providers' news

A publication for participating providers and their office staffs

inside

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 and its subsidiaries and affiliate companies, including Medi-Pak® Advantage.

ICD-10 countdown

9 months

until the October 1, 2014, ICD-10 compliance deadline.
Will you be ready?

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

Updated radiology authorization program for Tyson members

This correspondence serves as notice of change to the utilization review programs under the True Blue PPO provider agreements for the Tyson members that will be administered by AIM Specialty Health.

Effective January 1, 2014, **physicians who order high-tech radiology services on an outpatient basis for any Tyson member or dependent must obtain prior authorization (approval) before services can be considered for reimbursement under the member's health plan.** Prior authorization requirements apply to all Tyson members who receive services from an Arkansas provider.

Prior approval is not required for emergency or inpatient services or if a patient is kept in the observation department of a hospital. Prior authorization does not guarantee payment and is not a guarantee of coverage. Radiology services must be covered under the patient's coverage policy and are subject to the member's eligibility and benefit plan provisions.

AIM Specialty Health uses the following criteria to approve or deny a prior authorization request from a physician:

1. American College of Radiology "Appropriateness Guidelines";
2. Specialty society guidelines and diagnostic algorithms;
3. Literature reviews specific to a given test for a given condition or symptom; and
4. BlueAdvantage National Account coverage policies.

The *AIM Guidelines for Clinical Use of Diagnostic Imaging Examinations* were developed from practice experiences, literature reviews, specialty criteria sets and empirical data. AIM guidelines are located on their website at www.aimspecialtyhealth.com. The guidelines are available in a PDF format that may be printed for future reference.

For additional information, please refer to the updated "Radiology Management Reference Guide".

The following outpatient high-tech imaging services require prior authorization*:

- CT scan
- Nuclear cardiology
- MRI/MRA
- PET scan
- Echocardiography

**A separate authorization number is required for each procedure ordered.*

How to receive prior authorization:

Providers may obtain prior authorization by calling AIM Specialty Health at 1-866-688-7443 or visit their website at aimspecialtyhealth.com. Call center hours of operation are Monday through Friday, 8 a.m. to 5 p.m. CST.

Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact AIM within two business days of the date of service and before the claim is submitted to obtain proper authorization for the studies, which will still be subject to review.

The prior authorization implementation recommendations for ordering physicians and participating facilities:

Participating providers of diagnostic imaging services that require prior authorization should develop a process to ensure appropriate authorization numbers are obtained. The following recommendations are offered for review and consideration in developing a procedure that will be effective for each facility. These recommendations are for informational purposes only.

Ordering physician:

It is the responsibility of the physician ordering the high tech imaging service to call AIM for prior authorization. A separate authorization number is required for each procedure ordered.

Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call. Please note, the Rad Express program administered by NIA will not be recognized by AIM.

To expedite the authorization process, please have the following information ready before calling the AIM utilization management staff:

- Name and office telephone number of ordering physician,*
- Member name and ID number,*
- Requested examination,*
- Name of provider office or facility where the service will be performed,*
- Anticipated date of service (if known); and
- Details justifying examination:*

(Continued on page 3)

Updated radiology authorization program for Tyson members (continued from page 2)

-- Symptoms and their duration;
-- Physical exam findings;
-- Conservative treatment patient already has completed (for example: physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications);
-- Preliminary procedures already completed (for example: X-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation); and
-- Reason the study is being requested (for example: further evaluation, rule out a disorder)

**Required information*

Please be prepared to fax the following information when requested:

- Clinical notes
- X-ray reports
- Previous CT/MRI reports
- Specialist reports/evaluation ultrasound report

Participating imaging facilities:

It is the responsibility of the ordering physician to ensure that prior authorization is obtained. The rendering facility should not schedule procedures without prior authorization.

For urgent tests, the rendering facility can begin the process, and AIM will follow up with the ordering physician to complete the process. **Procedures performed that have not been properly authorized will not be reimbursed, and the member cannot be balance billed.** A separate authorization number is required for each procedure ordered.

Imaging procedures for emergency or inpatient services or if a patient is kept in the observation department of a hospital do not require prior authorization. If an emergency clinical situation exists outside of a hospital emergency room, providers should proceed with the examination and call AIM the next business day at 1-866-688-1449 to proceed with the normal review process.

To ensure that authorization numbers have been obtained, the following recommendations should be considered:

- Communicate to all personnel involved in outpatient scheduling that prior authorization is required for the listed procedures.
- If a physician office calls to schedule a patient for a procedure requiring prior authorization, request the authorization number.
- If the provider has not obtained prior authorization, inform the provider of the requirement and advise them to call AIM toll-free at 1-866-688-1449.
- Facilities may elect to institute a time period in which to obtain the authorization number (for example, one business day).
- If a patient calls to schedule a procedure that requires prior authorization and the patient does not have the authorization number, the patient should be directed back to the referring physician who ordered the examination.

Modifications to Type of Bill codes for home health claims

The National Uniform Billing Committee (NUBC) maintains the Type of Bill code set used by the healthcare industry on institutional claims. In 2012, the NUBC voted to revise the Type of Bill codes used for home health claims. The revision simplifies the code set by using one Type of Bill code for all home health services provided under a home health plan of care and discontinuing use of the 033X Type of Bill. Effective for home health claims received on or after October 1, 2013, Arkansas Blue Cross and Blue Shield, BlueAdvantage of Arkansas, and Health Advantage no longer accepts institutional claims submitted with Type of Bill 033X.

The following information outlines the modifications that have been made to align Type of Bill values with CMS requirements.

- Type of Bill 033X (home health – outpatient) was discontinued effective October 1, 2013.
- The description for Type of Bill 032X has been modified from home health – inpatient (plan of treatment under part B) only to home health services under a plan of treatment.
- The description for Type of Bill 034X has been changed from home health – other (for medical and surgical services not under a plan of treatment) to home health services not under a plan of treatment.

Annual Medicare Advantage compliance training for providers

The annual Medicare Advantage Compliance Training is now available on AHIN and on the Arkansas Blue Cross and Blue Shield website (arkbluecross.com/providers under "Resource Center"). Providers may choose to use the compliance training provided by Arkansas Blue Cross. Arkansas Blue Cross provides this training as a service to providers in the event that they do not have compliance training.

