PROVIDERS' NEWS
A publication for participating providers and their office staffs
SEPTEMBER 2015

INSIDE

ICD-10 is here!

October 1, 2015
is the compliance date for ICD-10. Please see the related articles in this issue for additional information regarding ICD-10.

ICD Assist

Did you know that Arkansas Blue Cross and Blue Shield is offering a free tool* to assist providers with ICD-10? Get comfortable with the new world of ICD-10!

Create an account today!

Website: http://icdassist.com

*This tool is free for Arkansas Blue Cross providers only. Your NPI number will be required for registration.

LIVE FEARLESS℠
Arkansas BlueCross BlueShield

ICD-10 compliance date is October 1, 2015

The U.S. Department of Health and Human Services (HHS) has issued a rule finalizing October 1, 2015, as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10. This new deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready for the October 1, 2015 compliance deadline.

Arkansas Blue Cross and Blue Shield has been actively performing ICD-10 end-to-end testing with providers and is ready to begin accepting ICD-10 claims coding.

Claims without ICD-10 codes will not be paid

By federal mandate, the ICD-10 compliance date is October 1, 2015. As a result, all claims submitted to the Arkansas Blue Cross and Blue Shield and its family of companies for dates of service or discharge dates on or after October 1, 2015 must utilize ICD-10 codes in place of ICD-9 codes. **Claims not billed with ICD-10 codes will be rejected.**

Claims effected by this change include claims submitted to Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, Health Advantage, Medi-Pak® Advantage, Federal Employees Program, USAble Administrators, Metallic Plans on the Arkansas Exchange, and includes claims for other Blue Plan members.

Arkansas Medicaid is also planning to do the same and has published a similar update on their site. Arkansas Blue Cross will monitor federal guidelines regarding their compliance and make changes to this policy as needed.

AHIN claims acceptance criteria regarding ICD-10

AHIN will have the following additional criteria to comply with the federal regulation related to ICD-10. Claims not meeting this criteria will be rejected at the time of submission.

Criteria:

All claim types:

- If a claim is submitted with ICD-9 and ICD-10 codes on the same claim, the claim will be rejected.
- ICD codes must have the correct qualifier indicating whether the code is an ICD-9 code or ICD-10 code.
- The October 1, 2015 compliance date applies to both the ICD diagnosis and ICD procedure codes.

Inpatient claims:

- If the discharge date (statement to date) is prior to the compliance date, ICD-9 codes must be submitted for all service lines on claim.
- If the discharge date (statement to date) is on or after compliance date, ICD-10 codes must be submitted for all service lines on the claim.
- For interim bills, the same rules will apply.
- For inpatient claims with admission date prior to compliance date but a discharge date (statement to date) after compliance date, ICD-10 must be submitted on all service lines on the claim.

Professional and outpatient claims:

- If the statement to date

(Continued on page 3)

AHIN claims acceptance criteria regarding ICD-10 (Continued from page 2)

or service date is prior to compliance date, ICD-9 codes must be submitted for all service lines on claim.
- If the statement to date or service date is on or after compliance date, ICD-10 codes must be submitted for all service lines on the claim.
- If a claim has service dates both prior to and on or after the compliance date, the claim must be split such that services prior to compliance date are billed on one claim with ICD-9 codes and services on or after compliance date are billed on second claim with ICD-10 codes.

Frequently asked questions for ICD-10

End to End Testing

- End to End testing was opened for providers in September 2014 which was published in the September 2014 issue of *Providers' News.* ICD-10 testing has been open for over a year.
- Arkansas Blue Cross will continue to accept test claims until the October 1, 2015 deadline. However, test claims received after August 31, 2015 may take longer to process and results may not be available before the October 1, 2015 compliance date. Please send an email to ICD10@arkbluecross.com if you wish to participate in testing.

Authorizations

The following is applicable to authorizations for physicians and outpatient services.

Can providers currently pre-authorize services associated with ICD-10 diagnoses? If not, when will Arkansas Blue Cross begin accepting ICD-10 diagnoses when pre-authorizing services?

- ICD-10s will be accepted starting on the October 1, 2015 compliance date.

If pre-authorization is required for services associated with ICD-9 diagnoses, will services performed on or after the transition date require re-authorization with an ICD-10 code or will ICD-9 pre-authorization received prior to the conversion carry over for those services?

- Re-authorization will NOT be required. Current pre-authorizations processed with ICD-9 codes will be valid after the compliance date of October 1, 2015.

CMS-AMA Guidance - Clarifications

During July 2015, CMS-AMA published guidance and additional clarifications on the ICD-10 guidelines. This section will try to clarify the guidance to ensure providers are not misled.

- CMS is still asking to submit a valid ICD code. A three digit code that has additional subdivisions would not be considered valid. The most specific ICD-10 code will be required similar to the way the most specific ICD-9 code is required.
- CMS's guidance applies only to post-payment reviews and hence no change will be made to the claims processing edits. Since this is specific to CMS only, Arkansas Blue Cross will make no changes to claims processing edits as a result of CMS's guidance.

