march 2014

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

6 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

Transition to CMS-1500 (02/12) claim form

Effective May 1, 2014, Arkansas Blue Cross and Blue Shield and its affiliates, USAble Corporation (True Blue and Arkansas' FirstSource® PPO networks) and Health Advantage (Health Advantage HMO network), will no longer accept the (08/05) version of the CMS-1500 professional medical services claim form. All providers who submit claims must use the new CMS-1500 (02/12) claim form.

For detailed instructions on how to properly complete the new CMS-1500 (02/12) claim form, Arkansas Blue Cross recommends following the National Uniform Claim Committee (NUCC) guidelines. The CMS-1500 (02/12) version guidelines can be found online at **nucc.org**.

If a CMS-1500 (08/05) version claim form is received on or after May 1, 2014, the claim will be rejected and a notification letter will be sent out with the following explanation:

"*Your claim was filed on the old CMS 1500 (08/05) form version. Claims received on or after May 1, 2014 must be filed using the new red CMS 1500 (02/12) form version*."

The CMS 1500 (02/12) form version contains changes to the layout. The new claim form also has additional required qualifier fields. It is important for providers to use the new layout with the new form. Printing the old claim layout on a new claim form will cause data to be misaligned. Misaligned data and/or missing qualifiers will cause claims to be rejected.

The following fields now require qualifiers:

- **Box 14: Date of Current Illness, Injury, or Pregnancy.** If a date is put in Box 14, the appropriate qualifier indicating the type of date is required. Valid qualifiers include:

Qualifier	Definition
431	Onset of current symptoms or illness
484	Last menstrual period

- **Box 15: Other Date.** If a date is put in Box 15, the appropriate qualifier indicating the type of date is required. Valid qualifiers include:

Qualifier	Definition
454	Initial treatment
304	Latest visit or consultation
453	Acute manifestation of a chronic condition
439	Accident
455	Last x-ray
471	Prescription
090	Report start (assumed care date)
091	Report end (relinquished care date)
444	First visit or consultation

- **Box 17: Name of Referring Provider or Other Source.** If a provider name is indicated in Box 17, the appropriate qualifier indicating the type of provider is required. Valid qualifiers include:

Qualifier	Definition
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

- **Box 21: Diagnosis or Nature of Illness or Injury.** An ICD indicator is now required. Use "9" to indicate ICD-9 codes are being used or "0" for ICD-10 codes (which will be required October 1, 2014). Box 21 also now allows for up to 12 diagnosis codes. It is important to only submit the diagnosis code. Providing a description in addition to the code will cause data to be misinterpreted or misaligned and result in a rejected claim. Service line diagnosis pointers (Box 24E) must be letters A through L, which corresponds to the appropriate diagnosis code. Up to 4 pointers can be indicated in Box 24E (e.g. "A", "CD", "BEM", "DGKL", etc.) per service line.

Another significant requirement change is "SAME" is no longer accepted when both the patient's (Box 5) and the insured's (Box 7) address is the same. The full address for the insured (Box 7) is always required. If the insured's address (Box 7) is missing, the claim will be rejected. The patient's address (Box 5) is only required if the address is different than the insured. Arkansas Blue Cross recommends both patient and insured addresses are indicated even if they are the same.

Arkansas Blue Cross employs Optical Character Recognition (OCR) technology to collect data from paper claim forms. All claim forms must be printed using Flint Red J-6983 (OCR Red "dropout"), or exact match, ink. Claim data must be printed with black ink. Claim forms that do not comply with NUCC printing standards will be rejected.

EDI online enrollment

Arkansas Blue Cross and Blue Shield's EDI Services Division will no longer accept paper enrollments for any electronic transactions. EDI (electronic data interchange) enrollment must now be completed online. All new providers and facilities must enroll using the online enrollment process.

The EDI online enrollment is available to providers only. Enrollment will not be accepted from a clearinghouse or billing agent. Providers or facilities can access the EDI enrollment at https://secure.ediservices.net/EDIS.Web/Login/Login.aspx

From the EDI site, providers can enroll for an electronic submitter number or make changes to their current electronic submitter number. Providers and facilities must first register to create a login and password. For additional information about online enrollment, select the "help" link located on the log-in page for the FAQ's.

The EDI enrollment link is also located on the Arkansas Blue Cross website under Providers and EDI (arkansasbluecross.com/providers/edi.aspx).

Providers with questions concerning enrollment should contact EDI at 501-378-2336 or at edi@arkbluecross.com.

Corrected claim submission and filing

What is a corrected claim? A corrected claim is a claim that is submitted in order to make corrections to one that has been previously submitted for processing and has been finalized and reported on a provider's remittance advice. Corrected claims should not be submitted unless the initial filing has been finalized and is listed on their remittance advice.

Corrected claims may be submitted electronically or by paper.

Electronic submission

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, the Federal Employee Program and BlueCard accept electronic corrected claims.

To file corrected claims electronically for the CMS 1500 claim form, providers should enter the number 7 in 2300/CLM05-3 and include the ICN number or BlueCard SCCF# of the original claim.

The original ICN or SCCF# (Document Control Number - DCN) should be placed in the REF segment of the Loop 2300 with a qualifier of Ref 01=F8. If these are not submitted, the claims will be returned as a duplicate. Providers need to ask their software vendor to open an area within the 2300 loop for the remarks in the NTE segment as to what was corrected on the claim.

In order to expedite processing time and identify the actual corrections and the reason for the correction for both facility and professional corrected claims, Arkansas Blue Cross would appreciate receiving a total replacement claim in order for a complete comparison to the original claim along with the explanation in the NTE segment.

To file corrected claims electronically for the UB claim form, the facility will need to use XX7 type of bill.

Paper submissions

Paper submissions must include a "Correction Claim Submission Form". The corrected claim submission form is available on the "Forms" page located under the "Provider" tab on the Arkansas Blue Cross website (arkansasbluecross.com/providers/forms.aspx). This form should be used when filing claim corrections by mail. Please refer to the form for additional filing instructions.

Timely filing

As a reminder, Arkansas Blue Cross set a 180 day timely filing limit for first-time claims as well as corrected claims. When it is necessary to file a corrected claim, please ensure it is done within 180 days of the original paid date or the corrected claim will be rejected or returned.

If you have questions regarding corrected claims, please contact Customer Service at: AHIN Customer Support: 501-378-2336 or EDI: 501-378-2419.