Providers are encouraged to customize the training to better fit their staff's needs. If a provider's office has an effective compliance program in place, as outlined in the "Seven Elements of an Effective Compliance Program", or has completed the training through Medicare or another plan sponsor, then they will not need to complete additional training. However, providers are required to keep the training materials, logs and certificates on file for 10 years.

CMS requires that the following be included in the compliance training:

- Training must be completed by all contracted physicians and staff members who provide services to Medicare Advantage beneficiaries.
- All new hires must complete the training within 90 days of their hire date.
- Training materials, training logs and certificates must be kept on file for 10 years, and in the event of an audit, a sample of this documentation may be requested.
- Annual training must be completed by December 31st.

Corizon no longer part of correctional medical services

USAble Corporation has been informed that Corizon will no longer be responsible for the provision of medical services for inmates of the Arkansas Department of Corrections as of January 1,2014. Therefore USAble's True Blue PPO will no longer be used as part of the provider network for the Arkansas Department of Corrections.

Medicare Part D pharmacy changes for 2014

Effective January 1, 2014, all 2014 Arkansas Blue Cross and Blue Shield Medicare Pharmacy claims will be processed by Prime Therapeutics. Prime will also handle member and pharmacy call center services and provide decision support for prior authorizations in the Medicare Pharmacy Program.

In accordance with CMS guidelines, a standard coverage determination (also known as a prior authorization) will be responded to within 72 hours, and an expedited request will be responded to within 24 hours. In some cases, Prime may need to request more information before a decision is made.

If a review is requested on Friday or on a weekend and more information is needed to make a determination, Prime will attempt to contact providers over the weekend to get the information. However, if providers fail to respond to the request for more information, the request may be denied in accordance with the CMS timeliness requirements. Arkansas Blue Cross understands the challenges this presents, but we are required to process requests timely, even over the weekend.

This information applies only to Arkansas Blue Cross Medicare plans and does not impact Arkansas Blue Cross commercial pharmacy plans or the Federal Employee Program.

Transitional care management services

Arkansas Blue Cross and Blue Shield and Health Advantage cover the new Transitional Care Management Services (TOC) codes to reimburse for services provided during the critical period of discharge from a facility. These services are billed using CPT code 99495 and 99496.

These CPT codes are billable when an established patient requires moderate or highly complex medical decision-making during a transition of care from an inpatient setting (including acute hospital, rehab hospital, long term acute care, partial hospital, observation status, or skilled nursing/nursing facility).

Reimbursement for these CPT codes requires an attempt to contact the patient within two business days of discharge, culminating in a successful contact (for example by phone) separate from a face-to-face visit. In addition, reimbursement requires that a face-to-face visit occur within seven days of discharge (CPT code 99496) or within 14 days of discharge (CPT code 99495).

This face-to-face visit is part of the TOC service and is not billable separately from the TOC code.

The TOC service is payable only once per 30 days. In the event of overlapping hospitalizations within a 30-day period, only one discharge is eligible for TOC reimbursement.

The TOC codes are payable only to primary care providers, including general practice/family medicine, internal medicine, pediatrics, or gerontology. The date of service can be billed either as the date of the face-to-face visit or the date 30 days after discharge (the latter being the Medicare policy).

Updated tool helps members calculate out-of-pocket costs

To help Arkansas Blue Cross and Blue Shield and Health Advantage members understand their options and find affordable healthcare, Arkansas Blue Cross has updated the Treatment Cost Calculator (formerly called the National Consumer Cost Tool). The Treatment Cost Calculator can only be accessed within the secure, members-only *My Blueprint* website.

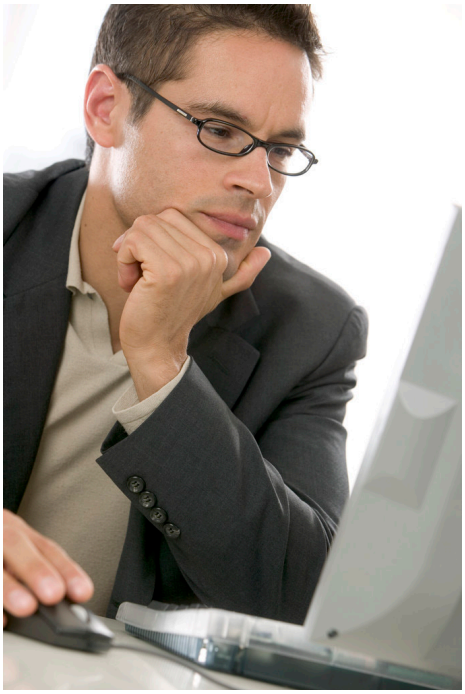
The calculator involves three simple steps:

1. Choosing which person needs treatment
2. Entering the ZIP code and radius of where treatment is sought
3. Selecting the procedure

The calculator will return all healthcare providers who perform the procedure in the area selected. If there are no providers available in the selected area, the tool automatically extends the search to find the nearest healthcare provider. As before, the results displays a range of minimum and maximum amounts and the average cost of a procedure, based on the claims history of health care providers.

With the updates, the calculator now also pulls information from a member's plan and benefits to determine coverage and how much of his/her deductible has been met, and calculates the potential out-of-pocket costs for a procedure. Additionally, the number of searchable procedures and treatments is set to increase from 359 to 1,632, making it a growing resource for members.

"We (Arkansas Blue Cross) wanted healthcare costs to be more transparent to members," says Karen Raley, vice president of Communications & Product Development. "The estimates of this calculator are procedure-, plan- and provider-specific, so we hope it makes finding affordable health care easier for our members."



Inpatient claims financial responsibility policy revision

The Blue Cross Blue Shield Association is taking steps to ensure consistency among all Blues Plans regarding inpatient pre-service review (also known as pre-authorization or pre-certification). Beginning July 1, 2014, inpatient facilities that fail to obtain pre-authorization or precertification when it is required, **will be financially responsible for any covered services not paid and the member will be held harmless**.