Contact Information

- Providers should contact the AHIN provider services if they experience problems with claims submissions.
- Arkansas Blue Cross customer service team has been trained to handle other ICD-10 related issues along with regular production issues and can be reached by calling the Arkansas Blue Cross customer service phone numbers located on the back of the member's ID card.

ICD-10 guidelines for paper claim submissions

The federally mandated ICD-10 compliance date of October 1, 2015 applies also to paper claims. All claims submitted to the Arkansas Blue Cross and Blue Shield and its family of companies, including paper claims, must apply the following guidelines to avoid claims from being rejected.

For CMS-1500 (02/12) claim form:

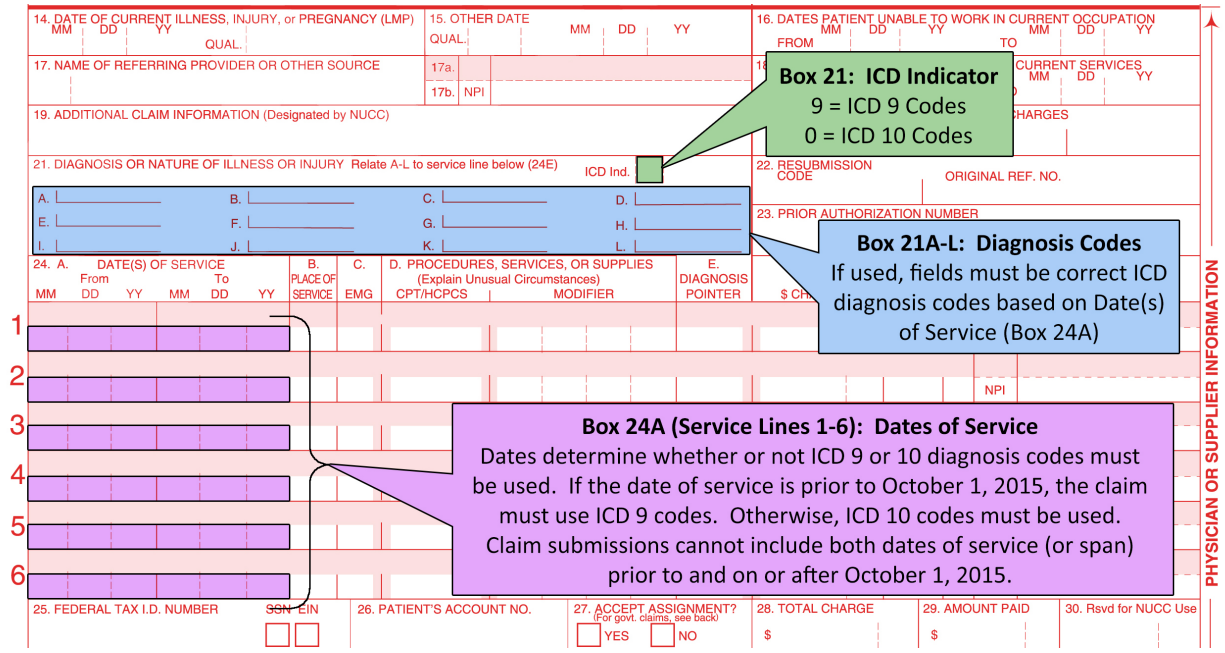
- Claims with dates of service prior to October 1, 2015, must be filed using ICD-9 indicator of nine (9) and ICD-9 diagnosis codes in Box 21. Claims with dates of service on or after October 1, 2015, must be filed using ICD-10 indicator of (0) and ICD-10 diagnosis codes in Box 21.
- Claims cannot have dates of services prior to October 1, 2015 and on or after October 1, 2015. Separate claims must be filed and appropriate ICD codes used based on the October 1, 2015 compliance date.

