi-private room, ICU, ancillary charges	100$	80%	100%	80%	100%	80%
Emergency Room	$200 copay	80%	$200 co-pay	80%	$200 copay	80%
Outpatient	100%	80%	100%	80%	100%	80%
Home Health Visits	50%	50%	50%	50%	50%	50%
	40 visit annual max		40 visit annual max		40 visit annual max	
Durable Medical Equipment	50%	50%	50%	50%	50%	50%
	($5,000 annual max)		($5,000 annual max)		($5,000 annual max)	
Mental Illness (psychiatric treatment), Alcohol and Drug Treatment	Not Covered		Not Covered		Not Covered	
Ambulance	100%	80%	100%	80%	100%	80%
	($1,000 Annual Max)		($1,000 Annual Max)		($1,000 Annual Max)	
Other Covered Services	100%	80%	100%	80%	100%	80%

BlueChoice® Managed Pharmacy Program

Plan Options	Formulary	Generics	Preferred Brands	Non Preferred Brands	Out-of-Network
Option 1	Essential Care	$10	$50	n/a	Not Covered
Option 2	Complete Care	$10	$30	$50	Not Covered

BlueChoice® Optional Riders/Value Added

Optional Riders	USAble Term Life ($10,000, $30,000, or $50,000)	Maternity	
Value Added	Lasik and Contact Lens Discounts	Health and Fitness Discounts	
Cross Selling Opportunities	Dental	Critical Illness	Long-Term Care

Maternity Rider

$5,000 Paid per pregnancy
12 month waiting period
Waive deductible, apply coinsurance (does not apply to calendar year coinsurance maximum)
Can add and drop rider at any time. Adding rider will require underwriting

BlueChoice® Plan Choices

Choices	Coinsurance	Stop-Loss	Office Visit Copay	RX Plan
$ 500	No Choice (80%)	$5,000 or $10,000	No Choice ($30/$50)	EC or Standard
$1,000	No Choice (80%)	$5,000 or $10,000	No Choice ($30/$50)	EC or Standard
$2,500	80% or 100%	No Choice ($10,000)	No Choice ($30/$50)	EC or Standard
$5,000	No Choice (100%)	No Choice ($0)	None or ($30/$50)	EC or Standard
$10,000	No Choice (100%)	No Choice ($0)	None or ($30/$50)	EC or Standard
$25,000	No Choice (100%)	No Choice ($0)	None or ($30/$50)	EC or Standard

Fee Schedule Updates

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

Effective April 1, 2006:

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
90733	$80.34	$0.00	$0.00	$0.00	$0.00	$0.00
S2115	$0.00	$0.00	$0.00	$3,001.05	$0.00	$0.00

Effective Immediately:

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
65767	BR			BR		

Effective June 21, 2006:

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
J9310	$488.44	$0.00	$0.00	$0.00	$0.00	$0.00
94772	$130.00	$34.50	$95.50	$0.00	$34.50	$0.00
E0445	BR	BR	BR	$0.00	$0.00	$0.00
75556	BR	$0.00	$0.00	$0.00	$0.00	$0.00
0159T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Effective July 17,2006

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
0067T	BR	$0.00	$0.00	BR	$0.00	$0.00

Effective August 2, 2006:

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS	Professional SOS	Technical SOS
E0470	$2566.00	$256.60	$0.00	$0.00	$0.00	$0.00

The following CPT4 and/or HCPCS Codes were updated effective July 1, 2006 in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
0155T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0156T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0157T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0158T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0160T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0161T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0163T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0164T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0165T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0170T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0171T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9229	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9230	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8085	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0733	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0734	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0735	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0736	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0737	BR	$0.00	$0.00	$0.00	$0.00	$0.00
J2278	$6.44	$0.00	$0.00	$0.00	$0.00	$0.00
J0636	$0.48	$0.00	$0.00	$0.00	$0.00	$0.00

