september 2010

providers' news

A publication for participating providers and their office staffs

inside

Observation bed place of service code – physician services

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

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

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

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

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

Health care reform impacts member policies differently

The newly enacted health care reform legislation will be implemented in phases until it is fully effective in 2014. During the implementation process, we will strive to give you important information and clarify how these changes will impact your day to day business with Arkansas Blue Cross Blue Shield, affiliates and subsidiaries.

It is important to understand that not all member plans will be required to meet all the coverage requirements of the new health care reform law. Policies that are "grand-fathered" are exempt from some of the requirements of health care reform. Conversely, certain changes must be made to all plans, whether they are grand-fathered or not. Additionally, HHS has not yet defined "essential health benefits", as we await additional guidance from HHS, we are making a good faith effort to comply with the regulations, which includes removal or changes to applicable annual dollar and lifetime dollar benefit maximums.

Because the health care reform provisions are implemented based on the plan or policy issue date, the date that provisions are effective will vary from member to member. The effective date will also be affected by the policy type (group or individual) and other factors. As an example, the provisions that take effect on September 23, 2010 will be implemented for most group policies at the first renewal occurring on or after that date. Individual policies will have effective dates that are based on the policy year date, which is almost always January 1, 2011.

We understand that there may be challenges in understanding when and how provisions apply to specific policies, and we want to help keep your eligibility and benefits process simple. As member coverage is modified to reflect the new benefits associated with health care reform, our systems will be updated to share the most up-to-date benefit information. We encourage you to continue verifying eligibility and benefits for your patients by using AHIN. AHIN every day and hour has the most up to date information available on your patients benefits.

If you are not currently using the AHIN system and would like information regarding this shareware program, please contact your Network Development Representative or visit our Web site at www.ArkansasBlueCross.com. Click on the "Provider" link and then click on "AHIN".

PCIP: New federal "pre-existing condition insurance plan" policyholders to access True Blue PPO provider network

As you may be aware, as part of the recently enacted Patient Protection and Affordable Care Act (PPACA), the new federal "Pre-existing Condition Insurance Plan" (PCIP) will provide health insurance coverage for up to 2,500 Arkansans for a limited time, based on availability of federal funds.

In Arkansas, the federal PCIP is administered by the Arkansas Comprehensive Health Insurance Pool (CHIP) and its subcontractor, BlueAdvantage Administrators of Arkansas, through a contract with the U.S. Department of Health and Human Services. CHIP also will continue to offer state-based pools for those who do not qualify for PCIP.

New federal PCIP policyholders will access the True Blue PPO network of health care providers.

Enrollment in the federal PCIP began August 1, 2010. The earliest effective date for coverage

PCIP: New federal "pre-existing condition insurance plan" policyholders to access True Blue PPO provider network (continued from page 2)

was September 1, 2010. PCIP policyholders will receive health plan ID cards as their coverage is approved.

PCIP is an individual, comprehensive major medical insurance plan for individuals. There is an annual deductible of $1,000. The annual out-of-pocket maximum for services performed by network providers is $2,000. PCIP has prescription drug coverage with $10, $30 and $70 copayments.

PCIP will not deny any applicant coverage or benefits simply because of health status. PCIP coverage is expected to last until 2014, when similar coverage will be available through health insurance exchanges.

PCIP covers many of the benefits policyholders would get from private health insurance plans, including:

- Prescription drug coverage ($10, $30 and $70 copayments)
- Care in medical offices for illness or injury
- Emergency services
- Inpatient and outpatient hospital services
- Coverage for pregnancy
- Certain transplants
- Diabetes treatment, equipment and supplies
- Home health care, skilled nursing and hospice care
- Outpatient rehabilitative services
- In-network wellness services and screening (subject to $25 copayment)
- Behavioral health services
- Inpatient and outpatient mental health and substance abuse services
- And more

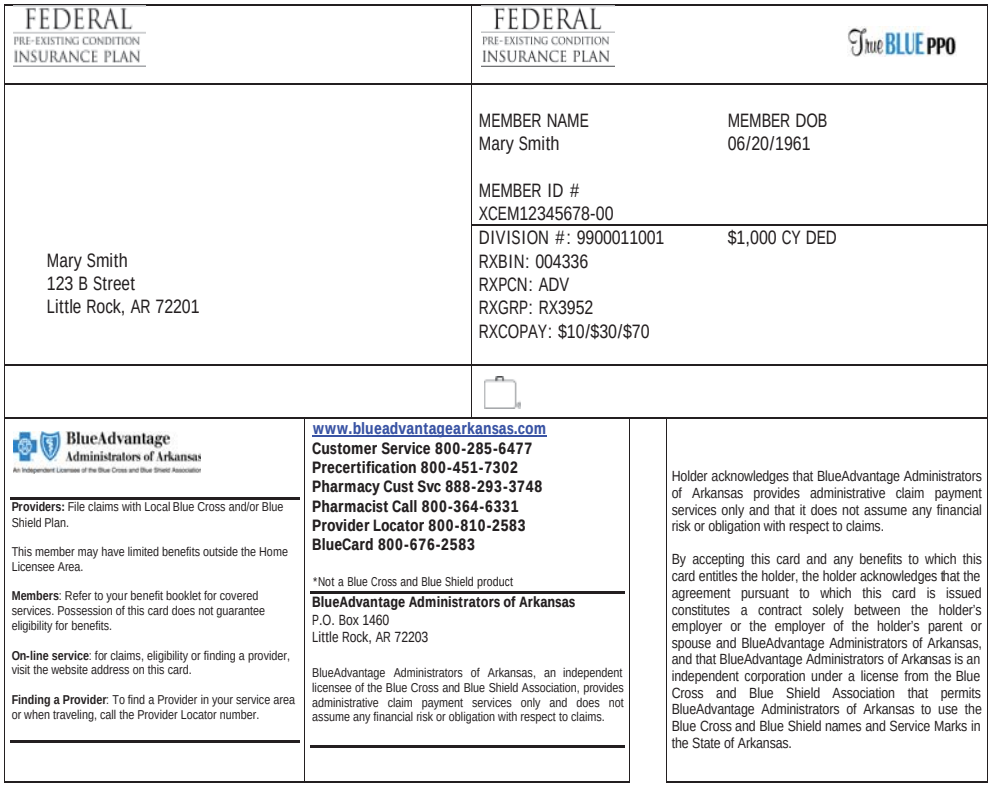
Most in-network services are subject to deductible and are reimbursed at 80 percent. Individuals may qualify for PCIP if they:

- Are an Arkansas resident;
- Are a U.S. citizen or national or an alien lawfully present in the United States;
- Have been uninsured for at least six months; and
- Within the last six months, have either been denied individual coverage, or been offered coverage only with an exclusionary rider, in the Arkansas individual insurance market.