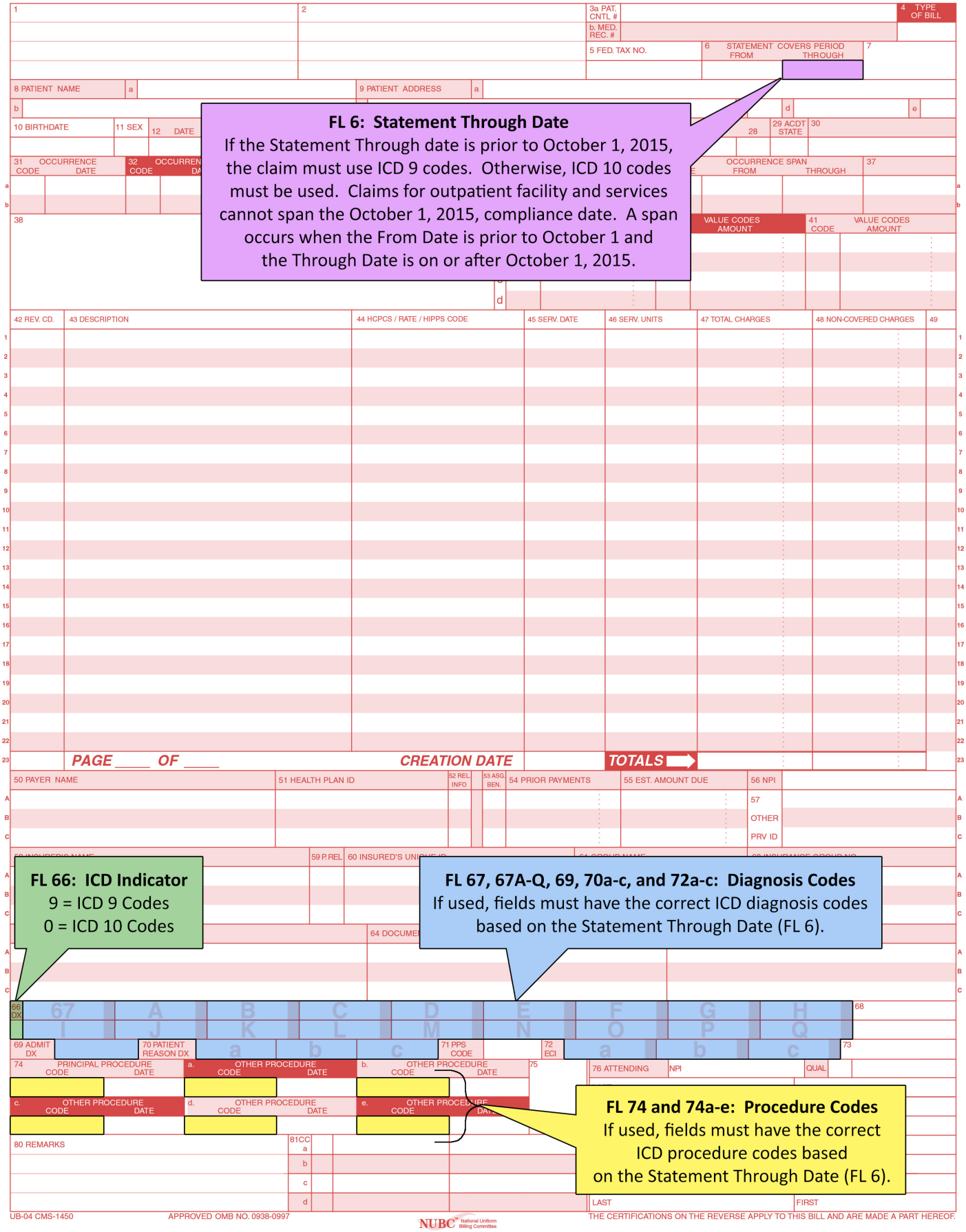
For UB-04 claim form:

- Claims with a Statement covers period through date in form location FL 6 prior to October 1, 2015, must be filed using ICD-9 indicator of nine (9) in FL 66, ICD-9 diagnosis codes as needed in FL 67, 67A-Q, 69, 70a-c, and 72a-c, and ICD-9 procedure codes as needed in FL 74 and 74a-e. Otherwise, claims with a through date (FL6) on or after October 1, 2015, must be filed using ICD-10 indicator of zero (0) and ICD-10 diagnosis and procedure codes in the appropriate form locations.
- Claims for outpatient facility and services cannot span the October 1, 2015 compliance date. The claims must be split and filed separately with the appropriate ICD codes."

Claims affected by these guidelines include claims submitted to Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, USAble Administrators, Health Advantage, Medi-Pak® Advantage, Federal Employees Program, Metallic Plans on the Arkansas Exchange, and includes claims for other Blue Plan members.

For detail instructions on how to properly complete the CMS-1500 (02/12) claim form, Arkansas Blue Cross recommends following the National Uniform Claim Committee (NUCC) guidelines located on their website at nucc.org.




FL 6: Statement Through Date
If the Statement Through date is prior to October 1, 2015, the claim must use ICD 9 codes. Otherwise, ICD 10 codes must be used. Claims for outpatient facility and services cannot span the October 1, 2015, compliance date. A span occurs when the From Date is prior to October 1 and the Through Date is on or after October 1, 2015.
FL 66: ICD Indicator
9 = ICD 9 Codes
0 = ICD 10 Codes
FL 67, 67A-Q, 69, 70a-c, and 72a-c: Diagnosis Codes
If used, fields must have the correct ICD diagnosis codes based on the Statement Through Date (FL 6).
FL 74 and 74a-e: Procedure Codes
If used, fields must have the correct ICD procedure codes based on the Statement Through Date (FL 6).
PAGE ____ OF ____
CREATION DATE
TOTALS
UB-04 CMS-1450
APPROVED OMB NO. 0938-0997
NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Imaging centers – CT dual auto injector equipment

In the September 2014 issue of *Providers' News,* Arkansas Blue Cross and Blue Shield and its affiliates, USAble Corporation and Health Advantage published updated assessment criteria which applies to all participating imaging centers that was effective January 1, 2015. Included in the update was a specific requirement for imaging centers performing CT, CTA and CCTA which outlines the required utilization of dual auto injector equipment for contrast enhanced studies.

