Arkansas Blue Cross and Blue Shield

Providers' News

March 2008

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Please Note:

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company and its 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.

Any five-digit Physician's Current Procedural Terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2008 American Medical Association. All Rights Reserved.

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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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Present On Admission (POA) Modifier Required on Facility Claims for Private Business

Arkansas Blue Cross Blue Shield and its subsidiaries will follow Medicare guidelines for the Present on Admission Modifier for private business facility claims. A modifier will be REQUIRED for each diagnosis code beginning October 1, 2008 (unless the facility is an exempt facility). Watch for more information in future newsletters.

The Present on Admission (POA) data element on electronic claims must contain the letters "POA", followed by a single POA indicator for every diagnosis that is reported. The POA indicator for the principal diagnosis should be the first indicator after "POA", and (when applicable) the POA indicators for secondary diagnoses would follow.

The last POA indicator must be followed by the letter "Z" to indicate the end of the data element (or FIs and A/B MAC's will allow the letter "X" which CMS may use to identify special data processing situations in the future)

Note on paper claims -- the POA is the eighth digit of the Principal Diagnosis field (FL67), and the eighth digit of each of the secondary diagnosis fields (FL 67 A-Q). On claims submitted electronically via 837, 4010 format, providers must use segment K3 in the 2300 loop, data element K301.

Following is an example of what this coding should look like on an electronic claim:

If the segment K3 reads as follows "POAYNUW1YZ," it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnosis. The principal diagnosis was POA (Y), the first secondary diagnosis was not POA (N), it was unknown if the second secondary diagnosis was POA (U), it is clinically undetermined if the third secondary diagnosis was POA (W), the fourth secondary diagnosis was exempt from reporting for POA (1), and the fifth secondary diagnosis was POA (Y).

The following are the POA Modifiers and their meanings:

- Y - Present on admission
- N - No, not present on admission
- U - No information in the record
- W - Clinically undetermined
- 1 - Unreported/Not Used- Exempt from POA reporting

The following hospitals are EXEMPT from the POA indicator requirement.

- Critical Access Hospitals
- Long-Term Care Hospitals
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Facilities
- Inpatient Rehabilitation Facilities
- Psychiatric Hospitals

Below are helpful links for information about this POA reporting:

http://www.nubc.org/public/whatsnew/POA.pdf
http://www.cms.hhs.gov/Transmittals/Downloads/R1240CP.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf

NPI Contingency Period to End May 23, 2008

Arkansas Blue Cross and Blue Shield and its affiliates will end all HIPAA National Provider Identifier (NPI) contingencies on May 23, 2008. In accordance with CMS NPI Guidance, this is the latest day allowable to end all NPI contingency plans.

Over the course of the contingency period Arkansas Blue Cross has closely monitored the NPI compliance of all submitted claims. By late Fall 2007, nearly all institutional claims received were NPI-compliant and Arkansas Blue Cross was able to lift its contingency plan for institutional claims on January 1, 2008.

The conversion to NPI compliance for professional claims did not progress as quickly. Therefore, Arkansas Blue Cross will continue to allow professional claims to be submitted under the contingency plan up until the mandatory end date of May 23, 2008.

After May 23, 2008, all electronic HIPAA transactions must utilize the NPI for provider identification or they will be rejected for being out of compliance with HIPAA. Paper claims must also use the NPI as the provider identifier or they too will also be rejected.

Additionally, all providers must register their NPI with Arkansas Blue Cross prior to using their NPI in submitting claims. Registration of NPI may be done in writing by mail, email or fax. Providers with access to the Advanced Health Information Network (AHIN) web site may register their NPI electronically .

For specific details pertaining to registration of an NPI with Arkansas Blue Cross, please refer to the '*Providers' News*' article Arkansas Blue Cross Needs Your NPI! published September 2006 and September 2007.

For providers who have not obtained an NPI, please do so as soon as possible. The most expeditious way to obtain an NPI is to apply online by visiting:

https://nppes.cms.hhs.gov/NPPES.

For additional assistance registering an NPI with Arkansas Blue Cross please contact your regional Network Development Representative.

COBA Alert - Professional Claims without a National Provider Identifier

As a COBA Trading Partner, Arkansas Blue Cross and Blue Shield has received the following notice:

Effective March 1, 2008, if a beneficiary or provider requests an adjustment on a claim that when originally adjudicated did not contain an NPI, Medicare will adjudicate the adjustment claim but will **not** cross the claim over due to the claim's lack of an acceptable NPI value. The CMS' Common Working File (CWF) will initially tag such claims for crossover, but these claims will not successfully pass Health Insurance Portability and Accountability Act (HIPAA) editing due to the lack of a valid required NPI. Consequently, our Medicare contractors will inform the providers via the customary special provider notification letters that Medicare could not cross the claims over due to lack of a valid NPI.

Personal Health Records Now Available!

Are patients good historians? Do patients provide a complete list of medications they are receiving from other physicians? In most cases, important health information is scattered across several different providers and facilities. These multiple records can lead to an incomplete story about a patient's health.

Arkansas Blue Cross and Blue Shield acknowledges the importance and value of technology in improving health care delivery with the introduction of **Q-Chart**, a payer-based personal health record. Q-Chart is available to over a million members and this same personal health record is now available to providers.

