june 2011

# providers' news

A publication for participating providers and their office staffs

## upcoming changes in outpatient facility fee schedule

Effective June 1, 2011, the following reimbursement policy applies for procedures performed in an outpatient facility or ambulatory surgery center for Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas, USAble Corporation, and Health Advantage members. In addition, changes in the outpatient facility fee schedules which are necessitated by updates to the 2011 Resource Based Relative Value System (RBRVS) Relative Value Units (RVUs) (published in the January 11, 2011 Federal Register) will be effective July 1, 2011. Complete listings of these changes were mailed directly to each facility business office manager on June 1, 2011. If you have not received this information, please contact Nancy Grove at nkgrove@arkbluecross.com.

| CPT Code | ASC Category | Outpatient Category |
|---|---|---|
| 22558 | 9 | 9 |
| 22585 | 5 | 5 |
| 22612 | 7 | 7 |
| 22614 | 4 | 4 |
| 22630 | 7 | 7 |
| 22632 | 4 | 4 |
| 22840 | 9 | 9 |
| 22842 | 9 | 9 |
| 55250 | 10 | 10 |

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

# preventive services covered under the affordable care act

## subject to change as regulations and further clarifications are received

**For non-grandfathered plans**

The Preventive Care Services coverage policy with coding for both ICD-9 and CPT or HCPC's codes is listed in the coverage policy coding instructions for the Preventive Care Services Coverage Policy which can be found in the "Providers" section of the Arkansas Blue Cross and Blue Shield Web site, www.arkansasbluecross.com/providers/

**Coding for Preventive Services**

Correctly coding preventive care services is key to receiving accurate payment for those services.

- Preventive care services must be submitted with an ICD-9 code that describes encounters with health services that are not for the treatment of illness or injury. Please avoid using general coding such as V70.0.
- These diagnosis codes must be identified as the primary diagnosis code on the claim form.
- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and the patient claims will be paid using their normal medical benefits rather than enhanced preventive care coverage.
- Use CPT coding designated as "Preventive Medicine Evaluation and Management Services" to differentiate preventive services from problem-oriented Evaluation and Management office visits (CPT codes 99381-99397, 99461, 99401-99404, S0610, and S0612). Non-preventive care services incorrectly coded as "Preventive Medicine Evaluation and Management Services" will not be covered as preventive care.

**Modifier 33 - Preventive Service:**

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be billed with the modifier 33. The correct coding for both ICD-9 and CPT or HCPC code is also required as listed in the coverage policy coding instructions of the Preventive Care Services coverage policy.

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# member and provider appeals or requests for re-review for arkansas blue cross and blue shield, health advantage and bluecard®

All re-review and appeal requests should be submitted in writing within 180 days of the denial of benefits on a claim and include:

- issue being questioned,
- date of service,
- patient's name and ID number,
- provider's name,
- assigned claim number(s),
- procedure and/or related CPT/HCPCS/DRG code(s) and applicable diagnosis code(s)
- reasons why the provider/member believes that the claim was incorrectly denied in whole or in part, and
- medical records relevant to the appeal should be included.

For greater efficiency, providers are encouraged to pursue resolution with customer service prior to filing a re-review or appeal with Arkansas Blue Cross and Blue Shield or Health Advantage. An appeal or re-review request should not be submitted with a corrected claim form; this will only delay the appeal or re-review response.

**Appeals and re-review requests on Arkansas Blue Cross and Health Advantage covered members:**

**Provider Re-Reviews:**

To request a re-review of a denied claim (in whole or in part) prior to the submission of an appeal. Please mark request; RE-REVIEW and submit re-reviews to:

Arkansas Blue Cross
Attn. Medical Re-Review
P. O. Box 3688
Little Rock, AR 72203

## member and provider appeals or requests for re-review (continued from page 2)

A request for appeal will not be considered, if the claim has not been reconsidered by the Medical Re-Review Department first.

**Provider Appeals:**

If the denial of the service continues to be disputed after the re-review is completed, a provider appeal may be submitted within 180 days of the original denial of the service. An appeal request on an Arkansas Blue Cross or Health Advantage member can be mailed, faxed, or emailed to the appropriate line of business:

Arkansas Blue Cross - Appeals
Attn. Appeals Coordinator
P.O. Box 2181
Little Rock, AR 72203

Fax: 501-378-3366
Email: appealscoordinator@arkbluecross.com

Health Advantage - Appeals
Attn: Member Response
P. O. Box 8069
Little Rock, AR 72203

Fax: 501-212-8518
Email: appeals@healthadvantage-hmo.com

**Member Appeals:**

Members should submit appeal requests in writing to the appeals coordinator or the member response coordinator at the above addresses, whichever is appropriate within 180 days of the denial of the service. The same information listed for provider appeals is required for a member appeal.

### Appeals and Re-review requests on out-of-state Blue Cross and Blue Shield Plan Members (BlueCard®):

Each Blue Cross Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association. Therefore, each Plan develops their own certificates and policies and controls benefits and benefit determination for their members. Arkansas Blue Cross and Blue Shield acts as the Host Plan for other Blue Cross Plans when Arkansas providers are used for services.

Arkansas Blue Cross only prices the claim when the member is covered under a Blue Cross Plan other than Arkansas Blue Cross and the provider is in Arkansas. The member's Home Plan determines if benefits are due, and is responsible for any denial of benefits coverage decisions and handling of appeal.

Providers who disagree with the way a BlueCard® claim was processed or paid may contact BlueCard® customer service at 1-800-880-0918 for assistance.

**Provider Re-review of the allowance for a service processed through BlueCard:**

Provider requesting re-review should send their request in writing to the Arkansas Blue Cross Medical Re-Review Team.

Arkansas Blue Cross
Attn: Medical Re-review
P.O. Box 3688
Little Rock, AR 72203

If the provider continues to dispute the allowance for a service after the re-review team's response, a written appeal may be filed with the Arkansas Blue Cross Appeals Coordinator to following address, fax or e-mail:

Arkansas Blue Cross
Attn. Appeals
P. O. Box 2181.
Little Rock, AR 72203

Fax: 501-378-3366
E-mail: appealscoordinator@ark-bluecross.com

**Arkansas Provider Appeals related to benefits available under an out of state Blue Cross Plan:**

Provider should send their written appeal to:

Arkansas Blue Cross
Attn. Appeals
P. O. Box 2181.
Little Rock, AR 72203

Arkansas Blue Cross will communicate with the member's out of state Plan for benefit information and the out of state Plan response will be communicated to the provider by the Arkansas Blue Cross Appeals Staff.

**Member Appeals:**

Members should submit their appeals directly to the Blue Cross and Blue Shield Plan in the state that issued their coverage (i.e., the Home Plan).