The rationale for requiring dual-syringe power injectors for CTs is to minimize the pooling of contrast in the injected extremity. This pooling reduces the effective contrast dose to the target organ being imaged while at the same time exposing the patient to as much as 30 percent unnecessary or non-imaged contrast dose.

As a reminder, Arkansas Blue Cross and its affiliates require all participating imaging centers to have dual-auto injector equipment in place and operational when performing any CT modality which includes CT, CTA and/or CCTA.

Category III CPT codes

Current Procedural Terminology (CPT), the official code book with rules and guidelines from the American Medical Association's CPT editorial panel, includes a section of Category III CPT codes. Category III codes are temporary codes created to identify emerging technology services and procedures.

Unlike unlisted or deleted codes, the Category III codes allow data collection for specific emerging technology services. If a Category III code is available, providers must use that code instead of an unlisted or deleted Category I code. The services or procedures represented by Category III codes may not have FDA approval, may not be performed by many health care professionals across the country, and the service or procedure may not have proven clinical efficacy.

Claims filed for services using Category III codes will be denied unless the code is addressed as a covered service in an Arkansas Blue Cross Medical Coverage Policy.

CMS issues guidelines for online provider directories

The Centers for Medicare & Medicaid Services (CMS) is requiring all Medicare Advantage plans to provide its enrollees with the most up-to-date information regarding participating providers on their online provider directories. CMS has issued guidelines that all Medicare Advantage plans and participating providers must follow.

Under the new CMS program, Medicare Advantage plans must have regular, ongoing communications with providers to ascertain their availability and, more specifically, whether they are accepting new patients. Plans are required to maintain accurate online provider directories by:

- Displaying all active participating providers
- Identifying providers whose practice is closed or providers not accepting new patients

(Continued on page 7)

CMS issues guidelines for online provider directories (Continued from page 6)

- Updating online provider directories in real-time
- Communicating with providers monthly regarding their network status and information accuracy.

Medicare Advantage plans are expected to require participating providers to inform the plan of any change to street addresses, phone numbers, office hours or any other change that can affect their availability. Medicare Advantage plans are also required to develop and implement a protocol to effectively address inquiries and complaints related to enrollees being denied access to a participating provider and make immediate corrections to their online provider directory.

In order to meet these CMS requirements, providers participating in the Medi-Pak® Advantage PFFS, Medi-Pak® Advantage LPPO, and Medi-Pak® Advantage HMO plans are now required to maintain and updated their information with Arkansas Blue Cross and Blue Shield.

To assist providers, Arkansas Blue Cross is developing an information update screen on the AHIN website. Providers will be able to update information such as their status of accepting new patients, their locations and their hours of service. On the AHIN provider detail page, providers will be able to update their patient restrictions under the network tab and update their office hours under the provider association tab. Reminders will also be published in subsequent editions of the Providers' News as well as monthly reminders on AHIN.

New modifiers to replace modifier 59

On January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) added four new modifiers to further define modifier 59. These four new modifiers can be used instead of modifier 59 (assuming the requirements for modifier 59 are met.) The new modifiers and their descriptions are noted below.

These new modifiers are set up in Claim Check Plus to work in the same manner as modifier 59, but are not included in C3 (Clear Claim Connection). Providers utilizing C3 will need to continue using modifier 59.

Modifier		Description
XE	Separate encounter	Service that is distinct because it occurred during a separate encounter.
XP	Separate practitioner	Service that is distinct because it was performed by a different practitioner.
XS	Separate structure	Service that is distinct because it was performed on a different organ/structure.
XU	Unusual non-overlapping service	The use of a service that is distinct because it does not overlap usual components or the main service.

Implant invoice requirement change

On November 1, 2011, Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage began working with hospitals and ambulatory surgical centers across the state in an effort to reduce administrative duties. A charge threshold was implemented for each provider that determined whether an invoice would be required to verify pricing for an implant or if the amount indicated in the 2400 Loop (claim line level) of the electronic claim would be used as the allowance.

Arkansas Blue Cross, BlueAdvantage and Health Advantage reserve the right to audit claim lines with billed amounts under the established thresholds. The most recent audit was performed by the Facility Reimbursement & Pricing department and concluded in May of 2015. During their review, claims from over 40 providers were audited. Overall results showed that providers were performing very well. However, the audit also revealed that some providers were submitting purchase orders instead of the manufacturer's invoice as proof of cost.

Beginning January 1, 2016, when an invoice is requested, Arkansas Blue Cross, BlueAdvantage and Health Advantage will no longer accept a purchase order in place of the manufacturer's invoice. For claims submitted on or after January 1, 2016, the manufacturer's invoice will be required to be submitted when implant invoices are requested.

As a reminder, implants are reimbursed at the provider's cost, plus applicable taxes and shipping and handling charges. In some cases, the vendor does not charge sales tax but the provider is required to pay sales and use tax to the State of Arkansas which ranges from 7.5 percent to 9 percent. When a vendor has not billed a provider for sales tax, it is acceptable for the provider to add the sales and use tax paid as part of their cost. In order to be reimbursed for shipping and handling charges, the cost must be on the manufacturer's invoice.