Updates to the notice of network terms and conditions

Effective March 1, 2014 the Network Terms and Conditions of participation applicable to all individual network participants and applicants for the Preferred Payment Plan, Medi-Pak® Advantage PFFS, Medi-Pak® Advantage LPPO, Medi-Pak® Advantage HMO, Arkansas' FirstSource® PPO, True Blue PPO, and Health Advantage HMO Networks has been updated in section XIV(B) to (A) clarify the four-year ineligibility period which begins with the date an adverse hospital privileging action was imposed; and (B) clarify the circumstances and conditions that must be present to qualify for re-consideration after the four-year ineligibility period expires. The following is the relevant language in subsection (B) of Section XIV which incorporates the updates:

B. Ineligibility Period and Conditions for Re-Application

If a hospital privileges action (whether a denial, termination, limitation, suspension or voluntary or involuntary surrender of privileges) is deemed by the networks as sufficiently egregious or significant to justify network exclusion, that action shall, by itself, render the affected practitioner ineligible for network participation (or consideration for network participation) for a minimum period of four years. After four years have expired from the date of a hospital privileges action, the affected practitioner shall no longer be deemed ineligible for consideration for network participation, based solely on the privileges action, provided the criteria set forth below are met when the affected practitioner's network status or application is reviewed by the networks and their credentialing or appeals committees.

With respect to any practitioner whose network participation is denied or terminated on the basis of a hospital privileges action that occurred less than four years prior to the date of the denial or termination and involved questions of competency or fitness, or the quality of services rendered, such practitioners shall be ineligible to participate or re-apply for participation in the networks for a period of four years from the date of the hospital privileges action. Notwithstanding the preceding sentence, if (i) a past hospital privileges action is renounced or withdrawn in writing by the hospital that took the action under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or, (ii) if the hospital that took the privileges action reinstates the practitioner to full privileges without restrictions or conditions of any kind under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or (iii) if a court of competent jurisdiction overturns the hospital privileges action in a final judgment not subject to further challenge/appeal by the hospital, then in such circumstances, the four-year ineligibility period shall expire upon presentation by the practitioner of sufficient documentation of the occurrence of such events. Practitioners claiming early expiration of a four-year ineligibility period on any of the above-referenced grounds must, in order to regain eligibility on such bases, fully respond to all inquiries of the networks regarding such circumstances, including but not limited to, supplying the networks with complete documentation of any court proceedings, hospital peer review process and related records and communications.

Upon expiration of any four-year ineligibility period referenced above, a practitioner to which it applied shall become eligible to be considered by the networks' Credentialing Committee if and only if the following additional conditions are met:

1. No other hospital privileges actions of any kind have been taken against the practitioner during the six-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date of a final credentialing/appeals decision); and
2. No other hospital privileges actions of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
3. The practitioner has not been subject during the six-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date

of a final credentialing/appeals decision) to any actions or required appearances before the Arkansas State Medical Board or any equivalent licensing or disciplinary board, committee or entity in Arkansas or in any other jurisdiction; and

4. No such Medical Board (or equivalent licensing or disciplinary board or entity) actions or required appearances of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
5. No malpractice lawsuits have been filed against the practitioner during the four-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date of a final credentialing/appeals decision); and
6. No malpractice lawsuits not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
7. The practitioner must not be disqualified by any other network standard, term or condition, including but not limited to the networks' published credentialing standards, terms and conditions of network participation, or network participation agreements.

Please note that satisfaction of the preceding seven conditions will not automatically qualify the practitioner for network admission, but will render a practitioner formerly ineligible due to a past hospital privileges issue, eligible to be considered by the Credentialing Committee. The Credentialing Committee still must find, based on all the circumstances presented at the time of re-application, that the practitioner is qualified under applicable credentialing standards, and in doing so will consider whether past quality or safety questions or issues, including any hospital privileges issues, have been adequately addressed and resolved. The Credentialing Committee may take into account all factors deemed relevant in this respect by the Committee, which may include but shall not be limited to (i) whether the practitioner has undergone any additional education, training or remediation of any kind; and (ii) whether the practitioner has cooperated with the peer review process or requirements of the hospital that took the adverse privileges action; and (iii) whether the practitioner has unrestricted privileges at any hospital.

With respect to hospital privileges actions not involving questions of competency or fitness of a practitioner, or the quality of any services rendered (e.g., non-habitual tardiness in completing medical records or charts, or willingness to sign up for call rotation), the affected practitioner shall be ineligible to participate in or re-apply for participation in the networks for one year from the date that the hospital privileges action is taken, unless, in the interim, the hospital renounces or withdraws the privileges action, or unless, in the interim, the hospital reinstates the affected practitioner to full hospital privileges without restrictions or conditions of any kind, or unless a court of competent jurisdiction overturns the hospital privileges action.

Special Note on Failure to Notify Networks of Privileges Actions:

Notwithstanding any of the preceding provisions regarding the ineligibility period or conditions for re-application, if a practitioner who is subject to the terms of a network participation agreement is subjected to any hospital privileges action but fails to furnish written notice of the same to the networks within the time frame specified in the network participation agreement(s), such practitioner shall be ineligible to participate in the network or to re-apply for participation in the networks for three years from the date that the networks learn of any such hospital privileges action, dated from the date of the networks' rejection or termination letter citing the hospital privileges action.

For avoidance of doubt, the three-year ineligibility period referenced in this paragraph shall apply regardless of whether, in the intervening time between occurrence of the privileges action and its discovery by the networks, privileges have been fully restored without restrictions or conditions (unless privileges are restored based on the hospital renouncing or withdrawing the privileges action under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or unless a court of competent jurisdiction overturns the hospital privileges action in a final judgment not subject to further challenge/appeal by the hospital).

Do not use out-of-network laboratories

Arkansas Blue Cross and Blue Shield and its affiliates have recently noticed an increase in the utilization of non-participating laboratory vendors and the performance of novel "cardiovascular risk" panels at an out-of-network laboratory. These panels include assays which are not covered benefits under the terms of the members' health plans or policies.

Many of the claims for novel "cardiovascular risk" panel at an out-of-network laboratory are being submitted to one particular out-of-network vendor, Health Diagnostic Laboratory ("HDL"). As a reminder, using HDL or other out-of-network laboratory service providers could result in termination of your network participation agreements with Arkansas Blue Cross and its affiliates, USAble Corporation (True Blue and Arkansas' FirstSource® PPO networks) and Health Advantage (Health Advantage HMO network).

Referral to out-of-network providers – including labs – constitutes a breach of the network participation agreement except where referral is unavoidable due to an emergency or if a covered service is not available in-network. Referral to out-of-network providers is not just a business or contract concern of Arkansas Blue Cross and its affiliates but these violations have adverse financial consequences for members as well if members are subjected to "balance billing" in excess of the in-network allowance.