**Please Note:**

Arkansas Blue Cross does NOT make benefit determinations or serve as final decision-maker with respect to the provision or denial of benefits where the patient involved is a member covered by another independent Blue Plan in another state; in such circumstances, Arkansas Blue Cross serves only as a communication conduit to get an appeal to the correct source and in that role will forward the appeal to the member's correct Home Plan for response by the other Blue Cross Plan.

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

# catchair youth asthma program

Diagnosing a child with asthma usually alarms a parent and child. As a provider, you now have two patients - a child who needs asthma management and a parent who needs asthma education. Arkansas Blue Cross and Blue Shield and its affiliates can help.

CatchAir Youth Asthma Program is a free and voluntary mail-only program that will support a provider's efforts to teach complex asthma education. The program is available to members of Arkansas Blue Cross and Blue Shield, Health Advantage and eligible Blue Advantage Administrators of Arkansas groups.

The program is divided into four age-specific levels with printed materials specific to each age group. The materials are mailed to the parent in the "Birth to 3 years old" grouping, while both the parent and child receive information in the 4 to 17 age levels.

Age-Specific Levels

- Birth to 3 years old
- 4 to 6 years old
- 7 to 11 years old
- 12 to17 years old

Examples of the free materials and resources parent and patient will receive

- Book and newsletters about asthma specific to child's age
- Low-literacy and interactive sheets on the basics of asthma
- Diaries and health record booklets to track asthma symptoms and medications
- Age-specific immunization schedule
- Asthma school and emergency management plans
- Healthy eating and fitness tips
- Telephone and Web resources that follow national asthma standards of care
- Life balance and coping tips for children with asthma and their family members
- A Registered Nurse case manager to assist the parent with health plan benefits

Children ages 4 to 17 receive free

- Age-specific asthma booklets, interactive sheets , games and puzzles related to the topic of asthma and fun ways to stay healthy
- Age-specific material series that focuses on everyday health

Please call your local Arkansas Blue Cross regional office if you have any questions or if you have a patient to refer to this service. Our goal is to support participating providers as you help parents and children learn more about asthma care.

# home sleep studies

Home sleep studies must be billed with the appropriate CPT code to distinguish the level of study provided. CPT code 95800 is the only level of sleep study covered in the home setting. The appropriate CPT codes for home sleep studies are:

| CPT Code | Description |
|---|---|
| 95800 | Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time |
| 95801 | Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone) |
| 95806 | Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement) |

# corizon contracts to access true blue

Corizon, Inc., formerly Correctional Medical Services, Inc., began using the True Blue PPO provider network of USAble Corporation on June 1, 2011. Corizon is responsible for coordinating the medical care of inmates housed in Arkansas state correctional institutions.

**Contract Amendment:**

Based on processed claims information from Corizon, many True Blue participating providers are already providing services to prisoners coordinated through Corizon. USAble understands that there may be True Blue providers that may not wish to see these patients. As a result of these concerns, Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation are amending the "General Obligation" section of their respective Preferred Payment Plan, Health Advantage HMO, True Blue PPO and Arkansas' FirstSource© PPO participating provider network agreements.

Under "General Obligation" the following language will be added at the end of the section:

> "The preceding notwithstanding, unless prohibited by applicable law, Provider [or Facility, as applicable] may decline to accept as patients or provide services to prison inmates whose health plan or claims administrator has entered into a network access agreement with [Arkansas Blue Cross and Blue Shield, for the Preferred Payment Plan agreement] [HMO, for the Health Advantage HMO agreement] or [USAble, for the True Blue and Arkansas' FirstSource PPO agreements]."

**Corizon Process Flow:**

Except in emergency cases, Corizon Representatives will contact True Blue providers to coordinate and verify the medical services that are to be rendered before the inmate and correctional officer(s) arrive at a medical practice. Providers will be required to complete the Provider Consultation Report for preliminary documentation of services provided. Please place the completed form in a sealed envelope and send it back with the correctional officer(s) when the inmate returns to prison or jail.

Authorization and payment is provided only for requested procedures or treatment of life-threatening conditions. Prior approval of the Corizon's medical director is required for additional procedures or hospitalizations. For conditions that will require multiple treatments, Corizon will try to approve as many of those visits as possible on the front end without recertifying.

Since True Blue contracts with contiguous county providers in bordering states, it is possible that an Arkansas inmate could be presented by Corizon for treatment in these contiguous counties.

**Claim Submission**

**Electronic Claim Submission:**

CMS-1500 and UB-04 can be filed electronically. Providers need to include the Department of Correction and Inmate Number in the patient identification number box on the claim form. Be sure to include the AR USAble Payer number 00520.

**Paper Claim Submission:**

True Blue PPO
C/O Arkansas Blue Cross
PO Box 2181
Little Rock, AR 72203-2181

**Claims Contact Information**

Corizon Customer Service
1-800-395-9500 ext. 9135

True Blue PPO Customer Service
1-501-378-2164

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# follow up letters for medical records requests

Effective May 18, 2011, Arkansas Blue Cross and Blue Shield has discontinued the third (40 day) request/reminder for Medical Records Requests (MRR). Now Arkansas Blue Cross will send the initial request and one follow-up letter at 20 days. Providers can also view their MRR requests through the 'MRR Search' feature on AHIN. This notice constitutes a change to the "Policy Requiring Timely Response to Medical Records Requests," published originally in Providers' News in the December 2010 edition, deleting the sentence which reads "A third request/reminder is also generated by the system on the fortieth day following the initial request.".

# injectable drug pricing for hospital outpatient departments - coverage policy change

Arkansas Blue Cross and Blue Shield is changing its reimbursement policy regarding payment of hospitals for outpatient administration of certain injectable drugs. Previously, in article published in the September 2004 issue of *Provider's News,* the company stated that administration fees for IV infusions, etc., would not be covered for facilities. The article specifically mentioned revenue codes 940 and 949.

In an effort to control costs and more consistently administer the coverage policy in this area, Arkansas Blue Cross will begin paying a nominal fee for these services.

Since the reimbursement for the facility practice expense is covered under other revenue codes when provided in the outpatient hospital setting, the reimbursement for the practice expense portion of these services has been removed from the fee schedule amount used for physicians.

Additionally, Arkansas Blue Cross will begin paying hospitals for injectable drugs (J0000-J9999, etc.) based on the Arkansas Blue Cross fee schedule which was developed to reimburse the cost of the medication. Potential sources for setting reimbursement amounts - depending on the drug involved and whether it is listed in a particular source - include Average Sales Price (ASP) plus 10% (with a 10% maximum of $400), wholesale acquisition cost (WAC), 85% of average wholesale price (AWP), or invoice from the provider.