Not all health plans require inpatient pre-authorization or pre-certification, but where it is required, inpatient providers who fail to obtain it will be financially responsible for any covered services not paid and the member will be held harmless. It will become very important for facilities to check member eligibility and pre-certification requirements, whether it be via a HIPAA 270 transaction or by calling the telephone number on the member's ID card

In order to implement the Blue Cross Blue Shield Association mandate, our provider agreement language must be revised. Please consider this notification as an amendment to the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage HMO and USAble Corporation's Arkansas' FirstSource® PPO and True Blue PPO provider network participation agreements. The following sections in the Hospital and PHO provider network participation agreements will now contain the additional language:

PRE-CERTIFICATION, PRENOTIFICATION AND ELIGIBILITY INQUIRIES

Non-Emergency Admissions

Facility understands and agrees that for Health Plans that require pre-certification or pre-notification and Facility fails to obtain pre-authorization or pre-notification, that Facility will hold Member harmless of any amounts not paid for Covered Services.

Emergency Admissions

Facility understands and agrees that for Health Plans that require pre-certification or pre-notification within 24 hours after admission or by the end of the next working day, if on a weekend or holiday and Facility fails to obtain pre-authorization or pre-notification, that Facility will hold Member harmless of any amounts not paid for Covered Services.

Original article located in the March 2013 issue of *Providers' News.*

Arkansas Comprehensive Primary Care Initiative welcomes two new participants

An update for medical practices in the federal Comprehensive Primary Care initiative

Good news! Starting on January 1, 2014, the Arkansas State Employees / Arkansas Public School Employees group (ASE/PSE) and in-state Walmart employee group will be participating in the Comprehensive Primary Care Initiative. The Walmart account is administered by BlueAdvantage Administrators of Arkansas and the ASE/PSE account is administered by Health Advantage.

If you have questions, please contact the network development representative in your local Arkansas Blue Cross regional office.

Baptist Health employee group health benefit changes for 2014

Beginning January 1, 2014, all members of the Baptist Health employee group will have an option for lower member cost sharing by seeing providers identified as part of the Baptist Health Physician Partners (BHPP) and/or a Baptist Health facility. For those providers/facilities not involved with BHPP, the Baptist Health members potentially will have higher out-of-pocket costs. The member ID card will indicate the different copayments for BHPP and non-BHPP providers.

Baptist Health employees and their dependents are required to select a primary care physician. The member can elect a physician assistant or certified nurse practitioner as their primary care physician as long as they are practicing as primary care. Please note that claims will be denied if no selection is made or if the member sees a physician outside the PCP's clinic.

PCP referrals for all specialty services, excluding OB/GYN and routine eye exam are still required. The referral information continues to be provided in the following fields/segments:

- Professional
  - HCFA 1500: field 17B
  - ANSI-837: Loop 2310A
- Institutional
  - UB04: Field 77 – first and last name of operating/referring physician and NPI
  - ANSI-837 – Loop 2310E or 2310F*

*Note: With the implementation of the ANSI 5010 format, the institutional segment now has a segment specific to referral/authorization information – 2310F.

Please note that provider participation in BHPP is between Baptist Health and the provider, not Health Advantage. However, Health Advantage will continue to administer the employee health plan on behalf of Baptist Health.

Information regarding these new networks can be found at healthadvantage-hmo.com.

ASE/PSE

Benefit changes for 2014

On January 1, 2014, the following benefit changes will be effective for Arkansas State Employees and Public School Employees groups:

- Copayments for members on the Gold Plan will be $35 for primary care office visits.
- Copayments on the Gold Plan will be $70 for specialist office visits.

Pre-certification for outpatient services that require pre-certification through American Health Holding (AHH) will need to be obtained by the provider of service. **Failure to obtain required pre-certification for outpatient services will result in a denial of services and the provider will have to write off charges for the covered services and hold the member harmless.**

Inpatient admission pre-certifications will need a date of service for scheduled procedures to complete the pre-certification process through AHH. If the date of service is not provided when a pre-certification is requested, AHH cannot complete the pre-certification process. If a pre-certification is not complete, claims will be denied if submitted prior to completion date.

For all 2014 benefit changes, please see the 2014 Summary Plan Description at arbenefits.org. Please contact AHH at 877-815-1017 prior to any outpatient service that requires pre-certification.

ASE/PSE

Inpatient pre-certification required October 1, 2013

Effective October 1, 2013, the ARBenefits health plan, sponsored by the State and Public School Life and Health Insurance Board and administered by the Employee Benefits Division, requires pre-certification for all inpatient hospital admissions for Arkansas State Employees and Public School Employees group members. Determinations for these admissions will be made for medical necessity, appropriate length of stay and level of care based on nationally accepted industry standards, and the ARBenefits Coverage Policy. **Failure to obtain appropriate pre-certification will result in the facility writing off the charges for covered services and holding the member harmless.**

FEP

Benefit changes for 2014

Standard Option only

- The catastrophic out-of-pocket maximum for "Self and Family" contracts increased to $6,000 per year when the Standard option member uses Preferred providers. The catastrophic out-of-pocket maximum is $8,000 per year when the Standard option member uses a combination of Preferred and Non-preferred providers.
- The calendar year deductible is now included in the out-of-pocket catastrophic protection maximum, in addition to coinsurance and copayments. Previously, the out-of-pocket maximum did not include the calendar year deductible.
- FEP now provides benefits for two hours of home nursing care per day, up to a maximum of 50 visits per calendar year.

Basic Option only

- The catastrophic out-of-pocket maximum for coinsurance and copayments for "Self Only" contracts is now $5,500 per year when the Basic option member uses Preferred providers.
- The catastrophic out-of-pocket maximum for coinsurance and copayments for "Self and Family" contracts is now $7,000 per year when the Basic option member uses Preferred providers.
- The copayment for diagnostic tests (such as EEGs, ultrasounds, and X-rays) when performed by a Preferred provider is now $40.
- The copayment for the diagnostic studies and radiological services is now $100 when performed by a Preferred provider.
- The copayment for the outpatient diagnostic testing and treatment services is now $150 per day per facility, when preformed at a Preferred facility.
- The copayment for outpatient diagnostic testing services such as EEGs, ultrasounds, and X-rays is now $40 per day per facility, when preformed at a Preferred facility.
- FEP now provides benefits for up to 10 visits per year for acupuncture performed by Preferred providers acting within the scope of their license or certification in the state where the services are provided.
- The copayment for surgical procedures performed outside of the office setting is now $200 per performing surgeon.
- The copayment for an inpatient admission to a Preferred facility is $175 per day up to a maximum of $875 for unlimited days.
- The copayment for a maternity inpatient admission to a Preferred facility is $175.