Please contact your Network Development Representative with any questions or email nkgrove@arkbluecross.com.

Medi-Pak® Advantage Part D prescriber requirements

CMS has made changes for any physician or other eligible professional (collectively referred to as "Providers") who prescribe Medicare Advantage (Part D) covered drugs. Providers must either enroll in the Original Medicare program or "opt out" in order to prescribe covered medications to their patients who have a Part D prescription drug benefit plan. Providers who are not enrolled should do so before January 1, 2016 to allow for the processing of applications and to ensure enrollees will continue to receive their Part D covered prescriptions.

Please note: Part D benefit plans will not be allowed to cover drugs that are prescribed by Providers who have not enrolled with or have not opted out of the Medicare program.

To comply with the CMS change Arkansas Blue Cross and Blue Shield will require all providers to be enrolled in Original Medicare before they can be considered for participation in any of its Medi-Pak® Advantage networks, including the Private Fee For Service (PFFS), Local Preferred Provider Organization (LPPO) or Health Maintenance Organization (HMO).

Liver biopsy and pathology reports for hepatitis C

Coverage criteria for direct antiviral agents for the treatment of chronic Hepatitis C requires a METAVIR fibrosis staging of >F2 (or equivalent histologic description by an alternative staging system such as Batts-Ludwig) that identifies architectural distortion of the portal triad with septal or bridging fibrosis. The gold standard for this information is a liver biopsy.

For some members with higher levels of fibrosis, APRI and FIB-4 are straightforward calculations using common blood tests (AST/ALT and platelet count) with demonstrated specificity which may be used with other findings (e.g. splenomegaly, portal hypertension, imaging evidence of cirrhosis, etc.) to allow a determination without biopsy. Please ensure all pathology reports have a detailed microscopic description as well as documentation of the staging system used for determination of fibrosis.

Medi-Pak® Advantage and CPT Category II codes

Current Procedural Terminology (CPT) Category II codes are tracking codes utilized by CMS to facilitate performance measurements. These codes ease the administrative burden of chart reviews for many HEDIS[1] performance measures. They can also support organizational quality improvement efforts and incentive programs.

Arkansas Blue Cross and Blue Shield understands that our providers are one of the most important factors in achieving improved quality performance goals. While currently conducting outreach to provider offices to obtain lab reports of HgbA1c tests for diabetic members, there is an opportunity to reduce contact with the health plan by providing additional information about lab results via claim submissions through the use of CPT II codes.

Beginning January 1, 2016 when billing the HgbA1c screening CPT code 83036, providers must also bill the associated CPT Category II codes which represent results of the tests in the form of a range of values. The following table lists the selected lab test, the billable CPT Category I code, the correlated CPT Category II codes and the associated value range.

Laboratory Test	CPT Code	CPT II Code	Associated Value Range
HbA1c screening	83036	3044F	Less than 7.0%
HbA1c screening	83036	3045F	Between 7.0% and 9.0%
HbA1c screening	83036	3046F	Greater than 9.0%

Further information on the use of CPT II codes will be available during September and October 2015. Please contact your Network Development Representative for further details and/or questions. We look forward to continued work with providers to both provide and report the quality care we provide to our Medi-Pak® Advantage members.

[1]The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance.

Medi-Pak Advantage® and Matrix Medical Network

Arkansas Blue Cross and Blue Shield continues to support our goal and our provider's efforts in providing high quality patient care. As such, Arkansas Blue Cross has joined with Matrix Medical Network to offer our Medi-Pak Advantage® members a no-cost, in-home health visit from a nationally certified nurse practitioner.

The in-home health visit is a one-on-one health evaluation to help identify any symptoms or risk factors found in the home that should receive further medical evaluation. This information can be helpful in coordinating access to appropriate medical services. A summary of a patients' evaluation will be released to their provider upon completion. A detail copy of the assessment may also be requested. Please note these visits are designed to enhance (not replace) the relationship between a provider and their patient. Matrix providers will encourage and/or assist our members in following up with their PCP as applicable.

Matrix Medical will be contacting Medi-Pak Advantage® members for this voluntary program beginning September 1, 2015. Please encourage your Medi-Pak Advantage® patients to take advantage of this valuable service.

If you have questions or would like more information regarding the program, please contact Angie Trammell, MSN, RN, PAHM at 501-378-2907 or aktrammell@arkbluecross.com.

Update: special alert on Private Option terminations

July 31, 2015 Terminations Status:

Based on information from the State of Arkansas, Arkansas Blue and Cross Blue Shield has re-instated many of the member records that were previously terminated July 31, 2015.

Arkansas Blue Cross has now revalidated all pending claims received for these members and other members terminated July 31, 2015, that were not reinstated by the State of Arkansas, with dates of service of August 1, 2015 and later (claims with the message "Private Option - claim on hold pending eligibility determination by the State of Arkansas").