The fee schedule amounts will be the same as the amounts used to reimburse physicians and will be paid at 100% of the Arkansas Blue Cross fee schedule amount. Unlisted J codes will be listed as BR (By Report) and will be reimbursed using one of the sources noted above for the drug and dosage provided.

Please note that whenever a valid HCPCS or CPT code is available for the drug given, the HCPCS/CPT code is required to be billed with Revenue Code 636. Claims without the appropriate HCPCS code will be rejected.

The following pricing changes will be effective July 1, 2011. "BR" on the fee schedule means "By Report" which means these codes will be given individual consideration and paid at a reasonable amount without including the practice expense.

Article originally printed in the March 2011 issue of Providers' News.

| Procedure | Allowance |
|---|---|
| 96360 | $11.44 |
| 96361 | $5.79 |
| 96365 | $13.81 |
| 96366 | $11.12 |
| 96367 | $11.72 |
| 96368 | $10.53 |
| 96369 | $13.81 |
| 96370 | $11.12 |
| 96371 | $0.45 |
| 96372 | $10.53 |
| 96373 | $10.53 |
| 96374 | $12.03 |

| Procedure | Allowance |
|---|---|
| 96375 | $6.38 |
| 96376 | BR |
| 96379 | BR |
| 96401 | $14.26 |
| 96402 | $11.72 |
| 96405 | $32.18 |
| 96406 | $49.24 |
| 96409 | $16.49 |
| 96411 | $13.22 |
| 96413 | $18.86 |
| 96415 | $11.72 |
| 96416 | $15.62 |

| Procedure | Allowance |
|---|---|
| 96417 | $13.81 |
| 96420 | $13.70 |
| 96422 | $13.70 |
| 96423 | $11.89 |
| 96425 | $14.61 |
| 96440 | $164.96 |
| 96446 | $25.10 |
| 96450 | $95.68 |
| 96521 | $14.71 |
| 96522 | $14.71 |
| 96523 | $2.82 |
| 96542 | $46.27 |

# modifier billings with claim check plus

Claim Check Plus has some very strict edits on procedure versus modifier. If the modifier is not valid for the procedure, the claim line will be denied. Some examples/ guidelines are:

- Modifier 50, bilateral, is not valid on a procedure with bilateral in the description or with PT/OT codes.
- RT or LT is not valid on a procedure with bilateral in the description
- Modifier 26 is not valid with surgical procedures
- Site specific modifiers are not appropriate with Evaluation and Management codes.
- Be sure the modifier is valid by using the CPT and/or HCPCS book.
- Repeat clinical diagnostic lab procedures should be billed with Modifier 91 and NOT with Modifier 76.
- Specific finger modifiers (F1-F9 and FA) are not valid with procedures specific to the hand.
- Specific toe modifiers (T1-T9 and TA) are not valid with procedures specific to the foot.
- Modifier AT is only valid with CPT codes 98940-98943
- Modifiers 24 and 25 are only valid with Evaluation and Management codes.

**Modifier 25**

Modifier 25: Significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service. It is important to bill modifier 25 with Evaluation and Management code IF a provider is performing an unrelated separate procedure. For example, when providing a minor surgery service, the visit on that day is included in the payment for the procedure.

However, when performing an E&M service unrelated to the minor surgical procedure, providers should append modifier 25 to the E&M code. If it is appended to the surgery code, the surgery line will be denied for incorrect coding. The same criteria applies when providing other procedures, including chemotherapy administration, allergy injections, chiropractic manipulation, etc. The visit is included in the other procedure codes unless it is a separate and identifiable E&M procedure.

Some criteria for the appropriate use of modifier 25:

- Are there signs, symptoms, and/or conditions that the physician must address before deciding to perform a procedure or service?
- Was the evaluation and management of the problem significant and beyond the normal preoperative and postoperative work?
- Is there more than one diagnosis present that is being addressed and/or affecting the treatment or outcome?

**Modifier 59**

Modifier 59: Distinct procedural service. A more detailed article regarding modifier 59 was printed in the September 2010 issue of Providers' News. Please refer to that article for complete billing instructions.

- Modifier 59 only applies to non-E&M services. If submitted with an E&M service, the E&M service will be denied as incorrect coding.
- Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or 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 individual.
- No other established modifier is appropriate, i.e., multiple or bilateral surgery.
- Modifier 59 should be used with caution.
- 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.

# only six months to go until the 5010

With six months to go, Arkansas Blue Cross and Blue Shield is ready for the latest requirements for HIPAA electronic transactions. Arkansas Blue Cross is now in the transition window where it is still acceptable to use the 4010 formats for electronic claims, remittance advices, claims status, eligibility inquiries, pre-authorization, enrollment and premium payment.

Beginning January 1, 2012, only the X12 5010 version of the HIPAA medical transactions, along with the NCPDP 3.0 version of pharmacy and supplier transitions, and the NCPDP 3.0 version of Medicaid pharmacy subrogation transactions will be HIPAA compliant. It is the desire of Arkansas Blue Cross to assist providers in keeping their cash flow moving. After December 31, 2011, HIPAA regulations will not permit us to accept electronic claims or any of the other transactions in the 4010 format.

On July 1, 2011, Arkansas Blue Cross will begin migrating providers to the 5010 format for providers who have completed testing and submitted a 5010 production request form to us. Please remember that the U. S. Department of Health and Human Services did adopt the errata changes as part of the 5010 requirements and those changes must be included in both test and production transactions.

Successfully testing the X12 5010 formatted transactions may not be a simple process; especially if you wait until the last minute. Providers are encouraged to talk with your vendors, make all necessary changes and begin testing now!

Providers may obtain more information regarding the X12 5010 transition at

www.arkansasbluecross.com/providers/5010resourcecenter.aspx.

As soon as you and your vendors are ready to begin testing, please contact EDI Services at 501-378-2419 or 866-582-3247 for further instructions.

# implementation of version 5010 - required /recommended actions to take

With the challenges of implementing version 5010, Arkansas Blue Cross Blue Shield and its affiliates are committed to assisting our trading partners with the transition. Information has been prepared and data has been gathered to aid in the transition.

The first step is to purchase a Technical Report Type 3 (TR3) implementation guides. TR3 guides can be purchased from Washington Publishing Company at wpc-edi.com. The Washington Publishing Company also offers the Change Description Guides which resemble the official X12 documents and highlight the changes for version 5010. Electronic submitters can also purchase the Change Description Guides from the Washington Publishing Company.

