December 2009

providers' news

A publication for our providers and their office staffs

inside

Arkansas Blue Cross Adopts RBRVS for 2010

Effective April 1, 2010, Arkansas Blue Cross and Blue Shield will, for most services, adopt the 2010 Resource Based Relative Value System (RBRVS) Relative Value Units (RVUs) which were published in the November 25, 2009 Federal Register Final Rule. A new Arkansas Blue Cross fee schedule using the 2010 RBRVS will be available on the Advanced Health Information Network (AHIN) Web site bulletin board beginning January 1, 2010.

Per the Claims Filing and Coding Policies section of all provider agreements, the following revision will be implemented:

Effective April 1, 2010, Arkansas Blue Cross, USAble Corporation and Health Advantage will follow Medicare's policy to discontinue use of consult CPT codes 99241-99245 and 99251-99255. Consult codes submitted for services performed on or after April 1, 2010 will be denied.

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

"Never Events" Policy Reminders

"Never Events" are adverse events or errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. Identifying and addressing adverse medical events and "Never Events" has gained more attention throughout the health-care industry. Industry drivers include the following:

- The National Quality Forum (NQF) has identified a list of 28 "Never Events" that is gaining interest from various constituencies focused on health-care quality, including health plan organizations, employers and state hospital organizations.

- Since October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) no longer pays the extra cost of treating the 12 Hospital Acquired Conditions (HACs) that occur while the patient is in the hospital.

- CMS requires that most hospitals use a Present on Admission (POA) indicator on claims to indicate if the patient's specific condition was present when the patient was admitted to the hospital or if it was acquired during the inpatient stay (e.g., infection or ulcers). In addition, CMS will require all Medicare Advantage plans to report "Never Events" and claims with the POA indicator by January 1, 2010.

- The National Business Group on Health, which represents 300 large employers, supports the reporting of medical errors and continues to apply pressure to all payers for solutions.

- **The Blue Cross and Blue Shield Association will require Arkansas Blue Cross and Blue Shield to implement a "Never Events " policy effective January 1, 2010.**

As of October 1, 2008, Medicare-defined HACs are considered "Never Events" as they relate to this policy. HACs include:

- Pressure ulcers, Stages III and IV,
- Catheter-associated urinary tract infections,
- Vascular catheter-associated infection,
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG),
- Air embolism,
- Blood incompatibility,
- Foreign object retained after surgery,
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock),
- Surgical-site infections following certain orthopedic procedures,
- Surgical-site infections following bariatric surgery for obesity,
- Manifestations of poor glycemic control, and
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

In addition, "Never Events" include:

- Surgery performed on a wrong body part,
- Surgery performed on a wrong patient, and
- Wrong surgical procedure performed.

The Arkansas Blue Cross "Never Event" policy, effective January 1, 2010, states:

- All acute care hospitals participating in the Arkansas Blue Cross, USAble Corporation and Health Advantage provider networks must populate the POA indicator on all acute care inpatient hospital claims for all "Never Events", as applicable. POA has been required since October 1, 2008 for most hospitals. Valid POA values include:
  - Y =Yes
  - N = No
  - U = Unknown/No information in the record
  - W = clinically undetermined
  - 1 = exempt from reporting on 837 claim
  - blank = exempt from reporting on paper claim

- This policy applies to all acute care hospitals including critical access hospitals and specialty hospitals.

- All participating acute care inpatient hospitals will not receive or retain reimbursement for inpatient services related to "Never Events".

- All participating acute care inpatient hospitals will not bill members (hold harmless) for any inpatient services related to "Never Events".

All HACs should be billed normally using the correct diagnosis codes and will be accommodated through POA indicators. All appropriate E codes should be billed for "Never Events". All inpatient hospital claims will be passed through the Arkansas Blue Cross internal DRG grouper. Hospitals will NOT receive a higher reimbursement rate due to "Never Events" and members will not be responsible for higher deductible, copayments or coinsurance amounts due to "Never Events".

Arkansas Blue Cross, Health Advantage and USAble Corporation will not reimburse hospitals, ambulatory surgery centers or other outpatient

(Continued from page 2)

settings for surgery performed on a wrong body part, surgery performed on a wrong patient or the wrong surgical procedure performed. This includes all services related to these "Never Events".

- All services provided in the operating room or applicable surgical setting when the error occurs are considered related. These services will not be reimbursed nor will members be liable for their charges.
- All providers in the operating room or applicable surgical setting when the error occurs, who could bill individually for their services, are not eligible for payment nor will members be liable for their charges.
- All related services provided during the same hospitalization or outpatient setting in which the error occurred will not be reimbursed nor will members be liable for their charges.
- Providers should note that related services do not include performance of the correct procedure.

"Never Events" discovered through any and all avenues such as post pay audits and customer service calls are subject to this policy.

Billing Instructions for "Never Events"

Effective for inpatient discharges on or after January 1, 2010, hospitals shall separate a hospital stay into two claims where a "Never Event" surgical error is reported and a covered service is also being reported:

1) One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and
2) The other claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
3) Both the covered and noncovered claim shall have a matching "statement covers" period.

The noncovered TOB 110 must indicate in Form Locator (FL) 80 (Remarks) or on the 837i at Loop 2300, Billing Note NTE01=ADD, NTE02, one of the applicable erroneous surgery(s) two-digit codes (entered exactly as specified below):

1) For a wrong surgery on patient enter MX;
2) For a surgery on a wrong body enter MY;
3) For a surgery on wrong patient enter MZ.

For hospital outpatient, ambulatory surgical centers, practitioners and all TOBs for dates of service on or after January 1, 2010, providers should append the following applicable HCPCS modifiers to all lines related to the surgical error:

1) PA: Surgery wrong body part
2) PB: Surgery wrong patient
3) PC: Wrong surgery on patient

Correction for Billing Novel H1N1 Influenza Vaccine

The September 2009 issue of *Providers' News* contained an error in the article concerning billing of the H1N1 vaccine. The Centers for Medicare and Medicaid Services (CMS) issued HCPCS codes G9141 (Administration of H1N1) and G9142 (H1N1 Vaccine) to address billing of H1N1. Since the publication, Arkansas Blue Cross and Blue Shield received additional information from the American Medical Association (AMA). The AMA has also issued instructions to use CPT codes 90470 (Administration if H1N1) and 90663 (H1N1 Vaccine). Providers may use either the HCPCS codes or the CPT codes but not a mixture of the two for H1N1. The vaccine, whether billed using G9142 or 90663, should be billed with a zero charge. If more than one immunization is administered on the same day for the same patient, bill the H1N1 administration code for the subsequent immunization. Providers should use the appropriate initial administration code for the administration of the other vaccine. If more than two vaccines are given on the same day, providers should then use the appropriate "each additional administration" code for any subsequent administrations.

Mental Health Parity Reminder

The new Mental Health Parity (MHP) Act requires that mental health benefits be equal to physical health benefits. The effective dates will be the employer group health plan's annual renewal date.