- Pending Claims for the reinstated members are now being passed to the payer for adjudication.
- Pending Claims for non-reinstated member will have the claim message changed to the reject/error message "Coverage for This Patient Was Not In Effect on This Date of Service" and the claim will be rejected and will not be passed to the payer for adjudication.

Please note: Some of these members may have enrolled in new Metallic coverage with another carrier or Arkansas Blue Cross or may be eligible for traditional Medicaid, etc. Please check with your patient for current coverage information.

August 31, 2015 Terminations Processing

Beginning September 1, 2015, Arkansas Blue Cross will start holding claims for those individuals whose health insurance coverage was terminated August 31, 2015, by the State of Arkansas for not completing income verification paperwork in a timely manner. This "temporary" claims hold by Arkansas Blue Cross will be until the end of September. Please note, similar to the July 31, 2015 terminations, Arkansas Blue Cross expects many of these terminated members will have their Private Option coverage reinstated back to September 1, 2015.

(Continued on page 11)

Update: special alert on Private Option terminations (Continued from page 10)

When this reinstatement occurs, Arkansas will release the claims being held for adjudication. After September 30, Arkansas Blue Cross will begin releasing remaining claims on members not reinstated. Please note some of these members may have enrolled in new Metallic coverage, with another carrier or Arkansas Blue Cross, or may be eligible for traditional Medicaid, etc. Please check with your patient for current coverage information.

Providers will not have to refile any of the claims placed on hold. These claims can be located in AHIN's "reject" file and can be identified with the following claims status message:

"Private Option - Claim on Hold pending eligibility determination by the State of Arkansas."

On AHIN, these Private Option members will continue to reflect that coverage has ended on August 31, 2015. Arkansas Blue Cross encourages providers to discuss with patients showing "termination" status to contact their local county offices for assistance in reinstating their coverage under the Private Option or if no longer eligible for the Private Option, patients should contact Arkansas Blue Cross for assistance.

Medi-Pak® Advantage utilization management program

Beginning January 2016, Arkansas Blue Cross and Blue Shield's Medicare Advantage plans (Medi-Pak® Advantage HMO and Medi-Pak® Advantage LPPO) will implement a new utilization management program. The program is designed to promote quality, cost effective and medically appropriate services. The program uses a comprehensive approach by integrating key medical and utilization management activities so Arkansas Blue Cross can achieve its goals for members. Their primary goals are:

1. To achieve effective, high-quality outcomes that meet the expectations of members, purchasers and clinical health care professionals by ensuring that medically necessary care is delivered in the appropriate setting at the time such services are needed.
2. To monitor effective and efficient medical utilization of services.
3. To monitor member progress toward expected outcomes, resource use, and efficient and effective transitions across the continuum of care.

The utilization management program will consist of the following services in the areas of acute care management, transitions of care and pharmacy care management. The specific activities will include:

1. Prior authorization services for inpatient admissions, skilled nursing facility admissions, long-term acute care hospital admissions, and inpatient rehabilitation admissions.
2. Fourteen-day bundling for readmissions.
3. Prior authorization for medications covered by Medicare Part B.

Arkansas Blue Cross will offer outreach and provider training with respect to the program implementation and process to ensure quality care is provided to Medi-Pak® Advantage HMO and LPPO members. The Medi-Pak® Advantage case management team will provide more detailed information on the new process in September and October 2015.

If you have questions, please contact Medi-Pak® Advantage Case Management at 1-800-285-6658.

Please note: This does not change filing for members with Arkansas Blue Cross Medi-Pak Supplemental coverage.

Medi-Pak® Advantage claims vendor changing, submit claims now for timely processing

Beginning in 2016, Arkansas Blue Cross and Blue Shield will transition the Medi-Pak® Advantage claims payment vendor from TMG to Blue Cross Blue Shield of Michigan. This transition is a result of an innovative Medicare Advantage partnership with Blue Cross of Michigan that will allow Arkansas Blue Cross to better serve our members and providers. The transition should be seamless for our providers.

While Blue Cross of Michigan will provide back office support and handle enrollment, claims and customer service, Arkansas Blue Cross and Blue Shield will continue our responsibility for the CMS contracts and will continue to support Arkansas providers who care for our Medi-Pak® Advantage members. Effective January 1, 2016, the following changes will take place:

- Blue Cross of Michigan will begin processing claims, handling appeals and grievances dated January 1, 2016 and beyond.
- TMG will have a limited time to finish processing claims dated prior to January 1, 2016.
- Arkansas Blue Cross will continue handling appeals and grievances dated prior to January 1, 2016.

Arkansas Blue Cross encourages our providers to submit all Medi-Pak® Advantage claims dated prior to January 1, 2016 as soon as possible allowing TMG as much time to process claims as possible. Claims with dates of service prior to January 1, 2016 that are submitted after April 1, 2016 may result in delayed payment. However, Medi-Pak® Advantage's claims submission process will not change. Providers should continue to submit paper and electronic claims in the same manner as you do now.

A new dedicated provider service line option will be available when calling with questions regarding this transition. Arkansas Blue Cross will provide updated information regarding the transition later this fall.