The following CPT4 and/or HCPCS Codes were updated effective June 21, 2006 in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
92992	BR	.00	.00	BR	.00	.00
92993	BR	.00	.00	BR	.00	.00
93668	BR	.00	.00	BR	.00	.00
94642	BR	.00	.00	BR	.00	.00
99429	BR	.00	.00	BR	.00	.00
G0245	BR	.00	.00	BR	.00	.00
G0246	BR	.00	.00	BR	.00	.00
G0247	BR	.00	.00	BR	.00	.00
K0462	BR	.00	.00	.00	.00	.00
K0606	BR	BR	BR	.00	.00	.00
K0669	BR	BR	BR	.00	.00	.00
S4011	BR	.00	.00	BR	.00	.00
S4013	BR	.00	.00	BR	.00	.00
S4014	BR	.00	.00	BR	.00	.00
S4015	BR	.00	.00	BR	.00	.00
S4016	BR	.00	.00	BR	.00	.00
S4017	BR	.00	.00	BR	.00	.00
S4018	BR	.00	.00	BR	.00	.00
S4020	BR	.00	.00	BR	.00	.00
S4021	BR	.00	.00	BR	.00	.00
S4022	BR	.00	.00	BR	.00	.00
S4023	BR	.00	.00	BR	.00	.00
S4025	BR	.00	.00	BR	.00	.00
S4026	BR	.00	.00	BR	.00	.00
S4027	BR	.00	.00	BR	.00	.00
S4028	BR	.00	.00	BR	.00	.00
S4030	BR	.00	.00	BR	.00	.00
S4031	BR	.00	.00	BR	.00	.00
S4035	BR	.00	.00	BR	.00	.00
S4036	BR	.00	.00	BR	.00	.00
S4037	BR	.00	.00	BR	.00	.00
S4040	BR	.00	.00	BR	.00	.00
S4981	BR	.00	.00	BR	.00	.00
S9329	.00	.00	.00	.00	.00	.00
V2781	BR	.00	.00	.00	.00	.00

The following CPT4 and HCPCS Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule effective August 2, 2006.

CPT/HCPCS Code	Total
90281	$11.11
90283	$23.15
90371	$124.53
90375	$67.17
90376	$72.00
90378	$627.33
90379	$16.82
90384	$101.96
90385	$5.13
90386	$14.25
90389	$95.24
90396	$116.60
90585	$121.22
90586	$116.00
90632	$48.70
90633	$24.78
90634	$24.81
90636	$78.67
90645	$22.38
90647	$22.38
90648	$22.65
90649	$120.00
90655	$15.27
90656	$16.45
90657	$6.27
90658	$11.00
90660	$22.02
90669	$68.88
90675	$145.20
90676	$145.20
90680	$63.25
90690	$11.46
90691	$52.71
90693	$48.83

CPT/HCPCS Code	Total
90698	$18.71
90700	$18.71
90702	$19.03
90703	$19.07
90704	$19.91
90705	$15.10
90706	$16.81
90707	$40.13
90710	$122.33
90713	$25.88
90714	$19.00
90715	$40.33
90716	$70.17
90717	$56.62
90718	$19.00
90720	$7.51
90721	$43.39
90723	$79.91
90727	$7.50
90732	$28.11
90733	$76.32
90735	$80.34
90740	$118.47
90743	$29.86
90744	$24.35
90746	$59.24
90747	$118.47
90748	$50.65
J0128	$64.74
J0130	$475.56
J0132	$1.74
J0133	$0.03
J0135	$274.13
J0150	$19.52

CPT/HCPCS Code	Total
J0152	$65.08
J0170	$0.59
J0180	$128.25
J0190	$0.93
J0200	$0.80
J0205	$37.00
J0207	$446.43
J0210	$10.35
J0215	$27.20
J0256	$3.37
J0270	$1.89
J0275	$22.87
J0278	$1.40
J0280	$0.43
J0282	$0.20
J0285	$9.68
J0287	$11.65
J0288	$12.48
J0289	$18.27
J0290	$1.85
J0295	$4.70
J0300	$2.24
J0330	$0.15
J0360	$5.30
J0365	$2.44
J0380	$1.07
J0390	$0.35
J0395	$168.42
J0456	$26.34
J0460	$0.24
J0470	$22.71
J0475	$201.05
J0476	$73.71
J0480	$1,458.12