Depending on a member's employer group health plan benefits, and if subject to this new law, some Arkansas Blue Cross and Blue Shield and Health Advantage employer group plans and a number of the employer group health plans administered by BlueAdvantage Administrators of Arkansas will change as a result of the act. Members subject to this law will receive a new ID card with a mental health assistance telephone number which will indicate that the patient's health benefit plan now includes changes under MHP and services provided by New Directions®.

Behavioral Health Management:

Arkansas Blue Cross, Health Advantage, and BlueAdvantage have contracted with New Directions® Behavioral Health to perform behavioral health utilization management services. New Directions® is a full-service behavioral health organization and is accredited as an MBHO by NCQA and has URAC accreditation for utilization management.

Behavioral Health Pre-authorization Outpatient Services:

- A member may be seen a total of eight visits without pre-authorization or review. This applies to all behavioral health services for that member except for psychiatric medication management, which does not require authorization.
- Providers must obtain an authorization for payment of outpatient services after the eighth visit, in other words, beginning with the ninth visit except for psychiatric medication management.
- After a providers has made a request, they will receive a response from New Directions within 72 hours unless additional information is needed.

Inpatient, Partial Hospital and Intensive Outpatient Services:

- Contact New Directions for authorization of all inpatient, partial hospital and IOP services.
- New Directions will conduct concurrent stay reviews and will work with your staff to provide discharge planning.

For pre-authorization of behavioral health services for Arkansas Blue Cross, Health Advantage and BlueAdvantage members, contact New Directions at (877) 801-1159. For Walmart associates, call (877) 709-6822

New Directions WebPass:

New Directions now offers a Provider WebPass, allowing providers and office staff to:

- Submit pre-authorization requests
- Contact provider relations
- Update your online profile

To access the Provider WebPass, go to ndbh.com, select "Provider Section," then select "Provider WebPass."

Before using the New Directions® WebPass System, providers must obtain a user name and password from New Directions® Behavioral Health Provider Relations by downloading the Access Request Form and faxing the completed form to (913) 982-8227. Providers who do not have access to a fax machine please mail the form to:

Network Operations
P. O. Box 6729
Leawood, KS 66206-0729

Please complete this form today to obtain a user name and password. The registration should be completed by New Directions® Behavioral Health within two business days and new login information will be e-mailed at that time.

Claims:

Continue to submit mental health claims via AHIN. Individual policyholders applying for, or already with Arkansas Blue Cross, also may select MHP benefits.

Walmart

Important information if you provide services to Walmart Associates insured by the Walmart Associates Medical Plan.

Behavioral Health Management:

Arkansas Blue Cross and Blue Shield and BlueAdvantage Administrators of Arkansas have contracted with New Directions® to perform utilization management services. New Directions®, a full-service behavioral health organization, is accredited as an MBHO by NCQA and has URAC accreditation for utilization management.

Behavioral Health Pre-Authorization for Walmart Associates:

Outpatient Services:

- Providers may provide up to a total of eight visits to Walmart Associates without pre-authorization or review. This includes all providers for the Walmart Associate or family member except for psychiatric medication management, which does not require authorization.

- Providers must obtain an authorization for payment of outpatient services after the eighth visit, in other words, beginning with the ninth visit except for psychiatric medical management.

- After providers have made a request, they will receive a response from New Directions® within 72 hours unless additional information is needed.

Inpatient, Partial Hospital, and Intensive Outpatient Services:

- Contact New Directions® for authorization of all inpatient, partial hospital, and IOP services.

- New Directions® will conduct concurrent stay reviews and work with the provider's staff to supply the Walmart Associates with discharge planning.

To contact New Directions® for pre-authorization of behavioral health services please call (877) 709-6822

New Directions® WebPass:

New Directions® now offers the Provider WebPass which allows providers and office staff to:

- Submit (obtain) pre-authorization requests
- Contact Provider Relations
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P. O. Box 6729
Leawood, KS 66206-0729

Please complete this form today to obtain a user name and password. The registration should be completed by New Directions® Behavioral Health within two business days and new login information will be e-mailed at that time.

Claims:

Please continue to submit Walmart claims to the local Blue Cross and Blue Shield Plan.

Arkansas Blue Cross Employer Group Change

Effective January 1, 2010, the employees of Arkansas Blue Cross and Blue Shield will use the Health Advantage HMO provider network for its benefit plan. Previously, Arkansas Blue Cross employees used a separate network created as a self funded employer. Beginning in 2010, providers who have signed Health Advantage provider agreements will be considered "in network" for the employees of Arkansas Blue Cross.

Pharmacy

2010 Formulary Changes

Changes to the standard pharmacy formulary effective January 1, 2010:

1) The drugs listed below will move from tier 2 to tier 3.
2) PPIs (proton pump inhibitors): Nexium is moving to noncovered status and will not be covered as of January 1, 2010. The formulary alternative Kapidex will move from noncovered status to tier 3 on December 15, 2009. The generic for Prilosec, Omeprazole (prescription strength not over-the-counter), will also move from non-covered to tier 1 and will be covered beginning January 1, 2010. Please note that Prevacid will also be moved to noncovered status and will not be covered as of December 15, 2009 when the generic and over the counter version is available.
3) Veramyst is moving from non-covered to the tier 3.
4) Prenate DHA, Optinate, and Trilipix are moving to tier 2.

Medication	Formulary Alternatives
Asmanex	Flovent
Azopt	Travatan, Travatan Z, Xalatan, generics
Betoptic S	Generics
Diovan, Diovan HCT	Benicar, Benicar HCT, Losartan - available 2010
Encora	Generics
Exforge, Exforge HCT	AZOR, generics
Locoid Lipocream	Generics
Precare, Precare Premier	Prenate Elite, generics
Premarin	Cenestin, Enjuvia, generics
Premphase	Individual components as generics
Prempro	Individual components as generics
Primacare, Primacare Advantage, Primacare One	Prenate DHA, generics
Tricor	Trilipix, generics

Pharmacy

Coverage Changes to Xolair®

As of September 1, 2009, Arkansas Blue Cross and Blue Shield and its family of companies began covering the omalizumab injection, Xolair®, through its medical benefit. Arkansas Blue Cross no longer covers Xolair® under its retail pharmacy benefit.

In 2008, Genentech, the manufacturer of Xolair®, clarified that "Xolair® should only be administered in a health-care setting by health-care providers prepared to manage anaphylaxis that can be life-threatening."[1] As a general rule, any medication designated by the manufacturer to be administered in a health-care professional's office or designated by the manufacturer to be administered by a health-care professional will be subject to coverage under the medical benefit policy. The retail pharmacy coverage policy covers only those medications that are intended by the manufacturer for self-administration. The medical coverage policy 2009016 for this medication is available on the Arkansas Blue Cross Web site.