Health care providers should follow the same process for submitting PCIP policyholder claims as currently done for other True Blue PPO members.

Eligibility, benefit and claims information may be found on the Advanced Health Information Network (AHIN) or by calling PCIP Customer Service toll free at 1-800-285-6477.

More information about PCIP can be found on the CHIP Web site at www.chiparkansas.org.


FEDERAL PRE-EXISTING CONDITION INSURANCE PLAN

FEDERAL PRE-EXISTING CONDITION INSURANCE PLAN

True BLUE PPO

MEMBER NAME
Mary Smith

MEMBER DOB
06/20/1961

MEMBER ID #
XCEM12345678-00

DIVISION #: 9900011001
RXBIN: 004336
RXPCN: ADV
RXGRP: RX3952
RXCOPAY: $10/$30/$70

$1,000 CY DED

Mary Smith
123 B Street
Little Rock, AR 72201

BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

Providers: File claims with Local Blue Cross and/or Blue Shield Plan.

This member may have limited benefits outside the Home Licensee Area.

Members: Refer to your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits.

On-line service: for claims, eligibility or finding a provider, visit the website address on this card.

Finding a Provider: To find a Provider in your service area or when traveling, call the Provider Locator number.

www.blueadvantagearkansas.com
Customer Service 800-285-6477
Precertification 800-451-7302
Pharmacy Cust Svc 888-293-3748
Pharmacist Call 800-364-6331
Provider Locator 800-810-2583
BlueCard 800-676-2583

*Not a Blue Cross and Blue Shield product

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203

BlueAdvantage Administrators of Arkansas, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claim payment services only and does not assume any financial risk or obligation with respect to claims.

Holder acknowledges that BlueAdvantage Administrators of Arkansas provides administrative claim payment services only and that it does not assume any financial risk or obligation with respect to claims.

By accepting this card and any benefits to which this card entitles the holder, the holder acknowledges that the agreement pursuant to which this card is issued constitutes a contract solely between the holder's employer or the employer of the holder's parent or spouse and BlueAdvantage Administrators of Arkansas, and that BlueAdvantage Administrators of Arkansas is an independent corporation under a license from the Blue Cross and Blue Shield Association that permits BlueAdvantage Administrators of Arkansas to use the Blue Cross and Blue Shield names and Service Marks in the State of Arkansas.

In-network laboratories should be used

Physicians need to ensure that contracted reference laboratories are used if specimens are sent outside of a clinic. Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas, Heath Advantage and all other affiliated companies are receiving claims from labs that are not contracted. It is a contractual obligation that all contracted providers use other contracted providers when making referrals or using outside services.

In addition, we are receiving claims from out-of-state laboratories that are not contracted. The Blue Cross and Blue Shield Association claims-filing rules require that specimens collected within a Blue Plan's service area be filed directly to that local Blue Plan. Therefore, all specimens collected in Arkansas for all Blue Cross and affiliated companies' members, must be filed directly to Arkansas Blue Cross or its affiliates and subsidiaries. Claims for specimens collected in Arkansas should not be filed directly to another Blue Plan.

Ameritox, Berkeley, Genzyme, Myriad and Prometheus Labs are not contracted with Arkansas Blue Cross nor its local affiliates and subsidiaries.

If a provider needs a higher-level lab service, one that the provider does not believe can be processed within Arkansas, please first consult with some of the national labs with whom we have provider agreements. Some of them own other companies that likely may accommodate your service and are contracted with Arkansas Blue Cross and its family of companies. Please also check our Web sites to ensure that the service being ordered is covered by meeting our primary coverage criteria.

Payment for claims from out-of-network lab providers, both in state and out of state, may be denied, or at a minimum, the member will pay a higher portion.

HIPAA changes requiring ICD-10 procedure and diagnosis codes

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) published the "HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD–10–CM and ICD–10–PCS" final rule.

This rule will require that ICD-10 CM diagnosis codes be used instead of ICD-9 CM diagnosis code within all HIPAA electronic transactions beginning on October 1, 2013. This rule will also require that all inpatient procedures be reported using ICD-10 PCS codes instead of ICD-9 CM volume 3 codes beginning on October 1, 2013 as well. Outpatient institutional procedure codes and all professional procedure will continue using CPT 4 and HCPCS codes.

HHS also published the final rule that will require all HIPAA transactions to be transmitted in the ASC X12 5010 format by January 1, 2012. The current ASC X12 4010A1 format will not accommodate the use of ICD-10 codes. With the compliance date for the 5010 formats being January 1, 2012 and the ICD-10 codes becoming the mandate on October 1, 2013, HHS is allowing 21 additional months to complete all necessary work to accommodate the ICD-10 codes after the 5010 has become the standard.

When discussing HIPAA compliance with your vendors, please be sure to ask about their strategy for adopting the 5010 standard and the ICD-10 standards for all HIPAA covered transactions. Arkansas Blue Cross and Blue Shield is ready to begin testing 5010 claims transactions now. To begin testing, please contact EDI Services at 501-378-2419 or 1-866-582-3247 for further instructions.

AHIN

AHIN user administrator

The Advanced Health Information Network (AHIN) continues to look for ways to improve processes in providing health care professionals with the information they need at the point of service. In today's health care environment, Arkansas Blue Cross and Blue Shield understands the need for efficiency and a provider's desire to spend less time on the telephone and more time with their patients.