CPT/HCPCS Code	Total
J0500	$15.72
J0515	$3.90
J0520	$0.71
J0530	$13.59
J0540	$26.92
J0550	$33.90
J0560	$20.24
J0570	$35.18
J0580	$71.25
J0583	$1.70
J0585	$5.10
J0587	$8.25
J0592	$0.78
J0595	$0.87
J0600	$41.79
J0610	$0.57
J0620	$5.83
J0630	$39.32
J0636	$0.48
J0637	$33.80
J0640	$0.95
J0670	$1.42
J0690	$1.36
J0692	$8.13
J0694	$7.82
J0696	$4.00
J0697	$1.84
J0698	$4.49
J0702	$5.27
J0704	$0.94
J0706	$3.50
J0710	$10.34
J0713	$4.07
J0715	$3.56
J0720	$12.52
J0725	$1.71
J0735	$63.31

CPT/HCPCS Code	Total
J0740	$764.24
J0743	$13.21
J0744	$8.65
J0745	$0.43
J0760	$4.54
J0770	$26.08
J0780	$2.28
J0795	$4.43
J0800	$109.88
J0835	$15.36
J0850	$793.51
J0878	$0.33
J0880	$21.96
J0881	$3.15
J0882	$3.15
J0885	$9.71
J0886	$9.71
J0895	$15.51
J0900	$1.43
J0945	$0.76
J0970	$33.82
J1000	$0.81
J1020	$2.92
J1030	$5.44
J1040	$9.80
J1051	$8.02
J1055	$24.06
J1056	$23.80
J1060	$4.31
J1070	$5.36
J1080	$13.02
J1094	$0.24
J1100	$0.13
J1110	$26.28
J1120	$15.54
J1160	$1.08
J1162	$480.00

CPT/HCPCS Code	Total
J1165	$0.41
J1170	$1.84
J1180	$8.37
J1190	$188.58
J1200	$0.82
J1205	$13.33
J1212	$43.79
J1230	$0.75
J1240	$0.38
J1245	$1.77
J1250	$3.59
J1260	$4.45
J1265	$0.76
J1270	$3.29
J1320	$2.33
J1325	$13.73
J1327	$13.98
J1330	$0.46
J1335	$24.10
J1364	$3.51
J1380	$12.45
J1390	$1.33
J1410	$60.67
J1430	$75.14
J1435	$0.14
J1436	$74.26
J1438	$161.81
J1440	$191.64
J1441	$304.04
J1450	$12.33
J1451	$12.41
J1452	$220.48
J1455	$11.22
J1457	$1.30
J1460	$11.11
J1470	$22.23
J1480	$33.34

CPT/HCPCS Code	Total
J1490	$44.45
J1500	$55.57
J1510	$66.70
J1520	$77.75
J1530	$88.91
J1540	$100.07
J1550	$111.13
J1560	$111.13
J1563	$51.42
J1564	$0.81
J1565	$16.82
J1566	$23.15
J1567	$30.25
J1570	$38.66
J1580	$1.75
J1590	$0.46
J1595	$43.31
J1600	$9.84
J1610	$45.60
J1620	$187.51
J1626	$7.14
J1630	$1.34
J1631	$6.10
J1640	$6.92
J1642	$0.06
J1644	$0.13
J1645	$10.96
J1650	$5.66
J1652	$5.56
J1655	$2.28
J1670	$95.24
J1675	$1.00
J1700	$0.34
J1710	$4.69
J1720	$1.98
J1730	$116.41
J1742	$261.43

CPT/HCPCS Code	Total
J1745	$56.41
J1751	$12.92
J1752	$10.68
J1756	$0.38
J1785	$4.06
J1790	$1.12
J1800	$4.93
J1810	$6.18
J1815	$0.25
J1817	$2.54
J1825	$255.61
J1830	$68.40
J1835	$38.03
J1840	$1.10
J1850	$0.16
J1885	$0.52
J1890	$9.64
J1931	$24.06
J1940	$0.45
J1945	$153.68
J1950	$462.34
J1955	$16.90
J1956	$7.90
J1960	$3.17
J1980	$7.83
J1990	$21.89
J2000	$0.48
J2001	$0.02
J2010	$3.72
J2020	$24.68
J2060	$1.11
J2150	$1.04
J2175	$1.69
J2180	$3.94
J2185	$3.94
J2210	$4.08
J2250	$0.29