**What Has Changed?**

Many things have changed with version 5010. CMS has conducted an analysis of version 4010A1 to version 5010. Electronic submitters can download the CMS side-by-side comparison for the 837 professional and institutional, 835, 276/277 and the 270/271 free of charge. The documents are available at http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp#TopOfPage

Another change is the 997 Functional Acknowledgment will no longer be used. It is being replaced with the 999 Implementation Acknowledgment For Health Care Insurance. The 999 TR3 can also be purchased at www.wpc-edi.com.

**Important Dates To Remember**

- **July 1, 2011** – Providers who have successfully completed testing may begin submitting production claims upon approval from EDI Services.
- **December 31, 2011** – Electronic submitters must have completed 5010 testing and moved to production.
- **January 1, 2012** – Electronic submitters must be 5010 compliant. Only version 5010 will be accepted.

**Enrollment Requirements**

Electronic submitters currently enrolled with EDI Services are not required to re-enroll to exchange electronic data for version 5010. Existing electronic submitter ID numbers and passwords can be used to send and receive electronic data for version 5010. EDI Services will not

assign test submitter ID numbers and passwords to electronic submitters to test version 5010.

Before a submitter can begin testing they must complete the 5010 Contact Information form. A 5010 Contact Information form must be completed for each electronic submitter ID number assigned to a provider for the appropriate line of business. Follow the link below to complete and submit your contact information.

https://secure.arkansasbluecross.com/providers/5010ToolsAndUpdates/5010TestingContactInformation.aspx

The 5010 Move to Production for Private Business form must be completed when providers are ready to move into production for Private Business 5010 transactions. If providers have not completed the 5010 Move to Production for Private Business form before a production file is sent, that file will be sent to test. The claims will not be sent to the adjudication system for processing. The 5010 Move to Production for Private Business form can be found at:

https://secure.arkansasbluecross.com/providers/5010ToolsAndUpdates/5010MovetoProductionforPrivateBusiness.aspx

Electronic submitters may submit as many test files as they wish to the EDI Gateway. The EDI Gateway is available 24 hours a days, 7 days a week.

**Exchanging Version 5010 Electronic Data**

Electronic submitters will transmit and receive electronic data for version 5010 using the same Gateway options that are currently used today for version 4010A1. These options will not change at this time. However, future changes may be made to the Gateway menu options for sending and receiving files. Electronic submitters who use a script to send and receive files will need to make adjustments to their scripts. EDI Services will give sufficient notification to electronic submitters prior to the menu option changes to allow script users ample time to make the necessary changes.

Arkansas Blue Cross Blue Shield will be exchanging the following transactions.

| Transaction Type | Version Code |
|---|---|
| 270 / 271 Health Care Eligibility Benefit Inquiry & Response | 005010X279A1 |
| 276 / 277 Health Care Claim Status Request & Response | 005010X212 |
| 837 Health Care Claim: Professional | 005010X222A1 |
| 837 Health Care Claim: Institutional | 005010X223A2 |
| 837 Health Care Claim: Dental (FEP only) | 005010X224A2 |
| 835 Health Care Claim Payment/Advice | 005010X221A1 |
| 999 Implementation Acknowledgement for Health Care Insurance | 005010X231A1 |

A companion document is currently being developed to assist trading partners with the implementation of version 5010. Please access the 5010 Resource Center frequently for updates.

**Electronic Reports For 5010**

Currently, testers receive the following reports:

- TA1 Interchange Acknowledgment report (if requested)
- 999 Implementation Acknowledgment For Health Care Insurance
- Batch Processing Report

Reports will be returned in real time mode as they are today.

It is imperative that electronic submitters download the 5010 reports being returned. The 5010 reports will confirm if any syntax errors have been encountered, any rejections that may have occurred post syntax editing, and the claim volume that has been accepted into the processing system for further adjudication. These reports are for informational purposes and will not guarantee that payment will be made on the claim.

**Who to Call for Help**

Please call EDI Services at 501-378-2419, if you have questions regarding 5010 implementation. Providers may also submit questions regarding 5010 implementation to edi@arkbluecross.com or enrollment questions may be submitted to edi_enrollment@arkbluecross.com.

# 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 Cross and Blue Shield 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
- take Advantage of extended service hours. 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:

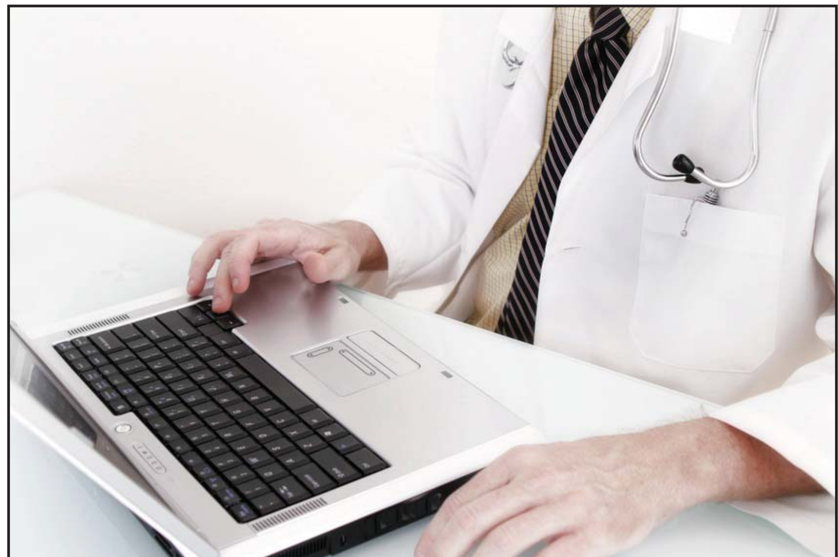
1. Log in to the Advanced Health Information Network (AHIN).
2. From the "Members" link located on the home page, select "Out-of-State BCBS/FEP". Enter the "Member First" and "Last Name", "Date of Birth" and "Member ID" as it appears on the member's ID card. Select the "Type of Service" you would like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

In addition to receiving eligibility verifications electronically, providers can always call the 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.

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



## cob questionnaire

Providers can obtain and submit Coordination of Benefits (COB) questionnaires to Arkansas Blue Cross and Blue Shield before filing a claim. Questionnaire responses should not be sent as an attachment to a claim. The two-page COB questionnaire should be printed as a one-sided document to prevent imaging problems. Do not print the COB questionnaire on the front and back of the page. If the member belongs to another Blue Plan, Arkansas Blue Cross will forward the COB questionnaire responses to the member's Blue Cross and Blue Shield Plan on the provider's behalf. The COB questionnaire is available on the Arkansas Blue Cross Web site and through the Advanced Health Information Network (AHIN). Completed forms can be faxed to 501-378-2433 or mailed to:

Arkansas Blue Cross<br>
Attn: Blue Card Support<br>
P.O. Box 2181<br>
Little Rock, AR 72203

Article originally printed in the June 2009 and June 2010 issues of Providers' News.