Please be aware that if a provider's network participation agreements is terminated due to breach, including a breach due to out-of-network lab referrals, then the provider will not be eligible or considered for re-admission to the networks for three years.

Most out-of-state labs are NOT in the Arkansas Blue Cross or its affiliates networks. Claims for specimens collected in Arkansas cannot be submitted through other Blues Plans via the BlueCard system. The claim must be filed with a participating Arkansas Blue Cross provider.

Other labs that are not in network for Arkansas Blue Cross or its affiliates include Ameritox, Aegis Sciences Corp, Ambry Genetics, Clarient Diagnostics, GenPath, Medical Diagnostic Lab (MDL), PerkinElmer Labs, Sequenom, Veracyte and Verinata.

For a list of current in network laboratory service providers, visit the Arkansas Blue Cross website at arkbuecross.com.

Transitional care management code amendment

The Transitional Care Management (TCM) codes (CPT codes 99495 and 99496) are intended to report management of a transition of a complex patient from one care setting to another, generally from an inpatient to outpatient status. The TCM codes are now reimbursable for any provider who meets the requirements as specified in the CPT manual, specifically including managing transition of the entire patient.

Please note, this service includes communication, medication management, reviewing the discharge records, interaction with other involved professionals, education, and assistance with scheduling follow-up with other providers and community services for all the patient's medical and psychosocial issues. This would generally fall in the purview of the patient's primary care provider.

The CPT code description states:

> "The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact and continuous access."

The CPT code manual provides other important details regarding these codes, which includes both an office visit and contact with the patient outside of the office visit with time frames for the face-to-face visit and for initial contact after discharge. These codes are payable to only one provider per discharge and it are not payable to a surgeon during the global period following surgery. These TCM codes are subject to post-pay review.

Arkansas health care payment improvement initiative

Update on Financial Settlements

Arkansas Blue Cross and Blue Shield, Health Advantage and US-Able Corporation joined the Arkansas health care payment improvement initiative (AHCPII) program with Arkansas Medicaid and QualChoice in 2012. We are nearing our first financial settlements for the Hip and Knee Replacement, Perinatal and Congestive Heart Failure episodes. Final settlement results will be available in the spring of 2014 and will identify those principal accountable providers ("PAPs") who

1. met the program targets for surplus sharing and will be issued a "Reward Payment" or
2. failed to meet program targets and will be required to return funds.

Once providers have received their reports they will have 30 days to appeal. Reward payments and refund request letters will be processed in June 2014.

For PAPs who meet program targets for surplus sharing, reward payments will be issued to the "pay to" entity on record for the PAP by Arkansas Blue Cross and Blue Shield. Checks will be delivered to the PAPs with their final settlement report.

For PAPs whose final results fall into the cost sharing levels, a refund request letter will accompany the PAPs final settlement report which identifies the amount of cost share applicable to the episode and PAP. In addition to the request letter, an extra letter copy and prepaid envelope will be enclosed to facilitate the refund process. The PAP will have a maximum of sixty (60) days to refund the applicable cost share amount.

After sixty (60) days, if the cost share portion has not been returned to Arkansas Blue Cross, an offset against current and future (if needed) Arkansas Blue Cross commercial claims payments will be initiated. The offset transaction will remain open until the total cost share amount has been recouped. Arkansas Blue Cross will also perform the cost share recoupment process for BlueAdvantage Administrators and Health Advantage.

Providers who have questions about the AHCPII episodic reimbursement program, its settlement process, or the appeals process, should refer to the Arkansas Blue Cross Provider Manual on the provider page at www.arkansasbluecross.com.

Telemedicine coverage policy pilot

Telemedicine is the use of telecommunication for the delivery of healthcare when distance separates the provider and the patient. Arkansas Blue Cross and Blue Shield will begin coverage of certain telemedicine services through a pilot project beginning April 1 and running through December 31, 2014. At the end of the pilot, the policy may be continued, modified, or discontinued. During the pilot, telemedicine services are limited to cases in which the member and the specialist physician are present within Arkansas.

The telemedicine services covered in the pilot program are limited to maternal fetal medicine (including consultation, follow-up, and genetics counseling), psychiatry and psychology. Please see the Coverage Policy manual for details, as there are specific criteria for the mechanism of telecommunication, provider types and location of the member and provider. Members must be referred for telemedicine services by an Arkansas Blue Cross credentialed provider who has seen the member face-to-face.

Only one copayment will apply per visit and should be collected by the provider who is billing the professional fee. A copayment does not need to be collected at the site where the patient is seen.

Telecommunication must be accomplished by means of the Arkansas e-Link Network. To connect to the e-Link network, providers may call the Center for Distance Health at 501-686-6998 or enroll online at arkansaselink.com. Proof of registration with e-Link by either the individual provider or the facility may be requested by Arkansas Blue Cross.

Coverage policy manual updates

Since December 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
1997057	Bone Growth Stimulation, Electrical, Appendicular Skeleton
1997113	Immune Globulin, Intravenous and Subcutaneous
1997159	Atherectomy, Peripheral/Visceral Artery, Percutaneous
1998010	Transplant, Small Bowel
1998107	Transplant, Heart
2000052	HDC & Allogeneic Stem and/or Progenitor Cell Support-Genetic Diseases and Acquired Anemias
2004038	Genetic Test: Lynch Syndrome and Inherited Intestinal Polyposis Syndromes
2005003	Genetic Test: Cytochrome p450 Genotyping
2006023	Artificial Heart, Total
2009034	Intensity Modulated Radiation Therapy (IMRT), Prostate
2011012	Preventive Services for Non-Grandfathered (ACA) Plans: Alcohol Misuse Counseling and/or screening
2011066	Preventive Services for Non-Grandfathered (ACA) Plans: Overview
2012035	Preventive Services for Non-Grandfathered (ACA) Plans: Contraceptive use and Counseling
2013031	Automated Whole Breast Ultrasound
2013038	Galectin Measurement
2013039	Needle Arthroscopy
2013040	Genetic Test: Alpha Thalessemia
2013041	Cardiovascular Risk Panels
2013042	Genetic Test: Macular Degeneration
2013043	Genetic Test: Fetal RHD Genotyping using Maternal Plasma
2013044	Genetic Test: Epilepsy
2013045	Genetic Test: Microarray-based Gene Expression Profile Analysis for Prostate Cancer Management
2013046	Genetic Test: Testing to Aid in the Management of Psychiatric Medications and Conditions (Genecept™)
2013047	Navigated Transcranial Magnetic Stimulation (nTMS)

Policy #	Policy Name
2013048	Repository Corticotropin Injection
2013049	Ocriplasmin (Jetrea®) for Symptomatic Vitreomacular Adhesion
2014001	Genetic Test: Analysis of MGMT Promoter Methylation in Malignant Gliomas
2014003	Telemedicine Services-Pilot Policy

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 phone 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.