Standard and Basic Options

- Benefits for chiropractic care are no longer limited to one office visit and one set of X-rays per year.
- Benefits for insulin and diabetic supplies are through the retail pharmacy for Basic and Standard Option or through the Mail Service Prescription Drug Program for Standard Option only. This requirement does not apply to FEP members who have Medicare Part B as primary.

Affordable Care Act

FEP will cover all mandated preventive or contraceptive benefits when the primary diagnosis is preventive or contraceptive. This must be located in Field 1.

Health Insurance Marketplace

Frequently asked questions about the marketplace

Please Note: The enrollment for both the Federal Health Insurance Marketplace and the state of Arkansas private option Health Insurance Marketplace for January 1, 2014 effective date have both been extended from December 15, 2013 to December 23, 2013. Due to the extension, Arkansas Blue Cross and Blue Shield is expecting to receive enrollment information on those Arkansans choosing the Arkansas Blue Cross plan or the multi-state plan near the end of December which will reduce the processing time needed to have ID cards and premium statements mailed to these new enrollees by January 1, 2014. We will do our best to update our information timely which is contingent on the timeliness and accuracy of the records submitted by the federal Health Insurance Marketplace and the state of Arkansas and for the Federal Health Insurance Marketplace enrollees the activation of their coverage is dependent on payment of applicable premium. Please check AHIN for eligibility status and benefit information before calling customer service.

October was a busy month with the opening of the Exchange Marketplace. Throughout October, Network Development representatives held workshops around the state on the exchange Health Insurance Marketplace (HIM) and private option.

All workshops had record attendance with much discussion among providers about the Health Insurance Marketplace, what it means from a provider perspective in seeing these new members, and exactly how the rollout of these Metallic Plans affects their day-to-day operations. The following are several of the top questions from the workshops.

Frequently Asked Questions

Are the Health Insurance Marketplace members' eligibility and benefits on AHIN?

Yes, eligibility, benefit and claims status information along with the status of applicable deductible and out-of-pocket accumulators are provided on AHIN. Please note, to avoid delays when calling to check new members' eligibility, which could occur due to the high volume of new enrollments effective January through March of next year, we strongly encourage that all providers use AHIN for eligibility, benefits and claims status and limit calls to our provider lines for claims processing questions. If you have any questions regarding AHIN, providers may contact AHIN Customer Support at 501-378-2336 or by e-mail at customersupport@ahin.net.

Are members required to have a PCP and do members need a referral to see a specialist?

Exchange members are not required to select a PCP and referrals are not required to a specialist. However, members should use True Blue PPO providers for all services. If services are provided by an out-of-network provider, the result will be higher out-of-pocket costs to the member.

Do providers have to see private option patients?

Providers who currently have restricted their practices to "current patients only" and are not accepting any new patients do not have to accept Health Insurance Marketplace members. If a practice is open, its open to all patients. This would include all Health Insurance Marketplace and private option members.

If a provider has a question regarding traditional Medicaid, who do they contact?

Any questions related to traditional Medicaid should still be directed to your Medicaid managed care service representative. If you are unsure who your representative is you can call 1-888-987-1200 x8686 or go to http://mmcs.afmc.org/HealthCareProfessionals/ProviderRelations.aspx for a map by county of MMCS provider representatives.

Where do providers file claims for the Blue Cross Multi-State Plan?

ALL claims should be filed to Arkansas Blue Cross and Blue Shield as you do today for BlueCard claims.

If an eligible member has elected to receive an advanced premium tax credit (APTC) but fails to pay their portion of the total premium, will Arkansas Blue Cross request a refund on any claims paid during the special three month grace period?

On the Health Insurance Marketplace, members who receive a federal subsidy (an advanced pre-

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FAQs: the marketplace (continued from page 9)

mium tax credit) that does not cover the full amount of the premium are allowed a three month grace period beginning on the premium statement due date missed. Note: The grace period is applicable after the member has paid their first premium payment and therefore effectuated their coverage. The three month grace period is defined as a period of three consecutive months, not a rolling period.

Arkansas Blue Cross will pay claims for the first month in which the member is delinquent and will not request refunds on claims. If the member's portion of the premium is not paid for month two or three, the member will be considered uninsured.

After the first month, the provider will be notified of the member's delinquent status via a message stating "Grace Period" on AHIN. Providers should continue to file claims during this time.

Arkansas Blue Cross will suspend claims for months two and three pending the receipt of the member's payment. Providers will not receive an remittance advice for suspended claims, but will be able to see on AHIN a suspended claim status code 766 "Services were performed during a Health Insurance Exchange (HIX) premium payment grace period."

Providers should collect payments from members per their usual office policy during the member's grace period. It is very important that providers verify coverage on AHIN prior to providing services to these members.

Once the member pays the past due premium, the provider's claims will be released for payment and any portions that were collected up front from the member should be refunded to them, minus any applicable copayment, coinsurance or deductible.

If the member fails to pay their premium within the grace period, after the third month the suspended claims will deny and the member will be considered no longer covered by Arkansas Blue Cross or the Multi-State Plan. Please remember, Arkansas Blue Cross will not request a refund for claims paid to the provider during the first month of delinquency for non-payment of premium for the special three month grace period. The grace period does not apply to private option members, as there is no member portion of premium.

Can our clearinghouse tell us through auto eligibility if a member is in grace period?

Electronically submitted eligibility (270) transaction codes sent by clearinghouses will receive a (271) transaction code from AHIN that says "in grace period". Providers will need to check with their clearinghouse to see how the information will be displayed.

NOTE: private option members are not subject to the grace period provisions.

What are the Services that need Prior Authorization?