BCBS Axis℠ cost

In previous issues of Providers' News, Arkansas Blue Cross and Blue Shield provided information regarding the National Consumer Cost Tool created by the Blue Cross Blue Shield Association. Improvements have been made as well as a new name: Blue Cross Blue Shield Axis℠.

Using aggregate cost data from more than 2.3 billion procedures annually, Blue Cross Blue Shield Axis℠ (BCBS Axis℠) powers employee tools and employer benchmark analytics with scalable, deep and accurate information on the cost of care in all areas of the U.S.

BCBS Axis℠ cost data provides real claims-driven costs in urban and rural communities for more than 1,630 treatment categories, eliminating a need to extrapolate data to cover geographic or provider gaps in coverage that can create inaccuracies.

How It's Used?

Employers

BCBS Axis℠ cost data provides employers and their local Blue Plan with meaningful benchmarks to guide current and future healthcare benefit decisions.

- **Savings Opportunity Analysis:** Blue Plans can analyze the costs incurred

(Continued on page 13)

BCBS Axis cost (Continued from page 12)

by employees to help employers identify potential cost-saving opportunities by top MSA and treatment category.

- **Benefit Differentials*:** Employers may limit coverage or incent use of particular providers for identified specialty care procedures, such as knee and hip replacements and cardiac care, by working with their local Blue Plan to tie benefit differentials to Blue Distinction® Centers and Blue Distinction Centers+. Channeling patients to providers that provide high-quality and cost-effective care may improve outcomes while lowering costs.
- **Reference-Based Benefit (RBB) Design:** Using the depth and breadth of Blue Cross national cost data to identify lower cost providers, employers may be able to limit coverage for certain specified services to a fixed dollar amount (reference price). Employees are responsible for costs above the reference price, creating incentives to shop smarter for common services and helping employers lower their healthcare costs without higher cost-sharing for employees.

Members/Employees

BCBS Axis℠ cost data powers member transparency tools and solutions, which guide decisions toward the most cost-effective care available in their area.

- **Cost estimator tools:** Enable members/employees in nearly every geography to comparison shop for common treatments and procedures based on estimated costs for more than 1,630 treatment categories.
- **Member out-of-pocket tools:** Allow members of participating Blue Plans to obtain estimates of the amount of money they may have to pay for healthcare services.
- **Concierge services, including member savings guidance:** Alert members of participating Blue Plans when a lower cost alternative is available for a routine or scheduled treatment.

Providers

De-identified, aggregate cost data can be shared with providers to improve local value-based programs and to empower providers to better manage the care and overall health of their patients, while containing costs. The data also delivers increased cost transparency for providers, enabling them to see how they compare against their peers.

BCBS Axis℠ cost data

BCBS Axis℠ has a distinct advantage when it comes to calculating cost. The breadth and depth of Blue Cross data allows for greater reliability and accuracy of cost estimates based on claims data from across the country.

BCBS Axis℠ cost data is real data derived from historical claims and member activity in almost every community and ZIP code, from urban to rural—not extrapolated to cover gaps in geographical coverage or provider history.

The Result

Accurate and actionable cost estimates on the most comprehensive list of treatment categories in the industry—more than 1,630—covering any "shoppable" procedure an employee/member might require.

More than 400 of the most commonly billed procedures:

- Inpatient (knee replacement)
- Outpatient (ACL repair by arthroscopy)
- Office visits (annual exams, immunizations)
- Diagnostic care (CT scan, MRI)

Expanding to more than 1,630 treatment categories, including:

- Allergy testing
- Physical therapy
- Immunizations
- Dialysis

*Benefit differentials are determined by the Employer and the local Blue Plan, and are not a feature of any Blue Distinction programs.

Place-of-service code for urgent care centers

This is a reminder that urgent care centers should use place-of-service code "20" for claims submission. Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage require all providers to use appropriate claims coding guidelines.

Coverage policy manual updates

Since June 2015, 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 Description
1999022	Percutaneous Angioplasty, Stenting and Atherectomy of the Lower Extremity, Abdominal Aortic and Visceral Arteries
2001009	Glucose Monitoring, Continuous
2003002	Whole Gland Cryosurgical Ablation of Prostate Cancer
2008010	Certified Nurse Practitioners
2008013	Certified Nurse Midwives
2008014	Physician Assistants
2008015	Clinical Nurse Specialist
2009019	Sleep Apnea, Testing
2011003	Chemodenervation, Botulinum Toxin for the Treatment of Chronic Migraine Headache
2011021	Preventive Services for Non-Grandfathered (PPACA) Plans: Cervical Cancer Screening
2011024	Preventive Services for Non-Grandfathered (PPACA) Plans: Tobacco use, Screening, Counseling and Interventions
2011029	Preventive Services for Non-Grandfathered (PPACA) Plans: Dental Caries Prevention in Preschool Children
2011033	Preventive Services for Non-Grandfathered (PPACA) Plans: Visual Impairment Screening In Children
2011045	Preventive Services for Non-Grandfathered (PPACA) Plans: Colorectal Cancer Screening
2011063	Scleral Contact Lens, Gas Permeable
2011066	Preventive Services for Non-Grandfathered (PPACA) Plans: Overview