Q-Chart is a collection of medical and pharmacy claims data as well as member entered information such as medical, social, and family history. Thousands of members have already reviewed their Personal Health Record (PHR) online since October 2007 and many continue to play a more active role in their own health care by adding information to their PHR such as:

- Over The Counter medications;
- Medical history (Personal, Social, Family);
- Immunizations;
- Allergies;
- Emergency contact information;
- Advance directives;
- And much more!

Q-Chart includes a health summary, risk factors (e.g. allergies, chronic conditions), treatment opportunities (e.g. a reminder to check cholesterol, have a mammogram), medication history, a list of outpatient and office visits as well as inpatient hospitals stays, immunization records and more. Under Medical History, a patient can enter and edit their personal medical history, family medical history, and social history (education, travel information, etc.). The PHR also offers a "clipboard" – a printable version of the health summary that members can take to provider appointments.

Providers can access their patients' PHR unless the member has elected to "opt out". Only a small percentage of members have elected to make their PHR unavailable to providers. Also, certain information that may exist in a patient's claim records will be hidden. In order to insure patient privacy, information that is considered highly sensitive is automatically hidden unless the patient chooses to make this information available to medical personnel.

When information is hidden, providers will see a placeholder indicating a sensitive diagnosis or procedure has been withheld. Highly sensitive categories of personal health information include:

- Substance abuse treatment and services
- Information regarding HIV or AIDS status, testing, diagnosis and/or treatment
- Information regarding mental health status, counseling and/or treatment
- Any treatment or service relating to sexual abuse, rape, abortion or sexually transmitted diseases

Patients who have multiple medical problems often see numerous specialists from unaffiliated facilities. No single provider has a longitudinal view of the patient's activity, preferences and health history across care sites, payers and time periods. Q-Chart allows providers to see each clinic visit, view diagnoses, and know what procedures, medication changes, or imaging has been ordered.

Providers may be able to detect possible interactions with various medications prescribed by different providers. Q-chart allows doctors to improve the continuity of care for patients who receive such fragmented healthcare, remain aware of recent health changes, and integrate this broader knowledge of the patient into their decision-making process to improve the overall quality of care delivered.

Access to a PHR can be especially useful in a life-threatening situation where delays and incomplete information can be fatal. In addition, PHR's have proven to be useful in natural disasters when important medical information is unavailable and/or patients may not be able to recall their current medications or recent healthcare activity. Such a resource saves providers considerable time in addressing current issues in the patient's medical care. PHR's can also save patients money and unnecessary risk by avoiding repetition of invasive procedures, labs, and imaging.

It is easy to see how beneficial the PHR's can be for both patients and providers. The patient's PHR is available anywhere, anytime. All providers need is an authorization and an internet connection. Each provider will be assigned a unique user ID and password for Q-chart.

To inquire or sign up for access, contact the Personal Health Record Customer Support.

Arkansas Blue Cross and Blue Shield
c/o Personal Health Record, 4 South
601 South Gaines
Little Rock, AR 72203
(501) 378-3253
personalhealthrecord@arkbluecross.com

Q-Chart has PHR's available for members of the following health plans:

- Arkansas Blue Cross and Blue Shield
- Health Advantage
- Blue Advantage Administrators
- Medi-Pak®
- Medi-Pak® Advantage
- USAble

In addition, there are plans in the near future for other health plans to add their members to Q-Chart.

Copayment Changes for Advanced Practice Nurses

Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation will begin applying primary care copayments during claims adjudication for certain Advance Practice Nurses (APNs). APNs must work in collaboration with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision. APNs must also have a written collaborative practice agreement with a physician.

The distinction between primary care benefits versus specialist benefits will be based on the specialty of the collaborating physician. For example, if the written collaborative practice agreement that has been supplied to Arkansas Blue Cross, Health Advantage, and Usable Corporation by the APN during the network enrollment process is signed by a primary care physician, then that APN will be considered a primary care APN for benefit application/claims adjudication purposes. In most cases, Family Medicine, General Practice, Internal Medicine, and Pediatrics will be considered primary care.

The copayment change is effective for dates of service beginning March 1, 2008 for Health Advantage and Blue Advantage Administrators. The copayment change will be effective on April 1, 2008 for Arkansas Blue Cross.

Please keep in mind that not all benefit plans make the distinction between primary care services and specialist services and that self-funded employer health plans have the option to implement or reject this benefit. Health Advantage members will not be allowed to choose an APN as a Primary Care Physician.

Coverage Policy Manual Updates

The following policies have been added to the Arkansas Blue Cross and Blue Shield Coverage Policy Manual or coverage has changed since December 2007. Other revised policies are not listed here because no change was made in coverage/non-coverage. To view the entire policy, providers can access the coverage policies at www.arkbluecross.com.

Policy #	Policy Title and Information
1997004	Alpha I Globulin Antitrypsin Replacement Therapy (Prolastin)
1997113	Immune Globulin, Intravenous and Subcutaneous
1998118	Surgery for Morbid Obesity
2007021	HIV Tropism, Testing
2007022	Cystatin C
2007023	Gene Test: Carbamazepine_HLA B*1502
2007024	Gene Test: HER2 Testing
2008002	Transanal Endoscopic Microsurgery (TREMS)
2008005	Suprachoroidal Delivery of Pharmacological Agents
2008006	Transcatheter Arterial Chemoembolization (TACE) to Treat Primary or Metastatic Liver Malignancies
2008007	Cardiac Event Recorder_Mobile Telemetry
2008008	Temsirolimus (Torisel) for Metastatic Renal Cell Carcinoma
2008009	Gene Test: Cytocrhome P450, Depression

Dental Anesthesia

When dental anesthesia is provided with a medical procedure, it should be billed as follows:

- D9220 - 1 unit for the first 30 minutes
- D9221 - 1 unit for each additional 15 minutes after the first 30 minutes.