The following Metallic Plan benefits require a prior authorization:

1. Hospital services in connection with dental treatment.
2. Advanced diagnostic imaging services*.
3. In vitro fertilization.
4. Autism spectrum disorder benefits.
5. Durable medical equipment with costs greater than $5,000.
6. Implantable osseointegrated hearing aids for patients with single-sided deafness, for chronic external otitis or otitis media.
7. Prosthetic devices with costs greater than $20,000.
8. Reduction mammoplasty.
9. Certain drugs, selected prescriptions and specialty medications.
10. All transplants other than kidney and cornea.
11. Neurologic rehabilitation facility services.
12. Pediatric vision services, vision therapy, developmental testing. Only refers to eye prosthesis.
13. Enteral feedings.
14. Gastric pacemaker.
15. "Off label" medicine use.
16. Outpatient diagnostic imaging* procedures required prior authorization through National Imaging Associates (NIA).

***Note: Multi-State Plans with group numbers beginning with EB1 (Bronze), EG1 (Gold), ES1 (Silver) and MS1 (Private Option) will not require prior authorization for diagnostic imaging.**

Can a provider pay a member's premium?

According to a document dated November 4, 2013, from CMS regarding third party payments of premiums for qualified health plans in the marketplaces, the Department of Health and Human Services has broad authority to regulate the federal and state Marketplaces (e.g., section 1321(a) of the Affordable Care Act). It has been suggested that hospitals, other health care providers, and other commercial en-

tities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces.

Health and Human Services has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces. Health and Human Services discourages this practice and encourages issuers to reject such third party payments. Health and Human Services intends to monitor this practice and to take appropriate action, if necessary.

In conjunction with the CMS statement, it is an Arkansas Blue Cross official policy to only accept premium payment from our members or groups.

To whom do providers direct patients to contact if they have questions about their plans?

Members may call Arkansas Blue Cross Customer Service at 1-800-800-4298 regarding their new plan. For general information regarding Health Insurance Marketplace products, members may call 1-855-625-0451 or go to the Arkansas Blue Cross website at arkansasbluecross.com and select "Free or Low-cost Health Insurance."

What do providers need to do to be in-network for the Metallic Plans?

Providers do not need to do anything as long as they are participating in the True Blue PPO network. Arkansas Blue Cross will be using the True Blue PPO network for the individual Metallic Plans sold both on and off the Health Insurance Marketplace. Participating providers, if appropriate, were mailed a contract amendment notifying them of a new fee schedule for these new Metallic Plans. Reimbursement for existing products that access the True Blue PPO network will not change.

What wellness benefits will the Metallic Plans use?

The PPACA wellness benefits are covered at 100% in-network only. The Patient Protection & Affordable Care Act (PPACA) wellness benefits will be used in the plans sold both on and off the Health Insurance Marketplace. The PPACA wellness benefits are posted on the AHIN Bulletin Board under *Provider News* and coverage policies are on the Arkansas Blue Cross website (arkansasbluecross.com).

What is the difference in a private option plan and a cost sharing reduction plan?

Plans with cost sharing reduction protect lower income people from high out-of-pocket costs when they receive medical services. Those plans have lower deductibles and copayments, and are based upon income.

There are cost sharing reduction plans for both the private option and for people who qualify for an advance premium tax credit (subsidy). People who qualify for the private option will not owe any premium for their insurance plan.

Private option members who fall below 100% of the federal poverty level and are not eligible for traditional Medicaid will have no out-of-pocket cost. Private option members who fall between 100-138% of the federal poverty level will also have lower out-of-pocket costs.

Consumers whose income falls between 139% and 250% of the federal poverty level may also enroll in a cost sharing reduction plan on the Health Insurance Marketplace, which also results in lower out-of-pocket expenses.

Are children covered under the Arkansas Private Option plan?

For 2014, the private option is for adults ages 19-64 years old. Children, including newborns, may be eligible for Medicaid programs such as ArKids.

Is pregnancy covered under the private option?

Beginning January 1, 2014, pregnant enrollees may be entitled to additional benefits under traditional Medicaid. Providers should encourage their patients to contact the Arkansas Medicaid offices in their county for information of the availability of these additional benefits. Additional benefits such as transportation services may be available for some enrollees. Also, if you patient is in enrolled in a private option plan with member copayments, the member may be eligible for traditional Medicaid benefits without copayments.

In keeping up with all of the new changes the Exchange and Private Option Metallic Plans will bring to providers, AHIN becomes an increasingly important day to day tool. Providers need to remember not only to verify coverage and benefits, but also to check to make sure members who receive advance premium tax credits are not in the three month grace period. Additionally, the Metallic Plans will comply with TROOP (True Out Of Pocket) re-

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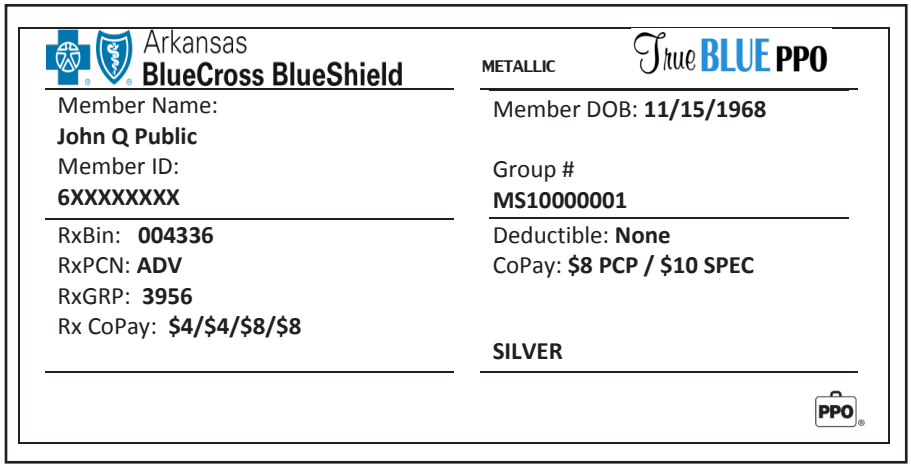
quirements where all out of pocket expenses, including all deductibles, coinsurances, medical copayments and prescription copayments are accumulated as a single out of pocket maximum. Once the TROOP max is met, copayments/coinsurance should no longer be collected. AHIN is updated nightly in order to bring the most up to date information possible to providers.