# BlueCard

## ra balancing instructions and guidelines related to cob

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 and Blue Shield 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.

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

**Example 1: Charges Discount Paid Payment**

| | |
|---|---|
| Total Charges = | $ 545.50 |
| Less Blue Cross Discount = | ($ 121.08) |
| Less Other Insurance Paid = | ($ 126.04) |
| Less payment on Remittance Advice = | ($ 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.

| | |
|---|---|
| Patient Responsibility on RA = | $ 327.21 |
| Less Other Insurance = | ($ 126.04) |
| New Patient Response = | $ 201.17 |

**Example 2: Charges Allowed Discount Coinsurance Payment**

| | |
|---|---|
| Total Charges = | $ 1190.85 |
| Less Blue Cross discount = | ($ 538.48) |
| Less payment on Remittance Advice = | ($ 489.29) |
| Difference is coinsurance = | $ 163.08 |

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

**Example 3: Charges Discount Paid Payment**

| | |
|---|---|
| Total Charges = | $ 242.00 |
| Less Blue Cross Discount = | ($ 104.68) |
| Less Other Insurance = | ($ 106.16) |
| Payment on Remittance Advice = | ($ 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 Discount = | ($ 3,782.86) |
| Less Other Insurance 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.

# coverage policy manual updates

The following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy Manual since March 2011. To view entire policies, access the coverage policies on the Arkansas Blue Cross Web site at arkansasbluecross.com.

**Updated Policies:**

| Coverage Policy | Description |
|---|---|
| 1997028 | Chemodenervation (Botulinum Toxins) |
| 1997054 | Bone Mineral Density Study |
| 1997091 | Tumor Antigen, Miscellaneous |
| 1997167 | PET Scan, Positron Emission Tomography, for Cardiac Applications |
| 1997188 | Allergen Specific IgE In Vitro Testing |
| 1997190 | Stem Cell Growth Factors, Epoetin |
| 1997228 | Echocardiography, Transesophageal (TEE) |
| 1997239 | Visual Evoked Potential |
| 1998041 | Allergy Testing |
| 1998076 | Meniscal Allograft Transplantation |
| 1998095 | Intraoperative Neurophysiologic Monitoring |
| 1998104 | Transplant, Liver |
| 1998110 | Chelation Therapy |
| 1998158 | Trastuzumab |
| 1998161 | Infliximab (Remicade) |
| 1999001 | Nerve Conduction Studies (NCS), Electromyography (EMG) |
| 2000009 | HDC & Autologous Stem &/or Progenitor Cell Support-Multiple Myeloma |
| 2000022 | Percutaneous Transluminal Endovascular Graft for Abdominal Aortic Aneurysm |
| 2000030 | Chemotherapy for Malignancy |
| 2000034 | Hyperhidrosis Treatment |
| 2000038 | Photodynamic Therapy for Malignancy |
| 2000039 | Transesophageal Therapy for GERD: Endoscopic Suturing, Transoral Incisionless Fundoplication |
| 2001007 | Fetal Surgery for Prenatally Diagnosed Malformations |
| 2002005 | Biventricular Pacemakers for the Treatment of Congestive Heart Failure |
| 2004016 | Ultrasound in Maternity Care: 1st Trimester Detection of Down Syndrome using Fetal US Assessment of Nuchal Translucency & Maternal Serum Assessment |
| 2004017 | Genetic Test: Screening, Detection and/or Management of Prostate Cancer (PCA3) (SNP Testing) (TMPRSS Fusion Genes) (GSTP1) |
| 2004027 | Stem Cell Growth Factor, Darbepoetin |
| 2006016 | Rituximab (Rituxan), Off-label Use |
| 2006026 | Genetic Test: Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts & Leukoencephalopathy (CADASIL) (NOTCH3) |
| 2006033 | Angioplasty/Stenting, Intracranial Artery Atherosclerosis, Stenosis, Percutaneous Including Intra- and Extracranial Vertebral Artery |
| 2007010 | Intravitreal Implant, Fluocinolone Acetonide (Retisert™) |
| 2008027 | Genetic Test: Colon Cancer, KRAS Mutation to Determine Tumor Sensitivity to Chemotherapy |
| 2009004 | Biochemical Marker's, Alzheimer's Disease |

**New Coverage Policies:**

| Coverage Policy | Description |
|---|---|
| 2010000 | Capsaicin (Qutenza) for the Treatment of Post-Herpetic Neuralgia |
| 2010002 | Tocolysis, Acute and Maintenance Therapy |
| 2010009 | Bevacizumab (Avastin) for Ocular Indications |
| 2011003 | Chemodenervation, Botulinum Toxin for the Treatment of Chronic Migraine Headache |
| 2011005 | Digital Breast Tomosynthesis |
| 2011006 | Ipilimumab (Yervoy™) |
| 2011007 | Minimally Invasive Lumbar Interbody Fusion |
| 2011008 | Left Atrial Appendage, Closure Device, Percutaneous |
| 2011009 | Genetic Test: HLA-B*5701 Testing for Abacavir Hypersensitivity Reaction |
| 2011010 | Screening for Serum Lipids - PPACA requirements for non-grandfathered plans |
| 2011011 | Screening for Abdominal Aortic Aneurysm - PPACA requirements for non-grandfathered plans |
| 2011012 | Screening for Alcohol Misuse Counseling - PPACA requirements for non-grandfathered plans |
| 2011013 | Aspirin to Prevent Cardiovascular Disease in Adults-PPACA requirements for non-grandfathered plans |
| 2011014 | Screening for Anemia: Pregnant Women- PPACA requirements for non-grandfathered plans |
| 2011015 | Screening for High Blood Pressure In Adults- PPACA requirements for non-grandfathered plans |
| 2011016 | Genetic Counseling And Evaluation for BRCA Testing - PPACA requirements for non-grandfathered plans |
| 2011017 | Preventative Medication for Breast Cancer - PPACA requirements for non-grandfathered plans |
| 2011018 | Screening for Breast Cancer - PPACA requirements for non-grandfathered plans (Mammography) |
| 2011019 | Counseling for Breastfeeding - PPPPACA requirements for non-grandfathered plans |
| 2011020 | Bacteriuria Screening In Pregnant Women - PPACA requirements for non-grandfathered plans |
| 2011021 | Screening for Cervical Cancer - PPACA requirements for non-grandfathered plans |
| 2011022 | Screening for Chlamydial Infection In Women - PPACA requirements for non-grandfathered plans |
| 2011023 | Screening for Hypothyroidism in Newborns - PPACA requirements for non-grandfathered plans |
| 2011024 | Screening for Tobacco Use, Counseling & Interventions- PPACA requirements for non-grandfathered plans |
| 2011025 | Screening for Obesity in Adults - PPACA requirements for non-grandfathered plans |
| 2011026 | Type 2 Diabetes Mellitus Screening for Adults - PPACA requirements for non-grandfathered plans |
| 2011027 | Screening for Rh Incompatability - PPPACA requirements for non-grandfathered plans |
| 2011028 | Screening for Phenylketonuria in Newborns - PPACA requirements for non-grandfathered plans |
| 2011029 | Prevention of Dental Caries in Preschool Children - PPACA requirements for non-grandfathered plans |
| 2011030 | Screening & counseling for Obesity in Children - PPACA requirements for non-grandfathered plans |
| 2011031 | Screening for Osteoporosis in Women - PPACA requirements for non-grandfathered plans |
| 2011032 | Behavioral Counseling to Prevent Sexually Transmitted Infections (STIs) - PPACA requirements for non-grandfathered plans |