BlueAdvantage Administrators of Arkansas to Implement Automated Offset Process for Claim Overpayments Effective April 1, 2008

BlueAdvantage Administrators of Arkansas will implement the following offset process for all members effective April 1, 2008.

When claim overpayments are noted, BlueAdvantage will send a letter to the provider's payment address requesting a refund of the overpaid amount. Details in the refund request letter will be the same as they are today which includes the patient's identification and account numbers, paid date, and check/EFT number.

Providers with questions regarding the refund request should contact the BlueAdvantage Customer Service immediately at the number noted on the refund request letter. Providers can either remit the overpayment amount directly back to BlueAdvantage or have the amount offset from a future payment.

Providers who agree with the overpayment determination and prefer to have the overpayment offset as soon as possible (and thus be able to 'close' the patient's account record more timely) should return the refund request letter with a message "Recoup immediately". The recoup transaction will then take place within ten (10) business days following the receipt of the provider's written instructions.

If BlueAdvantage Administrators of Arkansas has not received the requested refund after 30-days or if a provider has not notified BlueAdvantage to "Recoup immediately", then the amount of the overpayment will be withheld/ offset from the provider's next claims payment. Offset details will be reported on the Remittance Advice.

Note: the offset recovery process has been in place for Wal-Mart membership since January 1, 2008.

USAble Corporation and Health Advantage Suspends Use of Utilization Standards Applicable to Certain Non-Physician Disciplines

Effective immediately, USAble Corporation and Health Advantage will suspend use of the Utilization Standards Applicable to Certain Non-Physician Disciplines. This notice should serve as an amendment to Section VI (B) of the Notice of Payer Policies and Procedures and Terms and Conditions Applicable to All Individual Network Participants. The utilization standards previously set forth are suspended and under review and are not applicable until further notice.

All individual non-physician practitioners who have been denied network participation solely on the basis of Section VI (B) will be receiving a letter with instructions on how to re-activate their previously submitted network application. Signatures for release and attestation may be needed if outdated.

Signatures Go High Tech

Many providers have probably received Authorizations to Disclose Protected Health Information forms from Arkansas Blue Cross and Blue Shield that have signatures sections like the sample located on the following page.

All concerned must now adjust to the fact that electronic signatures are just as valid under applicable laws as the old fashioned hand written signatures.

The following are some common questions and answers regarding electronic signatures.

Q: Legally, how can Arkansas Blue Cross be sure the actual person submitted the electronic signature?

A: The law looks to the security measures attached to the process of obtaining the signature to determine if it was the "act" of the person. The attached sample shows an electronic signature that is fully compliant with the law and thus is legally binding and effective, just as an old-fashioned hand-written signature.

Q: What makes the electronic signature a valid signature?

A: Both the federal government and the state of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce.

- Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq.*,
- Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-32-101 *et seq.*
- Electronic signatures are specifically authorized in the business of insurance. [See 15 USC §§ 7001(i)].

Q: What protections do providers have if they accept the electronic signature?

A: When a provider agrees to accept an electronic signature then:

- The requirement for "written" record is satisfied;
- Electronic signature is considered a valid signature; and
- The electronic signature is legally binding and may not be denied simply because it is in electronic form.

Q: Why are providers seeing so many more electronic signatures?

A: Arkansas Blue Cross launched an online application in September 2007. Arkansas Blue Cross is encouraging applicants and agents to use the electronic signature method of enrollment because it speeds up the processing time, is more legible, and ensures Arkansas Blue Cross receives all the information needed. It's win-win for everyone.

Q: Do providers have to accept electronic signatures?

A: No. There is no legal requirement to accept an electronic signature. However, if a provider does not accept an electronic signature, it does cause a delay in their patients (Arkansas Blue Cross customers) getting applications processed as quickly as possible. As a result, Arkansas Blue Cross must send another authorization to the applicant and ask them for a "wet" signature. This can add 7-10 days to the processing time.

Arkansas Blue Cross knows that healthcare providers share our goal of ensuring individuals receive the health care needed. Providers also know when people have health insurance, they are more likely to obtain health care.

Arkansas Blue Cross hopes this mutual goal of getting individuals insured as quickly as possible will motivate all participating providers to accept electronic signatures on the Arkansas

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Blue Cross and Blue Shield Protected Health Information forms.

This authorization must be signed by each applicant who is 18 years of age or older.

Joe sample	Joe sample	(digital signature)	1/1/2008
Jane sample	Jane sample	(digital signature)	1/1/2008

Modifier Usage

When used appropriately, modifiers provide additional information that aids in the adjudication of a claim. When modifiers are used inappropriately, they will slow the process of a claim, require manual handling and usually require additional information from the provider's office.

Modifier 50: Bilateral Surgery

Charges must be submitted on **two** lines. The first line should include a descriptive modifier (i.e., LT (left side) or RT (Right side)). Modifier 50 should be in the first modifier position on the second line, with the descriptive modifier in the second position.