Until January 1, 2010, pre-authorization for Xolair® will be available by calling (501) 378-3392. Effective January 1, 2010, Xolair® will be subject to a pre-payment post-service review, the same review as other medications administered in physician's office, and the need for prior authorization will no longer be required.

Timeline summary:

- September 1, 2009 – Xolair® is no longer processed under the pharmacy benefit. It is billed under the medical benefit policy. Any requirements for a prior authorization will continue to be handled by the Arkansas Blue Cross Pharmacy Department at (501) 378-3392.
- January 1, 2010 – Xolair® will no longer require a prior authorization, but it will be subject to a pre-payment post-service review.

If you have any questions or need more information, please call the Arkansas Blue Cross Pharmacy Department at (501) 378-3392. (Reprinted from September 2009 issue of *Providers' News*)

[1] Xolair® prescribing information. South San Francisco, CA. Genentech, Inc: July 2008.

BlueCard®

Where and How do Providers Submit BlueCard® Claims?

Providers should submit BlueCard® claims electronically through the Advanced Health Information Network (AHIN) which is Arkansas Blue Cross and Blue Shield's preferred method of submitting claims. If a provider contracts with the member's Home Plan (for example: contiguous counties or overlapping service areas), then the provider should file the claim directly to the member's Home Plan. Providers need to include the member's complete identification number when submitting claims. The complete member identification number includes the three-character alpha prefix.

Do not make up alpha prefixes. Incorrect or missing alpha prefixes and member identification numbers only delay claims processing. Once Arkansas Blue Cross receives a claim, it is electronically routed to the member's Home Plan. The member's Home Plan processes the claim and approves payment and Arkansas Blue Cross will then pay the provider. (Reprinted from September 2009 issue of *Providers' News*)

BlueCard®

Claims Filing Procedures

With the New Year around the corner, many of your patients may receive new member ID cards. To help ensure prompt and accurate claims processing, please make sure you have a copy of the patient's current ID card and use that information when submitting claims.

As a provider servicing out-of-area BlueCard members, providers may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that providers have the most up-to-date information in a patient's file.

- Make copies of the front and back of the member's ID card and pass this key information to the billing staff.

- Blue Plan members' ID cards include a three-digit alpha prefix in the first three positions of the member's ID number. This alpha prefix identifies the member's Blue Plan and is critical for eligibility/benefits verification and claims processing. This may be followed by up to 14 additional characters, any combination of letters and numbers. When filing the claim, always enter the identification number exactly as it appears on the member's card, including the alpha prefix.

  Examples of ID numbers:
  ABC1234567
  ABC1234H567
  ABC12345678901234
  Alpha Prefix

- Remember: member ID numbers must be reported exactly as shown on the ID card. Do not add, omit or alter any characters from the member ID number.

- Verify the ID card at every visit and make sure the correct ID card is on file.

- File the claims to Arkansas Blue Cross using the exact ID card number, including the alpha prefix. Do not add, omit or alter any characters from the member ID number.

- To check eligibility, benefits, etc., send an electronic eligibility inquiry to AHIN or call 1-800-676-BLUE (2583) and provide the three letter alpha prefix.

If you have any questions, please contact your Network Development Representative or call Arkansas Blue Cross Provider Services.

BlueCard® Guides

How do provider's find out about the member's eligibility?

Call 1-800-676-BLUE (2583). With the member's most current ID card in hand, providers can check available membership and coverage information by calling BlueCard® Eligibility at 1-800-676-BLUE (2583). An operator will ask for the alpha prefix on the member's ID card and will connect callers to the appropriate membership and coverage unit at the member's Blue Cross and Blue Shield Plan.

If you are unable to locate an alpha prefix on the member's ID card, check for a telephone number on the back of the ID card.

BlueCard®

Include the Onset/Occurrence Date on Claims

Arkansas Blue Cross and Blue Shield is requesting that providers routinely include the "Date of Current Illness" or "Occurrence Code" and the associated date in their claim submissions. This will help eliminate the need to contact Customer Service when a claim needing this information denies unexpectedly. When submitting Electronic Professional claims, the Date of Current Illness (also known as the onset date) is Populated in Loop 2300, Segment DTP (Date – Onset of Current Illness/Symptom) to indicate the first date of the symptom, illness, accident or injury, or last menstrual period (LMP) for pregnancy. The first date, if the patient has had the same or similar illness, is populated in Loop 2300 Segment DTP (Date - Similar Illness/Symptom Onset).

When submitting Electronic Institutional claims, Occurrence Codes and associated dates are populated in Loop 2300 HI Segment (Occurrence Information) and defines a significant event related to the claim. The most commonly recognized Occurrence Codes by Arkansas Blue Cross are listed below.

Remember that the first date of service is not always the onset/occurrence date. Claims may process differently, depending on what date is entered. Be sure that the actual onset/occurrence date is entered on all claims. Providing this information at time of submission could eliminate delays in a claim being adjudicated.

Occurrence Code	Definition
01	Auto Accident
04	Accident – Employment Related
05	Other Accident
10	Last Menstrual Period (LMP)
11	Onset of Symptom/Illness
33	First Day of Medicare Coordination Period for End Stage Renal Disease (ESRD)

Unlisted Procedure Code Usage

Claims filed using unlisted procedure code must always include a description to avoid delays in the handling of claims. Effective January 1, 2010, all claims submitted using unlisted procedure codes with no description of the services indicated will be returned for a full description.

BlueCard®

Verifying Blue Member Eligibility

At Arkansas Blue Cross and Blue Shield, provider satisfaction is a top priority. Arkansas Blue Cross understands providers need the right tools and resources to provide the best care to Blue members. For both Arkansas members and Out-of-State Blue members, providers can:

- Submit eligibility requests online,
- Receive real-time responses to your eligibility requests, plus
- Extended service hours for providers. Arkansas Blue Cross now processes electronic eligibility requests Monday through Saturday, 6:00 a.m. to midnight Central Time.

To submit Online Eligibility requests for Out of State Blue members, follow these three easy steps:

1. Log in to Advanced Health Information Network (AHIN).
2. From the "Members" link located on the home page, select "Out of State BCBS/FEP". Enter "Member First" and "Last Name", "Date of Birth" and "Member ID" as it appears on the Members ID card. Select the "Type of Service" in which you would like to obtain member benefits.
3. Submit the request by selecting the "Search" button.

In addition to receiving eligibility verifications electronically, you can always call BlueCard® Eligibility line at 1-800-676-BLUE (2583)

Provider satisfaction is very important to Arkansas Blue Cross and we are committed to improving services to our providers. If you have any questions, don't hesitate to contact Arkansas Blue Cross by:

- Talking to our Provider Relations Representative.
- Visiting us online at arkansasbluecross.com/providers/ahin.aspx.

