june 2012

providers' news

A publication for participating providers and their office staffs

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Reporting fraud, waste and abuse

If you suspect any potentially fraudulent activity by a provider, beneficiary or another entity, never confront the person suspected; instead call the FRAUD HOTLINE at 1-800-FRAUD-21 (1-800-372-8321). The Fraud Hotline is available 24 hours a day, 7 days a week. All reports are kept strictly confidential, and callers can remain anonymous.

This applies to Arkansas Blue Cross and Blue Shield, its subsidiaries and affiliate companies, including Medi-Pak® Advantage.

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AHCPII: State payers announce new payment initiative

As the health care industry faces increasingly stringent demands to control rising costs, both from the private and public sectors, payment transformation has become part of the national conversation. Effective payment transformation should address both the cost and quality of care by aligning incentives across stakeholders to reduce unwarranted variation in quality and increase cost efficient processes and practices. Physicians and hospitals should be rewarded for improved care coordination and improved outcomes. The Arkansas Health Care Payment Improvement Initiative (AHCPII) is an effort on the part of health care payers in Arkansas to transform the provider payment system in the state to reward high quality, cost efficient providers.

The AHCPII is a collaboration between Arkansas Medicaid, Arkansas Blue Cross and Blue Shield (and its affiliated companies Health Advantage and BlueAdvantage Administrators of Arkansas), and QualChoice. It was formed to replace our current payment model, which often rewards activity regardless of value, with a model that rewards health care providers for providing necessary, high quality and cost-effective care.

This Initiative was developed with input from hundreds of individuals and organizations including physician associations, hospital executives, clinicians, patients, advocacy groups and the Center for Medicare & Medicaid Services (CMS). Unrelated to the federal health care reform legislation passed in 2010, the AHCPII puts Arkansas on the leading edge of national efforts to improve health care quality and cost efficiency.

The first phase of the new payment initiative launches July 1, 2012. Initially, six episodes of care will be monitored. They include:

- Upper respiratory infections
- Hip and knee replacements
- Congestive heart failure
- Attention-deficit/hyper-activity disorder (ADHD)
- Pregnancy
- Developmental disabilities

During the first three to six months of the initiative, providers will have access to reports designed to help them understand their current practice patterns and the financial and quality outcomes they generate. The data for those reports will be pulled from existing claims data and from a limited set of data that providers will enter into a provider portal for some of the episodes.

The Provider Network Operations staff will work with providers to help identify opportunities for improved alignment with the new payment methodology. There will be no immediate change to reimbursement. Following this introductory period, reimbursement methodology changes will be implemented by Arkansas Blue Cross and its affiliated companies.

While the private payers (Arkansas Blue Cross and QualChoice) have joined with the public agencies (CMS and Arkansas Medicaid) to work on developing a common approach to assessing, tracking and promoting quality and cost efficiency, each private payer will separately and independently determine its own specific reimbursement changes and policies that may result from the broader, government-sponsored initiative. In addition, as shown on the following page, the implementation for each measure will be phased in on a payer-by-payer basis.

How is an episode of care defined for each of the six initial diagnoses? The chart (located on page 3) describes the definition of each episode in the initial transformation phase and identifies the payer involved in the episode.

How will the new payment model work? For each of the six episodes of care identified, a Principal Accountable Provider (PAP) will be designated. This PAP will be the provider with responsibility for the majority of care in a given episode. In some cases, the PAP will be a physician. In others, it will be a hospital or facility. (See the chart on page 3 for PAPs designated for the initial six episodes.)

The PAP will be eligible for gain and risk sharing based on the overall cost and quality of the care delivered to the patient during the episode period. This summer, PAPs will gain access to detailed reports analyzing their performance and thoroughly explaining the PAP role.

A Web site (www.paymentinitiative.org.) is currently available to provide ongoing education, a link to the provider portal, and additional resources related to the Initiative.

(Continued from page 2) state payers announce new payment initiative

Payers will offer staff assistance through town hall-style meetings across the state, informational webinars and other educational resources both online and offline throughout the transition period. No changes in reimbursement will occur during the transition period.

PAPs will submit claims as usual, as will non-PAPs involved in an episode of care as outlined. Both PAPs and non-PAPS will continue to receive fee-for-service payments throughout the transition period and once the new payment model is implemented.

At the end of the transition period (not sooner than three months and not later than six), providers will be notified that the new payment methodology is being implemented.

As noted previously, both PAPs and non-PAPs will continue to file claims and receive reimbursement as usual.

Following each designated performance period, the payer involved will reconcile the results of the episodes completed during that period against previously established and communicated cost thresholds and quality metric. Calculations will be risk-adjusted and consider factors impacting performance such as outliers, average costs, geography, patient population, etc. If the PAP meets or exceeds these target metric, additional incentive will be paid. If performance falls short of the targets, risk amounts will be withheld from future payments.

Health care costs are unsustainable. As a nation, as a state and as individuals, we are all paying the price of an uncoordinated delivery system based on misaligned incentives. It is essential that we as stakeholders in health care delivery and financing take the lead in building a new model that will serve our country, our state and our patients and provide the kind of high-quality, affordable care that is our mutual goal.

For more information, visit the Web site at www.paymentinitiative.org or contact your regional Network Development Representative.

Episode	Definition/Scope	Payers Launching July 1	Principal Accountable Provider (Pap)
• Hip/Knee Replacements	• Surgical procedure plus all related claims from 30 days prior to procedure to 90 days after	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicare*	• Surgeon; hospital may also be consider as a Co-PAP
• Perinatal	• Pregnancy-related claims for mothers from 40 weeks before to 60 days after delivery; excludes neonatal care	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicaid	• Physician who delivered the baby
• Ambulatory URI	• 21-day window beginning with initial consultation and including URI-related outpatient and pharmacy costs; excludes inpatient costs and surgical procedures	• Medicaid and • Medicare*	• Initial treating physician*
• Acute/Post-acute CHF	• Hospital admission plus care within 30 days of discharge	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicare*	• Hospital
• ADHD	• 12-month episode including all ADHD services and pharmacy costs with exception of initial assessment	• Medicaid	• Treating physician or licensed clinical psychologist
• Developmental Disabilities	• Assessment or annual review plus 12 months of DD services	• Medicaid	• Primary DD treating provider

***Episodes appropriate for Medicare if CMS determines that Medicare will participate in this program.**

CPCI: Arkansas Blue Cross collaborates to improve primary care in Arkansas through federal initiative

Arkansas Blue Cross and Blue Shield, QualChoice, and Arkansas Medicaid recently teamed together to apply for — and become an initially selected market for — one of seven national four-year health care initiatives by the Centers for Medicare and Medicaid Services (CMS) Innovation Center to help primary care practices deliver higher quality, better coordinated and more patient-centered care.

"We are extremely pleased to be a part of this effort to transform primary care in Arkansas," said Mark White, president and chief executive officer of Arkansas Blue Cross. "This program will help create patient-centered medical homes throughout the state, which will care for our citizens with chronic illnesses, and make a monumental difference in the long-term health of Arkansans."

The Comprehensive Primary Care Initiative (CPCI), sponsored by the CMS Innovation Center, will help fund the transformation of 75 selected primary care practices into patient-centered medical homes through the payment of a per-member-per-month (PMPM) fee to the primary care doctors who participate. The total payment is estimated to be more than $50 million for the affected Medicare beneficiaries. Health Advantage (a subsidiary of Arkansas Blue Cross), QualChoice and Arkansas Medicaid have agreed to also pay a PMPM fee to the providers who participate.

The CPCI practice application eligibility tool is now available at: http://innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html. This tool is a short, straightforward questionnaire for primary care practices to help them understand whether they will be eligible to apply for the initiative. Primary care practices may begin using the application eligibility tool now; it will be held open on the CMS Web site for the entire practice application phase.