If a provider bills bilateral surgery on one line with modifier 50, the payment will reflect one half of one side. A corrected claim must be submitted to obtain correct payment.

Modifier 51: Multiple Surgery

The Arkansas Blue Cross and Blue Shield computer systems will automatically assign Modifier 51 to the secondary surgical procedure(s) based on the Relative Value Units (RVU) assigned to the procedures. Arkansas Blue Cross will not apply multiple surgery guidelines to procedures exempt from Modifier 51 based on CPT or to add-on codes. Modifier 51 does not apply to these groups of procedures by definition. Addition of Modifier 59 to these procedures will result in manual adjudication of the claim.

Modifier 59: Distinct Procedural Service

Modifier 59 continues to be the most misused modifier. Use of modifier 59 should be rare, should only be used when no other modifier is applicable, and should never be used if there is only one service on a claim. Inappropriate use of Modifier 59 will delay processing of the claim.

An appropriate use of Modifier 59:

- Two procedures are provided. When entered in Clear Claim Connection via AHIN, one of the procedures denies as inclusive in the other procedure billed.
- The two procedures represent distinct services that will be supported by the medical records.

Inappropriate uses of modifier 59:

- Evaluation and Management services;
- Multiple or bilateral surgery where Modifier 50 or 51 is appropriate;
- Single line claims.

Modifier 25: Significant, Separately Identifiable Evaluation & Management Service

Modifier 25 should only be used with Evaluation and Management procedure codes, and only when you have provided an E&M service that is separate and identifiable from the other procedure(s) provided on the same day.

ASE/PSE: Services Requiring Pre-Certification by American Health Holding

The following is a revised list of services requiring pre-certification by American Health Holding (AHH) for Arkansas State Employees (ASE) and Public School Employees (PSE) only. Prior to rendering any of the following services, providers **must** obtain an authorization number from AHH at 1-800-592-0358. Clinical information will be required before an authorization number will be issued. If providers call without the clinical information or further review is required, a reference number will be issued. **The reference number is not an authorization number**. Services should not be rendered until an authorization number is received from AHH. Effective June 1, 2008 claims received without an authorization number will be denied.

1. **Acute Inpatient Hospital Admissions** (includes Medical, Surgical, Obstetrics, Mental Health, Substance Abuse)
2. **Medical Rehabilitation**
3. **Skilled Nursing Facility (SNF)**
4. **Hospice In-Patient**
   Does Not Require Pre-certification, but member must be in case management.
5. **Neuro/Psych Residential Treatment**
6. **Residential Mental Health/Substance Abuse**
7. **Outpatient Surgery**
   Pre-certification is required for the following procedures:
   - Excellence Shock Wave Therapy (ESWT)
   - Intradiscal Electrothermal Therapy (IDET)
   - Uvulopalatropharyngoplasty (UPPP)
   - Varicose vein excision and ligation
   - Blepharoplasty and/or brow lift
   - Gynomastia reduction
   - Mammoplasty (reduction or augmentation) Pectus excavatum repair
   - Radial keratotomy
   - Rhinoplasty
   - Ventral hernia repair
   - Procedures related to TMJ/TMD (member must be in case management)
8. **Outpatient Diagnostic**
   - MRI (Magnetic Resonance Imaging)
   - CT (Computed Tomography)
   - MRA (Magnetic Resonance Angiography)
   - PET (Positron Emission Tomography) Scan
   - IMRT (Intensity Modulated Radiation Therapy)
9. **Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology** (includes these services performed in a physician's office or home setting.)
10. **Outpatient Mental Health/Substance Abuse**
11. **Physician Office Mental Health/ Substance Abuse**
12. **Outpatient Pain Management Medication Therapy**
    Pre-certification required for the pain management narcotic pumps only.
13. **Enteral Feeds**
14. **Home Health Care**
15. **Home Hospice**
16. **Durable Medical Equipment (DME) & Prosthetics**
    Pre-certification is required for prosthetics, DME and DME repairs over $1,000.
17. **If other Commercial Insurance is Primary** (does not apply to Medicare and Workers Comp)
18. **Transplants**
    - Pre-notification is required for all solid organ and stem cell transplants.
    - All transplants, except kidney and cornea,

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must be approved by the Health Advantage Transplant Coordinator, regardless of approval from AHH. Please contact Health Advantage at 800-225-1891 in addition to contacting AHH

19. **Temporomandibular Joint (TMJ/TMD)**
    Member must be in case management.

20. **Wound Vacs**

21. **Benefit Exclusions**
    AHH will NOT pre-certify the following benefit exclusions:
    - Long Term Acute Care
    - Private Duty Nurse
    - Gastric Bypass
    - Left Ventricular Assist Device
    - Infertility where diagnosis is confirmed

Arkansas Blue Cross and Blue Shield and Health Advantage Coverage for Services Rendered to a Member Injured in an Accident

It has come to the attention of Arkansas Blue Cross and Blue Shield that several providers who render treatment to Arkansas Blue Cross and Health Advantage members injured in motor vehicle accidents have communicated statements such as,

> "Since auto insurance is involved, your regular health insurance cannot be billed until after the auto insurance has processed this claim"
>
> **or**
>
> "In the event of an accidental injury, our contracts with health plan carriers require that we seek payment from the property and casualty carriers first, before your account is ever billed to health insurance."

