Arkansas Blue Cross and Blue Shield

# Providers' News

September 2008

## Inside the September Issue:



## 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.



**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 Blue Cross and Blue Shield Radiology Provider Assessment Guidelines

This article is being re-printed due to an error in the version printed in the June 2008 edition of ***Providers' News***. The article in the June 2008 issue stated "MR systems with field strength of less that 0.4 Tesla will be considered very low field systems and will not be covered". The article should have stated "MR systems with field strength of less than 0.3 Tesla will not be covered".

Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation have created provider assessment guidelines that are intended to promote reasonable and consistent safety standards for the provision of imaging services. Arkansas Blue Cross, its subsidiaries and affiliate companies will accept providers into the imaging network if they meet the following guidelines:

## Plain Films

- Facilities performing plain films must comply with the Arkansas Board of Health Rules and Regulations.
- The Arkansas Consumer – Patient Radiation Health and Safety Act (Act 1071 of 1999), requires that individuals who use radioactive materials or medical equipment emitting or detecting ionizing radiation on human beings for diagnostic or therapeutic purposes, be licensed to do so.

Providers' staff performing plain film X-rays must be in compliance with the state mandate, with one of the following licenses:

- **Licensed Technologist License:** individuals trained on the job and licensed under the "grandfather" provision (this license is no longer issued);
- **Limited Licensed Technologist License:** Individuals who have passed the Limited Scope Examination in either chest, extremity, skull/sinus, spine and/or podiatry,
- **Radiologic Technologist License:** Individuals who have graduated from an accredited Radiologic Technology School and passed the American Registry of Radiologic Technologists (ARRT) Radiography registry exam, or
- **Temporary License:** Individuals who have trained on the job and are preparing to take the Limited Scope Examination).

For additional information on types of licenses go to *www.healthyarkansas.com/rtl/lic_info.html*

## Mammography

- Facilities must have a current MQSA (Mammography Quality Standards Act) certificate issued by the FDA.
- Diagnostic mammography must be performed under the direct supervision and interpretation of a board-certified or board-eligible radiologist who is on-site during the examination.

## Nuclear Cardiology

- Nuclear cardiology practices must meet all federal guidelines and be in compliance with the Nuclear Regulatory Commission Regulations. Nuclear cardiology practices must comply with the Arkansas Board of Health Rules and Regulations.
- Nuclear cardiology imaging systems must have the capability of assessing both myocardial perfusion and contractile function (ejection fraction and regional wall motion).
- Cardiac stress tests must be performed under the direct supervision of a licensed MD or DO who has a current Advanced Cardiac Life Support (ACLS) certification.

- It is recommended that nuclear cardiology practices employ a technologist who is certified in Nuclear Medicine through the ARRT, CNMT, or NMTCB or licensed by the state in nuclear medicine technology.
- Nuclear cardiology practices must achieve accreditation by January 1, 2009, by:
  - ICANL (Intersocietal Commission for the Accreditation of Nuclear Laboratories),
  - ACR (American College of Radiology), or
  - JCAHO (if a nuclear cardiology facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement).

Any new nuclear cardiology facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

## Positron Emission Tomography (PET)

- PET facilities must meet all federal guidelines and be in compliance with the Nuclear Regulatory Commission Regulations.
- PET facilities must comply with the Arkansas Board of Health Rules and Regulations.
- Only high performance full ring PET systems will be considered for privileging.
- PET examinations must be interpreted by a licensed MD or DO who is board certified or board eligible in radiology or nuclear medicine.
- It is recommended that PET facilities employ a technologist who is certified in Nuclear Medicine through the ARRT, CNMT, or NMTCB or a technologist who is licensed by the state in nuclear medicine technology.
- PET facilities must achieve accreditation by January 1, 2009, by:
  - ICANL (Intersocietal Commission for the Accreditation of Nuclear Laboratories),
  - ACR (American College of Radiology), or
  - JCAHO (if a PET facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement.)

Any new PET facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

## Computed Tomography (CT) and Magnetic Resonance Imaging (MR) - General Facility Requirements:

- All CT facilities utilizing equipment producing ionizing radiation must be in compliance with federal and state guidelines and be in compliance with the Arkansas State Board of Health Rules and Regulations for the Control of Sources of Ionizing Radiation.
- All CT facilities must have a documented Radiation Safety/ALARA Program.
- All MR facilities must meet all state and federal guidelines and comply with the Arkansas Board of Health Rules and Regulations
- All CT and MR providers must provide a written report within 10 business days from the date of service to the ordering provider. [Mammography reports must be completed within 30 days, per Mammography Quality Standards Act (MQSA) guidelines.]
- All CT and MR facilities must have a documented Quality Control Program inclusive of both imaging equipment and film processors.
- CT facilities must achieve accreditation by January 1, 2009, by:
  - American College of Radiology (ACR),
  - Intersocietal Commission for the Accreditation of Computed Tomography (CT) Laboratory Operations, or
  - JCAHO (if a CT facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement.)
- MR facilities must achieve accreditation by January 1, 2009, by:
  - American College of Radiology (ACR),
  - Intersocietal Accreditation Commission for Magnetic Resonance Labs (IACMRL) , or
  - JCAHO (if a MR facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement.)

Any new CT or MR facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

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## Medical and Technical Staff Requirements:

- It is recommended that CT and MR facilities employ an appropriately licensed or certified technologist (state licensed, ARRT, ARDMS, NMTCB).
- Contrast enhanced procedures must be performed with a licensed physician who has current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certification on-site.
- The interpreting physician is responsible for examining all of the visualized structures, and must report any clinically relevant abnormalities of these adjacent structures. In some cases, these structures may be seen only on the localization (scout) images. The technical parameters of a CT or MR examination may be tailored to evaluate specific anatomy or function, but the images obtained also demonstrate adjacent anatomy. For example, cardiac CT or MR examinations include portions of the lungs, mediastinum, spine and upper abdomen, and the evaluation of these structures must be included in the interpreting physician's written report.
- CT and MR studies must be interpreted by a licensed MD or DO, who is board certified or board eligible in radiology or nuclear medicine, or a licensed MD or DO, who has had exposure, training, and experience in the interpretation of CT and MR examinations in their area of expertise, including knowledge of the physics of CT and MR, understanding of radiation generation and exposure, knowledge of scanning principles and modes, knowledge of principles for intravenous contrast administration for safe and optimal imaging, knowledge of recognitions and treatment of adverse reactions to contrast administration, knowledge of principles of image post processing, and knowledge of normal anatomy and pathologic changes of the area being examined.

## Instrumentation Requirements:

- If offering cardiac CT applications, a multi-detector row helical CT with at least 16 detector rows and CT slice thickness of 1.5 cm. or less, or an electron beam CT scanner is a requirement. If offering CT coronary artery angiography, a 32 or greater multi-detector row, helical CT with sub-millimeter slices is a requirement.
- MR systems with field strength of 0.7 Tesla or greater will be considered high field systems.
- MR systems with field strength less than 0.7 Tesla will be considered low field strength systems.
- MR systems with field strength of less than 0.3 Tesla will be considered very low field systems and will not be covered.

## Additional Provisions and Considerations — Hospital Based/Owned and Physician Based/Owned Imaging Facility:

Hospital based/owned and Physician based/owned outpatient diagnostic imaging facilities must be associated / owned by a participating in-network hospital or physician.

## Data Storage:

The acquired images, post-processed and reconstructed images, and the data set must be stored and available for review according to the state guidelines for maintenance of patient medical records:

***Records must be kept for a period of five years from the ending date of service or until all audits, appeal hearings, investigations or court cases are resolved, whichever period is longer. (See AR ADC 016 06 024, Section 204.000B.)***

## Leased Services:

Leased equipment must meet the provider assessment guidelines for the imaging services provided, as described in this document.

Providers who perform diagnostic imaging services on imaging equipment that is leased on a part time or intermittent basis (e.g. two days per week) will not be eligible for reimbursement of such services by Arkansas Blue Cross Blue Shield.

### Mobile Services:

Mobile services must meet the Provider Assessment Guidelines for the imaging services provided, as described in this document.

**Note:** Transportable Services – Medical practices that maintain multiple facilities or locations may transport their own equipment from one location to another. This must be clearly detailed on the Privileging Application.

### Site Inspections:

All imaging providers are subject to unannounced site inspections. Providers who are found to have misrepresented information on their Privileging Application or to be non-compliant with any of the above Guidelines may be subject to removal from the imaging network.

### Multi-Specialty Group Practice:

- A Multi-Specialty Group Practice (MSGP) is defined as a provider group operating at one or multiple locations and consisting of various provider specialty types. The MSGP is organized as a legal entity. Practices with affiliations (but no legal relationship) with other provider practices or groups do not qualify as MSGP.
- MSGP Privileging Applications will be reviewed on a case-by-case basis.
- The MSGP must meet the specific modality guidelines as defined in the Privileging Guidelines.

# High-Tech Radiology Provider Assessment

National Imaging Associates (NIA) mailed packets to non-hospital based imaging centers during February, 2008. Please complete the assessment information requested and return the packet immediately to:

National Imaging Associates, Inc.
11050 Olson Drive, Suite 200
Rancho Cordova, CA 95670

The provider assessment information may also be completed on-line at **www.RadMD.com**.

Imaging Centers must meet the terms and conditions and high-tech radiology guidelines (see page 2-5 of this newsletter) in order to remain a participating provider in the provider networks of Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation. Imaging Centers who do not meet the guidelines based on the information provided in the assessment will be terminated from the provider networks effective January 1, 2009.

Providers, who have not completed and returned the assessment information, please do so immediately. Site visit surveys may also be required in order to remain a participating provider in the networks. Providers who have not received a provider assessment packet should contact their regional Network Development Representative immediately.

Due to the length of time it takes to become accredited, all advanced imaging centers that are now applying to become a new participant in the networks of Arkansas Blue Cross, Health Advantage or USAble Corporation must first pass the NIA provider assessment program. In other words, if an imaging center that performs high-tech radiological procedures is not currently in these networks and is making application to become a network provider, the imaging center must first pass the NIA provider assessment program to receive a participating provider agreement.

# RadExpress Program to Pilot with Physicians

In September 2006, Arkansas Blue Cross and Blue Shield and Health Advantage began working with National Imaging Associates, Inc. (NIA) on prior authorization of outpatient imaging management services. Physicians who order high-tech scanning procedures (i.e., PET scans, CT scans, MRI/MRA or Nuclear Cardiology) for any individual or group member (except Medi-Pak, ARHealth [where Medicare is primary] or the Federal Employee Program) must obtain prior authorization before the scan is performed in order to be eligible for reimbursement.

Arkansas Blue Cross and Health Advantage appreciate the cooperation of their physicians and their staffs in helping to ensure good medical practices for their members and proper, efficient utilization of high-tech scanning procedures.

As a result of a successful program to date, Arkansas Blue Cross and Health Advantage will begin piloting the RadExpress Program that allows physicians meeting certain criteria to expedite authorizations even more quickly.

Providers may be eligible for the RadExpress Program if they meet all of the following criteria:

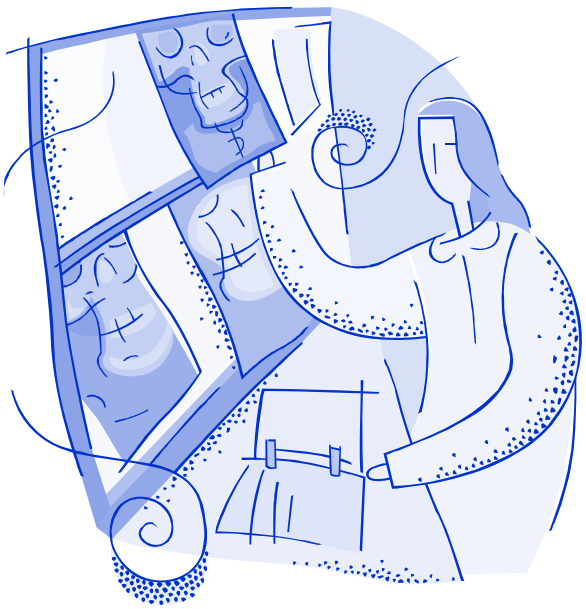
1. Provider has less than or equal to one request per quarter.
2. Provider has no financial interest (owns/lease/rent) in high-tech imaging equipment (CT scan, MRI/MRA scan, PET scan, or Nuclear Cardiology scans).
3. Providers with one or less request per month but greater than one request per quarter, are eligible for the program if there are no denials or withdrawals of requested procedures.

The RadExpress Program will continue to require providers to call NIA or use the online prior authorization request; however, an authorization will be issued without full clinical review. This process is necessary to gather member information and brief clinical information that will be analyzed on a quarterly basis to follow utilization patterns as well as to insure that appropriate criteria are met.

It will be necessary for the provider to continue to call in to request prior authorization so that an authorization number can be entered into the claims system for the claim to be paid.

More information will be forthcoming from Arkansas Blue Cross and Health Advantage. Physicians who qualify for the RadExpress Program will be notified by letter.

As a reminder, complete details are available through the Radiology Management Reference Guide and the Arkansas Blue Cross and Health Advantage Clinical Guidelines found on AHIN, on the Arkansas Blue Cross and Blue Shield or Health Advantage Web sites, and the National Imaging Web site at www.RadMD.com.