Please note that the full list of eligibility criteria has not yet been released and will ultimately determine eligibility for the program. The practice application eligibility tool is not the practice application for the initiative. However, completion of the practice application eligibility tool, which includes leaving a point of contact and e-mail address for the practice, is a prerequisite for receiving the URL of the online application once it becomes available. Practices must complete and submit the CPCI application in order to be considered for selection in the CPCI.

Blue-On-Blue: automation of the coordination of benefits

On May 10, 2012, Arkansas Blue Cross and Blue Shield and its affiliated companies implemented the automation of the Coordination of Benefits (COB) and claims routing within Arkansas Blue Cross and its affiliated companies. This automation process, known as Blue-On-Blue (BOB), will affect claims for Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, Health Advantage, and Federal Employees Program members that have more than one health insurance policy within Arkansas Blue Cross and its affiliated companies. (Note: this does not include BlueCard when the member has a policy with another Blue Plan.)

A phased implementation approach of BOB was formulated to ensure a smooth transition and minimize risks.

- Phase I (March, 2011) – Speci-

(Continued from page 4) automation of the coordination of benefits

fied the applicable level of coverage by indicating whether the coverage is primary, secondary or tertiary on the Member Coverage, Benefit and Claim screens.

- Phase II (September 2011) - Required COB information to be present on claims when the policy indicates member coverage is secondary or tertiary.
- Phase III (May 11, 2012) - Automated the routing of Blue-On-Blue ANSI 5010 claims to the appropriate payer(s).

With the implementation of BOB, providers no longer need to submit a second claim with the previous Arkansas Blue Cross payer's payment information. Arkansas Blue Cross will electronically crossover claims to the correct Arkansas Blue Cross affiliate as secondary or tertiary payer with the previous payer's payment information. The Blue-On-Blue process is similar to the crossover process utilized by Medicare.

Documentation of this process can be viewed on the Advanced Health Information Network (AHIN) bulletin board by clicking on "User/Guides Instructions" and then viewing "Blue-On-Blue Claim Processing".

The Initial and Add'l Payer columns display only when a Blue On Blue scenario is encountered. A link is provided on the ICN to review both claims related to the BOB scenario.

When a claim is passed from one BOB payer to another, AHIN will display all payers involved for BOB claims. In this example, the Initial Payer (FEP) is identified as Primary Payer and Health Advantage as the Add'l Payer. FEP payment information has been populated and routed to Health Advantage for processing.

The claim display on AHIN is always for the payer with the white background.

Other payer(s) of the claim have a gray background.

Click on an ICN link to change the display to the other payer's claim.

The Health Advantage claim under the Add'l Payer heading is displayed. Clicking the ICN link under the Initial Payer heading will take you to the FEP claim.

(Continued from page 5) automation of the coordination of benefits

Add'l Payer claims rejected by AHIN do not get assigned an ICN – No ICN will display when rejected for a claim edit.

Click on the No ICN Link to view the claim in error.

In this example, the secondary claim routed from the primary payer failed a claim edit(s) and was rejected. As a result, the claim was not routed to the add'l payer.

Correct a BOB claim as any other claim in error.

- The Add'l Payer heading does not display on the correction screen.
- ICNs cannot be assigned until the claim is corrected/validated

When the add'l payer claim encounters a claim edit, you may choose to correct the error and submit it in the same manner as any other rejected.

Add'l Payer claims that pass AHIN editing, but are rejected by the payer do get assigned a payer and an ICN.

Note: Documentation regarding the correction/resubmission of these claims can be viewed on the AHIN Bulletin Board. Click here to view the documentation

(Continued from page 6) automation of the coordination of benefits

Provider Sub Id: e9999 Clrhouse Sub Id: File Name:

Type: File Status:

Date: To

Viewed: Facility:

BOB Validation Report for a submitter.

This report contains claims that crossed over to other BOB payers on 04/27/2012.

Note: BOB claims will be included on the report based on the previous payer adjudication/finalized date – NOT the date the original/initial claim was submitted.

			Status	Facility	Date	Load
			Accepted	Test Clinic	04/30/2012	04/30/2012
		rt	Accepted	Test Clinic	04/30/2012	04/30/2012
			Accepted	Test Clinic	04/30/2012	04/30/2012
			Accepted	Test Clinic	04/30/2012	04/30/2012
		rt	Accepted	Test Clinic	04/30/2012	04/30/2012
-	e9999.e8888.837p.p.a.j5.999.rpt	999	Accepted	Test Clinic	04/30/2012	04/30/2012
-	e9999.e8888.837p.p.a.j83.ta1.rpt	TA1	Accepted	Test Clinic	04/27/2012	04/27/2012
-	e9999.e8888.837p.p.a.j83.rpt	Validation Report	Accepted	Test Clinic	04/27/2012	04/27/2012
-	e9999.e8888.837p.p.a.j83.999.rpt	999	Accepted	Test Clinic	04/27/2012	04/27/2012
-	e9999.e8888.837p.p.a.g26.ta1.rpt	TA1	Accepted	Test Clinic	04/27/2012	04/27/2012
✔	e9999.e8888.12115.bob.rpt	BOB Validation Report		Test Clinic	04/27/2012	04/27/2012

Blue-On-Blue Validation Reports are created once a day and will include the BOB claims for your facility that crossed over to the other BOB payers on that day. The reports will display in the report search results list (under the insurance link) for your facility.

Report

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BLUE ON BLUE CROSSOVER REPORT - April 17
Tuesday @ 19:48:58

SubmitterID: E9999
Provider   : 1234567890

CLAIMS ROUTED TO ADDITIONAL PAYERS

Patient   : Test Person            ID#       : M9
PatAcct   : 001100174683           DOB       : 01/
Payor     : BlueAdvantage          Sequence  : Se
PyrAlias  : BL00520                PayerKey  : US
ICN/PCN   : 120417N01WI5           StmtFrom  : 20
BatchID   : 0001BTCH01A80CF6       ClaimID   : 00
Total Chg : 174.00                 SubDate   : 20

Previous Payers:
Sequence   Payer               SubDate     ICN
Primary    Health Advantage    2012-04-04  120404M00RW3