Such statements are incorrect with respect to health insurance issued by Arkansas Blue Cross and Blue Shield and health plans provided by Health Advantage.

Arkansas Blue Cross and Health Advantage contracts provide coverage regardless of the reason a member receives health services and regardless of other possible payers for such services. (Arkansas Blue Cross and Health Advantage health plans coordinate benefits with other insurers and assert contractual subrogation rights against liable third parties.)

Health care providers providing services to members covered by Arkansas Blue Cross or Health Advantage health plans should not wait to file claims, regardless of the cause of the member's illness or injury. Delay in filing could result in a claim being denied for lack of timely filing.

Rendering Services to Family Members

Services rendered by a provider to a member of his/her immediate family are ineligible for coverage under all Policyholder's Benefit Certificates of Arkansas Blue Cross and Blue Shield, the Federal Employee Program, Blue Advantage Administrators of Arkansas and Health Advantage.

The immediate family of the provider rendering the services can include a spouse, parent, child, brother, or sister whether the relationship is by blood or exists in law. Refunds will be requested for any professional services performed by a provider on an immediate family member.

AHIN Announces New and Improved Member Benefit Displays

Arkansas Blue Cross and Blue Shield is pleased to announce enhancements in the Advanced Health Information Network (AHIN) display of Member Benefits. For providers already accessing AHIN for Eligibility and Benefit information for Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, and Health Advantage patients, Arkansas Blue Cross thanks you.

For providers who are not currently using AHIN, Arkansas Blue Cross would like to encourage them to begin using AHIN for all of their Eligibility and Benefit inquiries. This is the same Member Eligibility and Benefit information that Arkansas Blue Cross Customer Service Representatives are viewing.

For faster service when checking on member benefits and claim status, Arkansas Blue Cross recommends always access AHIN first or providers may also call MyBlueLine (Voice Response Unit) systems. MyBlueLine is an automated system available for use by a provider via the telephone.

1. AHIN access for patient eligibility and benefits available for provider's front office staff and admissions office staff. AHIN is **not** just for submitting claims! AHIN allows a provider's front office staff and admission office the ability to retrieve patient eligibility and benefit information. To access AHIN, go to the Arkansas Blue Cross and Blue Shield web site at www.arkbluecross.com, click on the Provider Page and Select the AHIN link. If an office, facility or hospital already uses AHIN, providers can have immediate access to eligibility, claims and claim-status information.

AHIN is available for more than a million Arkansas Blue Cross, Health Advantage, BlueAdvantage Administrators of Arkansas and USAble Administrators members and former members. AHIN access is free of charge and is EASY to use. For more information on setting up a front office staff or admissions staff to have this easy access to AHIN, please call **501-378-2336.** AHIN can limit access to only eligibility and benefit information.

2. My BlueLine, Arkansas Blue Cross and Blue Shield's Provider Service line is available 24/7 (1-800-827-4814). Use a natural, conversational voice to ask for patient specific information. Just pick up the phone, dial 1-800-827-4814 during business hours and talk. With My BlueLine, it really is that simple and it frees up Customer Service Staff to answer more complicated inquiries.

My BlueLine provides several choices:

- Eligibility and Benefits
- Claim Status
- Addresses

Please note that all eligibility and benefits information is conditional upon verification ***when the claim is received and processed***, and should not be relied upon as assurance of payment of the claim. While Arkansas Blue Cross strives to provide the most current information via AHIN and My BlueLine, Arkansas Blue Cross cannot guarantee that all information has been furnished timely or that computer entries have been updated at the time of the inquiry. All eligibility or benefits information given, via AHIN, My BlueLine or otherwise, is subject to the terms, conditions, exclusions, and limitations of the applicable member's health plan or insurance contract and the participating provider agreement, which take precedence over any inconsistent or contrary oral or written representations.

Data Required on Professional Claims Submitted Electronically for Secondary Payment to FEP

The Federal Employee Program (FEP) now has the capability of accepting electronically submitted secondary payment for professional claims. FEP requires the payment information from the primary payer to be submitted for each service at the line level. The type of insurance can be accepted at the claim level.

The following loops and specific data elements are required for FEP to accept these claims:

- 2400/SV102 (line item charge amount)
- 2400/AMT02 (Approved Amount) AAE qualifier
- 2430/SVD02 (Service line paid amount)
- 2320/SBR09 (Claim Filing Indicator Code)

With the implementation of the national co-ordination of benefits process for Medicare, it is unnecessary to submit claims to FEP for secondary payment for Medicare primary claims. FEP asks that providers not send electronic claims for payment secondary to Medicare until at least 30 days after the primary payment was made by Medicare.

If after 30 days a secondary payment has not been received by FEP, providers can confirm that FEP has received their crossover through the Advanced Health Information Network (AHIN). If providers see the claim in AHIN, there is no need to file paper for secondary payment.

HCPCS Codes not Accepted

Some HCPCS codes are defined for a specific purpose that would never apply to a claim where Arkansas Blue Cross and Blue Shield or a subsidiary is primary. These codes are rejected by AHIN except when on a Medicare crossover claim or a Blue Card claim.

C1000-C9999
'C' codes must be used on claims filed to Medicare by hospitals reimbursed based on the Outpatient Prospective Payment System (OPPS). Since Arkansas Blue Cross does not use OPPS reimbursement methodologies, it is not appropriate for participating hospitals to bill using these procedure codes.