To identify a Metallic plan, providers can look for the word Metallic on the member ID card. To the right is a Private Option member ID card example. To identify the private option enrollees, providers should reference the Group numbers on the cards:

- MS10000001 - (MSP - 94% AV cost share).
- MS10000002 - (MSP - zero cost share).
- MS00000001 and MS00000003 - (Local - 94% AV cost share).
- MS00000002 and MS00000004 - (Local - zero cost share).



Coverage policy manual updates

Since September 2013, the following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. To view entire policies, access the coverage policies located our website at arkansasbluecross.com.

New / Updated Policies:

Policy #	Policy Name
1997088	Hyperbaric Oxygen Pressurization (HBO)
1997195	Sleep Apnea and Other Pulmonary Diseases, Ventilation Support and Respiratory Assist Devices
1998051	Genetic Test: BRCA1 or BRCA2 Mutations
2002008	Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon
2002012	Epidural Adhesiolysis, Percutaneous
2004009	Transesophageal Therapy for GERD, Endoscopic Polymer Injections, Bulking Agents and Prosthetic Implants
2005003	Genetic Test: Cytochrome p450 Genotyping
2005020	Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate the Diagnosis and Management of Asthma and Other Respiratory Disorders

Policy #	Policy Name
2007018	Genetic Test: Inherited Thrombophilia, Prothrombin Gene Mutations (G20210A) and MTHFR Mutations
2008009	Genetic Test: Cytochrome P450, to Predict Response to Drugs for Depression
2008022	Genetic Test: Microarray-Based Gene Expression Testing for Cancers of Unknown Primary
2009024	Endothelial Keratoplasty
2009029	Immune Cell Function Assay
2009030	Genetic Test: Non-BRCA Breast Cancer Risk Assessment (e.g., OncoVue)
2009034	Intensity Modulated Radiation Therapy (IMRT), Prostate
2009047	Hormone Pellet Implantation for Hormone Replacement Therapy
2010017	Aqueous Shunts and Devices for Glaucoma
2010038	Lymphedema Pumps (Pneumatic Compression Devices) for the Treatment of Lymphedema and Venous Ulcers
2011024	Preventive Services for Non-Grandfathered (PPACA) Plans: Tobacco Use, Screening, Counseling and Interventions
2011036	Preventive Services for Non-Grandfathered (PPACA) Plans: Hearing Loss Screening In Newborns Up to Age 21
2011038	Preventive Services for Non-Grandfathered (PPACA) Plans: Gonorrhea Screening In Women & Adolescents
2011040	Preventive Services for Non-Grandfathered (PPACA) Plans: Human Immunodeficiency Virus (HIV) Counseling & Screening
2011061	Genetic Test: Melanoma, V600 Mutation Testing to Predict Response to BRAF Inhibitor Targeted Therapy
2011064	Viscocanalostomy and Canaloplasty
2011070	Electrical Stimulation, Auricular Stimulation and Cranial Electrotherapy Stimulation
2012008	Pneumatic Compression Device, Intermittent, for Home Use following Hip and Knee Arthroplasty, Hip Fracture Repair
2012051	Surgical Deactivation of Headache Trigger Sites
2012054	Measurement of Serum Antibodies to Infliximab and Adalimumab

Fee Schedule

HCPCS: K Codes

Effective January 1, 2014 Arkansas Blue Cross and Blue Shield will start accepting some high dollar HCPCS K codes. The following codes that will be accepted:

HCPCS Code	Description
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom motorized/power wheelchair base
K0014	Other motorized/power wheelchair base
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0607	Replacement battery for automated external defibrillator, garment type only, each
K0608	Replacement garment for use with automated external defibrillator, each
K0609	Replacement electrodes for use with automated external defibrillator, garment type only, each
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds
K0802	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle, not otherwise classified
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds

HCPCS Code	Description
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0824	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0826	Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838	Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds

(Continued on page 16)

HCPCS: K Codes (continued from page 15)

HCPCS Code	Description
K0840	Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0843	Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0850	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0852	Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0854	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0858	Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859	Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862	Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863	Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds

HCPCS Code	Description
K0864	Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0870	Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871	Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0879	Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880	Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0886	Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0898	Power wheelchair, not otherwise classified
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria

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
58565	$2,340.00	$0.00	$0.00	$500.00	$0.00	$0.00
78072	BR	$121.44	BR	$0.00	$121.44	$0.00
90661	$21.49	$0.00	$0.00	$0.00	$0.00	$0.00
90685	$24.21	$0.00	$0.00	$0.00	$0.00	$0.00
90688	$20.19	$0.00	$0.00	$0.00	$0.00	$0.00
95974	$314.20	$253.04	$0.00	$253.04	$253.04	$0.00
97799	BR	$0.00	$0.00	BR	$0.00	$0.00
0099T	$0.00	$0.00	$0.00	BR	$0.00	$0.00
0234T	BR	$0.00	$0.00	BR	$0.00	$0.00
0235T	BR	$0.00	$0.00	BR	$0.00	$0.00
0236T	BR	$0.00	$0.00	BR	$0.00	$0.00
0238T	BR	$0.00	$0.00	BR	$0.00	$0.00
A9562	$202.00	$0.00	$0.00	$202.00	$0.00	$0.00
E0486	$886.10	$0.00	$0.00	$0.00	$0.00	$0.00
E0601	$886.10	$88.61	$664.58	$0.00	$0.00	$0.00
G0452	BR	BR	$0.00	BR	BR	$0.00
J7685	$119.23	$0.00	$0.00	$0.00	$0.00	$0.00
K0868	$7,166.30	$716.63	$5,374.73	$0.00	$0.00	$0.00
K0869	$6,890.20	$689.02	$5,167.65	$0.00	$0.00	$0.00
K0870	$8,312.80	$831.28	$6,234.60	$0.00	$0.00	$0.00
K0871	$7,992.70	$799.27	$5,994.53	$0.00	$0.00	$0.00
K0877	$7,692.40	$769.24	$5,769.30	$0.00	$0.00	$0.00
K0878	$7,846.50	$784.65	$5,884.88	$0.00	$0.00	$0.00
K0879	$9,544.00	$954.40	$7,158.00	$0.00	$0.00	$0.00
K0880	$13,634.80	$1,363.48	$10,226.10	$0.00	$0.00	$0.00
K0884	$9,924.70	$992.47	$7,443.53	$0.00	$0.00	$0.00
K0885	$9,544.00	$954.40	$7,158.00	$0.00	$0.00	$0.00
K0886	$9,544.00	$954.40	$7,158.00	$0.00	$0.00	$0.00
K0890	$9,197.50	$919.75	$6,898.13	$0.00	$0.00	$0.00
K0891	$12,180.40	$1,218.04	$9,153.30	$0.00	$0.00	$0.00
P9016	BR	$0.00	$0.00	BR	$0.00	$0.00
Q4124	$13.08	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule

Anesthesia conversion factor

The Anesthesia conversion factor has been increased to $51.00 effective October 1, 2013. The following codes that also use the conversion factor for pricing have also been 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
99143	$138.72	$0.00	$0.00	$62.73	$0.00	$0.00
99144	$138.72	$0.00	$0.00	$62.73	$0.00	$0.00
99145	$34.68	$0.00	$0.00	$20.91	$0.00	$0.00
99148	$159.63	$0.00	$0.00	$71.91	$0.00	$0.00
99149	$138.72	$0.00	$0.00	$62.73	$0.00	$0.00
99150	$39.78	$0.00	$0.00	$23.97	$0.00	$0.00
D9220	$306.00	$0.00	$0.00	$306.00	$0.00	$0.00
D9221	$51.00	$0.00	$0.00	$51.00	$0.00	$0.00

Fee Schedule

Injection Code Updates

The following injection codes were updated on Arkansas Blue Cross and Blue Shield fee schedule.

CPT Code	Allowed
90371	$116.51
90375	$228.61
90376	$225.20
90385	$26.29
90585	$125.75
90586	$125.75
90632	$51.65
90655	$17.93
90672	$25.58
90675	$241.68
90685	$24.21
90686	$20.18

CPT Code	Allowed
90691	$65.05
90703	$40.86
90714	$20.25
90715	$35.15
A9576	$1.88
A9577	$2.30
A9578	$2.20
A9579	$2.03
A9581	$13.80
A9585	$0.42
J0129	$23.98
J0130	$677.30

CPT Code	Allowed
J0132	$2.76
J0133	$0.05
J0135	$536.53
J0150	$6.06
J0152	$113.75
J0171	$0.06
J0180	$152.04
J0207	$310.48
J0220	$214.91
J0221	$159.75
J0256	$4.19

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Injection code updates (Continued from page 19)

CPT Code	Allowed
J0257	$4.15
J0278	$1.12
J0280	$1.24
J0285	$11.83
J0287	$11.87
J0290	$1.74
J0295	$1.73
J0348	$0.88
J0360	$3.27
J0364	$34.39
J0400	$0.57
J0456	$3.45
J0461	$0.05
J0470	$30.74
J0475	$166.71
J0476	$77.07
J0480	$2,540.64
J0485	$3.95
J0490	$39.78
J0515	$21.86
J0558	$4.21
J0561	$5.28
J0585	$5.67
J0586	$7.34
J0587	$11.32
J0588	$4.66
J0594	$26.19
J0595	$1.81
J0597	$34.00
J0598	$51.31
J0610	$1.12
J0630	$71.81
J0636	$0.39
J0640	$4.68
J0641	$1.81

CPT Code	Allowed
J0670	$2.53
J0690	$0.91
J0692	$2.99
J0694	$5.40
J0697	$3.29
J0698	$1.82
J0702	$5.93
J0706	$0.54
J0712	$0.91
J0713	$2.14
J0718	$5.39
J0720	$30.64
J0725	$16.02
J0735	$22.76
J0740	$674.37
J0744	$1.20
J0770	$12.85
J0775	$40.11
J0780	$4.24
J0795	$8.09
J0834	$68.07
J0840	$2,443.90
J0850	$1,054.42
J0881	$3.75
J0882	$3.75
J0885	$11.67
J0886	$11.67
J0894	$36.17
J0895	$12.95
J0897	$14.72
J1000	$8.43
J1020	$3.12
J1030	$2.84
J1040	$5.51
J1070	$4.66

CPT Code	Allowed
J1080	$5.25
J1110	$34.81
J1120	$27.60
J1160	$2.12
J1162	$1,291.02
J1165	$0.56
J1170	$2.30
J1200	$0.66
J1205	$170.54
J1212	$82.49
J1230	$7.76
J1240	$5.40
J1245	$0.86
J1250	$8.64
J1260	$5.68
J1265	$0.53
J1267	$0.58
J1270	$1.74
J1290	$369.87
J1325	$16.36
J1327	$29.20
J1335	$35.05
J1364	$21.86
J1380	$9.04
J1410	$155.55
J1438	$265.31
J1440	$300.24
J1441	$476.85
J1450	$4.05
J1451	$7.46
J1458	$374.09
J1459	$37.98
J1460	$24.94
J1557	$38.25
J1559	$7.96

CPT Code	Allowed
J1560	$249.37
J1561	$42.09
J1566	$37.18
J1568	$32.75
J1569	$40.84
J1570	$76.66
J1571	$53.07
J1572	$37.52
J1573	$53.07
J1580	$1.51
J1610	$133.10
J1626	$0.52
J1630	$1.38
J1631	$20.40
J1640	$17.25
J1642	$0.16
J1644	$0.19
J1645	$13.51
J1650	$1.71
J1652	$4.07
J1670	$283.42
J1720	$5.02
J1740	$161.46
J1742	$82.09
J1743	$487.88
J1745	$80.25
J1750	$12.62
J1756	$0.28
J1786	$43.69
J1790	$2.23
J1800	$2.12
J1815	$0.61
J1817	$6.08
J1930	$38.65
J1931	$29.45
J1940	$3.75

CPT Code	Allowed
J1950	$777.83
J1953	$0.16
J1955	$9.08
J1956	$9.70
J1980	$17.97
J2010	$8.08
J2020	$41.30
J2060	$0.74
J2150	$1.48
J2175	$2.47
J2210	$4.10
J2250	$0.13
J2270	$5.50
J2271	$0.55
J2275	$3.93
J2280	$3.52
J2300	$1.32
J2310	$14.20
J2315	$2.92
J2323	$13.41
J2325	$62.67
J2354	$1.48
J2355	$287.66
J2357	$26.54
J2360	$5.44
J2370	$4.22
J2400	$17.19
J2405	$0.12
J2410	$2.45
J2425	$14.94
J2426	$7.73
J2430	$11.15
J2469	$20.16
J2501	$1.68
J2503	$1,067.76
J2505	$3,245.04