# AHIN

## you see what we see

Anytime providers need to check an Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, BlueCard, or Health Advantage patient's eligibility or benefit information, please use the Advanced Health Information Network (AHIN) and MyBlueLine Interactive Voice Response (IVR) system.

Many providers access the easy-to-use, self-service tools and then call provider and customer service representatives to "double check" even simple member information like membership effective dates, deductibles, copayments and coinsurance. Our self-service tools are available through the AHIN and MyBlueLine IVR system to assist providers in delivering quality care to our members. Arkansas Blue Cross ask that providers use our electronic and telephonic self-service tools to obtain patient eligibility and benefit (E&B) and claim status information.

By using our self-service tools, providers can simplify administrative activities, eliminate unnecessary paperwork and save time. The secure web-based tools are Health Insurance Portability Accountability Act-Administrative Simplification (HIPAA-AS) compliant and available 24 hours a day. There is no fee associated with using the Advanced Health Information Network.

To access AHIN, go to the Arkansas Blue Cross Web site, arkbluecross.com, select the "Providers" tab at the top and then select the "AHIN" link. AHIN access is free of charge and easy to use.

For more information on setting up a front office staff or admissions staff to have this easy access to AHIN, please call 501-378-2336. If needed, an AHIN account can be set up to limit access only to eligibility and benefit information.

Providers also may call MyBlueLine to check a patient's eligibility and benefits. MyBlueLine is available 24/7 by calling 1-800-827-4814. Use a natural, conversational voice to ask for patient-specific information, like eligibility and benefits, claims status and addresses.

AHIN and My BlueLine are easy to use and frees up our provider and customer service staff to answer more complicated inquiries. Remember, on our self-service tools, you see what we see.

# Fee Schedule

## fee schedule additions and 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 |
|---|---|---|---|---|---|---|
| 80104 | BR | BR | BR | $0.00 | BR | $0.00 |
| 88384 | $164.40 | $26.30 | $138.10 | $0.00 | $26.30 | $0.00 |
| 94011 | $158.28 | $0.00 | $0.00 | $158.28 | $0.00 | $0.00 |
| 94012 | $243.64 | $0.00 | $0.00 | $243.64 | $0.00 | $0.00 |

fee schedule updates (continued from page 14)

| CPT / HCPCS Code | Total / Purchase | Professional / Rental | Technical / Used | Total SOS / Purchase | Prof SOS / Rental | Tech SOS / Used |
|---|---|---|---|---|---|---|
| 94013 | $51.57 | $0.00 | $0.00 | $51.57 | $0.00 | $0.00 |
| C9280 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| C9281 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| C9282 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| C9729 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| E2374 | $488.93 | $48.89 | $366.70 | $0.00 | $0.00 | $0.00 |
| E2377 | $444.70 | $44.47 | $333.52 | $0.00 | $0.00 | $0.00 |
| G0166 | $238.90 | $0.00 | $0.00 | $238.90 | $0.00 | $0.00 |
| J0637 | $33.78 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J1267 | $0.77 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J1745 | $66.38 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J1956 | $18.26 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J2185 | $3.72 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J2248 | $1.80 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J2260 | $51.58 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J3357 | $116.36 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J9263 | $9.91 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| K0195 | $210.70 | $21.07 | $158.03 | $0.00 | $0.00 | $0.00 |
| L8680 | $388.51 | $0.00 | $0.00 | $388.51 | $0.00 | $0.00 |
| R0070 | $178.40 | $0.00 | $0.00 | $178.40 | $0.00 | $0.00 |
| R0075 | $44.60 | $0.00 | $0.00 | $44.60 | $0.00 | $0.00 |
| R0076 | $44.60 | $0.00 | $0.00 | $44.60 | $0.00 | $0.00 |
| S0189 | $60.00 | $0.00 | $0.00 | $0.00 | $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.

| Code | Allowance |
|---|---|
| 90371 | $121.02 |
| 90375 | $167.21 |
| 90376 | $163.89 |
| 90385 | $25.61 |
| 90585 | $119.06 |
| 90586 | $118.14 |
| 90632 | $52.84 |
| 90655 | $15.45 |
| 90675 | $202.12 |
| 90691 | $62.33 |
| 90703 | $28.68 |
| 90714 | $19.48 |
| 90715 | $41.95 |
| 90718 | $24.57 |
| A9576 | $2.38 |
| A9577 | $2.57 |
| A9578 | $2.37 |
| A9579 | $2.31 |
| A9583 | $13.31 |
| J0129 | $21.25 |
| J0130 | $544.52 |
| J0132 | $2.84 |
| J0135 | $401.71 |
| J0150 | $10.06 |
| J0152 | $91.37 |
| J0171 | $0.04 |
| J0180 | $141.66 |
| J0205 | $43.67 |
| J0207 | $334.15 |
| J0210 | $41.81 |
| J0215 | $36.78 |
| J0220 | $165.12 |
| J0256 | $3.95 |

| Code | Allowance |
|---|---|
| J0270 | $0.39 |
| J0275 | $26.75 |
| J0278 | $0.81 |
| J0282 | $0.28 |
| J0285 | $12.92 |
| J0287 | $9.98 |
| J0288 | $14.56 |
| J0289 | $15.62 |
| J0290 | $3.11 |
| J0295 | $2.63 |
| J0330 | $0.16 |
| J0348 | $1.31 |
| J0360 | $4.50 |
| J0364 | $4.97 |
| J0400 | $0.39 |
| J0456 | $4.83 |
| J0470 | $28.66 |
| J0475 | $213.52 |
| J0476 | $76.18 |
| J0480 | $2,133.89 |
| J0500 | $22.18 |
| J0515 | $62.98 |
| J0558 | $3.35 |
| J0561 | $4.23 |
| J0585 | $5.70 |
| J0586 | $7.87 |
| J0587 | $10.75 |
| J0592 | $0.75 |
| J0595 | $0.96 |
| J0597 | $28.63 |
| J0630 | $54.04 |
| J0637 | $12.72 |
| J0641 | $1.31 |