FILE AUDIT

PAYER          RECEIVED          ACCEPTED
               #    $$           #    $$
USABLE         1    174.00       1    174.00
TOTAL FILE     1    174.00       1    174.00
```

BOB Validation Report detail for a submitter.

This report contains claims that crossed over to BOB payers on 04/17/2012 (based on the previous payer adjudication/finalized date).

- Claim information for the claim that crossed over to an additional payer
  - Payer receiving the BOB claim
  - Payer Sequence
  - Payer ICN
  - Date of cross over
- Previous payer information (crossed over from)
  - Payer Sequence
  - Payer that crossed over the claim
  - Date original claim was submitted
  - ICN of original claim
  - Amount paid
  - Date claim was finalized
- Summary of claims crossed over for your facility

Note: BOB claims will be included on the report based on the previous payer adjudication/finalized date – NOT the date the original/initial claim was submitted.

Health Advantage is identified as the Initial Payer and the claim is now being routed to USAble for processing.

Got PHR? (personal health record)

A Personal Health Record (PHR) provides critical support to a physician practice's workflow. Arkansas Blue Cross and Blue Shield has visited with many of our network physicians who state the PHR is an excellent source of patient information. The PHR can strengthen the physician-patient relationship by reviewing the patients compliance with prescriptions, visits to other health care providers, discussion of the "gap in care" alerts that are documented on the PHR, personal and family medical history, etc. Reading the PHR Health Summary of a patient either prior to or during an office visit can significantly streamline patient flow from check-in to departure.

Knowledge is power and having valuable health information at your finger tips enables providers to make more informed health decisions about their patients. In most cases, a patient's health history is spread across multiple providers and health care facilities. As a result, providers are limited to only a portion of their patient's health history, generally resulting in forgotten medications, previous tests and/or surgeries from the past.

Arkansas Blue Cross and its affiliated companies offer an easy, on-line, partial solution to this problem in the form of the innovative PHR available to members and their treating physicians. The PHR database – which has been available to members and their providers for approximately two years now – is continually being enhanced to improve its functionality and increase its value both to members and their treating physicians. The latest such enhancement is a new tool known as "Q-Chart."

With the introduction of Q-Chart, Arkansas Blue Cross acknowledges the importance and value of technology to dramatically improve the amount of information readily available to providers. The Q-Chart is a secure Web-based portal that provides a vast amount of payer-based member medical and pharmacy claim data, as well as patient entered information.

The Q-chart portal has personal health records available for patients with the following health plans:

- Arkansas Blue Cross
- Health Advantage
- BlueAdvantage Administrators of Arkansas
- Medi-Pak
- Medi-Pak® Advantage
- USAble Administrators

Patients who have multiple medical issues often see numerous specialists from unaffiliated facilities. No single provider has a longitudinal view of their patient's activity and health history across an assortment of health facilities, payers and time periods.

However, providers now have access to invaluable timely access to their patient's health records, gathered from multiple health encounters reported via member claims data – located in one place – the PHR (Personal Health Record). The PHR includes:

- Personal profile
- Health summary
- Risk factors (e.g., allergies, chronic conditions)
- Treatment opportunities (e.g., reminders for mammograms or to check cholesterol)
- Current medications and medication history
- Inpatient & outpatient office visits
- Lab/radiology information
- Health tracker – patient entered information (e.g., blood sugar, blood pressure, & height/weight)
- Clipboard (a printable version of the patient's health summary)

Thousands of patients are playing a more active role in their health care by reviewing and updating their health information, such as:

- Medical
- Social and family history
- Allergies
- Emergency contact information
- Advance directives
- Immunizations
- And much more!

In the interest of maximizing the patient's control of the privacy of their medical data, the PHR automatically hides from an inquiring provider information about HIV/AIDS, drugs/alcohol abuse, sexual abuse, abortion services, rape, sexually transmitted diseases and mental health issues. However, the PHR program allows the patient to choose to make this information available to medical personnel. The patient may also choose to "hide" other specific information in the PHR, such as medications or office visits. In all cases where the patient hides information, a place holder displays "Information hidden at patient's request."

By having access to the PHR, providers may be able to detect possible interactions with various medications prescribed by different

(Continued from page 8) got PHR? (personal health record)

providers, be aware of recent health activities, and reduce repetitious procedures, labs and images.

The PHR would be exceptionally helpful in emergency situations where lack of health information can be fatal or during natural disasters where such information becomes unavailable. In situations like these, a patient may not be able to recall their current medications or recent health care activity. The patient's PHR is available anywhere, anytime with the proper authorization and an internet connection.

Want PHR?

To inquire or sign up for access to the PHR, contact the Personal Health Record Customer Support by email at personalhealthrecord@arkbluecross.com

or

Arkansas Blue Cross
c/o Personal Health Record, 4-S
601 South Gaines Street
Little Rock, AR 72201

Medical record vendors

When a health care provider enlists the services of a vendor (e.g. Smart Corp.) to assist them with medical records, it is the provider's responsibility to inform the vendor that Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, and USAble Administrators are not responsible for their fees.

Network participation agreements for all participating providers in the networks of Arkansas Blue Cross and its affiliates specify that participating providers must make medical records available to the network-sponsoring organizations and payers utilizing the networks without charge when they are requested for claims benefit/payment determination and utilization review programs related to network members. In addition, **cost for records requested for these purposes cannot be charged to members.**

Article originally printed in the March 2002 issue of *Providers' News.*

EFT requirement

Electronic Funds Transfer (EFT) or direct deposit will be required of all participating providers of Arkansas Blue Cross and Blue Shield's Preferred Payment Plan (PPP), Health Advantage's HMO network and USAble Corporation's Arkansas' FirstSource© PPO and True Blue PPO network effective October 1, 2012. This will be a requirement in order to participate in these provider networks beginning October 1, 2012. Dental providers will not be included at this time.

Implementing EFT will begin as follows:

1. Effective January 1, 2012, all new provider applicants will be required to enroll in EFT, regardless of whether this is a new clinic or an existing practice. For example, if a new physician is applying to participate in any of the networks mentioned previously, and the physician is applying to join an already established clinic, that clinic must be paid via EFT.
2. Effective January 1, 2012, all providers making a change to any of their information will be required to enroll in EFT. For example, a physician's office needs to change a telephone number within its clinic and submit a change of data form. That change will not be made until the clinic has enrolled in EFT.
3. Beginning October 1, 2012, all participating providers must be enrolled into EFT (excluding dental).

EFT enrollment may be completed on the Advanced Health Information Network (AHIN) or contact your regional Network Development Representative. See the "Claims Payments, Refunds & Offsets" section of the Arkansas Blue Cross Provider Manual at arkansasbluecross.com/providers.

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