In order to provide better assistance, AHIN has implemented several improvement processes over recent months, the newest of these being the role of AHIN User Administrator (AUA). The AUA plays a vital role in the support of AHIN users. The AUA has the ability to add users, delete users, reset passwords and manage the AHIN access for each user within their facility. The AUA also has the capability to access Medicare eligibility on AHIN and to give this access to other users within their facility.

All facilities are required to have an AUA by October 1, 2010. If your facility does not have an AUA, please log on to the AHIN home page. Once logged on, if you see the alert banner at the top of the home page, this means you do not have an AUA at your facility. Please follow the instructions provided in the alert to access the AUA request as well as the AUA role and responsibilities. Please review the importance of the role and responsibilities of the AUA. Once AHIN has received a request, you will be contacted by an AHIN representative. If you need more information, please call AHIN Customer Support at 501-378-2336 or e-mail customersupport@ahin.net.

New claims editing software to be implemented

Arkansas Blue Cross and Blue Shield will be implementing a new claims editing software, Claim Check Plus, during October and November. Claim Check Plus is designed to evaluate billing information and coding accuracy on submitted claims. It is guided by the coding criteria and protocols in the CPT Manual that are published by the American Medical Association and reflective of Arkansas Blue Cross' medical policies. It also incorporates code editing rules based on the HCPCS coding system.

Claim Check Plus will introduce additional automation to aid in the proper editing of claims. This will help evaluate claims for coding accuracy. Some claims that are coded inappropriately will be denied as incorrect coding. Also, not every claim adjudication can be automated; many will continue to require manual review.

Claim Check Plus is designed to spot irregularities, such as unbundling, mutually exclusive procedures and integral procedures. The software evaluates the coding accuracy of the procedure(s), not the medical necessity of the procedure(s). The types of services that will be evaluated include, but are not limited to:

- Policies based on the CPT manual
- Policies based on healthcare coding standards
- Multiple procedures performed on the same day
- Appropriateness of assistants at surgery
- The proper use of modifiers

Arkansas Blue Cross has always performed this type of review, and this software will allow us to do so in a much more consistent and efficient way. Claims will process with more consistency and accuracy. Claim Check Plus is essential for keeping pace with the complex developments in medical technology and the increasingly more specific coding required today.

In testing, many inappropriate coding situations were noticed, many involving both CPT and HCPCS modifiers. Some examples are:

- Modifiers 24 and 25 are only valid with evaluation and management procedures
- If a separate and identifiable service is performed on the same day as an Evaluation and Management service, you must report the E&M service with modifier 25.
- Modifier 77 is not valid with Evaluation and Management codes.
- Repeat clinical diagnostic laboratory tests should be billed using modifier 91, not 76.
- Category II codes are supplemental tracking codes. The only modifiers valid with these codes are 1P, 2P, 3P and 8P.
- Modifier AT should only be used with procedure codes 98940-98942
- When the same surgical service is provided on two sides of the body, you should use the appropriate LT, RT and 50 modifiers. One on the first line with LT, the second on the second line with RT and 50.
- When other than surgical services are provided on both the left and right sides of the body, it is appropriate to use modifiers LT and RT on separate lines, but is NOT appropriate to use modifier 50.
- 99238 and 99239 should be used to report all services provided to the patient on the day of discharge. It is not appropriate to bill a visit code on the same day as a hospital discharge.
- SS is not an appropriate ambulance modifier. You would never take a patient from the scene of one accident to the scene of another accident.
- PI is for PET Scans and is not valid for other services, including E&M.

As claims are edited, the software may create additional lines for the claim if warranted.

Please note that the NCCI, National Correct Coding Initiative, will be used in Claim Check Plus. This may result in some differences in payment from what you receive today.

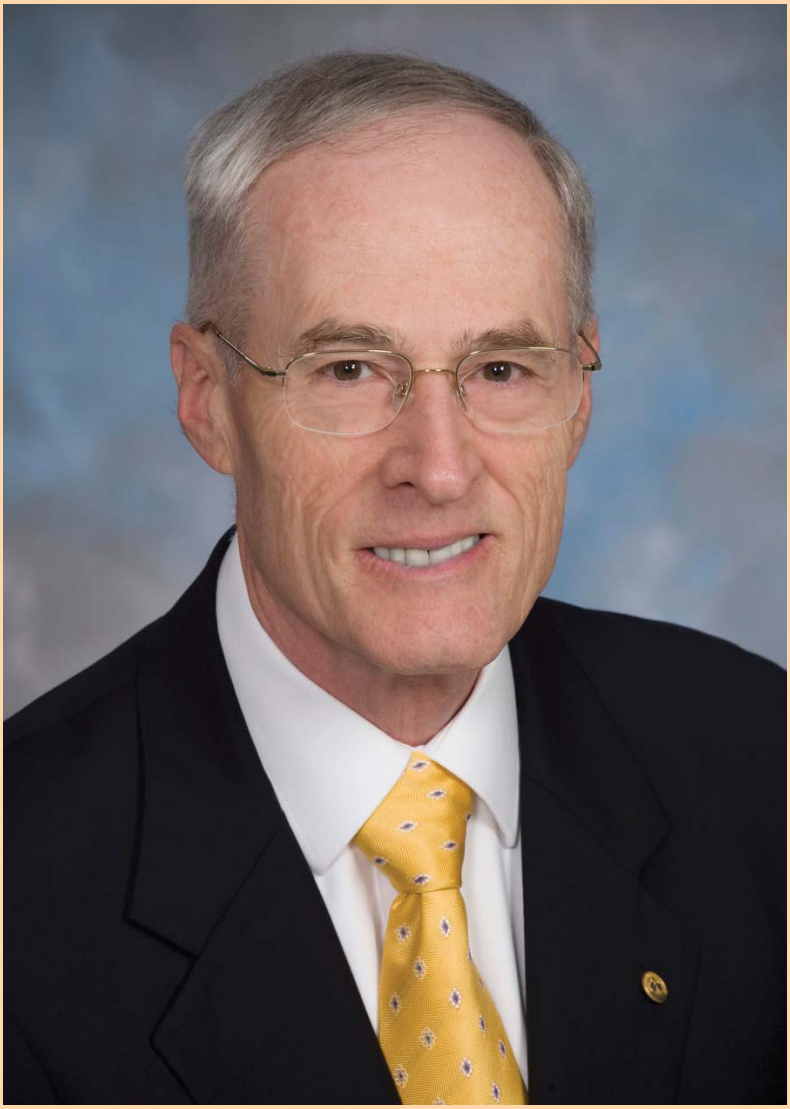
A new and improved Clear Claim Connection tool will be available for entry of claims scenarios. You will be able to enter diagnosis codes, place of service and specialty of the provider. All of these fields will be used to provide more comprehensive details regarding editing of the claim scenario.