Electronic provider access

The Blue Cross and Blue Shield Plans are launching a new tool that will give providers the ability to access out-of-area member's Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. Electronic Provider Access (EPA) will enable providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider will have the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The availability of EPA will vary depending on the capabilities of each Home Plan. Some Home Plans will be fully implemented and have electronic pre-service review for many services, while others will not yet have implemented electronic pre-service review capabilities.

Local access to the EPA is found on the Advanced Health Information Network ("AHIN") under the "Members" menu option.

2014 spring provider workshops

Providers interested in attending one of the workshops listed below can now register on-line. If you have any additional questions regarding a workshop in your area, contact your Network Development Representative.

Central Region - Little Rock

Embassy Suites
Tuesday, May 13

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Afternoon session
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Northeast Region Jonesboro

St. Bernard's Medical Center
- Auditorium
Wednesday, May 21

Morning session:
Registration 8: 30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Afternoon session:
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Northwest Region Mountain Home

Baxter Regional Medical Center
- Lagerborg Conference Center
Friday, April 11, 2014

Morning session:
Registration: 8:30 – 9 a.m.
Workshop: 9 – Noon

Northwest Region Springdale

Jones Center for Families
- Chapel
Thursday, April 10

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – Noon

South Central Region Hot Springs

National Park Community College
- Martin Eisele Auditorium
Wednesday, April 30

Afternoon session:
Registration 1:15 – 1:30 p.m.
Workshop 1:30 – 4:30 p.m.

Southeast Region Pine Bluff

Pine Bluff Country Club
Tuesday, April 22

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Southwest Region El Dorado

El Dorado Country Club
Thursday, May 8

Afternoon session:
Registration 1:30 – 2:00 p.m.
Workshop 2:00 – 4:00 p.m.

Southwest Region Texarkana

Texarkana Country Club
Tuesday, May 6

Afternoon session:
Registration 1:30 – 2:00 p.m.
Workshop 2:00 – 4:00 p.m.

West Central Region Fort Smith

Sparks Regional Medical Center
- Shuffield Center
Thursday, April 24

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – noon

To register on-line, please choose from the following locations:

- El Dorado: https://www.surveymonkey.com/s/EldoSpring2014
- Fort Smith: http://www.surveymonkey.com/s/abcbs2014-fortsmith
- Hot Springs: http://www.surveymonkey.com/s/ABCBS2014-SouthCentral
- Jonesboro: jdbailey@arkbluecross.com
- Little Rock: https://www.surveymonkey.com/s/ABCBS2014-CENTRAL
- Mountain Home: http://www.surveymonkey.com/s/abcbs2014-mountainhome
- Pine Bluff: http://www.surveymonkey.com/s/SE-Region-Spring-14
- Springdale: http://www.surveymonkey.com/s/abcbs2014-SPRINGDALE
- Texarkana: https://www.surveymonkey.com/s/TxkSpring2014

Physical therapy assistants and physical therapy aides

Physical therapy assistants and physical therapy aides are not recognized as providers under the Arkansas Blue Cross and Blue Shield member benefit contract. Physical therapy codes describing one-on-one contact or constant attendance are covered only when performed by a registered physical therapist or physician. Reimbursement for physical therapy codes that do not require one-on-one contact or constant attendance may be made when services are provided by an assistant working under the supervision of a registered physical therapist or physician. Physical therapy aides are not a covered provider, even when working under the supervision of a physical therapist.

ASE/PSE

Coverage policy changes for ASE/PSE:

Effective for dates of service starting June 1, 2014, Arkansas State and Public School Employees Gold and Bronze Plans will be subject to Health Advantage coverage policies. Starting with dates of service June 1, 2014, Employee Benefits Division (EBD) coverage policies will no longer be in effect.

For dates of service prior to June 1, 2014, please continue to reference arbenefits.org for coverage policy information. To access Health Advantage coverage policies for dates of service starting June 1, 2014, please visit healthadvantage-hmo.com.

BlueCard

Changes to remittance advice

Effective April 13, 2014, the following changes will be implemented to the remittance advice

New Message Codes:

The following new message codes will now be displayed when applicable:

1294 – Medicare-like rate applied for Native American member with approved purchaser order seen by non-Indian Health Services Provider.

1305 – All diagnostic reports are needed before the claim can be processed.

1306 – PET/MRI/CT scan report/ results are needed before claim can be processed.

1307 – EEG report with analysis is needed before the claim can be processed.

Discount Code 2- Sequestration Reduction Applied

When discount code 2 is displayed on the remittance advice the amount of that discount is also included in the total amount above.

New Medical Record Document Types:

There are 10 new medical record document types and three updated medical record document types.

The new medical record document types will provide the capability to order specific records versus requesting 'complete' medical records. The new medical record document types are as follows:

AD - Accident/Onset date
BG - Blood gases report
DE - Description of services/supply equipment
DR - Delivery report
DT - All diagnostic reports
ER - EEG report with analysis
OA - Ordering/referring physician name and address/NPI
SR - PET/MRI/CT scan report/ results
TN - Tooth number
VS - Vein study report

The following medical record type descriptions have been updated. They are as follows:

MD - Medication Record/Administration (current letter #996)
ST - Occupational, Physical, or Speech Therapy Evaluation/ Report (current letter #947)
TP - Treatment Plan/Notes (current letter #974)

Health Insurance Marketplace

Update on enrollment for federal Health Insurance Marketplace and state of Arkansas Private Option update

Please be advised that eligibility information for the 2014 federal Marketplace and state private option membership processing, include mailing ID cards to the members at the address provided by either the private option system or the federal exchange system and AHIN, is current and up to date through the end of February for March effective dates.

Due to the many challenges in the enrollment through the federal Health Insurance Marketplace, Arkansas Blue Cross and Blue Shield continues to receive enrollments that should have been transmitted earlier. Federal exchange member's coverage is not activated until their first premium payment is received and processed by Arkansas Blue Cross.

Arkansas Blue Cross expects a high volume of calls during March and April as the open enrollment period is set to end March 31, 2014. Additional staff has been placed in our service support area; however for eligibility inquiries, providers are strongly encouraged to use AHIN or MyBlueLine. Providers who are unable to locate a patient's information on AHIN or MyBlueLine should try the following:

Private Option

- If the member is not found on AHIN or MyBlueLine but has presented a letter of eligibility from Medicaid, please check the Medicaid eligibility system.
- If the patient is on the Medicaid eligibility system, their coverage has started with Medicaid and their coverage with Arkansas Blue Cross has not started and has not been sent to eligibility files from the private option system for the patient.
- If the patient cannot be located in the Medicaid eligibility system and the patient states they have enrolled with Medicaid, providers may want to contact their local Medicaid/DHS office for information.
- If the patient's coverage with Arkansas Blue Cross has not yet started, they may be covered under traditional Medicaid. Providers should use the patient's Medicaid number for medical services and also advise the patient to use his or her Medicaid number for the pharmacy and the pharmacies will handle their prescriptions.