# Telemedicine Credentialing

The Arkansas State Medical Board Centralized Credentials Verification Services (CCVS) has increased their fee for initial credentialing profiles of telemedicine physicians to $225.00. Initial CCVS profiles for physicians licensed and practicing in Arkansas currently cost $60.00. Because of increased cost of verifying information with multiple state licensing boards and hospitals in different states, CCVS implemented the higher fee for telemedicine physicians as an alternative to an across the board increase on all other fees.

Provider Network Operations (PNO) division of Arkansas Blue Cross and Blue Shield does not charge a fee for the normal initial CCVS profile for physician applicants to the True Blue PPO and Health Advantage HMO networks. Due to the significant cost increase imposed on telemedicine physicians, PNO will require telemedicine physicians to pay a fee of $165.00 before processing their application to cover the additional cost to complete the credentialing application.

Applicants classified as telemedicine physicians by CCVS must include a check for $165.00 with their application for the True Blue PPO and Health Advantage HMO networks. Personal or company checks are the only acceptable payment method. Payment check and network application should be sent to:

Provider Network Administrator
Attn: Telemedicine Fee
P. O. Box 2181
Little Rock, AR 72203-2181

# Physician Connection Cost Comparison and Physician Quality Measure Reports

Physicians should have received information from Arkansas Blue Cross and Blue Shield in 2007 introducing several initiatives that were planned for roll-out to PPO and HMO members of USAble Corporation and Health Advantage, respectively (as well as to members of their affiliate company, Arkansas Blue Cross and Blue Shield).

The first initiative described was a Web-based tool titled “Physician Connection,” designed to measure physician specialty-specific quality of care in selected areas, and to help physicians identify quality standards in the selected areas, consistent with evidence-based guidelines.

The second initiative described was the “Personal Health Record”, a claims-based electronic medical record for members and physicians, with “care reminders” linked to the evidence-based guidelines measured in the “Physician Connection” tool.

The third initiative addressed cost comparison information for physicians. This initiative measures physician services utilizing claims data submitted to USAble, Health Advantage and Arkansas Blue Cross by physicians participating in the Arkansas Blue Cross and Blue Shield Preferred Payment Plan (PPP) network, USAble Corporation’s PPO networks and Health Advantage’s HMO network, and compares costs to the statewide physician specialty average.

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In addition, the three network-sponsoring companies, Arkansas Blue Cross and Blue Shield (PPP network), Health Advantage (HMO network) and USAble Corporation (True Blue PPO and Arkansas' FirstSource® PPO are pleased to announce another in this series – the Physician Quality Measures Report.

## Cost of Care Information

Some physicians have received information from Arkansas Blue Cross in July 2008 about their Cost of Care Index, a web-based report that is designed to provide health plan members with ready access to claims-based cost information about network-participating physicians. As the result of very helpful feedback and recommendations received from physicians and the Arkansas Medical Society, Arkansas Blue Cross has modified the way in which the Cost of Care Index is calculated and displayed on the member Web sites. The following changes have been implemented:

- For each physician specialty Arkansas Blue Cross has identified the core medical categories that are the most common types of cases treated by the physicians in that specialty. Only the core categories have been used to determine the physician and specialty Cost of Care indexes.

- Two peer group norms have been developed for those specialties that indicated different practices for rural and urban health care settings. These specialties are: Family Medicine/General Practice, Internal Medicine, Pediatric Medicine, and General Surgery. Population estimates from the U.S. Census Bureau were used to determine rural and urban practices.

- Likewise for cardiologists who are highly specialized, four specialty norms have been created – non-invasive, invasive (cardiac catherizations), interventional (stent and angioplasty), and electrophysiology.

- The nomenclature describing the web-based Cost of Care Index chart that our members will see includes the following descriptors: Lower Cost, Average, and Higher Cost and no longer mentions the term "cost efficiency". Members will *not* have access to a physician's Cost Comparison Report with the specific index and other numerical values included in that report.

- The statistical methodology was modified so that only 14 percent of network physicians are represented in the higher cost group with a confidence interval of 99.75 percent.

In arriving at this rating methodology, the network-sponsoring companies actively solicited, received and responded to input from the UAMS College of Public Health (COPH). In addition, as a means of further addressing any physician concerns about the particular rating methodology employed, the network-sponsoring companies are in discussion with the College of Public Health (COPH) on an oversight role for all Physician Connection cost and quality ratings released to the public.

The network sponsors also intend to establish an appeal process for the ratings published on member Web sites. Information on this new ratings-specific appeals process will be provided at a later date. In the interim, a physician from either the regional office in the physician's area, or from the central office in Little Rock, will be available to discuss the Cost of Care Index. Contact information for these physicians is included in this letter.

The Physician Connection Cost Comparison Report was mailed directly to physicians and cannot be accessed by patients (Arkansas Blue Cross, USAble or Health Advantage members). The only information regarding physician costs published on the applicable Web site for each PPO and HMO member (including Web sites of USAble/BlueAdvantage Administrators, Health Advantage and Arkansas Blue Cross and Blue Shield) will be the symbolic Cost of Care Index.

## Physician Quality Measures Report

This latest transparency initiative is designed to provide both statewide specialty-specific quality comparison data to the networks' members, as well as a confidential, physician-specific comparison for each rated network-participating physician. The generalized state-wide specialty-specific comparison, available on-line to members since March, 2008, does not identify any physician, but allows members to compare how all network participating physicians in various specialties compare, as a group, with recommended care guidelines.

By contrast, the confidential, physician-specific Physician Connection Quality Measures Report will provide each rated physician his or her adherence rates for those same recommended guidelines, as compared with other physicians in the same specialty. These confidential, physician-specific Quality Measures Reports are *not* available on-line and will ***not*** be disclosed to members.

The following should be kept in mind for the quality measures:

- The Quality Measures are intended to help physicians identify care practices and standards that are consistent with evidence-based guidelines of quality and appropriate-ness.

- The Quality Measures were drawn from nationally-accepted standards; for example, AQA (formerly the Ambulatory Care Quality Alliance), National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), American Medical Association, American College of Physicians (ACP), Agency for Healthcare Research and Quality (AHRQ), and Healthcare Effectiveness Data and Information Set (HEDIS). The Quality Measures also drew on an extensive review of the current guidelines of major specialty associations (American College of Cardiology, American College of Radiology, AMA, etc.).

- Because of their source and evidence-based grounding, the Quality Measures have broad clinical acceptance.

- In arriving at the Quality Measure methodology, the network-sponsoring companies actively solicited, received and responded to input from the UAMS College of Public Health (COPH). In addition, the Quality Measures were reviewed with:
  - A multispecialty UAMS Advisory Group
  - Arkansas Chapter of the American Academy of Pediatrics
  - Arkansas Chapter of the American College of Obstetrics and Gynecology
  - QIO: Arkansas Foundation for Medical Care
  - CMS: Physician Quality Reporting Initiative (PQRI)

- The Quality Measures were developed for the following specialties: Allergy/Immunology, Cardiology, Endocrinology, Family Medicine/ General Practice, Internal Medicine, Neurol-ogy, Obstetrics-Gynecology, Ophthalmology, Otolaryngology, Pediatric Medicine, Pulmo-nary Medicine, and Urology.

- In deciding upon each Quality Measure, the network sponsors favored *process* measures that are under control of the physician and are clearly linked to patient outcomes.

- The Quality Measures were derived from claims data available to the network sponsors and not medical review of patient charts.

- The network sponsors used a method of gen-erous attribution to all physicians treating the patient – if *any* treating physician of a given member performed the health intervention, then all treating physicians for that member were acknowledged as having performed the intervention.

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- The quality adherence rates were determined for a three-year period ending December 31, 2007. Therefore, **only services provided to patients during this time period** were used in calculating the percent of time that a particular Quality Measure was met.

Should providers have questions regarding either the Cost of Care or Quality Measure Report, please contact the regional office nearest you. The medical director for each region will be able to assist providers.

# Arkansas Blue Cross and Blue Shield Regional Offices

## Central Region – Little Rock

320 West Capitol, Suite 900
Little Rock, AR 72201
Phone: (501) 379-4649
**Network Development Rep:** Pat Fournier
**Network Development Rep:** Jan Hodges
**Medical Director:** Dr. Clement Fox

## Northeast Region – Jonesboro

707 East Matthews
Jonesboro, AR 72401
Phone: (870) 935-4871 or 1-800-299-4124
**Network Development Rep:** Alison Morrison
**Medical Director:** Dr. Connie Meeks

## Northwest Region - Fayetteville

516 E. Millsap, Suite 103
Fayetteville, AR 72703
Phone: (479) 527-2310 or 1-888-847-1900
**Network Development Rep:** Terry Rhoads
**Medical Director:** Dr. Ray Bredfeldt

## South Central Region - Hot Springs

100 Greenwood Avenue, Suite C
Hot Springs, AR 71913
Phone: (501) 620-2620 or 1-800-588-5733
**Network Development Rep:** Alessandra Hendrix
**Medical Director:** Dr. Al Thomas

## Southeast Region - Pine Bluff

1801 West 73rd Street
Pine Bluff, AR 71603
Phone: (870) 536-1223
**Network Development Rep:** Jason Aud
**Medical Director:** Dr. Kim Davis

## Southwest Region - Texarkana

1710 Arkansas Blvd.
Texarkana, AR 71854
Phone:(870) 773-2584 or 1-800-470-9621
**Network Development Rep:** Judith Stoken White
**Medical Director:** Dr. Michael Martin

## West Central Region - Fort Smith

3501 Old Greenwood Road, Suite 5
Fort Smith, AR 72903
Phone:(479) 648-1635 or 1-800-299-4060
**Network Development Rep:** Mark Blaty
**Medical Director:** Dr. Cygnet Schroeder

# Revisions to Terms and Conditions of Participation - True Blue and Health Advantage HMO

USAble Corporation, the sponsor of the True Blue PPO network, and Health Advantage, the sponsor of the Health Advantage HMO network, have revised the terms and conditions of participation for both networks by removing the requirement to maintain the highest level of hospital privileges at a network participating hospital. MDs, DOs, CRNAs, Oral Surgeons, and Psychologists have been required to maintain the highest level of hospital privileges available to them in a network participating hospital. The networks' terms and conditions had allowed exceptions to this requirement under specific circumstances as outlined in the terms and conditions. The requirement to maintain hospital privileges has now been eliminated.

While the maintenance of hospital privileges is no longer a requirement of network participation, the networks will continue to publish hospital affiliation information, as verified through the appropriate sources, on their websites for member access. In addition, the networks will continue to review network participants' hospital privileges status for any disciplinary actions or other restrictions. Any adverse history with respect to hospital privileges (including but not limited to revocation, limitation, suspension, restriction or voluntary or involuntary surrender while under investigation) may be grounds for termination or restriction of network participation, or exclusion from the networks.

For a complete statement of the new network participation standards with respect to hospital privileges, see the published "Terms and Conditions of Network Participation," as revised, posted to the websites of USAble Corporation / BlueAdvantage Administrators of Arkansas and Health Advantage.

# Claims: Insulin Syringes

The appropriate HCPCS Code to use when billing for a box of 100 insulin syringes is S8490. The allowances for the individual syringe (HCPCS Codes A4206—A4209, A4213—A4215) will be reduced effective October 1, 2008 to the cost of one syringe billed using HCPCS Code S8490. For any diagnosis other than diabetes, these codes will be denied as over the counter items.

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

## Article from the March 2008 issue of the Providers' News

**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).**

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

# AHIN: Pharmacy Prior Authorization

Prior authorizations for appropriate utilization are an important component in the pharmacy benefit design. This beneficial program is sometimes criticized for delaying Arkansas Blue Cross and Blue Shield members access to covered medications. Arkansas Blue Cross' pharmacy division recognizes that the prior authorization process for medications can cause delays and has been looking into ways to speed this process along.

The goal of Arkansas Blue Cross' pharmacy division is to have each request reviewed and a coverage determination made within 48 hours of receiving the requested information from the physician. If the physician fills out the questionnaire completely and there is no need for additional medical records, this goal is met effectively.

As part of an initiative to cut out inefficiencies and speed up the process for members, providers, and internal staff, Arkansas Blue Cross' pharmacy division has taken advantage of a computer software program already available in most Arkansas physician offices — Arkansas Blue Cross and Blue Shield's Advanced Health Information Network (AHIN).

Thanks to the AHIN staff, an online physician entry form for prior authorization questionnaires has been developed. Physicians will have the option of filling out the questionnaires online and submitting them through AHIN. By cutting out phone calls and multiple faxes, turnaround time is reduced from 48 hours to less than 24 hours. By enabling the physicians to enter the prior authorization information online, three time consuming steps are eliminated allowing Arkansas Blue Cross members to get coverage of their medication faster.

Please contact AHIN Customer Support at (501) 378-2336 for information regarding set up and training.

# Pharmacy — Lupron DEPOT and Sandostatin LAR

Mailings will be sent to both members and providers of the drugs **Lupron DEPOT** and **Sandostatin LAR**. These drugs previously required a prior authorization under the member's pharmacy benefit. Since these drugs are physician administered, these drugs will now be paid under the member's medical benefit and will be reviewed post service but before payment is issued. As a member's prior authorizations expire, their claims will be moved to medical.