Access Only PPO Customers of USAble Corporation as of January 1, 2010

Access Only Group	PPO Network
Aalf's Manufacturing Inc / Midland's Choice	Arkansas' FirstSource PPO
Ark Sheet Metal Workers -Local #36-L	True Blue PPO
Arkansas Pipe Trades	True Blue PPO
Arkansas State University Athletes	Arkansas' FirstSource PPO
Arvest Bank	True Blue PPO
Ashley County Medical Center	Arkansas' FirstSource PPO

Access Only Group	PPO Network
BEKAERT - Rogers, AR Location	True Blue PPO - effective 12/1/09
BEKAERT - Van Buren, AR Location	True Blue PPO - effective 12/1/09
Brentwood Industries, Inc	Arkansas' FirstSource PPO
Bryce Corporation	True Blue PPO
Christus St. Michael - Cobra Employees.	Arkansas' FirstSource PPO
Diocese Of Little Rock / Christian Brothers	True Blue PPO - effective 9/1/09
Franklin Electric	Arkansas' FirstSource PPO
Harps Food Stores	True Blue PPO
Iberia Bank	True Blue PPO
KLA Benefits / Klipsch LLC	Arkansas' FirstSource PPO
LA Darling	True Blue PPO
Levi Hospital	Arkansas' FirstSource PPO
Magnolia Hospital	Arkansas' FirstSource PPO
Motor Appliance Corporation	Arkansas' FirstSource PPO
Nestle	True Blue PPO
Odom's Tennessee Pride Sausage	True Blue PPO
Razorback Concrete Company	True Blue PPO
Rea Magnet Wire	Arkansas' FirstSource PPO
Siplast Inc	Arkansas' FirstSource PPO
St. Michael - C H Wilkerson, Texarkana	Arkansas' FirstSource PPO
St. Michael Health System - Hospital	Arkansas' FirstSource PPO
St. Michael Health System - Rehabilitation Center	Arkansas' FirstSource PPO
Stevens Media Group	True Blue PPO
UFCW (Kroger & Consumer Market)	True Blue PPO
Wabash National / Cloud Corp	Arkansas' FirstSource PPO

Arkansas State and Public School Account Services/Codes that Require Pre-Certification

Several services, including but not limited to, high-tech radiology, physical and occupational therapy, speech therapy, and some outpatient surgeries require pre-certification by American Health Holding (AHH). Below are the specific codes and descriptions for services that have been identified as requiring the pre-certification. Provider who have questions about these services, please call American Health Holding at 1-800-592-0358 or fax to 866-317-0166.

Code Description	CPT and HCPCS Codes
All Inpatient Services	
Acute, Rehabilitation, Skilled Nursing, Cognitive/Neuro/Psych	
Outpatient Medical Procedures	
Intradiscal Electrothermal Therapy (IDET)	0062T, 0063T, 22526, 22527
Palatopharyngoplasty	42145
Varicose Vein Excision and Ligation	36475, 36476, 36478, 36479, 37700, 37718, 37722, 37760, 37765, 37766, 37785
Blepharoplasty and/or Brow Lift	15820,15821,15822,15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908
Gynecomastia Reduction	19300
Mammoplasty (Reduction or Augmentation)	19316, 19318, 19324, 19325
Rhinoplasty	30400, 30410, 30420, 30430, 30435, 30450
Panniculectomy	15830
Scar Revision: outside physician's office	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Septoplasty	30520
Durable Medical Equipment	
Glucose Monitoring Devices	A9277, A9278, S1030, and S1031
Defibrillator Vests (NO CODE)	E1399 and K0606
Spinal Cord Stimulator	L8680, L8685, L8686, L8687, and L8688
Insertion of spinal cord stimulator	63650, 63655, 63660. 63685, and 63688
Power Mobility Devices	E1230, E1239, K0010, K0011, K0012, K0800-K0898
Physical and Occupational Therapy	
Muscle and Range of Motion Testing	95831-95834, 95851-95852
Physical Medicine and Rehabilitation	97001-97546
Wound Care Management	97597-97755
Orthotic and Prosthetic Management	97760- 97799
Decompression/Repositioning	S9090, S9092
Electrical Stimulation	G0283
Services In A Home Setting	G0151, G0152, S9129, S9131
Revenue Codes	240, 420, 421, 422, 423, 424, 429, 430, 431, 432, 433, 434, 439

Arkansas State and Public School Account Services / Codes that Require Pre-Certification: (continued)

Code Description	CPT and HCPCS Codes
Speech Therapy	
Otorhinolaryngologic Services	92506-92508
Services In Home Setting	S9128, G0153
Revenue Codes	440, 441, 442, 443, 444, 449
High-Tech Radiology	
Head / Neck	70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 0042T
Chest	71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555
Spine & Pelvis	72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 77084
Upper Extremities	73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225
Lower Extremities	73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725
Abdomen	74150, 74160, 74170, 74175, 74181, 74182, 74183, 74185, 0066T, 0067T, S8037
Heart	75557, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 0144T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T, 0151T
Vascular	75635
Breast	77058 ,77059
Nuclear Medicine - Nervous System	78608, 78609
Nuclear Medicine - Cardiovascular System	78459, 78491, 78492
Nuclear Medicine - Other	78811, 78812, 78813, 78814, 78815, 78816, G0235
CT Scan, Limited	76380
Magnetic Rosonance Spectroscopy	76390
MRI Low Field	S8042

Arkansas State and Public School Employees Preventive Benefits (updated October 2009)

Arkansas State and Public School Employees and Retirees without Medicare have an Enhanced Wellness Benefit that offers members 100 percent coverage for many preventive services. There is no deductible, copayment or coinsurance required for the items on the chart below, if billed as listed, and not due to illness or a specific condition. These services are only covered 100 percent if billed by in-network providers.

CPT Codes	Ages	Diagnosis Code required
New Patient - Well Baby Visits:		
99381	Under 1 Year	Must be billed with diagnosis code V20.2
New Patient - Annual Preventive (Under 18 year of age):		
99382	Age 1-4	Early Childhood - Must be billed with diagnosis code V20.2
99383	Age 5-11	Late Childhood - Must be billed with diagnosis code V20.2
99384	Age 12-17	Adolescent - Must be billed with diagnosis code V20.2
New Patient - Annual Preventive (Over 18 years of age):		
99385	Age 18-39	Must be billed with diagnosis codes: V70.0, V72.31, or V76.10 - V76.19
99386	Age 40-64	
99387	Age 65+	
Established Patient - Well Baby Visits (Under 18 years of age):		
99391	Under 1 year	Must be billed with diagnosis code V20.2
Established Patient - Annual Preventive Care (Under 18 years of age):		
99392	Age 1-4	Early Childhood - Must be billed with diagnosis code V20.2
99393	Age 5-11	Late Childhood - Must be billed with diagnosis code V20.2
99394	Age 12-17	Adolescent - Must be billed with diagnosis code V20.2
Established Patient - Annual Preventive Care (Over 18 years of age):		
99395	Age 18-39	Must be billed with diagnosis codes: V70.0, V72.31, or V76.10 - V76.19
99396	Age 40-64	
99397	Age 65+	
Newborn Care - Well Baby Visits (under 18 years of age):		
99432	Under 1 Year	Must be billed with diagnosis code V20.2