Note: The private option system enrolls members by an auto assignment process if the member does not select a health plan. The member then has 30 days to decide to enroll in the health plan assigned or select another health plan. During these 30 days, Arkansas Blue Cross does not have information from the private option. Arkansas Blue Cross does not receive the member's information until after the 30 days.

Federal exchange

- If the patient cannot be located on AHIN or My BlueLine and the patient indicates they enrolled in the federal exchange (healthcare.gov), please be advised that there is a delay of a day or two from the federal enrollment and the transmission to Arkansas Blue Cross.
- Arkansas Blue Cross continues to receive changes from the federal exchange adjusting the original effective dates of the enrollments. These are transmitted to Arkansas Blue Cross in a separate transaction which requires a manual process and may take several days to complete.
- If the patient cannot be located on AHIN or MyBlueLine and the patient indicates they enrolled in the federal exchange, please have the patient contact the federal exchange.

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, 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 (MMCS) 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 Blue Cross Multi-State Plans?

ALL claims should be filed to Arkansas Blue Cross 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 premium 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 be denied and the member no longer will be considered 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.

(continued on page 14)

FAQs: the marketplace (continued from page 13)

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 Osseo integrated 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 requiring 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 entities 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 Affordable Care Act (ACA) wellness benefits are covered at 100% in-network only. The ACA wellness benefits will be used in the plans sold both on and off the Health Insurance Marketplace. The ACA 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 re-

duction 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 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 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 First.

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 a patient is enrolled in a private option plan with member copayments, the member may be eligible for traditional Medicaid benefits without copayments.

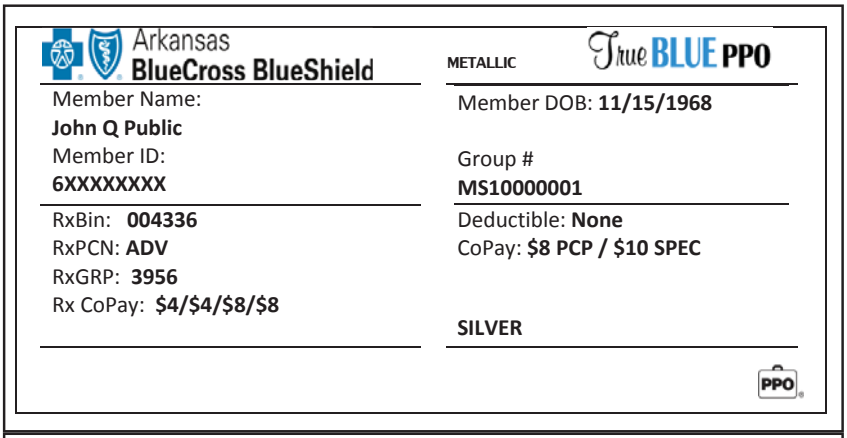
What if a patient needs traditional Medicaid services?

State Medicaid is establishing a provider referral process and form by which individuals with exceptional and predictable need for services that are not covered under the health plan are identified. Providers should encourage these patients to contact the Arkansas Medicaid offices in their county for information of their eligibility for additional benefits covered by Medicaid but not covered by their health plan.

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 True Out Of Pocket (TROOP) requirements 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. Below is an example of a private option member ID card.



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).

Fee Schedule

Fee schedule additions and updates

The following CPT and HCPCS codes were added or updated on the Arkansas Blue Cross fee schedule.

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
77293	$0.00	$0.00	$0.00	$601.37	$166.34	$435.04
80155	$0.00	$0.00	$0.00	$28.95	$2.03	$26.92
80159	$0.00	$0.00	$0.00	$37.85	$2.65	$35.20
80169	$0.00	$0.00	$0.00	$28.10	$1.97	$26.13
80171	$0.00	$0.00	$0.00	$27.14	$1.90	$25.24
80175	$0.00	$0.00	$0.00	$27.14	$1.90	$25.24
80177	$0.00	$0.00	$0.00	$27.14	$1.90	$25.24
80180	$0.00	$0.00	$0.00	$36.95	$2.59	$34.36
80183	$0.00	$0.00	$0.00	$27.14	$1.90	$25.24
80199	$0.00	$0.00	$0.00	$36.95	$2.59	$34.36
80203	$0.00	$0.00	$0.00	$27.14	$1.90	$25.24
81287	$0.00	$0.00	$0.00	BR	BR	BR
81504	$0.00	$0.00	$0.00	BR	BR	BR
81507	$0.00	$0.00	$0.00	BR	BR	BR
87389	$32.86	$2.30	$30.56	$0.00	$2.30	$0.00
87633	$568.60	$39.80	$528.80	$0.00	$39.80	$0.00
87661	$0.00	$0.00	$0.00	$47.87	$3.35	$44.52
88342	$125.82	$49.48	$76.34	$0.00	$49.48	$0.00
88343	$94.03	$20.07	$73.96	$0.00	$20.07	$0.00
88343	$0.00	$0.00	$0.00	BR	BR	BR
94640	$25.77	$12.89	$12.88	$0.00	$12.89	$0.00
97610	$0.00	$0.00	$0.00	BR	$0.00	$0.00
99288	$75.00	$0.00	$0.00	$75.00	$0.00	$0.00
99367	$68.95	$0.00	$0.00	$68.95	$0.00	$0.00
99368	$44.97	$0.00	$0.00	$44.97	$0.00	$0.00

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
99446	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
99447	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
99448	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
99449	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
99481	$0.00	$0.00	$0.00	BR	$0.00	$0.00
99482	$0.00	$0.00	$0.00	BR	$0.00	$0.00
0078T	BR	$0.00	$0.00	BR	$0.00	$0.00
0335T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0336T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0337T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0338T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0339T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0340T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0341T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0342T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0343T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0344T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0345T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0346T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
9001F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
9002F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
9003F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
9004F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
9005F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
9006F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
9007F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
A4555	$0.00	$0.00	$0.00	BR	$0.00	$0.00
A7047	$0.00	$0.00	$0.00	$132.22	$0.00	$0.00
A9520	$0.00	$0.00	$0.00	BR	$0.00	$0.00
A9575	$0.00	$0.00	$0.00	BR	$0.00	$0.00