Please note **Lupron** (different from Lupron DEPOT) and **Sandostatin** (different from Sandostatin LAR) are self administered drugs and will still be paid through the member's pharmacy benefit. These medications do require a prior authorization and are specialty drugs provided by Caremark Specialty Pharmacy.

If you have any questions, please call the Pharmacy Department at (501) 378-3392.

# Provider "Third Party Liability" or "Subrogation" Activities and Member Claims

Arkansas Blue Cross and Blue Shield would like to provide the following notice regarding applicable claims filing policies and procedures of Arkansas Blue Cross and its affiliate, Health Advantage, in situations in which a third party or their liability carrier are responsible for the injuries an Arkansas Blue Cross or Health Advantage member sustains (generally referred to for shorthand convenience as "Third Party Liability" or "Subrogation" matters). These policies and procedures have been in place for many years but are being restated for emphasis due to increasing Third Party Liability or Subrogation activities of some providers.

Providers are reminded that their network participation agreements obligate them to comply with all claims filing policies and procedures, including those published in *Providers' News*.

1. Arkansas Blue Cross and Blue Shield and Health Advantage encourage providers to *file all claims*, rather than holding such claims to pursue Third Party Liability or Subrogation. Filing the claim allows quick provision of any available health plan or insurance contract benefits to our members, and provides the fastest payment to providers.

2. Although filing of claims is strongly encouraged and preferred, Arkansas Blue Cross and Health Advantage provider contracts do not *require* that claims be filed with them, and recognize that state law specifically grants a lien to providers for Third Party Liability (i.e., providers can claim a part of any third party recovery the member may otherwise seek or be entitled to recover).

3. While Arkansas Blue Cross and Health Advantage understand this state lien law, and do not purport to change or challenge it, Arkansas Blue Cross and Health Advantage *do* require as an express term of their network participation agreements that participating providers must *not* pursue the *member* for any amounts in excess of the Arkansas Blue Cross or Health Advantage payment ("Excess Amounts") although participating providers may collect applicable member deductible, coinsurance or copayments. This means that while a provider can go after the *third party* or their carrier without violating their network participation agreement, the provider *cannot* attempt to recover "Excess Amounts" from the *member*. Any attempt to bill the member or collect against the member or their assets for Covered Services will be deemed a violation of the network participation agreement.

4. Providers are reminded that network participation agreements impose a 180-day timely filing requirement for all claims, and expressly bar collection – either from Arkansas Blue Cross or Health Advantage *or the member* – on claims not filed within 180 days. Thus, if a provider elects not to file a claim in favor of exclusively pursuing Third Party Liability or Subrogation, if that effort causes a delay in filing the claim past the 180-day filing deadline, providers cannot thereafter bill either the member or Arkansas Blue Cross or Health Advantage for any amount on such claims.

5. Providers are also reminded that while they may elect not to file a claim, members may still file the claim with Arkansas Blue Cross

or Health Advantage based on the provisions of their member certificate or evidence of coverage. If the member files a claim that a provider has withheld, Arkansas Blue Cross or Health Advantage will attempt to develop and process that member-submitted claim. Providers are contractually obligated in such circumstances to provide to Arkansas Blue Cross and Health Advantage information needed to evaluate and process the claim. Any payments determined due on such claims will be paid to the provider. Providers may not decline to accept the Arkansas Blue Cross or Health Advantage payment in such situations. If a provider does breach the participation agreement by declining to accept payment, Arkansas Blue Cross or Health Advantage will then make payment to the member. In either case, whether the payment is accepted or declined, and whether payment is made to the provider or the member (following provider refusal to accept), the provider cannot pursue collection against the member for Excess Amounts.

6. Arkansas Blue Cross and Health Advantage do not take a position regarding a provider's option to
   (a) file claims and receive the Arkansas Blue Cross or Health Advantage payment and also
   (b) pursue Third Party Liability or Subrogation for the remaining portion of their bills (the Excess Amounts).

   The only interest for Arkansas Blue Cross and Health Advantage is in ensuring that providers understand that once they become a participating provider in these networks, they *cannot pursue the member* for amounts beyond the Arkansas Blue Cross or Health Advantage payments.

7. To the extent that any of the preceding rules of network participation have not been clearly understood or interpreted by any provider or party, this *Providers' News* article shall be deemed to constitute notice of an amendment to the network participation agreement of Arkansas Blue Cross and Health Advantage participating providers.

8. With respect to Arkansas' FirstSource® PPO and True Blue PPO networks of USAble Corporation, the same policies and procedures as referenced above shall apply, with the only variation being that USAble Corporation is not a payer of any claims of self-funded groups that access these networks; accordingly, payment of all such self-funded group claims is always subject to funding and direction of the employer-sponsor as Plan Administrator of such plans.

# CPT Code: Modifier 47

CPT Code Modifier 47 (anesthesia by a surgeon) is **noncovered** by Arkansas Blue Cross and Blue Shield and its subsidiaries, similar to Medicare noncoverage. Payment for anesthesia provided by the performing surgeon (s) is included in the fee schedule allowance for the medical or surgical procedure.

It would be incorrect for the performing surgeon to provide anesthesia and bill using an anesthesia code (CPT Codes 00100-01999).

# Arkansas State & Public School Employees: Services Requiring Pre-Certification by AHH (American Health Holding)

Arkansas Blue Cross and Blue Shield continues to work with American Health Holding (AHH) to streamline the procedures that require pre-certification. The most recent changes to the list of services requiring pre-certification are noted in bold print below.

Prior to rendering any of the following services, providers must obtain an authorization number from American Health Holding (AHH) (1-800-592-0358). Clinical information will be required before an authorization number will be issued. If a provider calls without the clinical information or further review is required, a reference number will be issued. **A reference is not an authorization number**. Services should not be rendered until an authorization is received.

Effective June 1, 2008 any service listed below that is provided without a valid authorization by AHH will be denied. Services requiring AHH pre-certification include:

1. Acute Inpatient Hospital Admissions (includes Medical, Surgical, Obstetrics, Mental Health, Substance Abuse);
2. Medical Rehabilitation;
3. Skilled Nursing Facility (SNF);
4. Hospice InPatient - 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 outpatient surgical procedures:
   - Intradiscal Electrothermal Therapy (IDET;)
   - Uvulopalatropharyngoplasty (UPPP);
   - **Varicose vein excision and ligation – pre-cert required for services in OP setting and in MD office locations;**
   - Blepharoplasty and/or brow lift;
   - **Mastectomy for Gynomastia only;**
   - Mammoplasty (reduction or augmentation)
   - Septoplasty/Rhinoplasty;
   - Ventral hernia repair;
   - Scar revision; and
   - Procedures related to TMJ/TMD (member must be in case management).
8. Outpatient Diagnostic:
   - MRI;
   - CT;
   - MRA; and
   - PET Scan.
9. **Observation — does not require pre-certification regardless of the time the patient remains in Observation.**
10. **Outpatient chemotherapy—please notify AHH so the patient may be assigned a case manager. Claims will not be denied for no pre-certification.**
11. Outpatient Physical Therapy, Occupational Therapy, Speech Therapy (includes these services performed in a physician's office or home setting).
12. Outpatient Mental Health/Substance Abuse;
13. Physician Office Mental Health/Substance Abuse;
14. Outpatient Pain Management Medication Therapy - Pre-certification required for the pain management narcotic pumps only.
15. Enteral Feeds;
16. Home Health Care;
17. Home Hospice;
18. Durable Medical Equipment (DME) & Prosthetics - Pre-certification is required for prosthetics, DME and DME repairs over $1,000.00.
19. If other Commercial Insurance is Primary (does not apply to Medicare and Workers Comp).

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20. Transplants;
    - Pre-notification is required for all solid organ and stem cell transplants.
    - All transplants, except kidney and cornea, 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.
21. Temporomandibular Joint (TMJ/TMD) Member must be in case management.
22. Wound Vacs;

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

# "Mommy 2-B" Program Offered to Arkansas State and Public School Employees

The Employee Benefits Division (EBD), group administrator for the Arkansas State and Public School Employees, is now offering a new program for all maternity members of the Arkansas State and Public School Employees group.

The goal of the program is to decrease the number of premature births and pregnancy complications through education and support. Expecting mothers who call to enroll in the program will receive a 'Mommy 2 B' packet and calls from a case manager throughout their pregnancy.

Upon satisfactory completion of the program, the member will receive a one-time credit (per pregnancy) of the $250 in-patient copayment. To enroll in the program the expectant mother must call the Employee Benefits Division at (501) 684-5779 or (866) 451-8194.

# Paper Remittance Advice Revisions

The following changes are being made to the paper Remittance Advice (RA) for Arkansas Blue Cross and Blue Shield effective November 3, 2008.

- The dollar fields for **Total Charges**, **Non-Covered Charges**, **Other Insurance Paid**, and **Provider Payment** have been expanded to eleven positions including two decimals.
- The dollar field for the **Deductible** field was expanded from seven positions (including two decimals) to eight positions (including two decimals).
- The **Units of Service** field and the **DRG** field was expanded from three to four positions.
- The **Patient Responsibility**, **Provider Responsibility**, and **Provider Write-Off** fields were also expanded by 1 position. These fields will now allow a maximum of $999,999,999.99, which will contain commas and a decimal point.

The **Coinsurance** field, currently eight positions (including two decimals), did not change. The **Type of Service** and **Place of Service** columns have been removed.

This change does not apply to the Federal Employee Program (FEP).

# Personal Health Records Now Available!

## Article from the March 2008 issue of the Providers' News

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 un-necessary 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.

This change does not apply to the Federal Employee Program (FEP).

# NPI Required on Customer Service Emails

The templates for emails sent to Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation customer service are being updated to require a provider's NPI number instead of the Arkansas Blue Cross and Blue Shield 5-digit provider number. Since May 2008, an NPI is required for all telephone customer service inquiries .

The "Provider Number" field will currently accept an NPI, so please begin using an NPI in this field immediately to ease the transition. The "Provider Number" field will be updated to state "NPI number". The NPI will be a required field on all customer services emails beginning November 1, 2008

# 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 June 2008. 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 Name |
|---|---|
| 1997005 | Ambulatory Blood Pressure Monitoring |
| 1997031 | Alglucerase |
| 1997041 | Continuous Passive Motion Device |
| 1997111 | Intracardiac Electrophysiologic Studies |
| 1997113 | Immune Globulin, Intravenous and Subcutaneous |
| 1997155 | Ileal Bypass for Hypercholesterolemia |
| 1997188 | RAST Tests |
| 1997190 | Stem Cell Growth Factors, Epoetin |
| 1997251 | Pain Management, Transforaminal Nerve Block |
| 1998001 | Brachytherapy, Prostate |
| 1998023 | Ultrasound Accelerated Fracture Healing Device |
| 1998025 | Home Phototherapy for Neonatal Jaundice |
| 1998041 | Allergy Testing |
| 1998053 | Cervicography |
| 1998099 | Electrical Stimulation, Deep Brain (e.g. Parkinsonism, dystonia, multiple sclerosis, post-traumatic dyskinesia) |
| 1998105 | Transplant, Lung and Lobar Lung |
| 1998119 | Viscosupplementation for the Treatment of Osteoarthritis of the Knee |
| 1998140 | Verticle Expandable Prosthetic Titanium Rib |
| 1998144 | Pulmonary Arterial Hypertension, Pharmacological Treatment with Prostacyclin Analogues, Endothelin Receptors Antagonists, or Phosphodiesterase Inhibitors |
| 1998150 | Angioplasty - Stenting, Percutaneous, Carotid Artery |
| 1998154 | Electrical Stimulation, Transcutaneous Electrical Nerve Stimulator |
| 1998158 | Trastuzumab |

| Policy # | Policy Name |
|---|---|
| 1998161 | Infliximab (Remicade) |
| 1998163 | Stem Cell Growth Factors, Epoetin Alfa for Preoperative Elective Surgery |
| 1999013 | Endobronchial Brachytherapy |
| 2000016 | Apheresis, Lowering LDL Cholesterol (Lipid Apheresis |
| 2000034 | Hyperhidrosis Treatment |
| 2000050 | HDC & Autologous or Allogeneic Stem Cell Support-Epithelial Ovarian Cancer |
| 2001002 | Home Uterine Activity Monitor |
| 2001013 | Nerve Graft For Patients Undergoing Radical Non-Nerve-Sparing Prostatectomy |
| 2001040 | PET Scan, Positron Emission Tomography for Testicular Germ Cell Cancer |
| 2002007 | Varicose Veins: Endoluminal Radiofrequency or Laser Ablation |
| 2002011 | Brachytherapy, Breast |
| 2002016 | T-Wave Alternans |
| 2002025 | Donor Leukocyte Infusion |
| 2002027 | Sildenafil (Revatio) for Pulmonary Hypertension |
| 2003031 | Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee |
| 2004005 | Magnetic Resonance Spectroscopy |
| 2004011 | Photodynamic Therapy for Dermatologic Conditions |
| 2004023 | Ketogenic Diet as a Treatment for Refractory Epilepsy |
| 2004027 | Stem Cell Growth Factor, Darbepoetin |
| 2004029 | Genetic Test: Breast Cancer; Risk Recurrence to Determine Need for Adjuvant Therapy (Oncotype DX) |
| 2005009 | Palatal Stiffening Procedures |
| 2006016 | Rituximab (Rituxan), Off-label Use |
| 2006032 | Interspinous Distraction Devices (Spacers) |
| 2007012 | Genetic Test: Breast Ca Predict Need Adjuvant Chemotherapy, Assessment of Risk of Distant Metastasis (Mammaprint) |
| 2007023 | Genetic Test: Carbamazepine HLA-B*1502 |
| 2008017 | PathFinderTG® Molecular Testing |
| 2008018 | Stem Cell Growth Factors, pegfilgrastim |
| 2008019 | Reverse Shoulder Arthroplasty |
| 2008021 | Radiofrequency Treatment of Barrett's Esophagus |

# Access Only Reminder

Neither Arkansas Blue Cross and Blue Shield nor USAble Corporation is responsible for payment of any Access Only claims. Providers must look to the employer/sponsor of Access Only groups for all payment with respect to such claims.