Revision to payer policies and procedures and terms and conditions applicable for Arkansas' FirstSource® PPO, True Blue PPO and Health Advantage HMO provider networks and notice on behalf of Arkansas Blue Cross and Blue Shield for all participating providers

Publication Of Claims, Utilization, Quality and Other Practice Data

In this rapidly changing health care environment, health insurers and network sponsors are faced with the challenge of meeting market demand for more information about health care providers.

Consumers now expect to be able to find reliable, standardized comparative performance data for health care providers, including cost and quality rankings where available. As sponsors of health maintenance organization and preferred provider organization networks, respectively, Health Advantage and USAble Corporation are not alone in dealing with market pressure for increased transparency of cost and quality information relating to the medical services our members receive.

In order to address the needs of our customers in this regard, effective February 1, 2012, the published "terms and conditions" for participation in Health Advantage's HMO network and for USAble Corporation's Arkansas' FirstSource® and True Blue PPO networks were changed to remove from "Section VII. Publication of Utilization, Quality and Other Practice Data" any references to a provider "opting out" of or otherwise avoiding publication of the provider's utilization, cost, quality or other practice data. This means that as of February 1, 2012, any provider who participates in the Health Advantage HMO network or in either of the two PPO networks of USAble Corporation will be subject to publication of any and all claims, utilization, cost, quality or other practice data.

Participating providers should note that it may be necessary or beneficial to the networks or their members to publish provider claims, utilization, quality and other practice data to a wide variety of sources or audiences in order to facilitate new initiatives aimed at improving quality of services and devising new reimbursement or payment methodologies to contain rising health care costs. Accordingly, USAble Corporation, Health Advantage, and their parent entity, Arkansas Blue Cross and Blue Shield, may elect, in their discretion, to publish or release claims, utilization, cost, quality and other practice data that they collect or maintain regarding participating providers to members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies or the general public as deemed necessary or helpful with respect to various initiatives from time to time. Please note the revised wording for Section VII. "Publication of Utilization, Quality and Other Practice Data" reflected in full at the end of this notice.

While "opting out" of data publication for participating providers is no longer an option, providers will still receive an advance copy of any utilization, cost, quality or other practice data that Health Advantage, USAble Corporation or Arkansas Blue Cross intend to publish if the publication of such data will be made in a general distribution to all members, group health plans, employers or other network providers or the general public. Health Advantage and USAble Corporation will endeavor to provide such advance notice 45 days prior to the intended publication date. For more limited releases of provider claims, utilization, quality or other practice data to specific members, group health plans, employers, hospitals or other categories of providers, consultants, or vendors, or subsets of such audiences, advance copies of such releases will not be provided, but upon written request, interested providers will be furnished with a copy of the information specific to their practice that has been released by USAble Corporation, Health Advantage or Arkansas Blue Cross in the 12 calendar months preceding the date of the written request. Providers who have questions about their data may contact their respective regional Network Development Representative.

Special Note on Data of Non-Participating Providers

Finally, it should be noted that

(Continued from page 10) revision to payer policies and procedures and terms and conditions

while the preceding notice is primarily intended to alert participating providers to the changes being made in the terms and conditions of their network participation, USAble Corporation, Health Advantage and Arkansas Blue Cross also intend this statement to constitute notice to non-participating providers that any claims, utilization, quality, cost or other practice data that may be submitted to, collected or maintained by USAble Corporation, Health Advantage or Arkansas Blue Cross is also subject to publication or release, in their discretion, to members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies or the general public as deemed necessary or helpful with respect to various initiatives from time to time.

Effective June 1, 2012 section VII of the payer policies and procedures and terms and conditions will now read:

VII. Publication of Claims, Utilization, Quality and Other Practice Data

As a term and condition of network participation, all participating providers are deemed to authorize insurers, HMOs or self-funded payers whose members utilize the networks, to publish to such members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies and to the public generally (subject, of course, to applicable member confidentiality requirements and HIPAA Privacy standards) any data , including information obtained from claims submissions, regarding the rates of utilization or performance of services by such participating provider, any data concerning costs of care or services, any data regarding quality of services provided to members, any data (again, subject to protection of member identification/confidentiality) regarding member complaints, any data regarding malpractice claims, including but not limited to the filing of such claims, settlement of any such claims, insurance payments made as to such claims, judgments or awards made as to such claims, any data regarding complaints to the State Medical Board or other regulatory or disciplinary authorities regarding such participating provider, any data regarding provider's education, professional training, practice history, prior locations and licensure in any jurisdiction, and any other data concerning participating provider and provider's professional qualifications, competency or practice that may be useful and informative to such members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies and the public generally.

As a term and condition of network participation, participating providers agree to release the insurer, HMO or self-funded payer and their agents or representatives from any claims or liabilities related to the publication of any provider data to members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies or the public generally, so long as such publication is not deliberately and maliciously false.

If publication of provider data includes a rating or comparison of a provider's relative cost or quality of services, and if publication of the rating or comparison will be made in a general distribution to all members, group health plans, employers or other network providers or the general public, then in such circumstances, affected providers will be given a copy of the utilization and practice data that the network sponsor proposes to publish. The network sponsors will endeavor to give advance notice so that affected providers will have a 45-day review period before any such general publication of cost or quality ratings or comparisons is made. For more limited releases of provider claims, utilization, quality or other practice data to specific members, group health plans, employers, hospitals or other categories of providers, consultants, or vendors, or subsets of such audiences, advance copies of such releases will not be provided, but upon written request, interested providers will be furnished with a copy of the cost or quality rating or comparison information specific to their practice that has been released by USAble Corporation, Health Advantage or Arkansas Blue Cross in the 12 calendar months preceding the date of the written request.

Presbyopia correcting intraocular lens

On January 1, 2006, HCPCS added code V2788 (Presbyopia Correcting Function of Intraocular Lens). The billing and payment for Intraocular lenses (IOL) is included in facility payments for the related surgical procedure. HCPCS Code V2788 should be used to show the DIFFERENCE in the cost of the regular IOL and the Presbyopia correcting IOL.