| Code | Allowance |
|---|---|
| J0670 | $2.17 |
| J0690 | $0.60 |
| J0692 | $2.18 |
| J0694 | $7.78 |
| J0697 | $2.49 |
| J0698 | $5.27 |
| J0702 | $6.36 |
| J0713 | $2.16 |
| J0718 | $4.06 |
| J0725 | $9.87 |
| J0735 | $20.56 |
| J0740 | $788.69 |
| J0744 | $1.20 |
| J0745 | $1.40 |
| J0770 | $18.09 |
| J0775 | $39.01 |
| J0780 | $1.98 |
| J0795 | $5.36 |
| J0833 | $54.40 |
| J0834 | $79.48 |
| J0881 | $3.08 |
| J0882 | $3.08 |
| J0885 | $10.06 |
| J0886 | $10.06 |
| J0894 | $32.53 |
| J0895 | $13.45 |
| J1020 | $1.42 |
| J1030 | $2.90 |
| J1040 | $7.35 |
| J1051 | $8.50 |
| J1070 | $4.17 |
| J1080 | $5.44 |
| J1100 | $0.09 |

| Code | Allowance |
|---|---|
| J1110 | $23.43 |
| J1120 | $31.00 |
| J1160 | $1.09 |
| J1162 | $533.10 |
| J1165 | $0.79 |
| J1190 | $231.39 |
| J1200 | $0.82 |
| J1205 | $465.78 |
| J1212 | $74.39 |
| J1230 | $6.47 |
| J1245 | $1.18 |
| J1250 | $6.26 |
| J1260 | $4.40 |
| J1265 | $0.50 |
| J1270 | $3.25 |
| J1290 | $286.29 |
| J1325 | $15.11 |
| J1327 | $20.98 |
| J1335 | $29.39 |
| J1364 | $9.92 |
| J1380 | $7.92 |
| J1410 | $101.59 |
| J1438 | $207.27 |
| J1440 | $249.51 |
| J1441 | $392.41 |
| J1450 | $5.16 |
| J1451 | $7.75 |
| J1453 | $1.80 |
| J1455 | $11.35 |
| J1458 | $351.93 |
| J1460 | $19.42 |
| J1559 | $7.58 |
| J1560 | $194.21 |
| J1561 | $39.14 |
| J1562 | $7.54 |
| J1566 | $32.53 |
| J1568 | $37.48 |
| J1569 | $40.11 |
| J1570 | $60.15 |

| Code | Allowance |
|---|---|
| J1571 | $62.50 |
| J1572 | $37.17 |
| J1573 | $62.50 |
| J1580 | $1.08 |
| J1600 | $14.37 |
| J1610 | $101.27 |
| J1626 | $0.68 |
| J1630 | $6.17 |
| J1631 | $48.83 |
| J1644 | $0.36 |
| J1645 | $12.41 |
| J1650 | $7.11 |
| J1652 | $6.37 |
| J1655 | $4.67 |
| J1670 | $241.77 |
| J1720 | $3.76 |
| J1740 | $152.37 |
| J1742 | $185.49 |
| J1745 | $63.00 |
| J1750 | $12.17 |
| J1756 | $0.37 |
| J1786 | $43.67 |
| J1790 | $3.38 |
| J1800 | $2.87 |
| J1815 | $0.48 |
| J1817 | $2.44 |
| J1885 | $0.30 |
| J1930 | $31.62 |
| J1940 | $0.60 |
| J1945 | $317.38 |
| J1950 | $574.93 |
| J1953 | $0.61 |
| J1955 | $4.96 |
| J1956 | $5.58 |
| J1980 | $12.31 |
| J2010 | $5.89 |
| J2020 | $35.25 |
| J2060 | $0.74 |
| J2150 | $0.98 |

| Code | Allowance |
|---|---|
| J2175 | $1.82 |
| J2185 | $3.55 |
| J2210 | $5.95 |
| J2248 | $1.07 |
| J2250 | $0.07 |
| J2260 | $4.41 |
| J2270 | $2.04 |
| J2271 | $1.08 |
| J2275 | $2.98 |
| J2280 | $3.12 |
| J2300 | $1.05 |
| J2310 | $7.25 |
| J2315 | $2.50 |
| J2323 | $10.62 |
| J2325 | $45.81 |
| J2353 | $119.29 |
| J2354 | $1.36 |
| J2355 | $254.58 |
| J2357 | $21.25 |
| J2358 | $2.86 |
| J2360 | $5.87 |
| J2370 | $1.05 |
| J2400 | $13.22 |
| J2410 | $2.39 |
| J2425 | $11.78 |
| J2426 | $6.76 |
| J2430 | $15.36 |
| J2440 | $0.79 |
| J2469 | $19.63 |
| J2501 | $3.45 |
| J2503 | $1,064.81 |
| J2505 | $2,645.53 |
| J2510 | $11.94 |
| J2515 | $18.66 |
| J2540 | $0.73 |
| J2543 | $5.77 |
| J2550 | $2.12 |
| J2560 | $3.17 |
| J2562 | $291.21 |

injection code updates (continued from page 17)

| Code | Allowance |
|---|---|
| J2597 | $5.33 |
| J2675 | $1.56 |
| J2690 | $7.17 |
| J2700 | $2.21 |
| J2720 | $0.46 |
| J2724 | $13.14 |
| J2730 | $94.02 |
| J2760 | $58.43 |
| J2765 | $0.38 |
| J2770 | $166.63 |
| J2778 | $421.86 |
| J2780 | $0.99 |
| J2783 | $190.12 |
| J2785 | $53.77 |
| J2788 | $26.35 |
| J2790 | $89.03 |
| J2792 | $21.87 |
| J2796 | $46.98 |
| J2800 | $29.63 |
| J2805 | $75.44 |
| J2820 | $24.76 |
| J2916 | $5.19 |
| J2920 | $1.86 |
| J2930 | $2.63 |
| J2993 | $1,514.90 |
| J2997 | $41.24 |
| J3000 | $10.08 |
| J3010 | $0.43 |
| J3030 | $44.64 |
| J3070 | $9.62 |
| J3095 | $2.01 |
| J3101 | $53.55 |
| J3105 | $1.62 |
| J3120 | $4.29 |
| J3130 | $10.00 |
| J3230 | $9.30 |
| J3240 | $1,095.14 |
| J3246 | $8.58 |