Description	CPT Codes	Ages	Diagnosis Code Required
Preventive Care — Child:			
All Childhood immunizations	Mandated services	Through Age 18	Allowable with any diagnosis code.
Hepatitis A (Hep A)	90633 - 90634	One Series Per Lifetime	
Hepatitis B (Hep B)	90743 - 90744	One Series Per Lifetime	
Human papilloma virus (HPV)	Gardasil 90649	Age 9 - 18	
Influenza Vaccine	90657-90660	Codes specific for age	
Rotavirus	Rota Teq 90680	Age 8 - 32 weeks	
Meningitis	90733, 90734	Age 11 - 18	
Pneumococcal Conjugate Vaccine	90657-90660, 90732	Codes specific for age; Every five years	

Arkansas State and Public School Account Services / Codes that Require Pre-Certification: (continued)

Description	CPT Codes	Ages	Diagnosis Code Required
Preventive Care - Adult (Age 18 and over):			
Annual Physical		Age 18+	Must be billed with diagnosis codes: V70.0, V72.31, or V76.10-V76.19
Office Visit	99385 & 99395	Age 18-39	
Office Visit	99386 & 99396	Age 40-64	
Office Visit	99387 & 99397	Age 65+	
Laboratory Services	81000-81005, 80051, 80053, 80061, 85018, 85014, 85025, or 85027	Age 18+	

CPT Codes	Ages/Frequency	Diagnosis Code required
- Pap Smear		
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174-88175, G0101, Q0091	Age 18+ Annually	Allowable with any diagnosis code.
- Prostate Specific Antigen (PSA)		
84152, 84153, 84154, G0102, G0103	Age 40+ Annually	Allowable with any diagnostic code.

Description	CPT Codes	Ages/Frequency	Diagnosis Code Required
- Colorectal Cancer Screening (Choice of the following beginning at age 50):			
Fecal occult blood test and one of the following:	82270, 82274, G0107, G0328	Annually	Allowable with any diagnosis code.
- Sigmoidoscopy	45300 - 45339, G0104	Every 5 years	
- Colonoscopy	45378 - 45385, G0105 or G0121	Once every 10 yrs	
- Double contrast barium enema	74280, G0106	Once every 5 yrs	
- Cholesterol and HDL Screening			
Males Age 35+	82465, 83718—83721	Once every 5 yrs	Allowable with any diagnosis code.
Females Age 45+	82465, 83718-83721	Once every 5 yrs	
Immunizations – Adult (members age 18 and over):			
Diphtheria and Tetanus toxoid	90718-90719	Every 10 years	Allowable with any diagnosis code.
Hepatitis A & B (combined)	90636	Once Per Lifetime	
Hepatitis A (Hep A)	90632	Once Per Lifetime	
Hepatitis B (Hep B)	90740 (billed on time), 90747 (3 doses - billed 3 times), 90746 (4 doses - billed 4 times)	Once Per Lifetime	
Human Papilloma Virus (HPV)	Gardasil 90649	Age 19 - 26	
Influenza	90658	Annually	
Pneumococcal Conjugate	90732	Age 18 and over; Once every five years	
Meningitis	90733, 90734	Age 18 - 27	
Herpes Zoster (or a $30 copay at pharmacy)	90736	Adults 60 and over; Once per lifetime	

Screening Mammogram (including breast exam):		
Mammogram - with computer-aided detection	77052 billed with 77057 or G0202	Allowable with any diagnosis code.
Digital Mammogram - computer aided detection add-on codes are ineligible when billed with a digital mammogram	77051 billed with 77055, 77056, G0204, G0206 or Rev Code 403	

Myocardial Perfusion Imaging

CPT 78465 is the appropriate code for a SPECT rest and stress myocardial perfusion scan. Most often, both parts of this test are performed in one day. Sometimes, the rest portion is done on one day and the stress portion is done on a different day. In both cases, the appropriate code is a single instance of CPT 78465. Some providers have done portions of the test on different days and billed for two instances of CPT 78464 or for CPT 78464 on one day and CPT 78465 on a different day. Both of these represent incorrect coding and will be denied as fragmentation. Even if the test spans more than one day, it should be reported as a single instance of CPT 78465. In the rare instance when two independent SPECT myocardial perfusion imaging studies are completed within a short time, records should be submitted to justify the coding.

Medi-Pak Remittance Advice

Modifications were made to the Medi-Pak Remittance Advice (RA) effective with remittance advices created the week of December 7, 2009. Reversals, corrections, and related receivable lines for adjustments, excluding additional payments, will now be printed on a separate page of the Medi-Pak RA with a heading of "CLAIM ADJUSTMENTS, EXCLUDING ADDITIONAL PAYMENTS". This change should make it easier for providers to balance to the check amount. The claim data will be displayed in patient name order within the claim payment section and within the claim adjustment section.

Federal Employee Program 2010 Benefit Changes

Changes to the Standard Option:

- **Preferred retail pharmacies:** A member may be eligible to receive their first four generic prescriptions filled (and/or refills ordered) per drug per calendar year at no charge when the member changes from certain brand-name drugs to a corresponding generic drug replacement.
- **Catastrophic Protection Out-of-Pocket Maximum:** The amount the member pays for the member calendar year deductible no longer accumulates towards the member's Catastrophic Protection Out-of-Pocket Maximum. Previously, deductible amounts did accumulate towards the catastrophic maximum. In addition, the coinsurance and copayment amounts the member pays for mental health and substance abuse care performed by non-preferred providers are now included in the member Catastrophic Protection Out-of-Pocket Maximum. Previously, these types of expenses did not accumulate towards the maximum.
- **Copayments:** The member's copayment for office visits to preferred specialists are now $30 per visit. The member's $20 copayment for office visits to preferred primary care providers has not changed. Previously, the member paid $20 for visits to both specialists and primary care providers.
- **Coinsurance:** The member's coinsurance amount for certain non-preferred professional and outpatient facility services are now 35 percent of the Plan's allowance. Previously, the member's coinsurance amount was 30 percent of the Plan's allowance for certain medical and surgical services and 40 percent of the Plan's allowance for certain mental health and substance abuse services.
- **Anesthesiology:** Members now pay 35 percent of the Plan's allowance (plus any difference between the Arkansas Blue Cross and Blue Shield allowance and the billed amount) for anesthesia provided by a non-participating anesthesiologist or certified registered nurse anesthetist (CRNA) (deductible applies). Previously, members paid 100 percent of the amount billed up to a maximum of $800.
- **Inpatient Care:** The member's copayment for inpatient care at non-preferred hospitals is now $350 per admission. Previously,

(Continued from page 16)

members paid $300 per admission for medical and surgical care, and $400 per day for mental health and substance abuse care.