Robert Griffin, M.D., named senior vice president and chief medical officer for Arkansas Blue Cross and Blue Shield

Robert Griffin, M.D., of Fayetteville, has been named senior vice president and chief medical officer for Arkansas Blue Cross and Blue Shield, according to Mike Brown, executive vice president and chief operating officer.

In his new role, Griffin will offer his professional and technical counsel to the operation of existing health plan services and to the planning and development of future services. His role will be to promote improved services to members and health care providers.

Griffin attended the University of Arkansas at Fayetteville. He earned his bachelor's degree from the U. S. Military Academy at West Point, N.Y. Griffin earned his doctorate in medicine from Emory University in Atlanta, Ga. Prior to joining Arkansas Blue Cross, Griffin worked as the senior medical director for Blue Cross and Blue Shield of Vermont from 2003 to 2010. Griffin served in the U.S. Army from 1967 to 1999. Throughout the years, he rose in the ranks from infantry platoon leader to commanding general. He retired from active military service in 1999.



Griffin has earned certifications from the National Board of Medical Examiners and the American Board of Surgery. He is a fellow of the American College of Surgeons, a member of the American Academy of Physician Executives, National Eagle Scout Association, Military Officers Association of America, Association of Graduates of the U.S. Military Academy and former chairman of the Blue Cross and Blue Shield Association's National Council of Physician and Pharmacy Executives. Griffin served in combat in the Vietnam and Persian Gulf wars and has received many military honors including, but not limited to, a Distinguished Service Medal, Silver Star, Legion of Merit, Bronze Star Medal, Air Medal, Purple Heart, Combat Infantry Badge and Ranger Tab.

Modifier 59 Billing Instructions

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

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

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

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

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

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

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

Review of Modifier 59:

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

There are modifiers available that describe the body location. (i.e., LT and RT, for left and right side. There are others to describe specific Modifier 59 digits, eyelids, etc.) If a modifier is available that specifically describes the body location, that modifier should be used INSTEAD of Modifier 59.

Clear Claim Connection (CCC):

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

The code combination being billed should be entered into CCC, without Modifier 59. If Modifier 51 applies to the secondary procedure, the reimbursement for covered services will be based on 50% of

Modifier 59 Billing Instructions (continued from page 8)

the allowance for the secondary procedure(s). In cases such as this (where CCC indicates that Modifier 59 should be used), Arkansas Blue Cross will not ordinarily request medical records. While providers may append Modifier 59 to any claim when warranted, they should be aware that doing so will ordinarily trigger a request for medical records, and thus may delay the processing of the claim.

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

If CCC combines two procedures into one procedure that includes both of the services provided, providers should bill using the one procedure that includes both procedures. An example is CPT Codes 93501 & 93510 which are more accurately reported using CPT Code 93526. Arkansas Blue Cross receives in excess of 7,500 line items per month with Modifier 59 appended. Arkansas Blue Cross has reviewed numerous claims submitted with Modifier 59. Listed below are examples of inappropriate billing of Modifier 59.

Modifier 59 is NEVER appropriate with:

- E&M codes (CPT Codes 99200-99499);
- Anesthesia Procedures (CPT Codes 00100 - 01999 [except 01967] and 99100 - 99140);
- Single procedure on the date of service;
- Administration codes corresponding to injection, immunization or vaccine (the administration is paid separately from the code for the drug without addition of Modifier 59);
- Injection codes with multiple units (Providers are expected to bill for the appropriate dosage. If the injection code is for 50 mg and 100 mg is given, providers should bill with 2 units of service. Modifier 59 is not necessary.);
- EVERY administration code on a claim;
- E&M, influenza vaccine, and administration (this combination is acceptable without a Modifier 25 on the E&M and/or without Modifier 59 on the administration code);
- Code Combination in CCC accessed via AHIN, allows all services;
- Code Combination in CCC accessed via AHIN appends Modifier 51 to the secondary procedure(s) (Modifier 59 may be included in situations where it is necessary to identify a different lesion, session, etc., not defined by a more specific modifier. Colonoscopy procedures discussed separately in this newsletter is an example.);
- Code Combination in CCC accessed via AHIN replaces the two codes with one code that describes both services (i.e., CPT Code 93501 + 93510 = 93526);
- One upper and one lower GI Endoscopy procedure (The two procedures address different areas of the body based on definition.);
- E&M plus radiology plus one surgical procedure (In this scenario, Modifier 59 is not appropriate on the surgical procedure. If the E&M code meets the conditions described by Modifier 25, then the appropriate coding is to add Modifier 25 to the E&M procedure.)
- ALL clinical laboratory services billed on one day;
- Line items billed separately with RT and LT modifiers (These modifiers distinguish the different sites without using Modifier 59.);
- E&M and surgery on the same day (If the E&M service meets the conditions of Modifier 25, Modifier 25 should be appended to the E&M service. It is never appropriate to also bill Modifier 59 with the surgical procedure.); and
- Outpatient facility claims where only one surgical procedure was performed. (All ancillary, lab and radiology services will be combined with the surgical procedure and reimbursed

Article originally printed in the September 2006 issue of *Providers' News*.