A facility must obtain a waiver from the patient to bill the patient for the difference in cost. The patient waiver should explain why HCPCS Code V2788 is necessary rather than the standard IOL and the difference in cost.

If a member chooses to have multifocal lens rather than monofocal lens, the member is responsible for the cost of the multifocal lens minus the Arkansas Blue Cross and Blue Shield allowance to the facility for the monofocal lens:

- Allowance for monofocal lens = $225 if performed in an Ambulatory Surgery Center;
- Allowance for monofocal lens = $300 if performed in a Hospital Outpatient setting.

The Arkansas Blue Cross allowance for the monofocal lens is included in the total allowance to the facility for the procedure of extraction and replacement of the lens.

The previous article was printed in the December 2005 issue of Providers' News.

There are two additional HCPCS codes that also apply to the policy above. Those codes are:

- V2786 – Specialty Occupational Multifocal lens, per lens;
- V2787 - Astigmatism Correcting function of intraocular lens.

The additional cost above the monofocal lens is the patient's responsibility and a patient waiver is required in order to bill the patient for the difference in cost.

PB 5010 deadline

The US government mandated that the X12 version 5010 electronic transaction formats for claims and other transactions be effective April 1, 2012. All electronic transactions must be changed from the current X12 4010A1 format to the X12 5010 format. The versions are a result of the adoption of the 5010 X12 as the standard for medical care and affect the transactions listed below.:

Please visit the 5010 Resource Center for more information on how to become compliant on the Arkansas Blue Cross Web site at www.arkansasbluecross.com/providers/5010resourcecenter.aspx

Providers with questions regarding enrollment should call EDI Services at 501-378-2419 or submit their enrollment questions to edi_enrollment@arkbluecross.com.

Questions regarding connectivity to the NetX Gateway, uploading 5010 files, and downloading 5010 files should call EDI Services at 501-378-2419 or submit their questions to edi@arkbluecross.com.

Transactions affected:	
Eligibility (270/271)	Version 005010X279A1
Remittance Advice (835)	Version 005010X221A1
Claims (837) Professional	Version 005010X222A1
Claims (837) Institutional	Version 005010X223A2
Report (999) Acknowledgment	Version 005010X231A1
Claim Status (276/277)	Version 005010X212
Dental Claims (FEP only)	Version 005010X224A2

Proper coding for members in clinical trials

Providers treating a patient that is participating in a clinical trial should use the two modifiers below when submitting claims for such a member:

- Q0 - Investigational clinical service provided in a clinical research study that is in an approved clinical research study.
- Q1 - Routine clinical service provided in a clinical research study that is in an approved clinical research study.

Claim lines with Modifier Q0 would normally not be a covered service. Procedures that would normally be covered if the patient was not in a clinical trial should be submitted with modifier Q1. Claim lines appropriately billed with modifier Q1 would be a covered service assuming all other terms and conditions of coverage under the member's applicable insurance policy or health plan are met.

Claims filing rule reminders for durable medical equipment, laboratory, and specialty pharmacy

The following article was originally published in the December 2011 issue of *Providers' News* under the "BlueCard" heading. **While the claims filing policies and rules are required for BlueCard, these same claims filing rules apply to ALL laboratories, durable medical equipment/home medical suppliers and specialty pharmacies. In addition, based on further review of services being submitted for payment, the required claims data elements for durable medical equipment will be required for all Prosthetic and Orthotic providers and the specialty pharmacy required claims data elements will apply to home infusion therapy providers.**

In 2004, the Blue Cross and Blue Shield Association (the Association) revised its BlueCard claims filing rules for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. While these revisions are several years old, the Association has only recently tightened system requirements related to these rules. These rules apply to all provider networks and claims related to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage.

Claims for independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy are filed to the local Blue Cross and Blue Shield Plan (sometimes called the Host Plan). The local Blue Cross Plan is usually defined as the Plan in whose service area the services are rendered. The Blue Plan that issued coverage for a given member, or that contracted with their employer to administer their self-funded health plan, is referred to as the Home Plan.

Please note: Host Plan and Home Plans are in every case independent companies so that the Host Plan is not responsible for funding of any insurance issued by a Home Plan. The Host Plan's role is limited to a claims processing and customer services assistance function with respect to the out-of-state provision of services to the Home Plan's member.

Clinical Lab:

For clinical lab, the local Blue Cross Plan is defined as the plan in whose service area the specimen was drawn.

Example: a blood specimen is drawn at a physician's office in Little Rock that participates in the Health Advantage network on a member who has Health Advantage benefit coverage. The lab is sent to New York to be processed and is billed from North Carolina. This laboratory participates in the Health Advantage network. The claim must be billed directly to Health Advantage as the specimen was drawn in Arkansas. The claim will be processed as in network for covered services.

(Continued from page 13) claims filing rule reminders

Another example: A blood specimen is drawn in Hot Springs on a member who has health plan coverage administered through BlueAdvantage Administrators of Arkansas. The clinic where the specimen is obtained is not in any Arkansas Blue Cross provider networks. The lab specimen is sent to Denver, Colorado to be processed and will be billed by the lab from Denver. The lab is also not in any Arkansas Blue Cross or affiliates' provider network. The claim must be billed directly to BlueAdvantage as the specimen was obtained in Arkansas. The claim will be processed as out of network for covered services.

Information required on claims submitted for clinical lab:

- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.

Durable/Home Medical Equipment and Supply

For durable/home medical equipment and supply, the local Blue Plan is the plan in which service area the equipment was shipped to or purchased at a retail store.

For example: a member with Arkansas Blue Cross insurance living in Fort Smith, Arkansas orders diabetic supplies from a mail order supplier in Ohio. The supplier participates in the Host Plan's network in Ohio but not Arkansas. The claim must be filed directly to Arkansas Blue Cross because Arkansas is where the supplies were shipped. The claim will be processed as out of network for covered services.

Information required on claims submitted for durable/home medical equipment:

- Patient's Address, Field 5 on CMS 1500 Health Insurance Claim Form or in loop 2010CA on the 837 Professional Electronic Submission.
- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.
- Place of Service, Field 24B on the CMS 1500 Health Insurance Claim Form or in loop 2300, segment CLM05-1 on the 837 Professional Electronic Submission.
- Service Facility Location Information, Field 32 on CMS 1500 Health Insurance Form or in loop 2310 A (claim level) on the 837 Professional Electronic Submission.

Specialty Pharmacy

For specialty pharmacy, the local Blue Plan is defined as the plan in whose service area the ordering physician is located.

For example: a physician whose clinic is in Pine Bluff orders specialty drugs for a Health Advantage member who lives in Stuttgart. The specialty pharmacy is located in Jackson, Mississippi and is in the Mississippi Blue Cross and Blue Shield provider networks, but not in any Arkansas Blue Cross or affiliates' networks. The claim must be filed directly to Health Advantage as the ordering physician's practice location is in Arkansas.

The claim will be processed as out of network as the specialty pharmacy is not in any Arkansas Blue Cross or affiliates' provider networks. Information required on claims submitted for specialty pharmacy:

- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.