(continued on page 18)

Fess schedule updates (continued from page 17)

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
A9599	$0.00	$0.00	$0.00	BR	$0.00	$0.00
C5271	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C5272	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C5273	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C5274	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C5275	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C5276	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C5277	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C5278	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9133	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9441	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9497	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9737	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
E0450	$11,717.80	$1,171.78	$8,788.35	$0.00	$0.00	$0.00
E0461	$11,717.80	$1,171.78	$8,788.35	$0.00	$0.00	$0.00
E0463	$17,686.40	$1,768.64	$13,264.80	$0.00	$0.00	$0.00
E0464	$17,686.40	$1,768.64	$13,264.80	$0.00	$0.00	$0.00
E0486	$1,200.00	$0.00	$0.00	$0.00	$0.00	$0.00
E0766	$0.00	$0.00	$0.00	BR	$0.00	$0.00
E1352	$0.00	$0.00	$0.00	BR	$0.00	$0.00
G0202	$179.48	$50.31	$129.17	$0.00	$50.31	$0.00
G0204	$219.12	$62.96	$156.15	$0.00	$62.96	$0.00
G0206	$172.49	$50.31	$122.19	$0.00	$50.31	$0.00
G0452	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G0461	$0.00	$0.00	$0.00	$125.82	$49.48	$76.34
G0462	$0.00	$0.00	$0.00	$94.03	$20.07	$73.96
G0463	$0.00	$0.00	$0.00	BR	$0.00	$0.00
G9188	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9189	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9190	$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
G9191	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9192	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9193	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9194	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9195	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9196	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9197	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9198	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9199	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9200	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9201	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9202	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9203	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9204	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9205	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9206	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9207	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9208	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9209	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9210	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9211	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9212	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9213	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9214	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9215	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9216	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9217	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9218	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9219	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9220	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

(continued on page 20)

Fess schedule updates (continued from page 19)

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
G9221	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9222	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9223	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9224	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9225	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9226	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9227	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9228	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9229	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9230	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9231	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9232	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9233	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9234	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9235	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9236	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9237	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9238	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9239	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9240	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9241	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9242	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9243	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9244	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9245	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9246	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9247	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9248	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9249	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9250	$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
G9251	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9252	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9253	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9254	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9255	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9256	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9257	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9258	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9259	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9260	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9261	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9262	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9263	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9264	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9265	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9266	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9267	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9268	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9269	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9270	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9271	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9272	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9273	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9274	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9275	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9276	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9277	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9278	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9279	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9280	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

(continued on page 22)

Fess schedule updates (continued from page 21)

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
G9281	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9282	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9283	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9284	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9285	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9286	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9287	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9288	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9289	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9290	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9291	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9292	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9293	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9294	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9295	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9296	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9297	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9298	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9299	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9300	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9301	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9302	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9303	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9304	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9305	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9306	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9307	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9308	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9309	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9310	$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
G9311	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9312	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9313	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9314	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9315	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9316	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9317	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9318	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9319	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9320	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9321	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9322	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9323	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9324	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9325	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9326	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9327	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9328	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9329	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9340	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9341	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9342	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9343	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9344	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9345	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9346	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9347	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9348	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9349	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9350	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

(continued on page 24)

Fess schedule updates (continued from page 23)

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
G9351	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9352	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9353	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9354	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9355	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9356	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9357	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9358	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9359	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9360	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7302	$734.02	$0.00	$0.00	$0.00	$0.00	$0.00
J7302	$772.65	$0.00	$0.00	$0.00	$0.00	$0.00
L0455	$328.79	$0.00	$0.00	$0.00	$0.00	$0.00
L0457	$942.90	$0.00	$0.00	$0.00	$0.00	$0.00
L0467	$377.46	$0.00	$0.00	$0.00	$0.00	$0.00
L0469	$437.00	$0.00	$0.00	$0.00	$0.00	$0.00
L0641	$73.90	$0.00	$0.00	$0.00	$0.00	$0.00
L0642	$389.70	$0.00	$0.00	$0.00	$0.00	$0.00
L0643	$153.52	$0.00	$0.00	$0.00	$0.00	$0.00
L0648	$973.25	$0.00	$0.00	$0.00	$0.00	$0.00
L0649	$271.86	$0.00	$0.00	$0.00	$0.00	$0.00
L0650	$1,151.77	$0.00	$0.00	$0.00	$0.00	$0.00
L0651	$1,151.77	$0.00	$0.00	$0.00	$0.00	$0.00
L1812	$94.31	$0.00	$0.00	$0.00	$0.00	$0.00
L1833	$536.08	$0.00	$0.00	$0.00	$0.00	$0.00
L1848	$545.28	$0.00	$0.00	$0.00	$0.00	$0.00
L3678	BR	$0.00	$0.00	$0.00	$0.00	$0.00
L3809	$215.75	$0.00	$0.00	$0.00	$0.00	$0.00
L3916	$458.64	$0.00	$0.00	$0.00	$0.00	$0.00
L3918	$91.12	$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
L3924	$75.06	$0.00	$0.00	$0.00	$0.00	$0.00
L3930	$79.36	$0.00	$0.00	$0.00	$0.00	$0.00
L4361	$244.15	$0.00	$0.00	$0.00	$0.00	$0.00
L4387	$150.32	$0.00	$0.00	$0.00	$0.00	$0.00
L4397	$159.13	$0.00	$0.00	$0.00	$0.00	$0.00
L5969	$13,782.16	$0.00	$0.00	$0.00	$0.00	$0.00
L8679	$7,925.85	$0.00	$0.00	$0.00	$0.00	$0.00
Q0161	$0.00	$0.00	$0.00	$1.18	$0.00	$0.00
Q2028	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q3028	$0.00	$0.00	$0.00	$34.14	$0.00	$0.00
Q4137	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4138	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4139	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4140	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4141	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4142	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4143	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4145	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4146	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4147	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4148	$0.00	$0.00	$0.00	BR	$0.00	$0.00
Q4149	$0.00	$0.00	$0.00	$180.00	$0.00	$0.00
S9328	$42.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9960	$0.00	$0.00	$0.00	BR	$0.00	$0.00
S9961	$0.00	$0.00	$0.00	BR	$0.00	$0.00
T4544	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule

Fee schedule additions and updates

The following surgical codes were update on the Arkansas Blue Cross fee schedule.