BlueCard®

Access to out-of-area blue members' medical policy and prior authorization requirements soon available online

Effective October 1, 2010, providers will easily be able to look up medical policy applicable for out-of-area Blue patients, along with general prior authorization requirements, and contact information for initiating prior authorization.

To access medical policy and prior authorization requirements:

- Visit arkbluecross.com
- Select "Provider" page
- Click on "Medical Policy and Pre-Certification/Pre-Authorization" link
- Enter the patient's three-letter alpha prefix

Providers will be routed to the Home plan's medical policy and/or prior authorization requirements. Once medical policy and/or prior authorization requirements are viewed, providers will be reconnected to the local plan's Web site.

Arkansas Blue Cross and Blue Shield hopes this new Web functionality gives providers easy access to the information needed and provides a valuable supplement to the information currently received when verifying a patient's benefits and eligibility.

For questions, please call Arkansas Blue Cross and Blue Shield's BlueCard® Customer Service at 1(800)880-0918 or locally at (501) 378-2127.

How to file claims for BlueCard members

Regardless of where a patient's Blue Cross and Blue Shield Home Plan is located, providers should follow these three easy steps to file a claim:

1. Call BlueCard® Eligibility at 1-800-676-BLUE (2583) to verify the patient's eligibility and coverage.
2. Give the customer service representative the first three characters of the member's identification number (their alpha prefix number).
3. Submit the member's claim to Arkansas Blue Cross and Blue Shield using regular claims filing procedures after health care services have been provided to the patient.

While claims on BlueCard® members from out-of -state should be submitted in the first instance to Arkansas Blue Cross and Blue Shield for processing, the payer of all such claims is the patient/member's "Home Plan," (i.e., the separate Blue Cross and Blue Shield licensee company in the patient-member's home state). Arkansas Blue Cross and Blue Shield merely transmits the claim to the separate company for processing and payment (or denial), as appropriate in its discretion.

For questions regarding claims status, please call Arkansas Blue Cross and Blue Shield's BlueCard® Customer Service at 1(800)880-0918 or locally at (501) 378-2127.

Note: Providers should not collect payment up front from the member other than the required copayment.

Article originally printed in the August 2008 issue of *BlueCard® News*.

BlueCard®

Dental Claims

Regular dental claims are not handled through BlueCard® but dental related services that are covered under the medical benefits can be filed through BlueCard® using the appropriate dental codes. The member's Blue Cross and Blue Shield plan will instruct providers to consult the member's ID card and file regular dental claims directly to them. Article originally printed in the August 2008 issue of *BlueCard® News*.

Remittance advice balancing instructions and guidelines related to coordination of benefits

There has been an increase in inquiries due to the calculation on the remittance when two or more policies are involved on a claim. Below are examples of some of the more common calculations used in the coordination of benefits.

However, due to the differences in COB policies and rules for other Blue Cross carriers, an example cannot be provided for all instances. Therefore, when in doubt, bill the member the amount indicated in Member Liability on the remittance advice.If there is an error in payment, the member's Home Plan will initiate any necessary adjustments.

The following examples should assist providers in determining patient liability on claims.

Example 1: Charges Discount Paid Payment

Total Charges = $545.50
Less Blue Cross Disc. - $121.08
Less Other Insur Paid - $126.04
Less payment on RA - $ 97.21
Equals patient liability = $201.17

Providers bills patient is $201.17.

NOTE: The patient responsibility amount on the RA is $327.21, which includes the other insurance paid amount of $126.04.

Pat. Respon on RA = $327.21
Less Other Insurance - $126.04
New Patient Respons = $201.17

Example 2: Charges Allowed Discount Coinsurance Payment

Total Charges = $1190.85
Less Blue Cross Disc - $ 538.48
Less payment on RA - $ 489.29
Difference is coinsure = $ 163.08

Patient responsibility is $163.08 which is the coinsurance amount. Providers will need to bill the patient for this amount.

Example 3: Charges Discount Paid Payment

Total Charges = $242.00
Less Blue Cross Disc - $104.68
Less Other Insurance - $106.16
Payment on RA = $ 0.00
Patient responsibility = $ 31.16

No payment was made on this claim to subtract. Providers will need to bill the patient for $31.16.

NOTE: The patient responsibility amount on RA is displayed as $137.32 which includes the other insurance paid amount of $106.16. $106.16 - $137.32 = $31.16 current patient responsibility.

Example 4: Charges Discount Paid Payment

Total Charges = $5,444.86
Less Blue Cross Disct - $3,782.86
Less Other Insur Paid - $1,662.00
Patient responsibility = $ 00.00

There is no payment from the patient on this claim. The balance is zero with nothing remaining to bill the patient. The patient responsibility amount matched what the other insurance paid $1662.00.

Article originally printed in the June 2009 issue of *Providers' News.*

Coverage Policy Manual Updates

The following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy Manual since June 2010. To view entire policies, access the coverage policies located on the Arkansas Blue Cross Web site at arkansasblue-cross.com.

New Policies:

Policy ID	Policy Name
997153	Iron Therapy, Parenteral
1997220	Thermography
1998039	Temporomandibular Joint Dysfunction
1998046	External Enhanced Cardiac Counterpulsation (EECP)
1998102	Transplant, Allogeneic, Islet Cell or Pancreas for Diabetes Mellitus
1998144	Pulmonary Arterial Hypertension, Pharmacological Treatment with Prostacyclin Analogues, Endothelin Receptors Antagonists, or Phosphodiesterase Inhibitors
1999007	Infrared Dermal Thermometry
2000021	Photodynamic Therapy for Ophthalmology
2005003	Genetic Test: Cytochrome p450 Genotyping
2005004	Sacral Nerve Stimulation for the Treatment of Fecal Incontinence
2006022	Genetic Test: Long QT Syndrome
2007010	Intravitreal Implant, Fluocinolone Acetonide (Retisert™)
2009034	Intensity Modulated Radiation Therapy (IMRT) Prostate
2010000	Capsaicin (Qutenza) for the Treatment of Post-Herpetic Neuralgia
2010016	Electrical Stimulation, Occipital Nerve Stimulation for Treatment of Headaches
2010026	Genetic Test: Breast Cancer Predict; Risk of Non-familial Cancer
2010028	Sipuleucel-T (Provenge) for the Treatment of Prostate Cancer
2010029	Bioimpedance Devices for Detection of Lymphedema
2010030	OVA1, Detection of Ovarian Cancer
2010032	Bronchial Thermoplasty
2010033	High-Density Lipoprotein (HDL) Subclass Testing in the Diagnosis and Management of Cardiovascular Disease
2010034	Implantable Telescope for the Treatment of Age-Related Macular Degeneration
2010035	Intravenous Antibiotic Therapy and Associated Diagnostic Testing for Lyme Disease
2010036	Chemical Peels