CPT Code	Allowed
J2507	$529.24
J2510	$15.52
J2515	$33.45
J2540	$0.63
J2543	$1.77
J2545	$86.24
J2550	$1.63
J2560	$15.02
J2562	$309.56
J2590	$0.45
J2597	$5.85
J2675	$1.55
J2680	$19.75
J2690	$19.62
J2700	$2.28
J2720	$0.90
J2724	$14.83
J2730	$92.49
J2760	$119.22
J2765	$0.55
J2770	$202.10
J2778	$413.15
J2780	$1.10
J2783	$219.81
J2785	$55.56
J2788	$18.18
J2790	$86.00
J2791	$4.97
J2792	$19.42
J2794	$6.01
J2795	$0.10
J2796	$53.16
J2800	$39.66
J2805	$86.43
J2810	$0.32

(Continued on page 22)

Injection code updates (Continued from page 21)

CPT Code	Allowed
J2820	$29.74
J2916	$3.02
J2920	$1.81
J2930	$2.68
J2997	$58.25
J3000	$10.69
J3010	$0.62
J3070	$33.01
J3101	$82.15
J3105	$1.70
J3120	$7.49
J3130	$10.61
J3230	$20.70
J3240	$1,260.84
J3243	$1.84
J3246	$9.31
J3250	$10.77
J3260	$2.38
J3300	$4.11
J3301	$1.81
J3303	$3.01
J3315	$207.05
J3355	$70.06
J3357	$147.85
J3360	$3.39
J3370	$2.02
J3385	$362.28
J3396	$10.86
J3410	$0.41
J3411	$3.72
J3415	$8.55
J3420	$0.84
J3430	$0.80
J3465	$4.66
J3475	$0.24

CPT Code	Allowed
J3486	$9.93
J7040	$0.60
J7042	$0.50
J7060	$1.06
J7070	$2.10
J7100	$22.63
J7120	$1.04
J7183	$0.95
J7185	$1.18
J7186	$0.97
J7192	$1.17
J7193	$0.99
J7195	$1.44
J7197	$3.23
J7198	$1.70
J7308	$179.50
J7312	$203.75
J7321	$92.41
J7323	$159.55
J7324	$184.24
J7325	$13.34
J7326	$637.82
J7500	$0.13
J7501	$205.00
J7502	$3.31
J7504	$749.91
J7506	$0.04
J7507	$1.68
J7509	$0.56
J7511	$592.31
J7515	$0.92
J7516	$32.80
J7517	$1.08
J7520	$13.81
J7525	$142.37

CPT Code	Allowed
J7527	$6.73
J7605	$5.77
J7606	$6.55
J7608	$2.04
J7612	$0.24
J7613	$0.05
J7620	$0.18
J7626	$6.19
J7631	$0.51
J7639	$34.09
J7644	$0.25
J7682	$124.80
J7686	$478.87
J8501	$6.96
J8510	$11.47
J8520	$10.07
J8521	$33.48
J8540	$0.19
J8560	$57.90
J8600	$9.08
J8610	$1.13
J8700	$12.02
J8705	$92.69
J9000	$3.61
J9017	$51.38
J9019	$358.15
J9025	$5.97
J9027	$134.71
J9031	$125.75
J9033	$21.90
J9035	$67.21
J9040	$21.89
J9041	$46.69
J9042	$106.76
J9043	$144.67

CPT Code	Allowed
J9045	$3.16
J9050	$905.76
J9055	$54.66
J9060	$2.20
J9065	$24.95
J9070	$41.26
J9098	$566.32
J9100	$1.00
J9120	$671.58
J9130	$4.14
J9150	$31.22
J9155	$3.87
J9171	$4.81
J9178	$1.23
J9179	$102.37
J9181	$0.74
J9185	$87.54
J9190	$2.07
J9200	$69.76
J9201	$8.28
J9202	$201.96
J9206	$4.62
J9207	$71.39
J9208	$32.28
J9209	$2.97
J9211	$36.72
J9214	$21.52
J9217	$210.95
J9218	$10.66
J9225	$3,085.47
J9226	$16,117.65
J9228	$134.11
J9230	$160.89
J9245	$1,345.29
J9250	$0.27
J9260	$2.60

CPT Code	Allowed
J9261	$135.86
J9263	$0.56
J9264	$9.94
J9265	$4.52
J9268	$1,476.49
J9280	$25.52
J9293	$36.00
J9302	$48.39
J9303	$95.04
J9305	$61.87
J9307	$189.92
J9310	$705.85
J9315	$262.01
J9320	$285.32
J9328	$5.23
J9330	$58.21
J9340	$595.00
J9351	$2.28
J9355	$81.87
J9357	$1,095.10
J9360	$1.72
J9370	$6.00
J9390	$9.16
J9395	$93.26
P9043	$9.17
P9048	$45.84
Q0138	$0.71
Q0139	$0.71
Q0164	$0.03
Q0165	$0.04
Q0166	$2.64
Q0167	$3.48
Q0168	$7.09
Q0169	$0.06
Q0170	$0.02
Q0180	$72.25

CPT Code	Allowed
Q2009	$1.22
Q2017	$345.92
Q2036	$8.92
Q2037	$15.56
Q2050	$567.30
Q2051	$156.34
Q3025	$319.43
Q4074	$80.48
Q4081	$1.17
Q4101	$42.70
Q4102	$9.89
Q4103	$9.89
Q4104	$26.78
Q4105	$13.66
Q4106	$46.21
Q4107	$102.44
Q4108	$29.60
Q4110	$40.14
Q4111	$7.19
Q4112	$408.41
Q4113	$408.41
Q4114	$1,284.73
Q4115	$13.19
Q4116	$34.21
Q4121	$24.13
Q4123	$16.07
Q9956	$38.12
Q9957	$57.18
Q9958	$0.09
Q9963	$0.18
Q9965	$1.01
Q9966	$0.26
Q9967	$0.17

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providers' news staff

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Please Note

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