CPT/HCPCS Code	Total
J2260	$3.36
J2270	$1.47
J2271	$1.95
J2275	$1.71
J2278	$6.44
J2280	$4.07
J2300	$1.12
J2310	$2.61
J2320	$3.40
J2321	$6.94
J2322	$13.47
J2325	$31.20
J2353	$93.97
J2354	$4.56
J2355	$255.53
J2357	$17.15
J2360	$2.26
J2370	$0.52
J2400	$14.23
J2405	$3.87
J2410	$2.33
J2425	$11.93
J2430	$30.77
J2440	$1.38
J2460	$0.97
J2469	$18.38
J2501	$3.95
J2503	$1,096.89
J2504	$172.71
J2505	$2,249.72
J2510	$8.60
J2513	$13.23
J2515	$5.44
J2540	$0.73
J2543	$5.04
J2545	$46.41
J2550	$2.16

CPT/HCPCS Code	Total
J2560	$2.35
J2590	$2.31
J2597	$2.34
J2650	$0.35
J2670	$3.44
J2675	$1.89
J2680	$1.56
J2690	$1.94
J2700	$0.62
J2710	$0.09
J2720	$0.56
J2725	$22.65
J2730	$30.09
J2760	$24.54
J2765	$0.54
J2770	$113.42
J2780	$0.70
J2783	$115.86
J2788	$14.83
J2790	$101.96
J2792	$14.25
J2794	$4.97
J2795	$0.07
J2800	$8.81
J2805	$46.35
J2810	$0.04
J2820	$24.27
J2850	$21.13
J2910	$25.48
J2912	$0.12
J2916	$5.26
J2920	$1.47
J2930	$2.45
J2940	$42.30
J2941	$45.92
J2950	$0.46
J2993	$792.38

CPT/HCPCS Code	Total
J2995	$82.68
J2997	$32.61
J3000	$6.91
J3010	$0.30
J3030	$54.34
J3070	$5.03
J3100	$2,161.76
J3105	$7.59
J3110	$8.11
J3120	$7.47
J3130	$14.95
J3140	$0.68
J3150	$0.79
J3230	$3.25
J3240	$743.13
J3246	$7.99
J3250	$4.80
J3260	$1.82
J3265	$2.45
J3280	$4.33
J3285	$56.18
J3301	$1.42
J3302	$0.29
J3303	$1.35
J3305	$151.59
J3310	$6.26
J3315	$315.92
J3320	$26.79
J3350	$71.10
J3355	$51.28
J3360	$0.78
J3364	$47.67
J3365	$476.04
J3370	$3.37
J3396	$9.34
J3400	$49.25
J3410	$0.41

CPT/HCPCS Code	Total
J3411	$0.95
J3415	$3.23
J3420	$0.91
J3430	$3.49
J3465	$4.78
J3470	$17.87
J3471	$0.12
J3472	$140.45
J3475	$0.15
J3480	$0.02
J3485	$1.05
J3486	$20.67
J3487	$210.85
J3520	$0.48
J3530	
J7030	$0.98
J7040	$0.48
J7042	$0.40
J7050	$0.24
J7051	$0.02
J7060	$1.31
J7070	$2.37
J7100	$14.57
J7110	$8.95
J7120	$0.94
J7130	$0.02
J7188	$0.91
J7189	$1.13
J7190	$0.71
J7191	$2.04
J7192	$1.10
J7193	$0.92
J7194	$0.66
J7195	$1.02
J7197	$1.70
J7198	$1.35
J7300	$345.28

CPT/HCPCS Code	Total
J7302	$412.23
J7303	$35.10
J7304	
J7306	$412.23
J7308	$104.90
J7310	$4,409.60
J7317	$118.90
J7320	$201.24
J7330	BR
J7340	$28.94
J7341	$1.72
J7342	$15.75
J7343	$15.96
J7344	$69.70
J7350	$30.93
J7500	$0.22
J7501	$51.16
J7502	$4.08
J7504	$310.12
J7505	$903.90
J7506	$0.24
J7507	$3.57
J7509	$0.08
J7510	$0.08
J7511	$316.52
J7513	$362.29
J7515	$1.03
J7516	$20.14
J7517	$2.62
J7518	$2.25
J7520	$7.18
J7525	$141.91
J7608	$2.34
J7611	$0.09
J7612	$1.03
J7613	$0.08
J7614	$1.47