CPT Code	Non-Facility	Facility
10030	$1,169.95	$258.64
19081	$829.91	$282.86
19082	$646.90	$136.29
19083	$820.32	$265.35
19084	$636.29	$128.06
19085	$1,217.31	$310.18
19086	$944.62	$142.06
19281	$317.15	$161.47
19282	$211.10	$78.01
19283	$353.99	$162.66
19284	$248.74	$78.40
19285	$560.69	$138.02
19286	$456.90	$67.11
19287	$1,025.97	$220.24
19288	$798.94	$100.56
23333	$0.00	$724.20
23334	$0.00	$1,720.85
23335	$0.00	$2,056.48
33366	$0.00	$3,032.03
34841	BR	BR
34842	BR	BR
34843	BR	BR
34844	BR	BR
34845	BR	BR
34846	BR	BR
34847	BR	BR
34848	BR	BR

CPT Code	Non-Facility	Facility
37217	$0.00	$1,851.86
37236	$3,371.59	$739.33
37237	$1,472.39	$346.59
37238	$4,772.81	$517.62
37239	$2,368.79	$241.99
37241	$5,329.09	$717.78
37242	$8,859.91	$801.50
37243	$11,168.71	$955.78
37244	$7,947.58	$1,115.19
43191	$0.00	$221.79
43192	$0.00	$264.24
43193	$0.00	$314.57
43194	$0.00	$284.77
43195	$0.00	$315.19
43196	$0.00	$344.23
43197	$322.34	$140.41
43198	$359.61	$167.13
43211	$0.00	$426.90
43212	$0.00	$334.79
43213	$2,157.82	$473.94
43214	$0.00	$343.02
43229	$1,269.44	$361.69
43233	$0.00	$407.03
43253	$0.00	$472.28
43254	$0.00	$489.90
43266	$0.00	$405.18
43270	$1,264.51	$426.29

CPT Code	Non-Facility	Facility
43274	$0.00	$795.69
43275	$0.00	$655.77
43276	$0.00	$828.00
43277	$0.00	$659.81
43278	$0.00	$750.43
49405	$1,076.43	$340.03
49406	$1,076.03	$340.42
49407	$930.00	$361.96
52356	$0.00	$687.61
64616	$173.26	$157.02
64617	$257.16	$172.39
64642	$194.29	$159.04
64643	$130.94	$109.15
64644	$220.35	$174.00
64645	$157.83	$124.95
64646	$209.60	$172.36
64647	$243.22	$199.65
66183	$0.00	$1,688.71
92521	$176.76	$0.00
92522	$144.69	$0.00
92523	$298.81	$0.00
92524	$149.63	$0.00
93582	$0.00	$1,093.41
93583	$0.00	$1,217.24
94669	$46.92	$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	$117.14
90375	$227.57
90376	$222.19
90385	$25.84
90585	$124.20
90586	$124.20
90632	$53.62
90673	$37.94
90675	$245.46
90685	$24.16
90691	$65.51
90703	$40.95
90714	$20.07
A9576	$2.08
A9578	$1.69
A9579	$2.05
A9581	$14.09
A9583	$12.16
A9585	$0.43
J0129	$24.36
J0130	$710.83
J0132	$2.74
J0133	$0.06
J0135	$592.04
J0150	$6.76
J0151	$3.44
J0171	$0.11

CPT Code	Allowed
J0180	$152.03
J0207	$312.71
J0220	$214.89
J0221	$159.74
J0257	$4.17
J0278	$0.99
J0280	$1.46
J0285	$15.04
J0287	$10.89
J0290	$1.55
J0295	$1.82
J0348	$0.79
J0360	$3.25
J0364	$33.99
J0400	$0.58
J0401	3.63
J0456	$3.11
J0461	$0.04
J0470	$28.84
J0475	$173.17
J0476	$78.87
J0480	$2,567.36
J0490	$40.36
J0500	$34.68
J0515	$22.07
J0558	$4.23
J0561	$5.32

CPT Code	Allowed
J0585	$5.66
J0586	$7.83
J0587	$11.64
J0588	$4.65
J0592	$2.20
J0594	$26.59
J0595	$1.90
J0598	$51.19
J0610	$0.97
J0630	$71.84
J0636	$0.38
J0637	$13.29
J0640	$4.48
J0641	$1.82
J0670	$2.62
J0690	$0.83
J0692	$2.52
J0697	$3.43
J0698	$2.10
J0702	$6.03
J0712	$0.92
J0713	$2.15
J0717	$5.34
J0720	$31.31
J0725	$15.75
J0735	$21.57

(continued on page 28)

Injection code updates (continued from page 27)

CPT Code	Allowed
J0740	$679.32
J0744	$1.15
J0770	$12.05
J0775	$39.74
J0780	$4.27
J0795	$8.08
J0834	$65.13
J0840	$2,459.30
J0878	$0.66
J0881	$3.82
J0882	$3.82
J0885	$11.83
J0886	$11.83
J0894	$33.53
J0897	$14.86
J1000	$9.15
J1020	$3.33
J1030	$2.85
J1040	$5.47
J1050	$0.25
J1070	$4.74
J1080	$4.14
J1110	$46.37
J1120	$26.73
J1160	$3.80
J1162	$1,303.06
J1165	$0.63
J1170	$2.38
J1200	$0.71
J1205	$157.81
J1212	$81.94

CPT Code	Allowed
J1230	$7.69
J1240	$5.05
J1250	$5.93
J1260	$5.60
J1265	$0.57
J1267	$0.62
J1270	$1.73
J1290	$369.66
J1300	$212.80
J1325	$16.28
J1327	$28.85
J1335	$35.04
J1364	$28.84
J1380	$8.78
J1410	$169.69
J1438	$278.65
J1442	$1.03
J1450	$3.91
J1451	$7.24
J1453	$1.78
J1458	$374.70
J1459	$38.20
J1556	$40.18
J1557	$38.86
J1560	$249.41
J1561	$41.36
J1566	$38.32
J1568	$31.84
J1569	$40.91
J1570	$74.98
J1571	$53.34

CPT Code	Allowed
J1572	$37.50
J1573	$53.34
J1580	$1.40
J1602	27.28
J1610	$138.33
J1626	$0.47
J1630	$1.66
J1631	$20.76
J1640	$17.15
J1642	$0.17
J1644	$0.21
J1645	$13.69
J1650	$1.63
J1670	$285.40
J1720	$5.27
J1740	$164.25
J1742	$90.99
J1743	$487.85
J1750	$12.52
J1786	$43.68
J1800	$1.35
J1815	$0.64
J1817	$6.37
J1930	$39.40
J1931	$29.44
J1940	$2.52
J1950	$778.46
J1953	$0.14
J1955	$8.72
J1980	$18.25
J2010	$8.65