The BlueCard program has always relied on the provider agreement status and pricing of the local Blue Plan and that is still true. The mere fact that a claim is required to be submitted directly to a certain Blue Plan does not obligate any local Blue Plan to offer contracts to any lab, durable medical equipment supplier or specialty pharmacy.

However, the Association's rules for BlueCard have been revised to allow Blue Plans to contract with out of state clinical labs, durable medical equipment suppliers and specialty pharmacies. Each local Blue Plan will make its own decisions related to provider contracting and pricing.

Provider Type	How to file (Required fields)	Where to file	Examples
Independent Clinical Laboratory (any type of non hospital based laboratory) **Types of service include, but are not limited to:** Blood, urine, samples, analysis, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2310A (claim level) on the 837 Professional Electronic	File the claim to the Plan in whose state the specimen was drawn* * Where the specimen was drawn will be determined by which state the referring provider is located.	Blood is drawn* in lab or office setting located in **Arkansas.** Blood analysis is done in New York. **File to: Arkansas.** *Claims for the analysis of a lab must be filed to the Plan in whose state the specimen was drawn.
Durable/Home Medical Equipment and Supplies (D/HME) **Types of service include, but are not limited to**: Hospital beds, oxygen tanks, crutches, etc.	**Patient's Address:** • Field 5 on CMS 1500 Health Insurance Claim Form **or** • Loop 2010CA on the 837 Professional Electronic Submission. **Ordering Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2420E (line level) on the 837 Professional Electronic Submission. **Place of Service:** • Field 24B on the CMS 1500 Health Insurance Claim Form **or** • Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. **Service Facility Location Information:** • Field 32 on CMS 1500 Health Insurance Form **or** • Loop 2310C (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store.	A. Wheelchair is purchased at a retail store in Arkansas. **File to: Arkansas** B. Wheelchair is purchased on the internet from an online retail supplier in Ohio and shipped to Arkansas. **File to: Arkansas**
Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2310A (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan whose state the ordering physician is located.	Patient is seen by a physician in Illinois who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in Arkansas where the member lives for 6 months of the year. **File to: Illinois**

Imaging centers purchased by hospitals

Per the terms of participation for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage HMO network, and USAble Corporation's Arkansas' FirstSource® and True Blue PPO networks, advanced imaging centers must be accredited by one of the agencies that meets approval per these networks' required accreditation program. This includes advanced imaging centers purchased by another organization, including hospitals.

In most situations, a currently accredited imaging center can simply notify the accrediting agency (e.g. American College of Radiology or Intersocietal Accreditation Commission) and ask for a certificate with the new organization's name applied to it. Arkansas Blue Cross, Health Advantage, and USAble Corporation will need a copy of the new certificate

Please understand that if the imaging center's new owner is a hospital, the hospital's Joint Commission accreditation does not automatically apply. In order for this to apply, the hospital must be performing both inpatient and outpatient imaging services and the imaging center must have been part of the on-site review performed by the Joint Commission when the accreditation was given.

Imaging centers have 180 days from the date of the new owner's date of purchase to submit the proof of accreditation required to remain in network. Please submit proof of accreditation to:

Provider Network Operations
P. O. Box 2181
Little Rock, AR 72203

If you have questions, or need additional information, please contact you network development representative.

Reminder of printing guidelines for paper claims

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and Health Advantage encourage providers to file claims electronically since electronic claims are processed faster and more accurately than paper claims. However, in the event that a paper claim form is used, certain guidelines must be followed before the paper claim can be accepted. To ensure the paper claim is accepted and the claims data is read accurately, providers should adhere to the following guidelines:

- Use only red Form CMS-1500 08/05 and red Form UB-04 that confirm to CMS guidelines.
- Align the form carefully so that all data falls within the blocks on the claim form. Please be sure that all line-item information appears on the same horizontal line.
- Do not hand write claim information. Claim information must be printed or typed with black ink. Remember to regularly change your printer ribbon or ink cartridges.
- Keep the form clean by not printing, writing, or stamping extra data on the form. Please refrain from using correction fluid or correction tape. If an error occurs while completing the claim, please complete a new, red claim form for submission.
- Use only UPPERCASE letters for alphabetical entries. Don't mix fonts or use italics, script, percent signs, question marks or parentheses.
- The recommended font for Form CMS-1500 08/05 is 12-point Courier New set at 10 characters per inch (10-pitch), 6 lines per inch. The recommended font for Form UB-04 is 10-point Courier New set at 10 characters per inch (10-pitch) and 6 lines per inch.
- Please separate all forms carefully. Do not fold, staple, or tape claims. Do not place any stickers on the claim form. Remove any pin-feed edges from any continuous feed forms.

Since Optical Character Recognition (OCR) technology is used to convert paper claims to electronic data, paper claim forms that do not comply with these guidelines or are printed too light to be successfully read by OCR equipment may be rejected.

Common errors on CMS1500 paper claim submissions

There are several common submission errors that will cause a professional CMS-1500 paper claim to be rejected. In addition to failure to follow printing guidelines (see Reminder of Printing Guidelines for Paper Claims article located on the previous page) for paper claims, the following items are some of the most common errors found on paper claims submissions.

- Missing or invalid NPI numbers.
- Missing or invalid insured's ID number.
- Missing patient and/or insured name, address, date of birth and gender. Many providers will leave off information or simply enter "SAME" when the patient and the insured are the same person. While the use of the word "SAME" for both insured's name and address is accepted, we still recommend always completing all information for both even if it is the same person.
- Patient and/or insured name submitted in the wrong order. Both patient and insured names should be submitted in the following order: 1) Last name, 2) First name, 3) Middle initial.
- Missing or invalid federal tax ID number.
- Improperly formatted dates. Date fields should be submitted using either two-digit month/day/year (MM/DD/YY) or two-digit month/day and four-digit year (MM/DD/YYYY) format.
- Trying to indicate patient or insured is a female by putting the letter "F" in the check box intended for male. For check box fields, OCR technology is only looking for a marked box. It does not interpret the letter used. Simply put an "X" in the appropriate box.
- Check box mark ("X") is outside of the box. For check box fields, OCR technology is looking within a particular zone for the expected selection. If the "X" is outside the intended check box, it can get interpreted as a blank. If an "X" is place between two check boxes it may also be misinterpreted as to which was the intended selection.

To avoid unnecessary claims rejection, make sure the data on professional CMS1500 paper claims is submitted using standard NUCC guidelines. Providers can find NUCC guidelines at www.nucc.org.

Medi-Pak payments combined based on NPI

Arkansas Blue Cross and Blue Shield and its affiliated companies implemented the National Provider Identifier (NPI) usage in 2008. Currently, the Medi-Pak program generates a payment that posts to the Remittance Advice (RA) for each locally assigned provider number. A local provider number can be associated with multiple NPIs. Currently, Arkansas Blue Cross produces multiple checks for a single NPI.