H0001-H2037
'H' codes are specifically designated for state Medicaid agencies mandated by state law to establish separate codes for identifying mental health services that include alcohol and drug treatment services. Participating providers should use the appropriate CPT codes for these services.

K0000-K9999
'K' codes are identified as Temporary Codes for use by the DME Medicare Administrative Contractors (DME MACs). Arkansas Blue Cross does not recognize "K" Codes unless Medicare is primary. Participating providers should use the appropriate "E" Codes.

T1000-T9999
'T' codes are national codes designed for use by Medicaid state agencies. Participating providers should use the appropriate CPT or acceptable HCPCS codes for these services.

EPO and Darbepoetin

When EPO or Darbepoetin are administered, Arkansas Blue Cross and Blue Shield and its affiliates must have the hematocrit and hemoglobin test results to determine coverage. If providers bill electronically, this information can be entered in loop 2400, in the 'Line Note Text' field. An example of this entry:

2400 Line Note Text HGB 11 40 HCT 33 8.

If this information is submitted electronically, Arkansas Blue Cross ***may*** have the information needed to determine coverage without requesting additional information.

Providers not currently providing the hematocrit and hemoglobin test results but will submit it on future claims, please notify Arkansas Blue Cross. Please send the notification to the attention of the Edit Analyst in the Corporate Medical Director's Office. This will ensure Arkansas Blue Cross reviews the submitted information prior to requesting additional information.

Provider Workshops—Spring 2008

Arkadelphia

Tuesday, April 15, 2008
Ouachita Baptist University McClellan Hall
Session 1 - Registration 8:30
Chiropractic - 9:00 - 11:30
Session 2 - Registration 12:30
PT/OT/SP - 1:00 - 4:00

Conway

Tuesday, April 29, 2008
University of Central Arkansas
Brewer-Hegeman Conference Center - Room 5A/B
Session 1 - Registration 8:00
Chiropractic - 8:30 - 11:30
Session 2 - Registration 12:30
PT/OT/SP - 1:00 - 4:00

Jonesboro

Wednesday, May 14, 2008
St. Bernard's Regional Medical Center
Auditorium
Session 1 - Registration 8:00
Chiropractic - 8:30 - 11:30
Session 2 - Registration 12:30
PT/OT/SP - 1:00 - 4:00

North Little Rock

Tuesday, April 22, 2008
Wyndham Riverfront Hotel - Conference Rm
Session 1 - Registration 8:00
Chiropractic - 8:30 - 11:30
Session 2 - Registration 12:30
PT/OT/SP - 1:00 - 4:00

Mountain Home

Thursday, May 8, 2008
Baxter Regional Medical Center
Lagerborg Dining Room
Session 1 - Registration 7:30
Chiropractic - 8:00 - 11:00
Session 2 - Registration 1:30
PT/OT/SP - 2:00 - 5:00

Springdale

Tuesday, May 6, 2008
Harvey Jones Health Education Building
Corner of Emma & Berry Streets, 2nd Floor
Session 1 - Registration 8:00
Chiropractic - 8:30 - 11:30
Session 2 - Registration 12:30
PT/OT/SP - 1:00 - 4:00

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

Fee Schedule Updates

The following CPT / HCPCS codes were updated on the Arkansas Blue Cross fee schedule.

CPT/ HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
90707	$46.54	$0.00	$0.00	$0.00	$0.00	$0.00
90708	$26.11	$0.00	$0.00	$0.00	$0.00	$0.00
97039	BR			BR		
A9579	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J1642	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00
J2405	$1.19	$0.00	$0.00	$0.00	$0.00	$0.00
L3675	$200.00	$0.00	$0.00	$0.00	$0.00	$0.00

Injection Code Updates

The following injection codes were updated on the Arkansas Blue Cross and Blue Shield fee schedule on February 1, 2008.

Injection Code	Updated Fee
90281	$12.23
90283	$28.77
90371	$127.37
90375	$71.39
90376	$77.57
90385	$24.67
90585	$125.26
90586	$122.04
90632	$55.58
90633	$27.76
90634	$27.76
90645	$22.33
90647	$22.33
90648	$22.65
90655	$16.75
90656	$18.06
90660	$22.91
90665	$0.00
90669	$81.96

Injection Code	Updated Fee
90691	$59.44
90698	$0.00
90700	$32.77
90701	$0.00
90702	$25.96
90703	$21.02
90704	$22.15
90705	$17.43
90706	$18.69
90707	$44.93
90708	$0.00
90713	$26.94
90714	$20.26
90715	$35.69
90716	$78.83
90717	$58.31
90718	$12.02
90720	$0.00

Injection Code	Updated Fee
A9576	$2.56
A9577	$2.97
A9578	$2.78
A9579	$2.65
J0129	$19.44
J0130	$437.60
J0132	$2.22
J0133	$0.02
J0135	$343.91
J0150	$23.65
J0170	$1.08
J0207	$516.13
J0210	$17.44
J0215	$27.62
J0220	$132.29
J0256	$3.52
J0270	$2.06
J0275	$24.17