Access Only claims should be submitted directly to Arkansas Blue Cross. The claims will be priced and automatically forwarded to the third party administrator (TPA) for adjudication.

Providers should call the Customer Service number on the back of the card regarding payment, denial, benefits or eligibility. These questions must be directed to the appropriate group TPA responsible for adjudicating the claim. Should you have pricing questions please call (501) 378-2164.

Please refer to page 24 of the December 2007 Provider News for a complete list of Access Only groups.

# Reminder: Clinic Visits Billed by a Facility

Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation do not recognize facility charges for clinic visits. Facility charges for services performed in a clinic should be billed under revenue codes 0510-0519. These services will be denied and charges for these services should not be collected from Arkansas Blue Cross policyholders. Covered services performed in a clinic will be reimbursed when billed on a professional claim.

# Dental: Filing a Medical Claim on the Dental Claims Form

Arkansas Blue Cross and Blue Shield prefers general dentists and oral surgeons file medical claims on the CMS 1500 (08-05) claim form with the appropriate CPT/HCPCS procedure codes and ICD-9 codes. However, Arkansas Blue Cross understands that not all dental offices have software for the CMS 1500 (08-05) claim form. Therefore, dentists may file a paper claim for a medical service on the 2006 American Dental Association (ADA) Claim Form for all lines of business related to Arkansas Blue Cross.

Certain information is **required** in order for a medical claim to be processed correctly when it is filed on a dental claim form. Dentists should follow the normal guidelines for completing a dental claim form with the following exceptions:

- **Upper Right Hand Corner of Form:** The wording “Medical Claim” or “For Medical Benefits” should be written in large black letters in the upper right hand corner of the claim form. This wording alerts the mailroom

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to send the claim to the appropriate product line and not to the dental carrier.

- **Field 3 – Name, Address, City, State, Zip Code:** Enter the name of the medical insurance plan and address (i.e., Arkansas Blue Cross, Health Advantage, Blue Advantage, etc.). If the claim is for an out-of-state Blue Cross plan, enter the name of the particular plan. All out-of-state Blue Cross claims should be mailed to Arkansas Blue Cross. Information for field 3 is located on the member's identification card.

- **Field 15 – Subscriber Identifier:** Enter the member's ID number exactly as it appears on the member's medical ID card, including the 3 digit alpha prefix.

- **Record of Service Provided (Fields 24—33):** Enter the appropriate dental code.

- **Anesthesia, if Applicable to the Performing Provider** – When dental anesthesia is provided with a medical procedure, it should be billed as follows:
  - D9220 – 1 unit for first 30 minutes and
  - D9221 – 1 unit for each additional 15 minutes after the first 30 minutes.

- **Field 35 – Remarks:** Enter the medical diagnosis code(s). If the claim is due to an accident, enter the medical diagnosis code as primary and the accident diagnosis code as secondary. For the exact diagnosis code, please refer to the most current ICD-9 Diagnosis Code book. Providers may include a description of the diagnosis.

- **Field 46 – Date of Accident:** If service is related to an accident, enter the date the accident occurred.

### Filing as a Clinic Using the Clinic and Performing Provider NPI Numbers:

- **Field 48 – Name, Address, City, State, Zip Code**: Enter the clinic's name and address.

- **Field 49 – NPI:** Enter the 10-digit NPI of the clinic.

- **Field 54 – NPI:** Enter the 10-digit NPI of the servicing dental provider.

### Filing as the Performing Provider (not part of a clinic) Using the Performing Provider NPI Number:

- **Field 48 – Name, Address, City, State, Zip Code:** Enter the billing provider's name and address.

- **Fields 49 & 54 – NPI:** Enter the 10-digit NPI of the billing provider.

### Accidents:

Include the Accident Form for Dental Injury with the claim.

### Handwritten Claims:

Arkansas Blue Cross and Blue Shield does not accept handwritten claims. Handwritten claims will be returned to the provider.

Other than the above instructions, dentists should follow normal claims filing guidelines.

### Oral Surgeons:

Oral surgeons should file medical claims on the CMS 1500 (08-05) claim form and use the appropriate CPT/HCPCS procedure codes and ICD-9 diagnosis codes. Please note how to file anesthesia as stated above under item #5. Tooth numbers, if appropriate, should be entered in field 19 on the CMS 1500 form.

# Dental Fee Schedule

The following dental codes were updated on the Arkansas Blue Cross and Blue Shield fee schedule effective September 15, 2008.

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D0120 | Periodic oral examination | $ 27.00 |
| D0140 | Limited oral evaluation - problem focused | $ 36.00 |
| D0145 | Oral evaluation - patient under 3 | $ 28.00 |
| D0150 | Comprehensive oral examination | $ 37.00 |
| D0160 | Detailed and extensive oral evaluation (problem focused) | $ 50.00 |
| D0180 | Comprehensive periodontal evaluation | $ 50.00 |
| D0210 | Intraoral - complete series (including bitewings) | $ 87.00 |
| D0220 | Intraoral - periapical-first film | $ 18.00 |
| D0230 | Intraoral - periapical-each additional film | $ 15.00 |
| D0240 | Intraoral - occlusal film | $ 25.00 |
| D0250 | Extraoral - first film | $ 35.00 |
| D0260 | Extraoral - each additional film | $ 20.00 |
| D0270 | Bitewing - single film | $ 18.00 |
| D0272 | Bitewings - two films | $ 26.00 |
| D0273 | Bitewings - three films | $ 30.00 |
| D0274 | Bitewings - four films | $ 35.00 |
| D0277 | Vertical bitewings - 7 to 8 films | $ 60.00 |
| D0330 | Panoramic film | $ 67.00 |
| D0340 | Cephalometric film | $ 70.00 |
| D0460 | Pulp vitality tests | $ 25.00 |
| D0470 | Diagnostic casts | $ 40.00 |
| D1110 | Prophylaxis - adults | $ 48.00 |
| D1120 | Prophylaxis - child | $ 33.00 |
| D1201 | Topical application of fluoride (including prophy)-child | $ 52.00 |
| D1203 | Topical application fluoride - child | $ 19.00 |

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D1204 | Topical fluoride without prophy - adult | $ 19.00 |
| D1206 | Topical fluoride varnish for high caries risk patients | $ 19.00 |
| D1351 | Sealant - per tooth | $ 29.00 |
| D1510 | Space maintainer - fixed unilateral | $ 180.00 |
| D1515 | Space maintainer - fixed-bilateral | $ 250.00 |
| D1550 | Recementation of space maintainer | $ 40.00 |
| D2140 | Amalgam - one surface, primary or permanent | $ 68.00 |
| D2150 | Amalgam - two surfaces, primary or permanent | $ 83.00 |
| D2160 | Amalgam - three surfaces, primary or permanent | $ 98.00 |
| D2161 | Amalgam - four surfaces, primary or permanent | $ 118.00 |
| D2330 | Resin - one surface, anterior | $ 83.00 |
| D2331 | Resin - two surfaces, anterior | $ 104.00 |
| D2332 | Resin - three surfaces, anterior | $ 125.00 |
| D2335 | Resin - four or more surfaces or involving incisal angle (anterior) | $ 160.00 |
| D2390 | Resin-based composite crown, anterior | $ 160.00 |
| D2391 | Resin-based composite - one surface, posterior | $ 93.00 |
| D2392 | Resin-based composite - two surfaces posterior | $ 123.00 |
| D2393 | Resin-based composite - three surfaces, posterior | $ 155.00 |
| D2394 | Resin-based composite - four or more surfaces, posterior | $ 165.00 |
| D2510 | Inlay - metallic - one surface | $ 380.00 |
| D2520 | Inlay - metallic - two surfaces | $ 480.00 |
| D2530 | Inlay - metallic - three surfaces | $ 520.00 |
| D2542 | Onlay - metallic - two surfaces | $ 500.00 |
| D2543 | Onlay-metallic - three surfaces | $ 550.00 |
| D2544 | Onlay-metallic - four or more surfaces | $ 615.00 |
| D2610 | Inlay - porcelain/ceramic - one surface | $ 450.00 |
| D2620 | Inlay - porcelain/ceramic - two surfaces | $ 500.00 |
| D2630 | Inlay - porcelain/ceramic - three surfaces | $ 620.00 |
| D2642 | Onlay- porcelain/ceramic - two surfaces | $ 625.00 |
| D2643 | Onlay-porcelain/ceramic - three surfaces | $ 650.00 |
| D2644 | Onlay-porcelain/ceramic - four or more surfaces | $ 675.00 |

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D2650 | Inlay - composite/resin - one surface | $ 425.00 |
| D2651 | Inlay - composite/resin - two surface | $ 450.00 |
| D2652 | Inlay - composite/resin - three or more surfaces | $ 515.00 |
| D2662 | Onlay - composite/resin - two surfaces | $ 570.00 |
| D2663 | Onlay - composite/resin - three surfaces | $ 615.00 |
| D2740 | Crown - porcelain/ceramic substrate | $ 730.00 |
| D2750 | Crown - porcelain fused to high noble metal | $ 700.00 |
| D2751 | Crown - porcelain fused to predominantly base metal | $ 600.00 |
| D2752 | Crown - porcelain fused to noble metal | $ 640.00 |
| D2780 | Crown - 3/4 cast high noble metal | $ 645.00 |
| D2781 | Crown - 3/4 cast predominately base metal | $ 600.00 |
| D2782 | Crown - 3/4 cast noble metal | $ 610.00 |
| D2783 | Crown - 3/4 porcelain/ceramic (not veneers) | $ 725.00 |
| D2790 | Crown - full cast high noble metal | $ 645.00 |
| D2791 | Crown - full cast predominantly base metal | $ 580.00 |
| D2792 | Crown - full cast noble metal | $ 600.00 |
| D2910 | Recement inlay | $ 50.00 |
| D2920 | Recement crown | $ 50.00 |
| D2930 | Prefabricated stainless steel crown - primary tooth | $ 140.00 |
| D2931 | Prefabricated stainless steel crown - permanent tooth | $ 140.00 |
| D2932 | Prefabriated resin crown | $ 152.00 |
| D2933 | Prefabricated stainless steel crown with resin window | $ 180.00 |
| D2950 | Core buildup, including any pins | $ 128.00 |
| D2951 | Pin retention - per tooth, in addition to restoration | $ 45.00 |
| D2952 | Cast post & core in addition to crown | $ 228.00 |
| D2954 | Prefabricated post & core in addition to crown | $ 180.00 |
| D2962 | Labial veneer (porcelain laminate) - lab | $ 700.00 |
| D2980 | Crown repair, by report | $ 125.00 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) | $ 95.00 |
| D3310 | Root canal therapy - anterior (excluding final restoration) | $ 430.00 |
| D3320 | Root canal therapy - bicuspid (excluding final restoration) | $ 500.00 |

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D3330 | Root canal therapy - molar (excluding final restoration) | $ 630.00 |
| D3346 | Retreatment of previous root canal therapy - anterior | $ 510.00 |
| D3347 | Retreatment of previous root canal therapy - bicuspid | $ 570.00 |
| D3348 | Retreatment of previous root canal therapy - molar | $ 700.00 |
| D3351 | Apexification/recalcification - initial visit | $ 155.00 |
| D3352 | Apexification/recalcification - interim medication replacement | $ 100.00 |
| D3353 | Apexification/recalcification - final visit | $ 300.00 |
| D3410 | Apicoectomy/periradicular surgery - anterior | $ 400.00 |
| D3421 | Apicoectomy/periradicular surgery - bicuspid ( first root) | $ 495.00 |
| D3425 | Apicoectomy/periradicular surgery - molar (first root) | $ 600.00 |
| D3426 | Apicoectomy/periadicular surgery- each addt'l root | $ 185.00 |
| D3430 | Retrograde filling - per root | $ 120.00 |
| D3450 | Root amputation - per root | $ 200.00 |
| D3920 | Hemisection (including any root removal) | $ 260.00 |
| D3950 | Canal preparation & fitting of preformed dowel or post | $ 120.00 |
| D4210 | Gingivectomy/gingivoplasty - one to three teeth, per quadrant | $ 250.00 |
| D4211 | Gingivectomy/gingivoplasty - per tooth | $ 105.00 |
| D4240 | Gingival flap, including root planing - per quadrant | $ 315.00 |
| D4241 | Gingival flap, including root planing - one to three teeth, per quadrant | $ 168.00 |
| D4249 | Crown lengthening - hard/soft tissue, by report | $ 350.00 |
| D4260 | Osseous surgery (including flap entry & closure - four or more teeth per quadrant) | $ 600.00 |
| D4261 | Osseous surgery (including flap entry & closure - one to three teeth, per quadrant) | $ 350.00 |
| D4263 | Bone replacement graft - single site | $ 350.00 |
| D4264 | Bone replacement graft - each additional site in quadrant | $ 200.00 |
| D4266 | Guided tissue regeneration - resorbable barrier, per site | $ 380.00 |
| D4267 | Guided tissue regeneration - nonresorbable barrier, per site | $ 250.00 |
| D4270 | Pedicle soft tissue graft procedure | $ 300.00 |
| D4271 | Free soft tissue graft procedure (including donor site) | $ 475.00 |
| D4273 | Subepithelial connective tissue graft procedure | $ 450.00 |