Fee Schedule

Home Health Agency Fee Schedule

The following Home Health Agency codes were updated on the Arkansas Blue Cross fee schedule on October 1, 2010.

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. (Medicaid Allow is approximately $64.00)
552	S9123	Nursing care, in the home; by RN, per hour	$ 40 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 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	$ 32.00 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	$ 142 per visit	One unit equals one visit (up to approximately 2 hours)
551	99500-99512, 99600	LPN Visit See CPT code book for code descriptions Modifier TE Required	$ 100 per visit	One unit equals one visit (up to approximately 2 hours)
561	S9127	Social Work visit, in the home, per diem	$ 70.00	One unit equals one day's services
441	S9128	Speech Therapy, in the home, per diem	$ 75.00	One unit equals one day's services
431	S9129	Occupational Therapy, in the home per diem	$ 75.00	One unit equals one day's services
421	S9131	Physical Therapy, in the home, per diem	$ 138.00	One unit equals one day's services

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
59025	$72.91	$47.42	$25.49	$47.42	$47.42	$0.00
78459	$1,179.16	$128.64	$1,050.52	$0.00	$128.64	$0.00
78609	$1,275.67	$125.67	$1,150.00	$0.00	$125.67	$0.00
78609	$1,273.90	$123.90	$1,150.00	$0.00	$123.90	$0.00
88291	$46.83	$46.83	$0.00	$46.83	$46.83	$0.00
89342	$130.90	$0.00	$130.90	$0.00	$0.00	$0.00
90636	$89.85	$0.00	$0.00	$0.00	$0.00	$0.00
90700	$20.96	$0.00	$0.00	$0.00	$0.00	$0.00
90634	$22.78	$0.00	$0.00	$0.00	$0.00	$0.00
93225	$50.98	$0.00	$50.98	$0.00	$0.00	$0.00
93226	$76.47	$0.00	$76.47	$0.00	$0.00	$0.00
93232	$83.58	$0.00	$83.58	$0.00	$0.00	$0.00
93236	$164.21	$0.00	$164.21	$0.00	$0.00	$0.00
93271	$331.97	$0.00	$331.97	$0.00	$0.00	$0.00
93316	$0.00	$0.00	$0.00	$74.10	$74.10	$0.00
93352	$59.28	$59.28	$0.00	$59.28	$59.28	$0.00
93503	$0.00	$0.00	$0.00	$228.82	$228.82	$0.00
93580	$0.00	$0.00	$0.00	$1,621.31	$1,621.31	$0.00
93581	$0.00	$0.00	$0.00	$2,134.67	$2,134.67	$0.00
93613	$0.00	$0.00	$0.00	$627.78	$627.78	$0.00
93642	$626.11	$433.93	$192.18	$0.00	$433.93	$0.00
93660	$238.16	$166.58	$71.59	$0.00	$166.58	$0.00
93727	$56.91	$56.91	$0.00	$56.91	$56.91	$0.00
94657	$109.67	$66.39	$0.00	$66.39	$66.39	$0.00
0192T	BR	$0.00	$0.00	$0.00	$0.00	$0.00
0192T	BR	$0.00	$0.00	$1,733.94	$0.00	$0.00

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
A6549	BR	$0.00	$0.00	$0.00	$0.00	$0.00
G0428	BR	$0.00	$0.00	$0.00	$0.00	$0.00
G0429	BR	$0.00	$0.00	$0.00	$0.00	$0.00
G0431	$19.72	$1.38	$18.34	$0.00	$1.38	$0.00
G0432	BR	$0.00	$0.00	$0.00	$0.00	$0.00
G0433	BR	$0.00	$0.00	$0.00	$0.00	$0.00
G0435	BR	$0.00	$0.00	$0.00	$0.00	$0.00
J2260	$51.58	$0.00	$0.00	$0.00	$0.00	$0.00
Q9945	$1.92	$0.00	$0.00	$0.00	$0.00	$0.00
Q9946	$1.92	$0.00	$0.00	$0.00	$0.00	$0.00
Q9947	$1.50	$0.00	$0.00	$0.00	$0.00	$0.00
Q9948	$0.32	$0.00	$0.00	$0.00	$0.00	$0.00
Q9949	$0.38	$0.00	$0.00	$0.00	$0.00	$0.00
Q9950	$0.20	$0.00	$0.00	$0.00	$0.00	$0.00
Q9951	$0.22	$0.00	$0.00	$0.00	$0.00	$0.00
Q9952	$2.69	$0.00	$0.00	$0.00	$0.00	$0.00
Q9953	$64.53	$0.00	$0.00	$0.00	$0.00	$0.00
Q9954	$11.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q9955	$13.25	$0.00	$0.00	$0.00	$0.00	$0.00
Q9956	$43.71	$0.00	$0.00	$0.00	$0.00	$0.00
Q9957	$65.56	$0.00	$0.00	$0.00	$0.00	$0.00
Q9958	$0.08	$0.00	$0.00	$0.00	$0.00	$0.00
Q9959	$1.83	$0.00	$0.00	$0.00	$0.00	$0.00
Q9960	$0.16	$0.00	$0.00	$0.00	$0.00	$0.00
Q9961	$0.16	$0.00	$0.00	$0.00	$0.00	$0.00
Q9962	$0.19	$0.00	$0.00	$0.00	$0.00	$0.00
Q9963	$0.17	$0.00	$0.00	$0.00	$0.00	$0.00
Q9964	$0.30	$0.00	$0.00	$0.00	$0.00	$0.00
Q9965	$1.15	$0.00	$0.00	$0.00	$0.00	$0.00
Q9966	$0.33	$0.00	$0.00	$0.00	$0.00	$0.00
Q9967	$0.18	$0.00	$0.00	$0.00	$0.00	$0.00
R0070	$89.58	$0.00	$0.00	$89.58	$0.00	$0.00
R0075	$19.56	$0.00	$0.00	$19.56	$0.00	$0.00

Fee Schedule

Injection Code Updates

The following injection codes were updated on the Arkansas Blue Cross and Blue Shield fee schedule on April 1, 2010.