Injection Code	Updated Fee
J0278	$1.11
J0282	$0.17
J0285	$12.37
J0287	$10.79
J0295	$4.84
J0300	$7.97
J0330	$0.17
J0348	$1.94
J0360	$7.14
J0364	$3.47
J0365	$2.79
J0400	$0.30
J0456	$18.32
J0460	$0.62
J0470	$27.55
J0475	$204.80
J0476	$73.79
J0480	$1,563.02
J0500	$14.36
J0515	$23.23
J0530	$15.34
J0540	$34.32
J0550	$34.32
J0560	$24.72
J0570	$42.52
J0580	$48.40
J0583	$2.06
J0585	$5.47
J0594	$10.06
J0595	$0.61
J0600	$52.19
J0610	$0.65
J0630	$46.31
J0636	$0.35
J0637	$22.03
J0640	$0.90
J0670	$1.39
J0690	$1.47
J0692	$5.95

Injection Code	Updated Fee
J0694	$8.61
J0697	$4.13
J0698	$3.78
J0702	$5.82
J0706	$2.61
J0713	$3.75
J0715	$4.94
J0720	$15.53
J0725	$3.86
J0735	$67.57
J0740	$791.36
J0743	$14.80
J0744	$2.51
J0745	$1.59
J0760	$5.29
J0770	$23.93
J0780	$1.15
J0795	$4.42
J0835	$67.48
J0881	$3.01
J0882	$3.01
J0885	$9.32
J0886	$9.32
J0894	$28.20
J0895	$12.84
J0970	$38.52
J1000	$6.40
J1020	$2.36
J1030	$4.81
J1040	$9.06
J1051	$6.77
J1055	$20.31
J1056	$31.98
J1070	$5.08
J1080	$12.93
J1100	$0.12
J1110	$24.38

Injection Code	Updated Fee
J1120	$18.23
J1160	$4.01
J1162	$511.24
J1165	$0.56
J1170	$2.10
J1190	$170.40
J1200	$0.83
J1205	$154.81
J1212	$51.83
J1230	$3.51
J1240	$3.50
J1245	$1.00
J1250	$5.75
J1260	$4.99
J1270	$2.50
J1300	$183.44
J1324	$23.83
J1325	$15.11
J1327	$18.34
J1335	$26.32
J1364	$7.19
J1380	$14.54
J1410	$74.17
J1430	$79.54
J1438	$175.50
J1440	$207.00
J1441	$317.60
J1450	$9.40
J1451	$14.28
J1455	$11.11
J1457	$1.69
J1458	$326.27
J1460	$12.23
J1470	$24.46
J1480	$36.68
J1490	$48.92
J1500	$61.15

Injection Code	Updated Fee	Injection Code	Updated Fee	Injection Code	Updated Fee
J1510	$73.40	J1790	$1.23	J2354	$2.43
J1520	$85.55	J1800	$3.40	J2355	$258.98
J1530	$97.84	J1815	$0.29	J2357	$18.12
J1540	$110.12	J1817	$2.87	J2360	$10.21
J1550	$122.30	J1830	$120.88	J2370	$0.69
J1560	$122.30	J1835	$41.89	J2400	$14.47
J1561	$34.20	J1840	$4.25	J2405	$0.29
J1562	$7.36	J1850	$0.64	J2410	$2.36
J1566	$28.77	J1885	$0.42	J2425	$11.82
J1567	$28.77	J1945	$166.60	J2430	$30.82
J1568	$35.16	J1950	$471.45	J2440	$0.46
J1569	$32.92	J1955	$5.96	J2469	$17.30
J1570	$45.07	J1956	$6.25	J2501	$3.96
J1571	$61.62	J1980	$10.39	J2503	$1,087.30
J1572	$33.92	J1990	$21.89	J2504	$207.36
J1573	$61.62	J2010	$4.56	J2505	$2,279.07
J1580	$1.38	J2020	$27.79	J2510	$10.73
J1595	$54.69	J2060	$0.99	J2515	$8.00
J1600	$8.54	J2150	$0.91	J2540	$0.83
J1610	$75.88	J2175	$2.14	J2543	$5.28
J1626	$4.91	J2185	$3.92	J2545	$49.19
J1630	$1.86	J2185	$3.92	J2550	$1.58
J1631	$5.61	J2248	$1.42	J2560	$3.77
J1640	$7.61	J2260	$3.53	J2590	$2.15
J1642	$0.39	J2270	$2.86	J2597	$2.22
J1644	$0.23	J2271	$4.72	J2675	$1.65
J1645	$11.62	J2275	$4.45	J2680	$2.19
J1650	$6.04	J2278	$6.77	J2690	$2.76
J1652	$6.31	J2280	$2.92	J2700	$1.54
J1655	$2.38	J2300	$1.23	J2710	$0.08
J1670	$105.24	J2310	$3.18	J2720	$0.53
J1720	$2.22	J2315	$1.95	J2724	$12.68
J1740	$144.60	J2320	$4.90	J2730	$92.50
J1742	$332.29	J2321	$7.42	J2760	$24.96
J1743	$473.23	J2322	$19.59	J2770	$132.92
J1745	$57.41	J2325	$34.86	J2778	$422.12
J1751	$12.08	J2353	$105.78	J2780	$0.64
J1752	$12.08				
J1785	$4.08				