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D4275 | Soft tissue allograft | $ 475.00 |
| D4276 | Combined connective tissue and double pedicle graft | $ 550.00 |
| D4341 | Periodontal scaling and root planing - per quadrant | $ 155.00 |
| D4342 | Periodontal scaling and root planing - 1 to 3 teeth, per quadrant | $ 90.00 |
| D4910 | Periodontal maintenance (following active therapy) | $ 70.00 |
| D5110 | Complete denture - upper | $ 870.00 |
| D5120 | Complete denture - lower | $ 870.00 |
| D5130 | Immediate denture - upper | $ 920.00 |
| D5140 | Immediate denture - lower | $ 920.00 |
| D5211 | Upper partial - resin base (with conventional clasps,rests & teeth | $ 615.00 |
| D5212 | Lower partial - resin base (with conventional clasps,rests & teeth | $ 615.00 |
| D5213 | Upper partial - cast metal base with resin saddles | $ 1,000.00 |
| D5214 | Lower partial - cast metal base with resin saddles | $ 1,000.00 |
| D5225 | Maxillary partial denture - flexible base (incl. Clasps, rests, teeth) | $ 1,000.00 |
| D5226 | Mandibular partial denture - flexible base (incl. Clasps, rests, teeth) | $ 1,000.00 |
| D5281 | Removable unilateral partial denture -1 piece cast metal | $ 550.00 |
| D5410 | Adjust complete denture - upper | $ 40.00 |
| D5411 | Adjust complete denture - lower | $ 40.00 |
| D5421 | Adjust partial denture - upper | $ 40.00 |
| D5422 | Adjust partial denture - lower | $ 40.00 |
| D5510 | Repair broken complete denture base | $ 100.00 |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | $ 100.00 |
| D5610 | Repair resin saddle or base | $ 100.00 |
| D5620 | Repair cast framework | $ 155.00 |
| D5630 | Repair or replace broken clasp | $ 132.00 |
| D5640 | Replace broken teeth - per tooth | $ 85.00 |
| D5650 | Add tooth to existing partial denture | $ 115.00 |
| D5660 | Add clasp to existing partial denture | $ 145.00 |
| D5670 | Replace all teeth and acrylic on cast metal frame work (maxillary) | $ 550.00 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | $ 550.00 |
| D5710 | Rebase complete upper denture | $ 300.00 |

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D5711 | Rebase complete lower denture | $ 300.00 |
| D5720 | Rebase upper partial denture | $ 300.00 |
| D5721 | Rebase lower partial denture | $ 300.00 |
| D5730 | Reline complete upper denture (chairside) | $ 175.00 |
| D5731 | Reline complete lower denture (chairside) | $ 175.00 |
| D5740 | Reline upper partial denture (chairside) | $ 175.00 |
| D5741 | Reline lower partial denture (chairside) | $ 175.00 |
| D5750 | Reline complete upper denture (lab) | $ 275.00 |
| D6210 | Pontic - cast high noble metal | $ 635.00 |
| D6211 | Pontic - cast predominantly base metal | $ 570.00 |
| D6212 | Pontic - cast noble metal | $ 660.00 |
| D6240 | Pontic - porcelain fused to high noble metal | $ 670.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal | $ 580.00 |
| D6242 | Pontic - porcelain fused to noble metal | $ 645.00 |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis | $ 300.00 |
| D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis | $ 260.00 |
| D6600 | Inlay - porcelain/ceramic , two surfaces | $ 500.00 |
| D6601 | Inlay - porcelain/ceramic, three or more surfaces | $ 500.00 |
| D6602 | Inlay - cast high noble metal, two surfaces | $ 475.00 |
| D6603 | Inlay - cast noble metal, three or more surfaces | $ 525.00 |
| D6604 | Inlay - cast predominantly base metal, two surfaces | $ 495.00 |
| D6605 | Inlay - cast predominantly base metal, three or more surfaces | $ 525.00 |
| D6606 | Inlay - cast noble metal, two surfaces | $ 450.00 |
| D6607 | Inlay - cast noble metal, three or more surfaces | $ 495.00 |
| D6608 | Onlay - porcelain/ceramic , two surfaces | $ 500.00 |
| D6609 | Onlay - porcelain/ceramic , three or more surfaces | $ 525.00 |
| D6610 | Onlay - cast high noble, two surfaces | $ 610.00 |
| D6611 | Onlay - cast high noble metal, three or more surfaces | $ 610.00 |
| D6612 | Onlay - cast predominantly base metal, two surfaces | $ 500.00 |
| D6613 | Onlay - cast predominantly base metal, three or more surfaces | $ 510.00 |
| D6614 | Onlay - cast noble metal, two surfaces | $ 525.00 |

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D6615 | Onlay - cast noble metal, three or more surfaces | $ 530.00 |
| D6740 | Crown - porcelain / ceramic | $ 730.00 |
| D6750 | Crown - porcelain fused to high noble metal | $ 700.00 |
| D6751 | Crown - porcelain fused to predominantly base metal | $ 585.00 |
| D6752 | Crown - porcelain fused to noble metal | $ 650.00 |
| D6780 | Crown - 3/4 cast high noble | $ 590.00 |
| D6781 | Crown 3/4 cast predominately based metal | $ 555.00 |
| D6782 | Crown 3/4 noble metal | $ 565.00 |
| D6783 | Crown 3/4 porcelain / ceramic | $ 625.00 |
| D6790 | Crown - full cast high noble metal | $ 655.00 |
| D6791 | Crown - full cast predominantly base metal | $ 570.00 |
| D6792 | Crown - full cast noble metal | $ 600.00 |
| D6930 | Recement bridge | $ 65.00 |
| D6970 | Cast post & core in addition to bridge retainer | $ 225.00 |
| D6971 | Cast post as part of bridge retainer | $ 175.00 |
| D6972 | Prefabricated post and core in addition to bridge retainer | $ 160.00 |
| D6973 | Core build-up or retainer, including any pins | $ 150.00 |
| D6980 | Bridge repair - by report | $ 160.00 |
| D7111 | Coronal remnants - deciduous tooth | $ 50.00 |
| D7140 | Extraction, erupted tooth or exposed root | $ 80.00 |
| D7210 | Surgical removal of erupted tooth | $ 150.00 |
| D7220 | Removal of impacted tooth - soft tissue | $ 190.00 |
| D7230 | Removal of impacted tooth - partially bony | $ 230.00 |
| D7240 | Removal of impacted tooth - completely bony | $ 265.00 |
| D7241 | Removal of impacted tooth - completely bony with complications | $ 335.00 |
| D7250 | Surgical removal of residual tooth roots - cutting procedures | $ 160.00 |
| D7260 | Oral antral fistula closure | $ 250.00 |
| D7261 | Primary closure of a sinus perforation | $ 300.00 |
| D7280 | Surgical exposure of impacted or unerupted tooth - ortho | $ 200.00 |
| D7281 | Surgical exposure of impacted or unerupted tooth to aid eruption | $ 200.00 |
| D7310 | Alveoplasty in conjunction with extractions - per quadrant | $ 150.00 |

| CPT/ HCPCS Code | Description | Allowance |
|---|---|---|
| D7311 | Alveoplasty in conjunction with extractions - 1 to 3 , per quad | $ 75.00 |
| D7320 | Alveoplasty not in conjunction with extractions - per quadrant | $ 160.00 |
| D7321 | Alveoplasty not in conjuct. with extractions - one/three, per quad | $ 80.00 |
| D7340 | Vestibuloplasty - ridge extension (secondary epithelialization) | $ 290.00 |
| D7471 | Removal of exostosis - maxilla or mandible | $ 260.00 |
| D7472 | Removal of torus palatinus | $ 260.00 |
| D7473 | Removal of torus mandibularis | $ 260.00 |
| D7485 | Surgical reduction of osseous tuberosity | $ 260.00 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | $ 92.00 |
| D7530 | Removal of foreign body, skin, or subcutaneous alveolar tissue | $ 130.00 |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body | $ 280.00 |
| D7960 | Frenulectomy - separate procedure | $ 200.00 |
| D7970 | Excision of hyperplastic tissue-per arch | $ 235.00 |
| D7971 | Excision of pericoronal gingiva | $ 100.00 |
| D8010 | Limited orthodontic treatment of primary dentition | $ 1,000.00 |
| D8020 | Limited orthodontic treatment of transitional dentition | $ 1,000.00 |
| D8030 | Limited orthodontic treatment of adolescent dentition | $ 1,000.00 |
| D8040 | Limited orthodontic treatment of adult dentition | $ 1,200.00 |
| D8050 | Interceptive orthodontic treatment of the primary dentition | $ 2,000.00 |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | $ 2,000.00 |
| D8070 | Comprehensive ortho treatment of the transitional dentition | $ 5,000.00 |
| D8080 | Comprehensive ortho treatment of the adolescent dentition | $ 6,000.00 |
| D8090 | Comprehensive ortho treatment of the adult dentition | $ 7,000.00 |
| D8210 | Removable appliance therapy | $ 1,000.00 |
| D8220 | Fixed appliance therapy | $ 1,200.00 |
| D8680 | Orthodontic retention | $ 500.00 |
| D8693 | Rebonding or recementing and/or repair, fixed retainers | $ 40.00 |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedures | $ 46.00 |
| D9220 | Deep sedation (unconscious)/general anesthesia - first 30 minutes | $ 250.00 |
| D9221 | Deep sedation (unconscious)/general anesthesia - each additional 15 minutes | $ 65.00 |
| D9940 | Occlusal guards - by report | $ 300.00 |

# Home Infusion Therapy Services

The following HCPCS codes for Home Infusion Therapy Services will be updated on the Arkansas Blue Cross and Blue Shield fee schedule effective September 1, 2008.

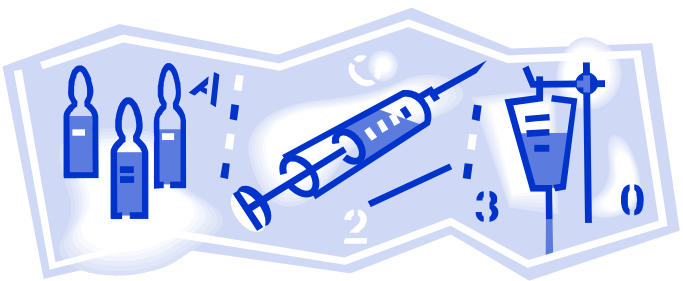
## Article from the June 2008 issue of the Providers' News

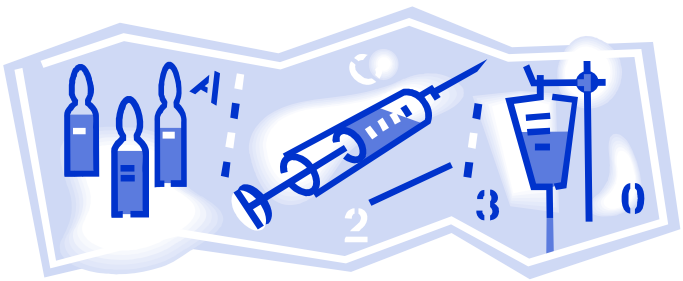
| HCPCS Code | Description | Updated Fee (per diem) |
|---|---|---|
| S9325 | Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately). (Do not use this code with S9326,S9327 or S9328.) | $ 32 |
| S9326 | Home infusion therapy, **continuous** (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment per diem (drugs and nursing visits coded separately). | $ 32 |
| S9330 | Home Infusion Therapy; **continuous** (24 hours or more) chemotherapy Infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment per day (drugs and nursing visits coded separately). | $ 38 |
| S9331 | Home Infusion Therapy; **intermittent** (less then 24 hours) chemotherapy Infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment per day (drugs and nursing visits coded separately). | $ 38 |
| S9373 | Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately). (Do not use with hydration therapy codes S9374-S9377 with daily volume scales.) | $ 32 |
| S9374 | Home infusion therapy, hydration therapy; **one liter per day** | $ 32 |
| S9375 | Home Infusion therapy, hydration therapy; **more than one liter but no more than two liters per day** | $ 32 |
| S9376 | Home Infusion Therapy, hydration therapy; **more than two liters but not more than three liters per day** | $ 32 |

*(Continued from page 32)*

## Home Infusion Therapy Services (continued)

| HCPCS Code | Description | Updated Fee (per diem) |
|---|---|---|
| S9377 | Home infusion therapy, hydration therapy; **more than three liters per day** | $ 32 |
| S9494 | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately). (Do not use with home infusion codes for hourly dosing schedules S9497—S9504.) | $ 45 |
| S9497 | Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every three hours** | $ 45 |
| S9500 | Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 24 hours** | $ 45 |
| S9501 | Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 12 hours** | $ 45 |
| S9502 | Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 8 hours** | $ 45 |
| S9503 | Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 6 hours** | $ 45 |
| S9504 | Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 4 hours** | $ 45 |