| Code | Allowance |
|---|---|
| J3250 | $4.71 |
| J3260 | $2.93 |
| J3262 | $3.61 |
| J3285 | $63.69 |
| J3300 | $3.36 |
| J3301 | $1.69 |
| J3303 | $1.42 |
| J3315 | $183.32 |
| J3355 | $68.05 |
| J3360 | $1.19 |
| J3370 | $3.12 |
| J3396 | $10.03 |
| J3410 | $1.43 |
| J3411 | $5.49 |
| J3420 | $0.29 |
| J3430 | $1.78 |
| J3465 | $6.25 |
| J3471 | $0.18 |
| J3473 | $0.66 |
| J3486 | $7.12 |
| J3487 | $231.73 |
| J3488 | $231.58 |
| J7030 | $0.48 |
| J7060 | $1.16 |
| J7100 | $21.24 |
| J7120 | $1.08 |
| J7184 | $72.99 |
| J7185 | $1.12 |
| J7187 | $0.93 |
| J7189 | $1.49 |
| J7192 | $1.15 |
| J7193 | $0.94 |
| J7194 | $0.91 |
| J7195 | $1.20 |
| J7197 | $2.62 |
| J7198 | $1.66 |
| J7308 | $147.47 |
| J7311 | $20,118.80 |

| Code | Allowance |
|---|---|
| J7312 | $203.82 |
| J7321 | $94.40 |
| J7323 | $154.47 |
| J7324 | $175.80 |
| J7325 | $12.40 |
| J7335 | $26.58 |
| J7500 | $0.15 |
| J7501 | $110.99 |
| J7502 | $3.32 |
| J7504 | $552.10 |
| J7505 | $1,178.49 |
| J7506 | $0.05 |
| J7507 | $3.24 |
| J7511 | $424.61 |
| J7515 | $0.86 |
| J7516 | $23.30 |
| J7517 | $1.45 |
| J7525 | $144.95 |
| J7605 | $5.53 |
| J7606 | $4.82 |
| J7608 | $2.04 |
| J7612 | $0.17 |
| J7620 | $0.18 |
| J7626 | $5.12 |
| J7631 | $0.53 |
| J7639 | $27.20 |
| J7644 | $0.27 |
| J7682 | $78.16 |
| J7686 | $414.26 |
| J8501 | $6.23 |
| J8510 | $3.80 |
| J8520 | $7.18 |
| J8521 | $23.64 |
| J8530 | $0.89 |
| J8560 | $31.29 |
| J8562 | $82.71 |
| J8600 | $4.98 |
| J8700 | $9.66 |

| Code | Allowance |
|---|---|
| J8705 | $80.20 |
| J9000 | $4.22 |
| J9001 | $533.63 |
| J9010 | $610.28 |
| J9015 | $954.79 |
| J9017 | $39.56 |
| J9020 | $65.77 |
| J9025 | $5.33 |
| J9027 | $121.01 |
| J9031 | $118.14 |
| J9033 | $19.31 |
| J9035 | $62.05 |
| J9040 | $15.93 |
| J9041 | $41.97 |
| J9045 | $3.69 |
| J9050 | $182.94 |
| J9060 | $1.65 |
| J9065 | $24.70 |
| J9070 | $7.84 |
| J9098 | $503.36 |
| J9100 | $1.34 |
| J9120 | $583.90 |
| J9130 | $3.45 |
| J9150 | $18.47 |
| J9155 | $2.73 |
| J9160 | $1,648.10 |
| J9171 | $19.17 |
| J9178 | $1.69 |
| J9181 | $0.65 |
| J9185 | $96.13 |
| J9200 | $39.09 |
| J9201 | $157.83 |
| J9202 | $210.44 |
| J9206 | $7.95 |
| J9208 | $36.71 |
| J9209 | $5.28 |
| J9211 | $149.16 |
| J9214 | $16.69 |
| J9217 | $217.47 |

| Code | Allowance |
|---|---|
| J9218 | $5.55 |
| J9225 | $1,421.78 |
| J9226 | $14,927.96 |
| J9230 | $160.29 |
| J9245 | $1,400.39 |
| J9250 | $0.21 |
| J9260 | $2.09 |
| J9261 | $113.75 |
| J9263 | $9.51 |
| J9264 | $9.75 |
| J9265 | $7.59 |
| J9266 | $2,658.56 |
| J9268 | $1,189.58 |
| J9280 | $22.60 |
| J9293 | $42.86 |
| J9300 | $2,795.25 |
| J9302 | $47.20 |
| J9303 | $90.82 |
| J9305 | $54.43 |
| J9310 | $618.41 |
| J9320 | $285.57 |
| J9340 | $118.83 |
| J9351 | $28.45 |
| J9355 | $71.10 |
| J9360 | $0.95 |
| J9370 | $4.03 |
| J9390 | $13.64 |
| J9395 | $86.26 |
| J9600 | $3,203.99 |
| P9041 | $10.19 |
| P9045 | $50.97 |
| P9046 | $21.00 |
| P9047 | $52.51 |
| Q0138 | $0.76 |
| Q0139 | $0.76 |
| Q0164 | $0.04 |
| Q0165 | $0.04 |
| Q0166 | $0.81 |
| Q0167 | $7.33 |

| Code | Allowance |
|---|---|
| Q0168 | $14.73 |
| Q0169 | $0.43 |
| Q0170 | $0.02 |
| Q0173 | $0.86 |
| Q0175 | $0.46 |
| Q0176 | $0.50 |
| Q0177 | $0.04 |
| Q0178 | $0.05 |
| Q0179 | $1.12 |
| Q0180 | $67.49 |
| Q2009 | $0.73 |
| Q2017 | $335.68 |
| Q2036 | $7.74 |
| Q2037 | $13.78 |
| Q2038 | $13.10 |
| Q3025 | $230.92 |
| Q4074 | $68.35 |
| Q4101 | $36.14 |
| Q4102 | $4.81 |
| Q4103 | $4.81 |
| Q4104 | $15.83 |
| Q4105 | $10.77 |
| Q4106 | $41.81 |
| Q4107 | $95.77 |
| Q4108 | $20.52 |
| Q4110 | $36.20 |
| Q4111 | $7.39 |
| Q4112 | $351.43 |
| Q4113 | $351.43 |
| Q4114 | $1,051.32 |
| Q4115 | $7.17 |
| Q4116 | $33.84 |
| Q9954 | $11.13 |
| Q9956 | $43.53 |
| Q9957 | $65.29 |
| Q9960 | $0.16 |
| Q9961 | $0.17 |
| Q9965 | $1.22 |
| Q9966 | $0.33 |

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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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