Injection Code	Updated Fee
J2783	$155.52
J2788	$28.46
J2790	$84.27
J2791	$5.55
J2792	$16.28
J2794	$5.10
J2800	$10.87
J2805	$57.36
J2810	$0.02
J2820	$26.27
J2916	$5.04
J2920	$2.05
J2930	$3.63
J2941	$51.21
J2993	$888.73
J2997	$35.75
J3000	$7.30
J3010	$0.34
J3030	$68.48
J3070	$6.00
J3100	$2,057.10
J3105	$2.63
J3120	$5.50
J3130	$10.69
J3230	$3.46
J3240	$873.16
J3243	$1.06
J3246	$7.87
J3250	$4.63
J3260	$1.80
J3265	$2.72
J3301	$1.56
J3315	$152.59
J3355	$56.17
J3360	$0.90
J3365	$476.04
J3370	$3.59
J3396	$9.48
J3411	$2.45

Injection Code	Updated Fee
J3415	$4.04
J3420	$0.57
J3430	$3.76
J3465	$5.34
J3470	$17.30
J3471	$0.13
J3473	$0.43
J3485	$1.20
J3487	$217.11
J3488	$225.28
J7030	$1.25
J7040	$0.62
J7042	$0.47
J7050	$0.31
J7060	$1.52
J7070	$3.03
J7100	$15.76
J7110	$11.58
J7120	$1.07
J7187	$0.92
J7189	$1.22
J7190	$0.81
J7192	$1.11
J7193	$0.93
J7194	$0.85
J7195	$1.11
J7197	$1.98
J7308	$114.87
J7310	$4,960.80
J7311	$20,118.80
J7321	$106.14
J7322	$185.28
J7323	$115.30
J7324	$178.22
J7330	$22,068.35
J7340	$31.33
J7341	$2.11

Injection Code	Updated Fee
J7342	$38.20
J7343	$20.76
J7344	$99.19
J7346	$800.82
J7347	$34.08
J7348	$96.01
J7348	$96.01
J7349	$42.49
J7500	$0.27
J7501	$50.48
J7502	$3.65
J7504	$392.14
J7505	$1,026.54
J7507	$4.02
J7509	$0.06
J7510	$0.02
J7511	$355.98
J7513	$335.01
J7515	$0.92
J7516	$20.31
J7517	$2.93
J7518	$2.57
J7520	$7.88
J7525	$145.28
J7602	$0.16
J7603	$0.46
J7605	$4.91
J7608	$2.36
J7620	$0.84
J7626	$5.29
J7639	$21.68
J7644	$0.22
J7669	$0.28
J7674	$0.43
J7682	$63.43
J8501	$5.44
J8510	$2.49

Injection Code	Updated Fee
J8515	$17.96
J8520	$4.77
J8521	$15.82
J8530	$0.89
J8540	$0.25
J8560	$29.78
J8610	$0.22
J8700	$7.99
J9000	$7.11
J9001	$428.73
J9010	$576.70
J9015	$828.21
J9017	$35.34
J9020	$56.97
J9025	$4.57
J9027	$120.94
J9031	$122.04
J9035	$59.76
J9040	$37.31
J9041	$35.82
J9045	$7.33
J9050	$159.94
J9055	$51.78
J9060	$2.65
J9062	$13.26
J9065	$35.01
J9070	$1.96
J9080	$3.93
J9090	$17.75
J9091	$19.65
J9092	$39.30
J9093	$2.00
J9094	$4.01
J9095	$10.02
J9096	$20.04
J9097	$40.08
J9098	$432.73
J9100	$2.01
J9110	$10.05

Injection Code	Updated Fee
J9120	$513.17
J9130	$5.80
J9140	$11.60
J9150	$20.75
J9151	$58.27
J9160	$1,467.24
J9170	$332.19
J9175	$4.24
J9178	$11.91
J9181	$0.43
J9182	$4.32
J9185	$247.01
J9190	$1.88
J9200	$58.75
J9201	$136.92
J9202	$199.53
J9206	$131.36
J9208	$36.98
J9209	$8.22
J9211	$302.03
J9213	$43.47
J9214	$14.85
J9217	$252.50
J9218	$8.06
J9219	$1,783.46
J9225	$1,537.41
J9226	$15,427.43
J9230	$150.22
J9245	$1,626.17
J9250	$0.27
J9260	$2.85
J9261	$91.69
J9263	$9.84
J9265	$14.12
J9266	$2,182.83
J9268	$1,933.03
J9280	$15.67

Injection Code	Updated Fee
J9290	$62.67
J9291	$125.33
J9293	$109.35
J9303	$86.18
J9305	$47.92
J9310	$529.01
J9320	$164.26
J9340	$42.86
J9350	$910.47
J9355	$61.38
J9360	$1.11
J9370	$8.04
J9375	$16.08
J9380	$40.21
J9390	$19.61
J9395	$84.62
J9600	$2,658.79
Q0165	$0.09
Q0166	$52.23
Q0167	$5.07
Q0168	$11.42
Q0169	$0.46
Q0170	$0.28
Q0173	$0.31
Q0175	$0.19
Q0179	$9.54
Q0180	$49.90
Q2009	$3.74
Q2017	$293.29
Q3025	$127.20
Q4080	$42.50
Q4081	$0.93
Q9954	$9.94
Q9957	$65.09
Q9960	$0.12
Q9963	$0.43
Q9964	$0.30

Providers' News

Arkansas Blue Cross and Blue Shield
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