- **Outpatient Mental Health and Substance Abuse Care:** Benefits for outpatient mental health and substance abuse care are no longer limited to 25 visits per year. However, members must now obtain prior approval for outpatient mental health and substance abuse care in order to receive benefits. Previously, if members did not obtain prior approval, Arkansas Blue Cross provided benefits at non-preferred benefit levels.
- **Inpatient Mental Health Care:** Benefits for inpatient mental health care at non-preferred facilities are no longer limited to 100 days per calendar year.
- **Inpatient Substance Abuse Care:** Benefits for inpatient care at non-preferred facilities to treat substance abuse are no longer limited to a single 28-day stay per lifetime.
- **Emergency Room Care:** Member's copayments for professional care provided in an emergency room by non-participating providers are waived when Medicare Part B is the primary payer.
- **Member's Responsibility:** Member's responsibility for the difference between the Nonparticipating Provider Allowance (NPA) and the billed amount may be limited.

Changes to the Basic Option:

- **Copayment:** The member's copayment for office visits to preferred specialists is now $35 per visit. Previously, the member paid $30 per visit. The member's $25 copayment for office visits to preferred primary care providers has not changed.
- **Inpatient Care Copayments:** The member's copayment for inpatient care at preferred hospitals is now $150 per day, up to $750 per admission. Previously, the member paid $100 per day, up to $500 per admission.
- **Maternity Services:** The member's total responsibility for facility-billed maternity services provided at preferred facilities is now limited to $150 per admission. Previously, the member paid $100 for the member inpatient facility care and $50 for each maternity-related visit to the outpatient department of a preferred facility, plus 30 percent of the Plan's allowance for drugs received in the outpatient department.
- **Outpatient Facility Care Copayment:** The member's copayment for most outpatient facility care at preferred hospitals is now $75 per day per facility. Previously, the member paid $50 per day.
- **Colonoscopy Screening:** The member's copayment for screening colonoscopies provided in the outpatient department of a preferred hospital is now $25. Previously, the member's paid $50 for a colonoscopy screening at preferred facilities.
- **Non-Preferred Brand-Name Drugs:** The member's coinsurance for nonpreferred brand-name drugs will not accumulate towards the Member Catastrophic Protection Out-of-Pocket Maximum.
- **Allowance for Drugs and Supplies:** The member pays 30 percent of the Arkansas Blue Cross allowance for drugs and supplies administered or obtained in connection with the member's care.
- **Screening Procedures:** Arkansas Blue Cross will provide benefits in full for screening procedures billed by the outpatient department of a hospital or ambulatory surgical center (does not include screening colonoscopies).

Changes to both the Standard and Basic Options:

- **Never Events:** Preferred and nonpreferred hospitals will not be able to bill the member for any inpatient services related to specific types of medical errors and hospital-acquired conditions known as "Never Events". In addition, Arkansas Blue Cross will no longer provide benefits to preferred and nonpreferred hospitals for inpatient services related to "Never Events".
- **Preventive Care:** Arkansas Blue Cross will now provide preventive care benefits for individual counseling on prevention and reducing health risks. In addition, Arkansas Blue Cross will now provide preventive care benefits for the administration and interpretation of a Health Risk Assessment (HRA) questionnaire. The member must use a preferred provider in order to receive these benefits.
- **Blue Health Assessment:** Members now have access to the Arkansas Blue Cross online "Blue Health Assessment" tool which confidentially assesses the member's overall health, identifies potential health risks, and provides the member with a personal health action plan – at no charge. The member may be entitled to receive an annual physical examination or one visit for counseling on prevention and reducing health risks at no charge when they complete a Blue Health Assessment questionnaire and sees a preferred health care provider.
- **Jump 4 Health Weight Management Program:** Children age 5

(Continued from page 17)

through 17 who meet certain Body Mass Index (BMI) criteria may be eligible to participate in our new Jump 4 Health Weight Management Program and receive up to four nutritional counseling visits at no cost when they use preferred providers.

- **H1N1 Vaccine:** Arkansas Blue Cross now provides benefits for the H1N1 (swine) influenza vaccine.
- **Generic Drugs:** Members have received information clarifying the advantages of using generic drugs.
- **Vaccine Network:** Many of the preferred retail pharmacies now participate in the Arkansas Blue Cross vaccine network, allowing members the convenience of receiving certain vaccines at no charge at pharmacies in the vaccine network. Members now have benefits for Human Papillomavirus (HPV), Meningococcal, Pneumococcal, and Herpes Zoster (shingles) vaccines provided by preferred retail pharmacies that participate in the Arkansas Blue Cross vaccine network. Previously, these vaccines were not available through the vaccine network.
- **Speech-Generating Devices:** Members now have benefits for speech-generating devices, limited to $1,000 per calendar year.
- **Oxygen:** Members now have benefits for oxygen billed for by skilled nursing facilities, nursing homes, and extended care facilities. Previously, benefits were not available for these types of expenses.
- **Nutritional Counseling:** Members now have benefits for up to six nutritional counseling visits per year. Previously, Arkansas Blue Cross provided benefits for up to four nutritional counseling visits per year.
- **Stem Cell Transplants:** Members now have benefits for additional types of stem cell transplants.
- **Inpatient Hospice Care:** Members now have benefits for up to seven days of inpatient hospice care for members not previously enrolled in a home hospice care program, in addition to seven days of inpatient care every 21 days for members enrolled in a home hospice care program. Previously, members had benefits for up to five days of inpatient hospice care only for those members already enrolled in a home hospice program. Also, members now have benefits for up to seven days of continuous home hospice care. Previously, benefits were not available for this type of hospice care.
- **Chiropractors:** Doctors of Chiropractic (DC) are now listed as "physicians." Previously, these types of providers were listed as "other covered health care professionals." Arkansas Blue Cross also clarified reimbursable chiropractic services.
- **Mental Health and Substance Abuse Professionals:** Arkansas Blue Cross added licensed mental health and substance abuse professionals who provide mental health and/or substance abuse services within the scope of their license, to the list of covered health care professionals.
- **Outpatient Intensity-Modulated Radiation Therapy (IMRT):** Members must now obtain prior approval for outpatient intensity-modulated radiation therapy (IMRT). Previously, these types of services did not require prior approval.
- **Surgical Procedures by Non-Participating Provider:** Members may request prior approval and receive specific benefit information in advance for surgical procedures (including maternity care) to be provided by a non-participating provider when the charge for that care will be $5,000 or more.
- **Outpatient Exams and Screening:** Clarification was made to the member regarding the benefit payment levels that apply to routine physical examinations and screening procedures performed in the outpatient department of a hospital.
- **Colonoscopies:** Clarification was made to the member regarding the benefit payment levels that apply to colonoscopies.
- I**mmunizations and Vaccines:** Clarification was made to the member regarding U.S. Food and Drug Administration (FDA) limitations on the use of immunizations and vaccines.
- **Telephone Consultations:** Clarification was made to the member regarding benefits that are not available for telephone consultations related to the member's medical care.
- **Genetic Screening:** Benefits are not available for genetic screening.
- **Oral Tocolytic Agents:** Maternity care benefits are not provided for oral tocolytic agents.
- **Deluxe Lens:** Benefits are not available for deluxe lens features for eyeglasses.
- **Private Duty Nurses:** Benefits are not available for private duty nursing in any setting.
- **Van Services:** Benefits are not available for wheelchair van services or gurney van services.
- **Shift Differentials:** Benefits are not available for professional charges for shift differentials.