Code	Allowance
90371	$120.39
90375	$167.52
90376	$167.57
90385	$25.81
90585	$114.58
90586	$114.72
90632	$48.63
90633	$22.78
90647	$23.05
90664	BR
90666	BR
90667	BR
90668	BR
90675	$181.64
90691	$60.62
90703	$26.16
90714	$21.09
90715	$41.16
90718	$15.96
0223T	BR
0224T	BR
0225T	BR
0226T	BR
0227T	BR
0228T	BR
0229T	BR
0230T	BR
0231T	BR
0232T	BR
0233T	BR
A9576	$2.36
A9577	$2.64
A9578	$2.54
A9579	$2.23
J0129	$20.62

Code	Allowance
J0130	$509.90
J0132	$2.59
J0135	$389.24
J0150	$11.83
J0152	$88.38
J0170	$0.77
J0180	$141.63
J0205	$43.65
J0207	$353.79
J0210	$39.86
J0215	$31.88
J0220	$132.11
J0256	$3.91
J0270	$0.68
J0275	$26.55
J0278	$0.56
J0280	$0.41
J0282	$0.28
J0285	$13.54
J0287	$10.40
J0288	$12.48
J0290	$2.16
J0295	$2.59
J0330	$0.12
J0348	$1.48
J0360	$4.76
J0364	$4.49
J0400	$0.37
J0456	$6.14
J0470	$28.95
J0475	$213.43
J0476	$76.31
J0480	$2,075.01
J0500	$21.98
J0515	$48.13

Code	Allowance
J0560	$28.30
J0570	$48.78
J0580	$51.52
J0583	$2.62
J0586	$7.94
J0592	$0.78
J0594	$17.18
J0595	$1.13
J0610	$0.34
J0630	$54.11
J0637	$12.41
J0640	$0.98
J0641	$0.67
J0670	$2.55
J0690	$0.63
J0692	$3.37
J0694	$6.15
J0697	$2.87
J0698	$4.74
J0702	$6.55
J0706	$0.51
J0713	$2.31
J0718	$3.94
J0725	$8.59
J0735	$81.78
J0740	$797.09
J0743	$12.44
J0744	$1.34
J0745	$1.14
J0770	$17.67
J0780	$1.94
J0795	$5.22
J0833	$67.32
J0834	$92.28
J0881	$3.09

Code	Allowance
J0882	$3.09
J0885	$10.05
J0886	$10.05
J0894	$31.30
J0895	$11.25
J0970	$21.22
J1020	$1.50
J1030	$3.48
J1040	$6.64
J1051	$9.15
J1070	$3.78
J1080	$4.64
J1110	$22.14
J1120	$28.94
J1160	$1.16
J1162	$533.66
J1165	$0.70
J1170	$1.81
J1200	$0.82
J1205	$389.11
J1212	$73.38
J1230	$6.49
J1245	$0.94
J1250	$5.95
J1270	$3.04
J1300	$192.92
J1325	$14.12
J1327	$20.54
J1335	$28.66
J1364	$8.86
J1380	$8.84
J1390	$17.68
J1410	$96.82
J1438	$201.90
J1440	$239.30
J1441	$375.32
J1450	$6.05
J1451	$7.89
J1453	$1.74
J1455	$10.75
J1457	$2.09
J1458	$351.23

Code	Allowance
J1459	$36.49
J1460	$18.82
J1470	$37.64
J1480	$56.46
J1490	$75.29
J1500	$94.11
J1510	$112.96
J1520	$131.67
J1530	$150.57
J1540	$169.47
J1550	$188.22
J1560	$188.22
J1561	$39.18
J1562	$7.56
J1566	$31.96
J1568	$39.00
J1569	$40.00
J1570	$55.11
J1571	$52.46
J1572	$38.15
J1573	$52.46
J1580	$0.91
J1600	$14.71
J1610	$88.78
J1626	$1.08
J1630	$1.47
J1631	$2.66
J1640	$8.81
J1644	$0.35
J1645	$12.29
J1650	$6.96
J1652	$6.21
J1655	$2.91
J1670	$237.42
J1720	$3.44
J1740	$149.77
J1742	$284.72
J1745	$60.93
J1750	$13.03
J1790	$2.29
J1800	$3.31
J1815	$0.47

Code	Allowance
J1817	$2.28
J1885	$0.30
J1930	$30.44
J1931	$26.58
J1940	$0.26
J1945	$243.68
J1950	$547.41
J1953	$0.55
J1955	$5.21
J1956	$5.66
J1980	$10.73
J2010	$5.34
J2020	$34.58
J2060	$0.76
J2150	$0.95
J2175	$1.69
J2185	$4.27
J2210	$6.93
J2248	$1.13
J2250	$0.10
J2260	$3.48
J2270	$2.18
J2271	$1.04
J2275	$2.40
J2278	$6.85
J2280	$3.13
J2300	$1.03
J2310	$6.00
J2315	$2.51
J2323	$9.18
J2325	$41.75
J2353	$115.67
J2354	$1.04
J2355	$254.48
J2357	$20.59
J2360	$6.84
J2370	$0.72
J2400	$13.07
J2405	$0.18
J2410	$2.38
J2425	$11.84
J2430	$15.30