# Home Health Agencies Codes

The following HCPCS codes for Home Health Agencies will be updated on the Arkansas Blue Cross and Blue Shield fee schedule effective October 15, 2008.

| Revenue Code | CPT/ HCPCS Code | Description | Allowance | Comments |
|---|---|---|---|---|
| 571 (Home Health Aide Visit) | 99600 | Unlisted home health service or procedure | Per Case Manager | This code and service only paid when pre-approved by case management. Detailed description of service will likely be requested. |
| 552 | S9123 | Nursing care, in the home; by RN, per hour | $30.00 Per hour | This code and service only paid when pre-approved by case management. Detailed description of service will likely be requested. |
| 572 | S9122 | Home health aide or certified nurse assistant, per hour. | $17.00 Per Hour | One unit equals one hour. This service will require case management approval. Four hours/units equals one Home Health Aide visit |
| 552 | S9124 | Nursing care, in the home; by LPN, per hour | $26.00 Per hour | This code and service only paid when pre-approved by case management. Detailed description of service will likely be requested. |
| 551 | 99500-99512, 99600 | RN Visit—See CPT code book for code descriptions Modifier TD Required | $118.00 per visit | One unit equals one visit (up to 2 hours) |
| 551 | 99500-99512, 99600 | LPN Visit—See CPT code book for code descriptions Modifier TE Required | $109.00 per visit | One unit equals one visit (up to 2 hours) |
| 561 | S9127 | Social Work visit, in the home, per diem | $70.00 | One unit equals one day's services |

*(Continued from page 34)*

## Home Health Agency Codes (continued)

| Revenue Code | CPT/ HCPCS Code | Description | Allowance | Comments |
|---|---|---|---|---|
| 441 | S9128 | Speech Therapy, in the home, per diem | $70.00 | One unit equals one day's services |
| 431 | S9129 | Occupational Therapy, in the home per diem | $70.00 | One unit equals one day's services |
| 421 | S9131 | Physical Therapy, in the home, per diem | $107.00 | One unit equals one day's services |

# Federal Employee Program (FEP): Dental Fee Schedule Update

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

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

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

Effective September 15, 2008, the FEP Dental Fee Schedule has been updated for Standard and Basic Option. Please see the updated new dental schedules on the following pages.

# FEP — Standard Option Dental Fee Schedule

Below is a list of dental services covered under Standard Option effective September 15, 2008.

| Dental Code | Service | Up to Age 13 | Age 13+ | MAC |
|---|---|---|---|---|
| **Clinical oral evaluations** | | | | |
| D0120 | Periodic oral evaluation* | $12.00 | $8.00 | $27.00 |
| D0140 | Limited oral evaluation | $14.00 | $9.00 | $36.00 |
| D0150 | Comprehensive oral evaluation | $14.00 | $9.00 | $37.00 |
| D0160 | Detailed and extensive oral evaluation | $14.00 | $9.00 | $50.00 |
| **Radiographs** | | | | |
| D0210 | Intraoral complete | $36.00 | $22.00 | $87.00 |
| D0220 | Intraoral periapical-single first film | $7.00 | $5.00 | $18.00 |
| D0230 | Intraoral periapical-each additional film | $4.00 | $3.00 | $15.00 |
| D0240 | Intraoral -occlusal film | $12.00 | $7.00 | $25.00 |
| D0250 | Extraoral-single film | $16.00 | $10.00 | $35.00 |
| D0260 | Extraoral-each additional film | $6.00 | $4.00 | $20.00 |
| D0270 | Bitewing-first film | $9.00 | $6.00 | $18.00 |
| D0272 | Bitewing-two film | $14.00 | $9.00 | $26.00 |
| D0274 | Bitewing-four film | $19.00 | $12.00 | $35.00 |
| D0277 | Bitewings-vertical-seven or eight films | $12.00 | $7.00 | $60.00 |
| D0290 | Posterior-anterior or lateral skull and facial bone survey film | $45.00 | $28.00 | $65.00 |
| D0330 | Panoramic film | $36.00 | $23.00 | $67.00 |
| **Tests and laboratory exams** | | | | |
| D0460 | Pulp vitality tests | $11.00 | $7.00 | $25.00 |
| **Palliative treatment** | | | | |
| D9110 | Palliative (emergency) treatment of dental pain minor procedures | $24.00 | $15.00 | $46.00 |
| D2940 | Fillings (sedatives) | $24.00 | $15.00 | $40.00 |
| **Preventive** | | | | |
| D1120 | Prophylaxis-Child * | $22.00 | $14.00 | $33.00 |
| D1110 | Prophylaxis-Adult* | | $16.00 | $48.00 |
| D1203 | Topical application of fluoride (excluding prophylaxis) child | $13.00 | $8.00 | $19.00 |
| D1204 | Topical application of fluoride(excluding prophylaxis) adult | | $8.00 | $19.00 |
| **Space maintenance (passive appliances)** | | | | |
| D1510 | Space maintainer-fixed-unilateral | $94.00 | $59.00 | $180.00 |
| D1515 | Space maintainer-fixed-bilateral | $139.00 | $87.00 | $250.00 |
| D1520 | Space maintainer-removable-unilateral | $94.00 | $59.00 | $180.00 |
| D1525 | Space maintainer-removable-bilateral | $139.00 | $87.00 | $220.00 |
| D1550 | Space maintainer-recementation of space maintainer | $22.00 | $14.00 | $40.00 |

*** Limited to two per person per calendar year**

| Dental Code | Service | Up to Age 13 | Age 13+ | MAC |
|---|---|---|---|---|
| **Amalgam restorations (including polishing)** | | | | |
| D2140 | Amalgam-one surface, primary or permanent | $25.00 | $16.00 | $68.00 |
| D2150 | Amalgam-two surfaces, primary or permanent | $37.00 | $23.00 | $83.00 |
| D2160 | Amalgam-three surfaces, primary or permanent | $50.00 | $31.00 | $98.00 |
| D2161 | Amalgam-four surfaces, primary or permanent | $56.00 | $35.00 | $118.00 |
| **Filled or unfilled resin restorations** | | | | |
| D2330 | Resin--one surface, anterior | $25.00 | $16.00 | $83.00 |
| D2331 | Resin--two surfaces, anterior | $37.00 | $23.00 | $104.00 |
| D2332 | Resin-three surfaces, anterior | $50.00 | $31.00 | $125.00 |
| D2335 | Resin--four or more surfaces or involving the incisal angle | $56.00 | $35.00 | $160.00 |
| D2391 | Resin Based Composite - one surface posterior | $25.00 | $16.00 | $93.00 |
| D2392 | Resin Based Composite - two surfaces posterior | $37.00 | $23.00 | $123.00 |
| D2393 | Resin Based Composite - Three surfaces posterior | $50.00 | $31.00 | $155.00 |
| D2394 | Resin Based Composite - Four or more surfaces posterior | $50.00 | $31.00 | $165.00 |
| **Inlay restorations** | | | | |
| D2510 | Inlay--metallic--one surface, permanent | $25.00 | $16.00 | $380.00 |
| D2520 | Inlay--metallic--two surfaces, permanent | $37.00 | $23.00 | $480.00 |
| D2530 | Inlay--metallic--three surfaces, permanent | $50.00 | $31.00 | $520.00 |
| D2610 | Inlay--porcelain/ceramic--one surface | $25.00 | $16.00 | $450.00 |
| D2620 | Inlay--porcelain/ceramic--two surfaces | $37.00 | $23.00 | $500.00 |
| D2630 | Inlay--porcelain/ceramic--three surfaces | $50.00 | $31.00 | $620.00 |
| D2650 | Inlay--composite/resin--one surface | $25.00 | $16.00 | $425.00 |
| D2651 | Inlay--composite/resin--two surfaces | $37.00 | $23.00 | $450.00 |
| D2652 | Inlay--composite/resin--three surfaces | $50.00 | $31.00 | $515.00 |
| **Other restorative services** | | | | |
| D2951 | Pin Retention--per tooth, in addition to restoration | $13.00 | $8.00 | $45.00 |
| **Extractions- includes local anesthesia and routine post-operative care** | | | | |
| D7140 | Extraction Erupted Tooth or Exposed Root | $30.00 | $19.00 | $80.00 |
| D7210 | Surgical removal of erupted tooth, requiring elevation of mucope-riosteal flap and removal of bone and/or section of tooth | $43.00 | $27.00 | $188.00 |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | $71.00 | $45.00 | $200.00 |
| D9220 | General Anesthesia in connection with covered extractions | $43.00 | $27.00 | $250.00 |

**FEP Fee Schedule Amount** is the amount Standard Option Pays toward a covered dental service. **MAC (Maximum Allowable Charge)** is the maximum amount Preferred network dentists will charge the FEP member for a covered dental service. The MAC may be updated periodically and is subject to change. For providers who sign a participating agreement with Arkansas Blue Cross and Blue Shield agree to accept the Arkansas Blue Cross Dental Fee schedule. (**Note:** This is the FEP Maximum Allowable charge.) When members use a Preferred network dentist, the member pays the difference between the FEP fee schedule and the MAC charge.

# FEP — Basic Option Dental Fee Schedule

Listed below is a complete list of all FEP dental services covered under the Basic Option Plan effective September 15, 2008.

Members pay a $20 copayment for each evaluation charge. FEP pays 100% of the Maximum Allowable Charge (MAC) for all other covered dental services. This is a complete list of all dental services covered under the Basic Option.

Under the Basic Option Plan, a preferred provider must perform the service. If a provider is a participating dentist with Arkansas Blue Cross and Blue Shield, the provider is also considered a Preferred provider under Basic Option.

| Service and ADA code | | MAC |
|---|---|---|
| 0120 | Periodic oral evaluation | $27.00 |
| 0140 | Limited oral evaluation | $36.00 |
| 0150 | comprehensive oral evaluation | $37.00 |

Note: Benefits are limited to a combined total of 2 evaluations per person per calendar year for 0120 and 0150

| Radiographs | | MAC |
|---|---|---|
| 0210 | Intraoral- complete series including bitewings (limited to 1 complete series every 3 years) | $87.00 |
| 0270 | Bitewing- single film | $18.00 |
| 0272 | Bitewing- two films | $26.00 |
| 0274 | Bitewing - four films | $35.00 |

Note: Benefits are limited to a combined total of 4 films per person per calendar year for 0270, 0272, and 0274.

| Preventive | | MAC |
|---|---|---|
| 1110 | Prophylaxis - adult (up to 2 per calendar year) | $48.00 |
| 1120 | Prophylaxis - child (up to 2 per calendar year) | $33.00 |
| 1203 | Topical application of fluoride (prophylaxis not included) -child (up to 2 per calendar year) | $19.00 |
| 1351 | Sealant- per tooth, first and second molars only (once per tooth for children up to age 16 only) | $29.00 |

Note: Benefits are limited to a combined total of 2 visits per person per calendar year for 1110, 1120, and 1203.