Federal Employee Program New Wellness Initiatives Under the Service Benefit Plan

Beginning January 1, 2010, the Federal Employee Program (FEP) Service Benefit Plan will reward members when they complete either the adult Blue Health Assessment or a child's BMI assessment. The intent of these programs is to encourage wellness and prevention and aim to remove barriers to care.

The member reward will be enhanced benefits:

If an adult member completes the Blue Health Assessment, the copayment for their subsequent physical examination or an individual preventive counseling visit will be waived. The member will receive a certificate that entitles them to a preventive visit at no charge and the member will be directed to present the certificate to the physician at the time care is rendered. The member must complete the Blue Health Assessment and present a certificate of completion in order for the provider to waive the copayment for the visit.

The second incentive targets children who complete a BMI assessment. Once the BMI assessment is complete, the member will receive a certificate to present at the time care is rendered. The copayments for up to four nutritional counseling visits will be waived. The incentive is limited to children ages 5 through 17 whose BMI falls in the 85th percentile or higher according to standards established by the Centers for Disease Control and Prevention (CDC). Only those children who meet these requirements will be presented with a certificate. The member must complete the child BMI Assessment and present a certificate of completion in order for the provider to waive the copayment for the visit.

The certificate for both programs will include the member's name, contract ID number, effective date and expiration date.

Provider Instructions:

1. If a FEP Service Benefit Plan member presents a certificate, please do not collect the copayment amount from the member at the time the service is rendered. The reimbursement from the local BlueCross and BlueShield Plan will include the amount of the copayment.
2. If a member presents a certificate and an office visit copayment is collected in error for these types of visits, provider will be required to refund the copayment amount to the member upon receiving payment from the local BlueCross and BlueShield Plan.
3. To ensure correct reimbursement, the claim must be filed with the appropriate evaluation/management procedure code and diagnosis to reflect that the visit was primarily a routine/annual examination for adults or the appropriate medical nutrition therapy/nutritional counseling codes and diagnosis to reflect the visit was primarily a nutritional counseling visit for children.
4. Providers may retain the certificate for their records; it is not required to submit the certificate with the claim.
5. The child certificate encompasses four visits, so providers are asked to sign and date the certificate when presented by the member in order for the member to track usage of visits.
6. For questions about the certificate or the process, please contact the local BlueCross and BlueShield Plan.

Members will be instructed not to pay their copayments for these visits, so Arkansas Blue Cross wants to ensure members do not get charged copayment amounts for these visits. Please follow these important directions and do not charge a copayment when a member brings in a certificate. Reimbursement for these visits will be 100 percent of the Plan allowance, including payment of the copayment amount.

What action do providers need to take?

1. Please ensure that the entire office staff is aware of these programs and the process, especially those that normally collect member copayments and arrange appointments. If the patient is a FEP Service Benefit Plan member, providers may want to ask if they have a certificate to waive the copayment amount.
2. Beginning January 1, 2010, providers should follow the directions on the certificate that are listed above when a certificate is presented by a FEP Service Benefit Plan member to ensure a positive member experience with provider's office and the patient's health coverage.

Arkansas Blue Cross hopes these programs will encourage wellness and prevention. We appreciates your support of these programs which encourage good health practice for our FEP Service Benefit Plan members.

FEP: Sample Certificate for Annual Physical Exam or Individual Preventive Counseling

XXXXXXXXX

MyBlue Wellness Certificate

Sample A. Sample
MEMBER NAME

XXXXXXXXXXXXXX
CONTRACT ID#

This certificate entitles the above Service Benefit Plan member to:

One (1) Free Annual Physical Examination or Individual Preventive Counseling Office Visit at a BlueCross BlueShield Plan Preferred Provider. Valid from XX/XX/XXXX to XX/XX/XXXX.

Provider Information and Instructions

- *Please do not collect copayment amount from the member at time of visit. Your reimbursement for this visit will include the payment of the copayment.*
- *If you collect an office visit copayment in error for this visit, you will be required to refund this amount to the member upon receiving payment from the BlueCross BlueShield Plan.*
- *To ensure correct reimbursement this claim must be filed with the appropriate evaluation/management procedure code and diagnosis to reflect that the visit was primarily a routine/annual examination.*
- *You may retain this certificate for your records; it is not required to be submitted with the claim.*
- *If you have a question about this certificate or the process, please contact the local BlueCross BlueShield Plan.*

BlueCross BlueShield
Federal Employee Program

BLUE HEALTH ASSESSMENT

SAMPLE

XXXXXXXXX

MyBlue Wellness Certificate

Sample A. Sample
MEMBER NAME

XXXXXXXXXXXXXX
CONTRACT ID#

This certificate entitles the above Service Benefit Plan member to:

Four (4) Nutritional Counseling Visits with no member cost-share at a BlueCross BlueShield Plan Preferred Provider upon presentation of this certificate. Valid from XX/XX/XXXX to XX/XX/XXXX.

❑ Visit #1 Acknowledgement: PROVIDER SIGNATURE _____ DATE _____

❑ Visit #2 Acknowledgement: PROVIDER SIGNATURE _____ DATE _____

❑ Visit #3 Acknowledgement: PROVIDER SIGNATURE _____ DATE _____

❑ Visit #4 Acknowledgement: PROVIDER SIGNATURE _____ DATE _____

SAMPLE

Provider Information and Instructions

- *Please sign and date the certificate when presented by the member in order for the member to track usage of visits.*
- *Please do not collect copayment or coinsurance amount from the member at time of visit. Your reimbursement for these visits will include the payment of the member copayment or coinsurance.*
- *If you collect an office visit copayment in error for any of these visits, you will be required to refund this amount to the member upon receiving payment from the BlueCross BlueShield Plan.*
- *To ensure correct reimbursement this claim must be filed with the appropriate medical nutrition therapy/nutritional counseling codes and diagnosis to reflect the visit was primarily a nutritional counseling visit.*
- *You may retain this certificate for your records after the fourth visit; it is not required to be submitted with the claim.*
- *If you have a question about this certificate or the process, please contact the local BlueCross BlueShield Plan.*

BlueCross BlueShield
Federal Employee Program

Healthy Kids Healthy Teens Healthy Families

Coverage Policy Manual Updates

The following policies were added or updated in the Arkansas Blue Cross and Blue Shield Coverage Policy Manual since September 2009. To view the entire policies, access the coverage policies located on the Arkansas Blue Cross Web site at arkansasbluecross.com.