CPT/HCPCS Code	Total
J7616	$0.63
J7622	$0.01
J7624	$0.11
J7626	$4.55
J7627	$4.94
J7628	$0.49
J7629	$0.49
J7631	$0.06
J7633	$0.05
J7635	$0.12
J7636	$0.12
J7637	$0.06
J7638	$0.13
J7639	$19.51
J7640	$1.00
J7641	$0.01
J7642	$1.08
J7643	$1.08
J7644	$0.22
J7648	$0.45
J7649	$1.83
J7658	$6.85
J7659	$6.91
J7668	$0.24
J7669	$0.24
J7674	$0.40
J7680	$7.59
J7681	$27.06
J7682	$55.80
J7683	$0.11
J7684	$0.18
J8501	$4.82
J8510	$2.05
J8515	$16.57
J8520	$3.78
J8521	$12.57
J8530	$1.01

CPT/HCPCS Code	Total
J8540	$0.08
J8560	$34.36
J8565	$56.73
J8600	$4.34
J8610	$0.25
J8700	$7.52
J9000	$6.54
J9001	$385.90
J9010	$551.99
J9015	$770.73
J9017	$34.56
J9020	$56.33
J9025	$4.29
J9027	$121.34
J9031	$116.00
J9035	$59.17
J9040	$25.58
J9041	$31.30
J9045	$14.42
J9050	$146.63
J9055	$51.85
J9060	$1.96
J9062	$11.52
J9065	$40.19
J9070	$2.08
J9080	$4.16
J9090	$17.40
J9091	$20.79
J9092	$41.58
J9093	$5.03
J9094	$9.55
J9095	$12.64
J9096	$22.76
J9097	$40.96
J9098	$393.45
J9100	$1.56
J9110	$7.81

CPT/HCPCS Code	Total
J9120	$14.49
J9130	$4.43
J9140	$8.87
J9150	$24.53
J9151	$58.50
J9160	$1,460.47
J9165	$25.16
J9170	$309.18
J9175	$3.49
J9178	$25.69
J9181	$0.50
J9182	$5.04
J9185	$241.60
J9190	$1.85
J9200	$65.73
J9201	$122.40
J9202	$207.45
J9206	$131.53
J9208	$56.90
J9209	$8.27
J9211	$278.78
J9212	$4.08
J9213	$35.20
J9214	$14.22
J9215	$6.87
J9216	$301.46
J9217	$255.12
J9218	$8.25
J9219	$2,265.50
J9225	$2,120.62
J9230	$13.63
J9245	$1,250.23
J9250	$0.20
J9260	$2.07
J9263	$8.89
J9264	$8.27
J9265	$16.21

CPT/HCPCS Code	Total
J9266	$1,675.65
J9268	$2,100.82
J9270	$88.13
J9280	$19.76
J9290	$79.02
J9291	$158.04
J9293	$353.57
J9300	$2,378.64
J9305	$42.94
J9310	$488.44
J9320	$154.81
J9340	$47.65
J9350	$819.49
J9355	$57.32
J9357	$369.60
J9360	$1.03
J9370	$5.58
J9375	$11.16
J9380	$27.89
J9390	$23.14
J9395	$84.32
J9600	$2,605.61
P9041	$11.46
P9045	$28.50
Q0136	$12.27
Q0144	$25.51
Q0163	$0.04
Q0164	$0.03
Q0165	$0.03
Q0166	$38.93
Q0167	$4.73
Q0168	$9.74
Q0169	$0.32
Q0170	$0.58
Q0171	$0.01
Q0172	$0.04
Q0173	$0.73

CPT/HCPCS Code	Total
Q0174	$0.79
Q0175	$0.20
Q0176	$0.22
Q0177	$0.08
Q0178	$0.09
Q0179	$35.92
Q0180	$49.89
Q2004	$28.25
Q2009	$5.44
Q2017	$277.45
Q3025	$102.88
Q3026	$59.12
Q4079	$7.46
Q4080	$32.36
Q9945	$0.31
Q9946	$1.93
Q9947	$1.31
Q9948	$0.33
Q9949	$0.36
Q9950	$0.22
Q9951	$0.22
Q9952	$3.02
Q9953	$31.62
Q9954	$9.32
Q9955	$13.25
Q9956	$42.79
Q9957	$64.31

Providers' News

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