**Not covered: Any service not specifically listed above.**

# Fee Schedule Updates

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

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 70336 | $614.10 | $121.52 | $492.58 | $0.00 | $121.52 | $0.00 |
| 70450 | $271.57 | $69.95 | $201.62 | $0.00 | $69.95 | $0.00 |
| 70480 | $374.95 | $104.93 | $270.02 | $0.00 | $104.93 | $0.00 |
| 70481 | $434.21 | $113.22 | $320.98 | $0.00 | $113.22 | $0.00 |
| 70482 | $500.09 | $118.56 | $381.53 | $0.00 | $118.56 | $0.00 |
| 70486 | $330.29 | $93.07 | $237.22 | $0.00 | $93.07 | $0.00 |
| 70487 | $396.28 | $107.30 | $288.98 | $0.00 | $107.30 | $0.00 |
| 70488 | $477.72 | $116.19 | $361.53 | $0.00 | $116.19 | $0.00 |
| 70490 | $335.54 | $105.52 | $230.02 | $0.00 | $105.52 | $0.00 |
| 70491 | $395.41 | $113.22 | $282.18 | $0.00 | $113.22 | $0.00 |
| 70492 | $472.49 | $118.56 | $353.93 | $0.00 | $118.56 | $0.00 |
| 70498 | $723.03 | $144.64 | $578.38 | $0.00 | $144.64 | $0.00 |
| 70543 | $1,084.26 | $176.06 | $908.20 | $0.00 | $176.06 | $0.00 |
| 70545 | $663.78 | $98.40 | $565.38 | $0.00 | $98.40 | $0.00 |
| 70546 | $1,099.38 | $147.61 | $951.78 | $0.00 | $147.61 | $0.00 |
| 70547 | $664.39 | $97.81 | $566.58 | $0.00 | $97.81 | $0.00 |
| 70548 | $682.18 | $98.40 | $583.78 | $0.00 | $98.40 | $0.00 |
| 70549 | $1,099.38 | $147.61 | $951.78 | $0.00 | $147.61 | $0.00 |
| 70551 | $659.30 | $121.52 | $537.78 | $0.00 | $121.52 | $0.00 |
| 70552 | $756.32 | $146.42 | $609.90 | $0.00 | $146.42 | $0.00 |
| 70553 | $1,114.11 | $193.25 | $920.86 | $0.00 | $193.25 | $0.00 |
| 70554 | $809.72 | $171.91 | $637.81 | $0.00 | $171.91 | $0.00 |
| 71250 | $352.42 | $94.85 | $257.58 | $0.00 | $94.85 | $0.00 |
| 71260 | $416.10 | $101.37 | $314.73 | $0.00 | $101.37 | $0.00 |
| 71270 | $508.89 | $113.22 | $395.67 | $0.00 | $113.22 | $0.00 |
| 71275 | $650.60 | $158.28 | $492.32 | $0.00 | $158.28 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 71550 | $687.43 | $119.15 | $568.28 | $0.00 | $119.15 | $0.00 |
| 71552 | $1,159.06 | $185.55 | $973.51 | $0.00 | $185.55 | $0.00 |
| 71555 | $701.56 | $149.39 | $552.18 | $0.00 | $149.39 | $0.00 |
| 72126 | $414.32 | $99.59 | $314.73 | $0.00 | $99.59 | $0.00 |
| 72127 | $500.80 | $104.33 | $396.47 | $0.00 | $104.33 | $0.00 |
| 72128 | $352.42 | $94.85 | $257.58 | $0.00 | $94.85 | $0.00 |
| 72129 | $414.92 | $100.18 | $314.73 | $0.00 | $100.18 | $0.00 |
| 72130 | $499.60 | $104.33 | $395.27 | $0.00 | $104.33 | $0.00 |
| 72131 | $352.02 | $94.85 | $257.18 | $0.00 | $94.85 | $0.00 |
| 72133 | $500.40 | $104.33 | $396.07 | $0.00 | $104.33 | $0.00 |
| 72141 | $628.38 | $131.01 | $497.38 | $0.00 | $131.01 | $0.00 |
| 72142 | $767.18 | $157.68 | $609.50 | $0.00 | $157.68 | $0.00 |
| 72146 | $656.55 | $131.01 | $525.54 | $0.00 | $131.01 | $0.00 |
| 72147 | $726.38 | $157.68 | $568.70 | $0.00 | $157.68 | $0.00 |
| 72148 | $646.66 | $121.52 | $525.14 | $0.00 | $121.52 | $0.00 |
| 72149 | $755.12 | $146.42 | $608.70 | $0.00 | $146.42 | $0.00 |
| 72156 | $1,124.10 | $210.44 | $913.66 | $0.00 | $210.44 | $0.00 |
| 72158 | $1,106.51 | $193.25 | $913.26 | $0.00 | $193.25 | $0.00 |
| 72159 | $713.18 | $145.24 | $567.94 | $0.00 | $145.24 | $0.00 |
| 72191 | $626.90 | $149.39 | $477.52 | $0.00 | $149.39 | $0.00 |
| 72192 | $339.09 | $89.51 | $249.58 | $0.00 | $89.51 | $0.00 |
| 72193 | $396.38 | $95.44 | $300.94 | $0.00 | $95.44 | $0.00 |
| 72194 | $489.08 | $99.59 | $389.49 | $0.00 | $99.59 | $0.00 |
| 72195 | $648.63 | $119.15 | $529.48 | $0.00 | $119.15 | $0.00 |
| 72196 | $740.70 | $142.27 | $598.43 | $0.00 | $142.27 | $0.00 |
| 72197 | $1,101.09 | $184.95 | $916.14 | $0.00 | $184.95 | $0.00 |
| 72198 | $695.78 | $147.61 | $548.18 | $0.00 | $147.61 | $0.00 |
| 73200 | $323.93 | $89.51 | $234.42 | $0.00 | $89.51 | $0.00 |
| 73202 | $473.91 | $99.59 | $374.32 | $0.00 | $99.59 | $0.00 |
| 73220 | $1,090.45 | $176.65 | $913.80 | $0.00 | $176.65 | $0.00 |
| 73221 | $619.38 | $110.26 | $509.12 | $0.00 | $110.26 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 73222 | $704.65 | $132.79 | $571.86 | $0.00 | $132.79 | $0.00 |
| 73225 | $680.08 | $139.90 | $540.18 | $0.00 | $139.90 | $0.00 |
| 73700 | $323.93 | $89.51 | $234.42 | $0.00 | $89.51 | $0.00 |
| 73701 | $383.42 | $95.44 | $287.98 | $0.00 | $95.44 | $0.00 |
| 73702 | $477.70 | $100.18 | $377.52 | $0.00 | $100.18 | $0.00 |
| 73706 | $632.21 | $157.09 | $475.12 | $0.00 | $157.09 | $0.00 |
| 73718 | $633.78 | $110.26 | $523.52 | $0.00 | $110.26 | $0.00 |
| 73719 | $726.65 | $132.79 | $593.86 | $0.00 | $132.79 | $0.00 |
| 73721 | $625.78 | $110.26 | $515.52 | $0.00 | $110.26 | $0.00 |
| 73722 | $708.25 | $132.79 | $575.46 | $0.00 | $132.79 | $0.00 |
| 73725 | $698.36 | $149.39 | $548.98 | $0.00 | $149.39 | $0.00 |
| 74150 | $342.00 | $97.81 | $244.18 | $0.00 | $97.81 | $0.00 |
| 74160 | $430.67 | $104.93 | $325.74 | $0.00 | $104.93 | $0.00 |
| 74170 | $544.09 | $115.00 | $429.09 | $0.00 | $115.00 | $0.00 |
| 74175 | $651.43 | $155.91 | $495.52 | $0.00 | $155.91 | $0.00 |
| 74182 | $779.10 | $142.27 | $636.83 | $0.00 | $142.27 | $0.00 |
| 74185 | $695.78 | $147.61 | $548.18 | $0.00 | $147.61 | $0.00 |
| 74251 | $282.66 | $56.91 | $225.75 | $0.00 | $56.91 | $0.00 |
| 74260 | $238.05 | $40.90 | $197.14 | $0.00 | $40.90 | $0.00 |
| 74291 | $55.78 | $16.60 | $39.19 | $0.00 | $16.60 | $0.00 |
| 75600 | $457.81 | $43.27 | $414.53 | $0.00 | $43.27 | $0.00 |
| 75635 | $781.10 | $199.18 | $581.92 | $0.00 | $199.18 | $0.00 |
| 75809 | $96.50 | $37.94 | $58.56 | $0.00 | $37.94 | $0.00 |
| 75810 | $880.90 | $93.07 | $0.00 | $0.00 | $93.07 | $0.00 |
| 75820 | $135.44 | $58.69 | $76.76 | $0.00 | $58.69 | $0.00 |
| 75880 | $139.65 | $58.09 | $81.56 | $0.00 | $58.09 | $0.00 |
| 75962 | $475.46 | $45.05 | $430.40 | $0.00 | $45.05 | $0.00 |
| 75966 | $547.85 | $111.45 | $436.40 | $0.00 | $111.45 | $0.00 |
| 75978 | $469.87 | $43.87 | $426.00 | $0.00 | $43.87 | $0.00 |
| 76100 | $144.17 | $48.02 | $96.15 | $0.00 | $48.02 | $0.00 |
| 76101 | $186.17 | $47.42 | $138.74 | $0.00 | $47.42 | $0.00 |
| 76102 | $237.35 | $46.83 | $190.52 | $0.00 | $46.83 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 76380 | $248.30 | $80.03 | $168.27 | $0.00 | $80.03 | $0.00 |
| 76390 | $548.23 | $110.85 | $437.38 | $0.00 | $110.85 | $0.00 |
| 76506 | $138.29 | $53.94 | $84.34 | $0.00 | $53.94 | $0.00 |
| 76511 | $144.19 | $78.84 | $65.35 | $0.00 | $78.84 | $0.00 |
| 76512 | $137.57 | $78.84 | $58.73 | $0.00 | $78.84 | $0.00 |
| 76513 | $118.05 | $55.72 | $62.33 | $0.00 | $55.72 | $0.00 |
| 76514 | $18.61 | $14.82 | $3.79 | $0.00 | $14.82 | $0.00 |
| 76516 | $93.20 | $45.05 | $48.15 | $0.00 | $45.05 | $0.00 |
| 76519 | $97.80 | $45.65 | $52.15 | $0.00 | $45.65 | $0.00 |
| 76529 | $94.36 | $48.02 | $46.34 | $0.00 | $48.02 | $0.00 |
| 76536 | $128.20 | $45.05 | $83.14 | $0.00 | $45.05 | $0.00 |
| 76604 | $108.00 | $45.05 | $62.95 | $0.00 | $45.05 | $0.00 |
| 76645 | $107.02 | $43.87 | $63.16 | $0.00 | $43.87 | $0.00 |
| 76705 | $124.55 | $48.61 | $75.94 | $0.00 | $48.61 | $0.00 |
| 76770 | $159.79 | $60.47 | $99.32 | $0.00 | $60.47 | $0.00 |
| 76775 | $125.16 | $48.02 | $77.14 | $0.00 | $48.02 | $0.00 |
| 76776 | $171.56 | $62.24 | $109.32 | $0.00 | $62.24 | $0.00 |
| 76800 | $161.87 | $88.33 | $73.54 | $0.00 | $88.33 | $0.00 |
| 76801 | $172.34 | $80.03 | $92.31 | $0.00 | $80.03 | $0.00 |
| 76802 | $110.49 | $68.17 | $42.31 | $0.00 | $68.17 | $0.00 |
| 76805 | $183.94 | $80.03 | $103.91 | $0.00 | $80.03 | $0.00 |
| 76810 | $140.48 | $79.44 | $61.04 | $0.00 | $79.44 | $0.00 |
| 76811 | $301.01 | $154.72 | $146.29 | $0.00 | $154.72 | $0.00 |
| 76812 | $259.35 | $144.64 | $114.70 | $0.00 | $144.64 | $0.00 |
| 76813 | $177.33 | $96.63 | $80.70 | $0.00 | $96.63 | $0.00 |
| 76814 | $121.54 | $78.84 | $42.70 | $0.00 | $78.84 | $0.00 |
| 76815 | $117.90 | $52.76 | $65.14 | $0.00 | $52.76 | $0.00 |
| 76816 | $137.71 | $69.36 | $68.36 | $0.00 | $69.36 | $0.00 |
| 76817 | $130.02 | $60.47 | $69.56 | $0.00 | $60.47 | $0.00 |
| 76818 | $162.28 | $85.96 | $76.33 | $0.00 | $85.96 | $0.00 |
| 76819 | $128.76 | $62.84 | $65.93 | $0.00 | $62.84 | $0.00 |
| 76820 | $89.01 | $41.50 | $47.51 | $0.00 | $41.50 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 76821 | $130.22 | $57.50 | $72.71 | $0.00 | $57.50 | $0.00 |
| 76825 | $259.07 | $135.75 | $123.32 | $0.00 | $135.75 | $0.00 |
| 76826 | $134.35 | $66.99 | $67.36 | $0.00 | $66.99 | $0.00 |
| 76827 | $106.34 | $46.83 | $59.51 | $0.00 | $46.83 | $0.00 |
| 76828 | $82.58 | $46.24 | $36.34 | $0.00 | $46.24 | $0.00 |
| 76830 | $143.44 | $56.32 | $87.13 | $0.00 | $56.32 | $0.00 |
| 76831 | $144.82 | $58.09 | $86.73 | $0.00 | $58.09 | $0.00 |
| 76856 | $143.84 | $56.32 | $87.53 | $0.00 | $56.32 | $0.00 |
| 76857 | $116.18 | $31.42 | $84.76 | $0.00 | $31.42 | $0.00 |
| 76870 | $141.09 | $52.76 | $88.33 | $0.00 | $52.76 | $0.00 |
| 76873 | $236.73 | $128.04 | $108.68 | $0.00 | $128.04 | $0.00 |
| 76886 | $125.32 | $50.98 | $74.34 | $0.00 | $50.98 | $0.00 |
| 76936 | $421.13 | $166.58 | $254.56 | $0.00 | $166.58 | $0.00 |
| 76937 | $49.42 | $25.49 | $23.93 | $0.00 | $25.49 | $0.00 |
| 76946 | $73.95 | $30.83 | $43.13 | $0.00 | $30.83 | $0.00 |
| 76948 | $73.36 | $30.23 | $43.13 | $0.00 | $30.23 | $0.00 |
| 76950 | $97.97 | $47.42 | $50.55 | $0.00 | $47.42 | $0.00 |
| 76965 | $254.24 | $111.45 | $142.79 | $0.00 | $111.45 | $0.00 |
| 76970 | $93.97 | $32.01 | $61.96 | $0.00 | $32.01 | $0.00 |
| 76977 | $26.11 | $4.74 | $21.36 | $0.00 | $4.74 | $0.00 |
| 77014 | $222.04 | $69.36 | $152.68 | $0.00 | $69.36 | $0.00 |
| 77021 | $565.09 | $124.49 | $440.60 | $0.00 | $124.49 | $0.00 |
| 77031 | $322.94 | $131.01 | $191.93 | $0.00 | $131.01 | $0.00 |
| 77058 | $962.32 | $133.38 | $828.94 | $0.00 | $133.38 | $0.00 |
| 77059 | $1,105.69 | $133.38 | $972.31 | $0.00 | $133.38 | $0.00 |
| 77076 | $112.67 | $56.91 | $55.76 | $0.00 | $56.91 | $0.00 |
| 77078 | $181.64 | $20.16 | $161.48 | $0.00 | $20.16 | $0.00 |
| 77079 | $94.75 | $17.78 | $76.96 | $0.00 | $17.78 | $0.00 |
| 77082 | $41.00 | $13.63 | $27.36 | $0.00 | $13.63 | $0.00 |
| 77084 | $650.00 | $129.82 | $520.18 | $0.00 | $129.82 | $0.00 |
| 77280 | $221.77 | $57.50 | $164.27 | $0.00 | $57.50 | $0.00 |
| 77285 | $368.35 | $85.36 | $282.98 | $0.00 | $85.36 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 77290 | $536.41 | $126.86 | $409.55 | $0.00 | $126.86 | $0.00 |
| 77301 | $2,394.63 | $650.89 | $1,743.73 | $0.00 | $650.89 | $0.00 |
| 77315 | $219.96 | $126.86 | $93.10 | $0.00 | $126.86 | $0.00 |
| 77327 | $266.30 | $113.22 | $153.07 | $0.00 | $113.22 | $0.00 |
| 77332 | $102.42 | $43.87 | $58.55 | $0.00 | $43.87 | $0.00 |
| 77470 | $453.70 | $170.73 | $282.98 | $0.00 | $170.73 | $0.00 |
| 77600 | $392.34 | $126.86 | $265.48 | $0.00 | $126.86 | $0.00 |
| 77605 | $621.99 | $168.95 | $453.04 | $0.00 | $168.95 | $0.00 |
| 77610 | $544.99 | $122.71 | $422.28 | $0.00 | $122.71 | $0.00 |
| 77615 | $768.79 | $168.95 | $599.84 | $0.00 | $168.95 | $0.00 |
| 77620 | $404.29 | $131.60 | $272.68 | $0.00 | $131.60 | $0.00 |
| 77750 | $491.86 | $402.51 | $89.35 | $0.00 | $402.51 | $0.00 |
| 77761 | $467.37 | $307.07 | $160.30 | $0.00 | $307.07 | $0.00 |
| 77762 | $665.59 | $467.13 | $198.46 | $0.00 | $467.13 | $0.00 |
| 77763 | $954.13 | $700.10 | $254.03 | $0.00 | $700.10 | $0.00 |
| 77776 | $547.88 | $380.58 | $167.31 | $0.00 | $380.58 | $0.00 |
| 77777 | $817.03 | $609.99 | $207.04 | $0.00 | $609.99 | $0.00 |
| 77778 | $1,185.90 | $914.69 | $271.21 | $0.00 | $914.69 | $0.00 |
| 77782 | $875.95 | $171.91 | $704.04 | $0.00 | $171.91 | $0.00 |
| 77783 | $1,204.13 | $272.10 | $932.04 | $0.00 | $272.10 | $0.00 |
| 77789 | $136.45 | $93.66 | $42.79 | $0.00 | $93.66 | $0.00 |
| 77790 | $118.95 | $85.36 | $33.59 | $0.00 | $85.36 | $0.00 |
| 78006 | $216.22 | $39.72 | $176.51 | $0.00 | $39.72 | $0.00 |
| 78016 | $312.46 | $66.99 | $245.47 | $0.00 | $66.99 | $0.00 |
| 78206 | $368.96 | $78.84 | $290.12 | $0.00 | $78.84 | $0.00 |
| 78290 | $292.60 | $56.32 | $236.28 | $0.00 | $56.32 | $0.00 |
| 78456 | $348.58 | $82.99 | $265.59 | $0.00 | $82.99 | $0.00 |
| 78588 | $329.78 | $89.51 | $240.27 | $0.00 | $89.51 | $0.00 |
| 78600 | $186.86 | $36.16 | $150.70 | $0.00 | $36.16 | $0.00 |
| 78610 | $196.41 | $26.08 | $170.33 | $0.00 | $26.08 | $0.00 |
| 78635 | $281.49 | $50.39 | $231.10 | $0.00 | $50.39 | $0.00 |
| 78645 | $291.31 | $46.24 | $245.07 | $0.00 | $46.24 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 78701 | $226.58 | $40.31 | $186.27 | $0.00 | $40.31 | $0.00 |
| 78740 | $205.54 | $46.83 | $158.71 | $0.00 | $46.83 | $0.00 |
| 78804 | $616.32 | $87.73 | $528.58 | $0.00 | $87.73 | $0.00 |
| 78811 | $1,629.23 | $129.23 | $1,500.00 | $0.00 | $129.23 | $0.00 |
| 78812 | $1,660.06 | $160.06 | $1,500.00 | $0.00 | $160.06 | $0.00 |
| 78813 | $1,665.98 | $165.98 | $1,500.00 | $0.00 | $165.98 | $0.00 |
| 78814 | $1,781.40 | $181.40 | $1,600.00 | $0.00 | $181.40 | $0.00 |
| 78815 | $1,800.96 | $200.96 | $1,600.00 | $0.00 | $200.96 | $0.00 |
| 78816 | $1,805.70 | $205.70 | $1,600.00 | $0.00 | $205.70 | $0.00 |
| 79200 | $255.32 | $163.02 | $92.30 | $0.00 | $163.02 | $0.00 |
| 79403 | $325.02 | $187.92 | $137.10 | $0.00 | $187.92 | $0.00 |
| 86923 | $9.14 | $0.64 | $8.50 | $0.00 | $0.64 | $0.00 |
| 86960 | $9.14 | $0.64 | $8.50 | $0.00 | $0.64 | $0.00 |
| 88182 | $133.83 | $61.06 | $72.77 | $0.00 | $61.06 | $0.00 |
| 88311 | $26.16 | $19.56 | $6.59 | $0.00 | $19.56 | $0.00 |
| 88312 | $113.26 | $43.87 | $69.39 | $0.00 | $43.87 | $0.00 |
| 88313 | $80.96 | $19.56 | $61.39 | $0.00 | $19.56 | $0.00 |
| 88314 | $112.53 | $37.35 | $75.19 | $0.00 | $37.35 | $0.00 |
| 88319 | $170.25 | $43.87 | $126.39 | $0.00 | $43.87 | $0.00 |
| 88331 | $130.17 | $99.00 | $31.17 | $0.00 | $99.00 | $0.00 |
| 88332 | $60.39 | $49.20 | $11.19 | $0.00 | $49.20 | $0.00 |
| 88334 | $77.87 | $58.69 | $19.19 | $0.00 | $58.69 | $0.00 |
| 88346 | $129.14 | $69.95 | $59.19 | $0.00 | $69.95 | $0.00 |
| 88355 | $368.56 | $148.20 | $220.36 | $0.00 | $148.20 | $0.00 |
| 88356 | $398.83 | $240.68 | $158.15 | $0.00 | $240.68 | $0.00 |
| 88358 | $110.59 | $78.84 | $31.75 | $0.00 | $78.84 | $0.00 |
| 88360 | $156.28 | $90.70 | $65.59 | $0.00 | $90.70 | $0.00 |
| 88361 | $203.75 | $98.40 | $105.35 | $0.00 | $98.40 | $0.00 |
| 88362 | $345.99 | $178.43 | $167.56 | $0.00 | $178.43 | $0.00 |
| 88367 | $275.50 | $103.15 | $172.36 | $0.00 | $103.15 | $0.00 |
| 88368 | $246.00 | $112.04 | $133.96 | $0.00 | $112.04 | $0.00 |
| 88385 | $557.70 | $119.75 | $437.96 | $0.00 | $119.75 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 88386 | $582.11 | $150.57 | $431.54 | $0.00 | $150.57 | $0.00 |
| 90681 | $101.75 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| 90696 | $45.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| 90698 | $90.20 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| 91000 | $99.47 | $59.28 | $40.19 | $0.00 | $59.28 | $0.00 |
| 91022 | $254.27 | $122.71 | $131.56 | $0.00 | $122.71 | $0.00 |
| 91034 | $259.54 | $83.58 | $175.96 | $0.00 | $83.58 | $0.00 |
| 91035 | $557.52 | $135.16 | $422.36 | $0.00 | $135.16 | $0.00 |
| 91037 | $200.13 | $84.18 | $115.96 | $0.00 | $84.18 | $0.00 |
| 91038 | $181.80 | $95.44 | $86.36 | $0.00 | $95.44 | $0.00 |
| 91110 | $1,110.41 | $308.26 | $802.15 | $0.00 | $308.26 | $0.00 |
| 91111 | $824.52 | $87.73 | $736.79 | $0.00 | $87.73 | $0.00 |
| 91120 | $467.60 | $80.03 | $387.57 | $0.00 | $80.03 | $0.00 |
| 92240 | $289.22 | $93.66 | $195.56 | $0.00 | $93.66 | $0.00 |
| 92284 | $76.76 | $18.97 | $57.79 | $0.00 | $18.97 | $0.00 |
| 93025 | $290.11 | $66.39 | $223.72 | $0.00 | $66.39 | $0.00 |
| 93307 | $236.46 | $80.03 | $156.43 | $0.00 | $80.03 | $0.00 |
| 93308 | $139.94 | $46.24 | $93.71 | $0.00 | $46.24 | $0.00 |
| 93320 | $104.31 | $33.20 | $71.11 | $0.00 | $33.20 | $0.00 |
| 93350 | $259.53 | $129.82 | $129.71 | $0.00 | $129.82 | $0.00 |
| 95805 | $633.72 | $151.16 | $482.56 | $0.00 | $151.16 | $0.00 |
| 95806 | $276.96 | $133.38 | $143.58 | $0.00 | $133.38 | $0.00 |
| 95807 | $620.31 | $131.01 | $489.30 | $0.00 | $131.01 | $0.00 |
| 95808 | $784.51 | $212.82 | $571.70 | $0.00 | $212.82 | $0.00 |
| 95810 | $967.69 | $280.39 | $687.30 | $0.00 | $280.39 | $0.00 |
| 95819 | $263.23 | $90.11 | $173.13 | $0.00 | $90.11 | $0.00 |
| 95827 | $366.83 | $87.73 | $279.10 | $0.00 | $87.73 | $0.00 |
| 95829 | $1,552.51 | $516.92 | $1,035.59 | $0.00 | $516.92 | $0.00 |
| 95866 | $130.29 | $106.11 | $24.18 | $0.00 | $106.11 | $0.00 |
| 95869 | $55.00 | $31.42 | $23.59 | $0.00 | $31.42 | $0.00 |
| 95870 | $54.20 | $31.42 | $22.79 | $0.00 | $31.42 | $0.00 |
| 95872 | $250.09 | $219.93 | $30.16 | $0.00 | $219.93 | $0.00 |