Effective August 1, 2012, the Medi-Pak system will generate provider payments based on NPI. Claims included on the RA will be based on the billing provider's "Pay To" NPI. This change could result in professional and facility claims being listed on the same remittance advice since they are billed and submitted using the same NPI.

Medi-Pak® Advantage

Revised Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC)

On March 5, 2012, CMS released a revised version of the Notice of Medicare Non-Coverage (NOMNC) and the Detailed Explanation of Non-Coverage (DENC). The notices will ensure all Medicare beneficiaries, whether enrolled in Original Medicare or in a Medicare Advantage (MA) plan (e.g. Medi-Pak® Advantage), receive the same notices prior to termination of Medicare-covered skilled nursing facility (SNF), home health agency (HHA), hospice and comprehensive outpatient rehabilitation facility (CORF) services.

The revised Notice of Medicare Non-Coverage combines the non-coverage notices previously issued to beneficiaries in Original Medicare (CMS 10123) and MA plans (CMS 10095). This new notice retains the number of the Original Medicare notice (CMS 10123) and the name of the MA notice (NOMNC). Similarly, the revised DENC combines the detailed notices previously provided to beneficiaries in Original Medicare (CMS 10124) and MA plans (CMS 10095). The new notice retains the number of the Original Medicare notice (CMS 10124) and the name of the MA notice (DENC).

The updated notices are located at www.cms.gov/bni/09_MAEDNotices.asp. Providers and MA plans are encouraged to use the updated notices as soon as possible, but must begin using them no later than May 31, 2012.

Note: SNFs, HHAs and CORFs are responsible for issuance of the NOMNC to MA enrollees. However, all MA plans are responsible for knowing the rules regarding issuance of the NOMNC because they confer rights to enrollees and affect contracted SNFs, HHAs, and CORFs. MA plans are responsible for issuance of the DENC. Detailed guidance can be found at:

- NOMNC instructions: www.cms.gov/MMCAG/Downloads/NOMNCInstructions.pdf
- DENC instructions: www.cms.gov/MMCAG/Downloads/DENCInstructions.pdf
- Chapter 13 (§§90.2 - 90.8): www.cms.gov/manuals/downloads/mc86c13.pdf
- General MA appeals information: www.cms.gov/MMCAG/

For questions regarding the updated notices, please send an email to Part_C_Appeals@cms.hhs.gov.

New rule for Medi-Pak® Advantage paper claims

Effective June 30, 2012, paper claims submitted to Arkansas Blue Cross and Blue Shield for Medi-Pak® Advantage members must comply with ANSI 5010 submission requirements. This means the billing provider's address in Item Number 33 of the CMS-1500 professional claim form and Form Locator 01 of the UB-04 facility claim form must be a physical street address.

Claims with only a post office box in the billing provider's address may be rejected. This change is consistent with provider billing address requirements for Medi-Pak® Advantage electronic claims.

The billing provider's address on the claim form is not necessarily the same as a pay-to address. Arkansas Blue Cross will issue any non-electronic payment to the pay-to address currently on file for providers. Item Number 33 of the CMS1500 and Form Locator 01 of the UB04 are not utilized as pay-to addresses.

Paper claims for other products by Arkansas Blue Cross, Health Advantage, and BlueAdvantage Administrators will for now continue to accept a U. S. Post Office Box address beyond June 30, 2012. However, providers are encouraged to pro-actively work towards making all paper claims submissions ANSI 5010 compliant.

AHIN

Readable Medicare 277CA report

The Advanced Health Information Network (AHIN) has created a readable report for the Medicare 277CA report. This report will make it easier for providers to understand the reason for claim rejections and number of claims accepted. The original ANSI version of the report will also be available on AHIN.

For additional help with interpretation of a report, please send an email to Medicare5010support@arkbluecross.com. This email will be forwarded to Palmetto GBA for interpretation of the report. Once Palmetto GBA contacts you, please use the original 277CA report in the ANSI format. Palmetto GBA will not help providers with the AHIN readable 277CA report.

Additional information regarding this report on AHIN is located on the AHIN Bulletin Board under User Guides/Instructions.

ASE and PSE

Coverage Policy Reminder: Arkansas State and Public School Employees

Coverage policies for members of the Arkansas State and Public School ARBenefits Plan are on-line at www.ARBenefits.org. While these policies are similar to the Arkansas Blue Cross and Blue Shield coverage policies, there are some differences—especially the preventive services coverage.

Example: Bone Density Study for ARBenefits

Effective January 1, 2012, the coverage guidelines for bone mineral density studies has been changed, due to the ARBenefits coverage policy ARB0066. All ARBenefits coverage policies may be viewed at www.ARBenefits.org.

Bone mineral density testing is covered under the preventive medicine benefit, once every two years, for women 65 and older (CPT codes 76977, 77078, 77080, 77081, and 77083)

For anyone not meeting the criteria are subject to medical review. If a member does not meet the criteria as outlined in ARBenefits coverage policy ARB0066, claims will be denied as not being medically necessary.

Bone mineral density testing is covered under the medical benefit for:

- Females age 60-64
- Males age 70 or older
- Males of any age with a diagnosis of:
  - 253.4 Other anterior pituitary disorders
  - 257.1 Postablative testicular hypofunction
  - 257.2 Other testicular hypofunction
- Males or females with a diagnosis of:
  - 252.0x Hyperparathyroidism
  - 733.0x Osteoporosis
  - 733.1x Pathologic fracture

New dental claims administrator

In an effort to ensure excellent service, Arkansas Blue Cross and Blue Shield its third party administrator division, BlueAdvantage Administrators of Arkansas, transitioned to a new dental customer service and claims administrator on May 1, 2012.

In April, members received new member ID cards and Group administrators received letters explaining the transition. Dental providers received several newsletters, brochures and a packet of information regarding the transition.

The new number for customer service for dental providers is 1-888-224-5213.

Dental paper claims may be submitted to:

Dental Claims Administrator
PO Box 69436
Harrisburg, PA 17106-9436

Note: Change does not apply to dental claims for the Federal Employees Program (FEP) members. Providers should continue to submit FEP dental claims to:

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

Coverage policy manual updates

The following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy Manual since March 2012. To view entire policies, access the coverage policies located on the Arkansas Blue Cross Web site at arkansasblue-cross.com.

New / Updated Policies:

Policy#	Policy Name
1997080	Neuromuscular Stimulation, Functional
1997128	Leuprolide (Lupron)
1997153	Iron Therapy, Parenteral
1997208	Spinal Cord Neurostimulation for Treatment of Intractable Pain
1997229	Cardiac Event Recorder, External Loop Recorder
1997248	Pain Management, Facet Joint Block
1998026	Insulin Infusion Pumps, External
2002009	Phototherapy for Psoriasis (UVB)

Policy#	Policy Name
2004026	MR Guided Ultrasound Ablation - Uterine Fibroids and Other Tumors
2006036	Radiofrequency Treatment: Transvaginal and Transurethral for Urinary Stress Incontinence
2008010	Advanced Nurse Practitioners
2008015	Clinical Nurse Specialist
2009031	Ingestible pH and Pressure Capsule
2009050	Sleep Apnea and/or Snoring, Laser-Assisted Uvulopalatoplasty (LAUP)
2011025	Preventive Services For Non-Grandfathered Plans: Obesity Screening In Adults
2011030	Preventive Services For Non-Grandfathered Plans: Obesity In Children; Screening & Counseling
2011043	Preventive Services For Non-Grandfathered Plans: Depression Screening, Adults
2011054	Autism Spectrum Disorder, Interventions other than Early Behavioral Intervention
2011066	Preventive Services For Non-Grandfathered Plans: Overview
2012008	Intermittent Pneumatic Compression Device for Home Use following Hip and Knee Arthroplasty
2012009	Skin and Soft Tissue Substitutes, Bio-Engineered Products
2012010	Optical Coherence Tomography for Imaging of Coronary Arteries
2012011	Proteomics, Predict Response to Chemotherapy (VeriStrat®)
2012012	Genetic Test: Uveal Melanoma, Gene Expression Profile To Predict Risk Of Metastasis
2012013	Genetic Test: UGT1A1 to Predict Toxicity to Irinotecan (Invader Assay)