New Policies

Policy ID	Policy Name
2009018	Percutaneous or Intraoperative, Treatment of Fracture Non-Unions or Bone Defects with Autologous Bone Marrow with or without Demineralized Bone Matrix (DBM)
2009026	Biofeedback as a Treatment of Headache
2009031	Ingestible pH and Pressure Capsule
2009032	Genetic Test: Allomap Testing
2009033	Femoroacetabular Impingement, Surgical Treatment of
2009037	Genetic Test: JAK2 Mutation Test for Myeloproliferative Disorders
2009038	Shoulder Resurfacing
2009039	Intraepidermal Nerve Fiber Density
2009040	Radioimmunotherapy in the Treatment of Non-Hodgkin Lymphoma
2009041	Electrocardiographic Body Surface Mapping
2009042	Embolectomy, Mechanical, Endovascular, for Treatment of Acute Stroke
2009044	Electrical Stimulation, Vagus Nerve Stimulation for Treatment of Obesity
2009045	Electromagnetic Navigation Bronchoscopy
2009046	Genetic Test: Breast Cancer Predict; Risk of Distant Metastasis to Determine Need for Adjuvant Chemotherapy (Mammostrat®)
2009029	Immune Cell Function Assay in Solid Organ Transplantation
2009030	Genetic Test: Non-BRCA Breast Cancer Risk Assessment (OncoVue)

(Continued from page 22) Coverage Policy Manual Updates

Updated Policies

Policy ID	Policy Name
1997008	Measurement of Apolipoprotein B
1997052	Inotropic Agents for Congestive Heart Failure
1997130	Cardiac Event Recorder, Continuous 24-Hr (Holter)
1997210	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, TomoTherapy
1997249	Pain Management, Facet Nerve Denervation, other than Radiofrequency
1997257	Air Fluidized Beds
1998076	Meniscal Allograft Transplantation
1998099	Electrical Stimulation, Deep Brain (e.g. Parkinsonism, dystonia, multiple sclerosis, post-traumatic dyskinesia)
1998104	Transplant, Liver
2000009	HDC & Autologous Stem &/or Progenitor Cell Support-Multiple Myeloma
2000021	Photodynamic Therapy for Ophthalmology
2000046	HDC & Allogeneic or Autologous Hematopoietic Stem Cell Support-Malignant Astrocytomas & Gliomas
2001010	Breast Ductal Lavage for Detection of Malignancy
2003056	Celiac Disease Antibody Testing
2004037	Implantable Infusion Pump
2004054	Whole Body Computed Tomography Scan as a Screening Test
2005014	Abarelix (Plenaxis™)
2005018	HDC Progenitor Cell Support AL Amyloidosis (Light Chain Amyloidosis)
2006041	Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)
2008002	Transanal Endoscopic Microsurgery (TEMS)
2008019	Arthroplasty, Reverse Shoulder
2009010	Phototherapy, (UVA-1)

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 January 1, 2010.

HCPCS Codes	Code Description	Updated Fee (Per Diem)
S9374	Home infusion therapy, hydration therapy; one liter per day	$42
S9375	Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day	$42
S9376	Home infusion therapy, hydration therapy, more than two liters but not more than three liters per day	$42
S9377	Home infusion therapy, hydration therapy, more than three liters per day	$42
Total Parenteral Nutrition (TPN)		
S9365	Home infusion therapy, TPN; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (includes standard TPN formula, lipids, specialty amino acid formulas. Drugs and nursing visits coded separately) per diem	$150
S9366	Home infusion therapy, TPN; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (includes standard TPN formula, lipids, specialty amino acid formulas. Drugs and nursing visits coded separately) per diem.	$195
Antibiotic, Antiviral or Antifungal Therapy		
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), per diem.	$55
S9500	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours	$55
S9501	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours	$55
S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours	$55
S9503	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 6 hours	$55
S9504	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 4 hours	$55

(Continued from page 24) Home Infusion Therapy Services

Chemotherapy		
S9330	Home infusion therapy; continuous chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs an nursing visits coded separately), per diem.	$48
S9331	Home infusion therapy; intermittent chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs an nursing visits coded separately), per diem.	$48
Continuous Home Infusion Therapies		
S9336	Home infusion therapy, continuous anticoagulant infusion therapy (e.g., heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately) per diem	$35
S9345	Home infusion therapy, anti-hemophilic agent infusion therapy (e.g., factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately) per diem	$35
S9346	Home infusion therapy, alpha-1-proteinaseinhibitor (e.g. Prolastin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately) per diem	$35
S9348	Home infusion therapy, sympathomimetic / inotropic agent infusion therapy (e.g. Dobutamine); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs & nursing visits coded separately) per diem	$35
S9351	Home infusion therapy, continuous anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately) per diem	$37
S9353	Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately) per diem	$ 35
S9359	Home infusion therapy, anti-tumor necrosis factor intravenous therapy; (e.g., Infliximab) administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately) per diem	$35
Intermittent Home Infusion Therapy Injection, IM, SUBQ, IV Push Therapies		
S9363	Home infusion therapy, anti-spasmodic intravenous therapy; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	$ 35
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), per diem (do not use this code with S9326,S9227 or S9328)	$42
S9326	Home infusion therapy, continuous pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	$42

Fee Schedule

Fee Schedule Updates

The following CPT and HCPCS codes were 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
77371	$1,212.11	$0.00	$1,212.11	$1,212.11	$0.00	$1,212.11
90470	$26.67	$0.00	$0.00	$0.00	$0.00	$0.00
90650	$128.00	$0.00	$0.00	$0.00	$0.00	$0.00
A4606	$20.18	$0.00	$0.00	$0.00	$0.00	$0.00
A5500	$61.48	$0.00	$0.00	$0.00	$0.00	$0.00
A6534	$90.13	$0.00	$0.00	$0.00	$0.00	$0.00
A6542	$347.84	$0.00	$0.00	$0.00	$0.00	$0.00
A6549	$73.92	$0.00	$0.00	$0.00	$0.00	$0.00
G9141	$26.67	$0.00	$0.00	$0.00	$0.00	$0.00
G9141	$34.38	$0.00	$0.00	$0.00	$0.00	$0.00
G9142	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q2024	$137.50	$0.00	$0.00	$0.00	$0.00	$0.00
S0625	$108.60	$45.00	$63.60	$0.00	$45.00	$0.00
S2118	$0.00	$0.00	$0.00	$1,899.63	$0.00	$0.00
V5265	$8.51	$0.00	$0.00	$0.00	$0.00	$0.00

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providers' news staff

Providers' News is published four times a year for providers and their office staffs by Arkansas Blue Cross and Blue Shield.

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Please Note

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company and its affiliates. The newsletter does not pertain to Medicare. Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

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