| CPT/ HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS/ Used |
|---|---|---|---|---|---|---|
| 95873 | $54.80 | $32.01 | $22.79 | $0.00 | $32.01 | $0.00 |
| 95874 | $54.00 | $32.01 | $21.99 | $0.00 | $32.01 | $0.00 |
| 95921 | $100.10 | $72.91 | $27.19 | $0.00 | $72.91 | $0.00 |
| 95922 | $115.02 | $79.44 | $35.59 | $0.00 | $79.44 | $0.00 |
| 95925 | $125.60 | $45.65 | $79.96 | $0.00 | $45.65 | $0.00 |
| 95926 | $123.81 | $45.05 | $78.76 | $0.00 | $45.05 | $0.00 |
| 95927 | $127.99 | $46.83 | $81.16 | $0.00 | $46.83 | $0.00 |
| 95934 | $61.87 | $42.68 | $19.19 | $0.00 | $42.68 | $0.00 |
| 95957 | $312.50 | $165.39 | $147.11 | $0.00 | $165.39 | $0.00 |
| 95958 | $504.23 | $352.12 | $152.11 | $0.00 | $352.12 | $0.00 |
| 99100 | $50.00 | $0.00 | $0.00 | $50.00 | $0.00 | $0.00 |
| 99116 | $250.00 | $0.00 | $0.00 | $250.00 | $0.00 | $0.00 |
| 99135 | $250.00 | $0.00 | $0.00 | $250.00 | $0.00 | $0.00 |
| 99140 | $100.00 | $0.00 | $0.00 | $100.00 | $0.00 | $0.00 |
| 99455 | $221.85 | $0.00 | $0.00 | $183.60 | $0.00 | $0.00 |
| 99456 | $356.25 | $0.00 | $0.00 | $311.25 | $0.00 | $0.00 |
| 0066T | $239.54 | $79.44 | $160.11 | $0.00 | $79.44 | $0.00 |
| 0067T | $239.54 | $79.44 | $160.11 | $0.00 | $79.44 | $0.00 |
| A4565 | $5.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| A4570 | $5.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| E0445 | $1,304.20 | $130.42 | $0.00 | $0.00 | $0.00 | $0.00 |
| E0463 | $14,063.80 | $1,406.38 | $10,547.85 | $0.00 | $0.00 | $0.00 |
| G0122 | $239.54 | $79.44 | $160.11 | $0.00 | $79.44 | $0.00 |
| G8485 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| G8486 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| G8487 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| G8488 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J0835 | $106.58 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J2248 | $1.87 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| S4989 | $359.09 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

**YOU SEE WHAT WE SEE**...anytime you need to check an Arkansas Blue Cross and Blue Shield, BlueAdvantage, BlueCard or Health Advantage patient's eligibility or benefits always use **AHIN FIRST!**

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