2012014	Genetic Test: Asthma, HLA-DR and HLA-DQ Genotyping
2012015	Chromoendoscopy as an Adjunct to Colonoscopy
2012016	Computed Tomography (CT) Perfusion Imaging

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
24357	$1,164.25	$0.00	$0.00	$685.17	$0.00	$0.00
43289	BR	BR	BR	BR	BR	BR
86890	$0.00	BR	$0.00	$0.00	BR	$0.00
86891	$0.00	BR	$0.00	$0.00	BR	$0.00
93295	$105.01	$105.01	$0.00	$105.01	$105.01	$0.00
93296	$39.41	$0.00	$39.41	$0.00	$0.00	$0.00
93297	$40.79	$40.79	$0.00	$40.79	$40.79	$0.00
93563	$88.90	$0.00	$0.00	$88.90	$88.90	$0.00
93564	$91.00	$0.00	$0.00	$91.00	$91.00	$0.00
93565	$69.10	$0.00	$0.00	$69.10	$69.10	$0.00
93566	$251.21	$0.00	$0.00	$68.65	$68.65	$0.00
93567	$206.54	$0.00	$0.00	$77.43	$77.43	$0.00
93568	$228.84	$0.00	$0.00	$70.74	$70.74	$0.00
94640	$23.56	$1.65	$21.91	$0.00	$1.65	$0.00
94640	$23.56	$11.78	$11.78	$0.00	$0.00	$0.00
99091	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9288	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9289	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9290	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9291	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9733	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
E0118	$216.26	$21.63	$162.19	$0.00	$0.00	$0.00
E0430	$287.40	$0.00	$0.00	$0.00	$0.00	$0.00
G8907	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8908	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8909	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8910	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8911	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8912	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8913	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8914	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8915	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8916	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8917	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G8918	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7186	BR	$0.00	$0.00	$0.00	$0.00	$0.00
J7665	$0.50	$0.00	$0.00	$0.00	$0.00	$0.00
J9043	$139.71	$0.00	$0.00	$0.00	$0.00	$0.00
J9213	BR	$0.00	$0.00	$0.00	$0.00	$0.00
J9215	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q0144	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q2004	BR	$0.00	$0.00	$0.00	$0.00	$0.00
S0353	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
S0354	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
S0596	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
S3721	BR	BR	BR	$0.00	$0.00	$0.00
S8930	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9109	$515.00	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule

Injection code updates

The following injection codes were updated on Arkansas Blue Cross fee schedule on April 1, 2012.

Code	Allowance
90371	$117.65
90375	$194.37
90376	$181.92
90385	$25.63
90585	$118.44
90586	$124.68
90632	$54.53
90670	$143.25
90675	$209.22
90691	$65.07
90703	$33.44
90714	$20.72
90715	$39.10
90717	$74.35
90718	$17.73
90732	$68.41
A9576	$2.02
A9577	$2.51
A9578	$2.34
A9579	$2.22
A9583	$13.04
J0129	$22.55
J0130	$571.20
J0135	$445.64

Code	Allowance
J0150	$7.29
J0152	$109.26
J0171	$0.04
J0205	$43.67
J0207	$336.64
J0210	$44.10
J0215	$39.79
J0220	$213.53
J0256	$4.09
J0257	$4.04
J0270	$0.70
J0278	$0.62
J0280	$0.50
J0285	$13.13
J0287	$10.85
J0288	$14.56
J0290	$2.88
J0295	$3.09
J0348	$1.41
J0360	$5.14
J0364	$5.82
J0456	$4.91
J0461	$0.01
J0470	$29.07

Code	Allowance
J0475	$190.75
J0476	$79.29
J0480	$2,316.83
J0490	$39.86
J0500	$29.82
J0515	$26.52
J0558	$3.62
J0561	$4.56
J0583	$2.89
J0586	$7.51
J0588	$4.65
J0595	$0.95
J0598	$47.51
J0600	$196.72
J0610	$0.68
J0630	$59.38
J0636	$0.58
J0637	$13.12
J0638	$92.69
J0640	$2.17
J0641	$1.73
J0670	$5.27
J0690	$0.72
J0692	$3.04

Code	Allowance
J0694	$6.37
J0697	$2.41
J0698	$1.92
J0702	$5.72
J0706	$0.35
J0712	$0.76
J0713	$2.53
J0718	$4.52
J0720	$20.76
J0725	$12.62
J0735	$28.94
J0740	$787.47
J0744	$1.15
J0770	$12.57
J0780	$1.46
J0795	$5.54
J0834	$71.44
J0878	$0.53
J0881	$3.39
J0882	$3.39
J0885	$10.15
J0886	$10.15
J0894	$34.55
J0895	$10.47

Code	Allowance
J0897	$14.97
J1020	$3.30
J1030	$3.48
J1040	$6.74
J1051	$8.62
J1070	$3.65
J1080	$6.67
J1100	$0.13
J1110	$26.87
J1120	$31.82
J1160	$1.73
J1162	$814.83
J1165	$0.37
J1170	$1.74
J1200	$0.73
J1205	$288.47
J1212	$90.03
J1230	$7.24
J1240	$4.57
J1245	$0.86
J1250	$6.02
J1260	$5.56
J1265	$0.55
J1267	$0.53
J1270	$0.70
J1290	$296.28
J1300	$203.28
J1325	$14.86
J1327	$24.45

Code	Allowance
J1335	$31.11
J1364	$10.91
J1380	$7.86
J1410	$119.65
J1438	$228.11
J1440	$270.75
J1441	$430.63
J1450	$4.74
J1451	$7.35
J1453	$1.78
J1457	$2.16
J1458	$359.90
J1459	$36.44
J1460	$22.43
J1560	$224.34
J1561	$39.11
J1566	$32.77
J1568	$36.03
J1569	$41.81
J1570	$78.71
J1571	$50.09
J1572	$36.33
J1573	$50.09
J1580	$1.30
J1600	$26.04
J1610	$115.20
J1626	$1.16
J1630	$2.83
J1631	$18.40

Code	Allowance
J1640	$11.04
J1642	$0.16
J1644	$0.24
J1645	$11.47
J1650	$5.39
J1652	$5.71
J1670	$261.69
J1720	$4.27
J1740	$157.97
J1742	$199.36
J1745	$71.63
J1750	$12.58
J1756	$0.30
J1790	$2.76
J1800	$3.13
J1815	$0.50
J1817	$2.94
J1930	$34.57
J1940	$0.50
J1945	$412.73
J1950	$631.54
J1953	$0.27
J1955	$8.42
J1980	$14.97
J2020	$38.52
J2060	$0.82
J2150	$1.24
J2175	$1.83
J2210	$5.48

Code	Allowance
J2270	$1.81
J2271	$1.48
J2275	$3.77
J2278	$6.88
J2280	$3.65
J2300	$0.95
J2310	$8.48
J2315	$2.96
J2323	$11.55
J2325	$51.22
J2353	$128.03
J2354	$1.71
J2355	$253.44
J2357	$23.64
J2360	$9.05
J2370	$1.19
J2400	$15.69
J2405	$0.13
J2410	$2.38
J2425	$12.24
J2426	$7.10
J2430	$10.11
J2440	$1.32
J2469	$19.18
J2501	$2.09
J2503	$1,071.72
J2504	$270.09
J2505	$2,910.72
J2507	$314.13

(Continued from page 25) injection code updates

Code	Allowance
J2510	$13.23
J2515	$22.65
J2540	$0.74
J2543	$3.15
J2545	$52.06
J2550	$1.73
J2560	$20.45
J2562	$297.44
J2590	$0.55
J2597	$5.96
J2675	$3.76
J2680	$15.28
J2690	$10.09
J2700	$2.93
J2720	$0.53
J2724	$13.63
J2730	$88.18
J2765	$0.35
J2770	$181.42
J2778	$416.74
J2780	$0.89
J2783	$209.32
J2785	$54.76
J2788	$26.13
J2790	$87.23
J2791	$5.39
J2792	$17.07
J2794	$5.51

Code	Allowance
J2796	$49.66
J2800	$29.40
J2805	$78.95
J2810	$0.26
J2820	$25.82
J2916	$4.02
J2920	$2.01
J2930	$2.98
J2997	$48.22
J3000	$11.15
J3010	$0.35
J3030	$64.88
J3070	$14.23
J3095	$2.13
J3101	$68.89
J3105	$5.87
J3120	$4.93
J3130	$9.86
J3230	$9.40
J3240	$1,095.43
J3246	$9.06
J3250	$6.00
J3260	$2.71
J3262	$3.60
J3303	$1.79
J3315	$201.52
J3355	$64.24
J3357	$130.64

Code	Allowance
J3360	$1.06
J3370	$2.84
J3385	$363.32
J3396	$10.46
J3410	$1.32
J3411	$3.31
J3415	$6.98
J3420	$0.47
J3465	$6.83
J3471	$0.23
J3475	$0.10
J3485	$1.49
J3486	$8.19
J3487	$235.25
J3488	$231.54
J7060	$1.09
J7070	$2.15
J7100	$22.58
J7120	$1.07
J7185	$1.14
J7308	$156.77
J7321	$93.07
J7323	$153.28
J7324	$173.03
J7325	$12.85
J7500	$0.23
J7502	$3.75
J7504	$642.82

Code	Allowance
J7505	$1,202.32
J7506	$0.03
J7507	$2.35
J7509	$0.97
J7510	$0.03
J7511	$462.83
J7515	$1.02
J7516	$35.40
J7517	$1.56
J7518	$3.46
J7525	$145.20
J7605	$5.32
J7606	$5.23
J7608	$3.31
J7612	$0.21
J7613	$0.07
J7614	$0.30
J7620	$0.31
J7626	$5.15
J7631	$0.37
J7639	$29.24
J7682	$87.69
J8501	$6.42
J8510	$4.28
J8520	$8.18
J8521	$27.06
J8540	$0.39
J8560	$49.02

Code	Allowance	Code	Allowance	Code	Allowance	Code	Allowance
J8562	$85.04	J9179	$94.68	J9310	$667.63	Q4103	$7.71
J8600	$7.68	J9181	$0.83	J9315	$235.07	Q4104	$19.63
J8610	$0.12	J9185	$92.68	J9320	$285.16	Q4105	$10.60
J8700	$10.56	J9190	$1.58	J9328	$5.00	Q4106	$42.96
J8705	$85.11	J9200	$70.76	J9330	$54.27	Q4107	$98.81
J9000	$3.62	J9201	$36.58	J9340	$148.73	Q4108	$28.03
J9001	$560.34	J9202	$179.82	J9351	$6.97	Q4110	$32.75
J9010	$610.20	J9206	$4.84	J9355	$77.32	Q4112	$170.06
J9015	$1,141.91	J9207	$68.22	J9360	$1.29	Q4113	$287.39
J9017	$42.20	J9208	$32.96	J9370	$4.88	Q4114	$1,145.39
J9025	$5.61	J9209	$4.67	J9390	$11.18	Q4116	$33.60
J9027	$127.44	J9211	$108.60	J9395	$89.53	Q9954	$10.95
J9031	$124.68	J9214	$18.68	Q0138	$0.66	Q9956	$41.82
J9033	$19.57	J9217	$223.57	Q0139	$0.66	Q9957	$62.73
J9035	$63.40	J9218	$5.38	Q0163	$0.02	Q9958	$0.08
J9040	$31.41	J9228	$130.19	Q0164	$0.06	Q9960	$0.15
J9043	$90.68	J9245	$1,406.17	Q0165	$0.06	Q9961	$0.19
J9045	$3.70	J9250	$0.20	Q0166	$1.31	Q9963	$0.21
J9055	$52.44	J9260	$2.03	Q0167	$5.08	Q9965	$0.97
J9060	$1.88	J9261	$124.33	Q0168	$14.21	Q9966	$0.28
J9065	$24.07	J9263	$10.18	Q0169	$0.09		
J9070	$15.56	J9264	$9.97	Q0170	$0.07		
J9100	$0.90	J9265	$7.52	Q0180	$69.41		
J9120	$601.90	J9268	$873.12	Q2009	$0.47		
J9130	$3.61	J9280	$18.88	Q2017	$335.13		
J9150	$18.34	J9293	$31.16	Q3025	$260.54		
J9155	$3.08	J9302	$47.23	Q4081	$1.02		
J9171	$12.19	J9303	$90.71	Q4101	$38.02		
J9178	$1.77	J9305	$57.15	Q4102	$7.71		

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providers' news staff

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