CPT Code	Allowed
J2020	$42.23
J2060	$0.76
J2150	$1.84
J2175	$2.88
J2210	$4.49
J2250	$0.15
J2270	$6.03
J2271	$0.64
J2275	$3.60
J2278	$6.87
J2280	$4.59
J2300	$1.71
J2310	$18.56
J2315	$2.86
J2323	$14.55
J2325	$63.03
J2354	$1.35
J2355	$287.74
J2357	$26.65
J2360	$6.30
J2370	$3.35
J2400	$22.21
J2405	$0.11
J2410	$2.47
J2425	$14.98
J2426	$7.95
J2430	$8.93
J2469	$20.12
J2501	$1.70
J2503	$1,070.13
J2505	$3,355.39
J2507	$592.80

CPT Code	Allowed
J2510	$15.55
J2515	$33.53
J2540	$0.56
J2543	$1.67
J2545	$87.77
J2550	$1.68
J2560	$17.32
J2562	$310.73
J2590	$0.44
J2597	$5.51
J2675	$1.57
J2680	$20.89
J2690	$25.29
J2700	$2.14
J2720	$0.97
J2730	$93.14
J2760	$120.72
J2765	$0.82
J2770	$206.55
J2778	$413.08
J2780	$1.15
J2783	$222.96
J2785	$55.26
J2788	$15.25
J2790	$88.41
J2791	$4.91
J2792	$19.65
J2794	$6.18
J2795	$0.11
J2796	$53.68
J2800	$41.75
J2805	$85.99

CPT Code	Allowed
J2810	$0.30
J2820	$30.92
J2916	$2.68
J2920	$1.78
J2930	$2.51
J2997	$62.01
J3000	$10.84
J3010	$0.65
J3060	$32.14
J3070	$164.27
J3095	$4.27
J3101	$82.18
J3105	$1.80
J3130	$6.91
J3230	$23.22
J3240	$1,258.58
J3246	$9.34
J3250	$9.77
J3260	$2.72
J3300	$3.85
J3301	$1.90
J3303	$1.70
J3315	$193.17
J3355	$71.70
J3357	$153.78
J3360	$4.03
J3370	$1.91
J3385	$369.33
J3396	$11.05
J3410	$0.35
J3411	$3.57

(continued on page 30)

Injection code updates (continued from page 29)

CPT Code	Allowed
J3415	$8.67
J3420	$2.18
J3430	$0.85
J3465	$4.26
J3475	$0.23
J3480	$0.02
J3486	$10.79
J3489	$109.64
J7030	$1.23
J7040	$0.62
J7042	$0.51
J7050	$0.31
J7060	$1.12
J7070	$2.22
J7100	$31.37
J7120	$1.06
J7183	$0.94
J7189	$1.75
J7190	$0.97
J7192	$1.18
J7193	$1.00
J7194	$1.15
J7195	$1.38
J7197	$3.25
J7198	$1.71
J7301	650.32
J7308	$259.06
J7312	$203.71
J7316	$1,088.62
J7321	$94.97
J7323	$158.10

CPT Code	Allowed
J7324	$183.72
J7325	$13.38
J7326	$578.23
J7500	$0.17
J7502	$3.28
J7504	$766.93
J7506	$0.06
J7507	$1.52
J7508	$0.44
J7509	$0.52
J7510	$0.11
J7511	$593.91
J7515	$0.89
J7516	$32.95
J7517	$1.13
J7518	$4.29
J7520	$15.09
J7525	$141.61
J7527	$7.11
J7605	$6.01
J7606	$6.62
J7608	$1.78
J7612	$0.18
J7614	$0.09
J7620	$0.19
J7626	$5.83
J7631	$0.42
J7639	$34.12
J7644	$0.24
J7682	$125.19
J7686	$478.85

CPT Code	Allowed
J8501	$7.05
J8510	$11.34
J8520	$10.42
J8521	$34.68
J8530	$1.03
J8540	$0.18
J8560	$61.14
J8600	$9.44
J8610	$1.08
J8700	$10.08
J8705	$92.89
J9000	$3.23
J9015	$1,738.03
J9017	$51.21
J9025	$5.65
J9027	$134.81
J9031	$124.20
J9033	$22.20
J9035	$68.29
J9040	$19.53
J9041	$47.39
J9042	$111.13
J9043	$144.60
J9045	$3.28
J9047	$30.46
J9050	$1,481.23
J9055	$54.64
J9060	$2.16
J9065	$23.15
J9070	$54.56
J9100	$0.98

CPT Code	Allowed
J9130	$4.16
J9150	$27.17
J9155	$3.66
J9171	$4.14
J9175	$4.32
J9178	$1.26
J9179	$102.17
J9181	$0.76
J9185	$73.92
J9190	$2.21
J9200	$72.16
J9201	$7.70
J9202	$202.20
J9206	$4.72
J9208	$37.25
J9209	$3.05
J9211	$37.11
J9214	$21.48
J9217	$217.45
J9218	$9.11
J9225	$3,059.51
J9226	$16,090.59
J9228	$134.12
J9245	$1,298.68
J9250	$0.26
J9260	$2.64
J9261	$136.00
J9262	238.57
J9263	$0.28
J9264	$9.90
J9265	$4.56
J9268	$1,480.14

CPT Code	Allowed
J9280	$24.50
J9293	$35.06
J9302	$49.07
J9303	$94.88
J9305	$62.47
J9306	$10.62
J9307	$199.32
J9310	$721.09
J9315	$271.08
J9320	$289.58
J9328	$5.35
J9330	$59.29
J9351	$2.46
J9354	$30.34
J9355	$83.82
J9357	$1,102.47
J9360	$1.54
J9370	$5.72
J9371	15.05
J9390	$9.92
J9395	$93.23
J9400	$9.75
Q0138	$0.72
Q0139	$0.72
Q0163	$0.04
Q0164	$0.02
Q0166	$2.78
Q0167	$2.94
Q0169	$0.03
Q0180	$68.15
Q2009	$1.24
Q2017	$360.83

CPT Code	Allowed
Q2043	$31,985.76
Q2050	$534.02
Q3027	$34.14
Q4074	$83.02
Q4081	$1.18
Q4101	$42.72
Q4102	$10.08
Q4103	$10.08
Q4104	$26.89
Q4105	$15.80
Q4106	$46.20
Q4107	$103.27
Q4108	$30.68
Q4110	$41.80
Q4111	$7.31
Q4112	$441.92
Q4113	$441.92
Q4114	$1,304.04
Q4115	$8.78
Q4116	$34.23
Q4121	$24.05
Q4123	$15.77
Q9956	$38.43
Q9957	$57.64
Q9960	$0.18
Q9963	$0.17
Q9965	$1.14
Q9966	$0.22
Q9967	$0.18

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providers' news staff

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Please Note

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