Injection Code Changes (continued from page 17)

Code	Allowance
J2440	$0.72
J2469	$19.70
J2501	$3.65
J2503	$1,065.60
J2505	$2,569.57
J2510	$11.95
J2515	$13.08
J2540	$0.68
J2543	$5.90
J2550	$1.54
J2560	$3.41
J2562	$278.58
J2590	$0.57
J2597	$1.16
J2675	$1.52
J2690	$6.14
J2700	$2.20
J2724	$12.84
J2730	$92.84
J2760	$56.33
J2765	$0.34
J2770	$161.86
J2778	$421.27
J2780	$0.93
J2783	$182.74
J2785	$53.32
J2788	$28.51
J2790	$90.47
J2791	$5.38
J2792	$20.75
J2796	$46.01
J2800	$28.65
J2805	$75.66
J2810	$0.03
J2820	$26.58
J2916	$6.87
J2920	$1.99
J2930	$2.70
J2993	$1,420.38
J2997	$40.43
J3000	$7.60

Code	Allowance
J3010	$0.35
J3030	$49.84
J3070	$9.39
J3101	$48.87
J3105	$1.98
J3120	$3.62
J3130	$6.05
J3230	$9.12
J3240	$1,095.76
J3243	$1.27
J3246	$8.19
J3250	$4.85
J3260	$2.29
J3300	$3.35
J3301	$1.61
J3303	$1.39
J3315	$171.17
J3355	$63.34
J3360	$1.12
J3370	$3.36
J3396	$9.87
J3410	$1.39
J3415	$5.46
J3420	$0.31
J3430	$1.90
J3465	$6.13
J3470	$22.05
J3473	$0.64
J3485	$1.39
J3486	$6.67
J3487	$230.38
J3488	$231.85
J7042	$0.34
J7060	$1.16
J7070	$2.31
J7100	$21.07
J7185	$1.08
J7189	$1.43
J7190	$0.91
J7192	$1.14
J7194	$0.88

Code	Allowance
J7197	$2.66
J7198	$1.65
J7308	$141.88
J7321	$92.93
J7323	$122.00
J7324	$181.46
J7325	$12.23
J7500	$0.13
J7501	$101.04
J7502	$3.50
J7504	$527.06
J7505	$1,179.17
J7506	$0.04
J7507	$3.46
J7509	$0.08
J7511	$417.47
J7513	$547.40
J7515	$0.90
J7516	$25.34
J7517	$1.38
J7518	$3.32
J7520	$10.47
J7525	$145.03
J7605	$5.39
J7606	$4.87
J7608	$2.09
J7612	$0.22
J7613	$0.07
J7614	$0.33
J7620	$0.23
J7626	$5.05
J7631	$0.46
J7639	$26.53
J7644	$0.26
J7682	$78.16
J8501	$6.05
J8515	$3.63
J8520	$7.13
J8521	$23.37
J8530	$0.89
J8540	$0.38

Code	Allowance
J8560	$29.46
J8600	$5.01
J8610	$0.13
J8700	$9.46
J8705	$77.58
J9000	$3.06
J9001	$507.51
J9010	$611.99
J9015	$919.24
J9017	$38.87
J9020	$63.40
J9025	$5.21
J9027	$121.12
J9031	$114.72
J9033	$19.30
J9035	$60.78
J9040	$27.53
J9041	$40.86
J9045	$4.14
J9050	$183.20
J9060	$1.96
J9062	$9.82
J9065	$26.35
J9070	$5.26
J9080	$10.53
J9090	$26.32
J9091	$52.63
J9092	$105.26
J9098	$486.65
J9100	$1.55
J9110	$3.82
J9120	$593.75
J9130	$3.87
J9140	$7.65
J9150	$32.53
J9151	$59.97
J9155	$2.52
J9160	$1,606.09
J9171	$18.75
J9178	$2.17
J9181	$0.42
J9185	$120.06

Code	Allowance
J9200	$44.82
J9201	$154.58
J9202	$206.00
J9206	$7.07
J9208	$31.56
J9209	$4.48
J9211	$54.72
J9214	$16.43
J9217	$213.66
J9218	$4.27
J9225	$1,455.86
J9226	$14,707.35
J9230	$160.60
J9245	$1,460.85
J9250	$0.20
J9260	$2.00
J9261	$110.01
J9263	$4.64
J9264	$9.73
J9265	$12.02
J9268	$1,318.23
J9280	$20.99
J9290	$83.97
J9291	$167.94
J9293	$42.52
J9300	$2,795.36
J9303	$90.73
J9305	$53.75
J9310	$602.38
J9320	$291.77
J9328	$5.10
J9330	$52.85
J9340	$118.14
J9350	$1,088.42
J9355	$69.22
J9370	$4.71
J9375	$9.42
J9380	$23.56
J9390	$10.60
J9395	$86.36
J9600	$3,107.43
Q0138	$0.82

Code	Allowance
Q0139	$0.82
Q0163	$0.02
Q0164	$0.05
Q0165	$0.06
Q0166	$3.93
Q0167	$7.37
Q0168	$14.64
Q0169	$0.42
Q0170	$0.03
Q0172	$0.03
Q0173	$0.78
Q0175	$0.60
Q0176	$0.57
Q0179	$6.20
Q0180	$65.70
Q2017	$337.24
Q2025	$8.50
Q2026	NonCovered
Q2027	NonCovered
Q3025	$201.67
Q4081	$1.00
Q4101	$35.42
Q4102	$4.57
Q4103	$4.57
Q4104	$16.59
Q4105	$9.69
Q4106	$41.69
Q4107	$98.51
Q4108	$19.94
Q4109	$82.10
Q4110	$35.79
Q4111	$7.73
Q4112	$361.02
Q4113	$361.02
Q4114	$980.77
Q9954	$11.00
Q9956	$43.71
Q9957	$65.56
Q9960	$0.16
Q9961	$0.16
Q9965	$1.15

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providers' news staff

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Please Note

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies. 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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