Policy#	Policy Description
2012031	Preventive Services for Non-Grandfathered (PPACA) Plans: Well-Woman Visits for Adult Women
2012036	Preventive Services for Non-Grandfathered (PPACA) Plans: Anemia, Screening in Infants, Children and Adolescents
2012041	Preventive Services for Non-Grandfathered (PPACA) Plans: Pregnancy Screening, Sexually Active Females Without Contraception, Late Menses or Amenorrhea
2012055	Preventive Services for Non-Grandfathered (PPACA) Plans: Prevention of Falls in Community-Dwelling Older Adults
2013015	Treatment of Varicose Veins/Venous Insufficiency
2014003	Telemedicine Services-Pilot Policy
2014008	Infertility Services
2015001	Omalizumab (Xolair) for Chronic Urticaria
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients with Non-Small-Cell Lung Cancer
2015011	Vedolizumab (Entyvio) for Inflammatory Bowel Disease
2015012	Alcohol Injections for Treatment of Peripheral Neuromas
2015013	Genetic Test: Fanconi Anemia
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015015	Vagal Nerve Blocking Therapy for the Treatment of Obesity
2015016	Focal Treatments for Prostate Cancer
2015017	Genetic Test: Mutation Testing for Limb-Girdle Muscular Dystrophies
2015018	Electronic Brachytherapy for Nonmelanoma Skin Cancer
2015019	Vegf Inhibitors for the Treatment of Ocular Conditions (Bevacizumab) (Aflibercept) (Ranibizumab)
2015020	Genetic Test: Chek2 Mutations for Breast Cancer
2015021	Genetic Testing: Chek2 Mutations for Breast Cancer

Medicaid claims handling for Medicaid members

Blue Cross and Blue Shield Plans currently administer Medicaid programs in California, Delaware, Hawaii, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, South Carolina, Tennessee, Texas, Virginia and Wisconsin as a Managed Care Organization (MCO), providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each Blue Plan. Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out-of-state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires prior authorization.

Identifying Medicaid Members to Determine Eligibility and Benefits

Blue Plan ID cards do not always indicate that a member has a Medicaid product. Blue Plan ID cards for Medicaid members do not include the suitcase logo that you may have seen on most Blue Cross ID cards, but they do include a disclaimer on the back of the ID card providing information on benefit limitations. For members with such ID cards, you should obtain eligibility and benefit information and prior authorization for services using the same tools as you would for other Blue Plan members.

- Submit an eligibility inquiry by calling the BlueCard Eligibility Line at 800-676-BLUE.
- Submit an eligibility inquiry using BlueExchange.
- Obtain preservice review using the Electronic Provider Access (EPA) tool

Medicaid Reimbursement and Billing

Claims for all Blue Cross Medicaid members should be submitted to your local Blue Plan. If you are contracted with your local Blue Plan for Medicaid, your local Medicaid rates will only apply for Arkansas Blue Cross and Blue Shield members; they do not apply to out-of-state Medicaid members. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state. Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations (42 CFR 447.15).

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member's plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.

Medicaid Billing Data Requirements

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

(Continued on page 17)

Medicaid claims handling for Medicaid members (Continued from page 16)

Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims. These data elements and other data elements that are important to submit, when applicable, on Medicaid claims.

Effective March 2016, applicable Medicaid claims submitted without these data elements will be denied. Prior to March 2016, applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- National Drug Code
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- Billing Provider (Second) Address Line
- Billing Provider Middle Name or Initial
- (Billing) Provider Taxonomy Code
- (Rendering) Provider Taxonomy Code
- (Service) Laboratory or Facility Postal Zone or Zip Code
- (Ambulance) Transport Distance
- (Service) Laboratory Facility Name
- (Service) Laboratory or Facility State or Province Code
- Value Code Amount
- Value Code
- Condition Code
- Occurrence Codes and Date
- Occurrence Span Codes and Dates
- Referring Provider Identifier and Identification Code Qualifier
- Ordering Provider Identifier and Identification Code Qualifier
- Attending Provider NPI
- Operating Physician NPI
- Claim or Line Note Text
- Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT))
- Service Facility Name and Location Information
- Ambulance Transport Information
- Patient Weight
- Ambulance Transport Reason Code
- Round Trip Purpose Description
- Stretcher Purpose Description

Medicaid Encounter Data Reporting

The data elements mentioned above need to be included on Medicaid claims, so that Blue Plan MCOs are able to comply with encounter data reporting requirements applicable in their respective state.

Provider Enrollment Requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from your local Blue Plan regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement. To view provider enrollment requirements for Blue Cross Medicaid states, please visit [Insert Plan URL where information on provider enrollment requirements is posted].

(Continued on page 18)

Commonly Asked Questions

How do I submit Medicaid claims?

Medicaid claims should be submitted to your local Blue Plan in the same manner as you submit claims for other Blue Plan members. You will also receive your payment in the same manner, although the payment amount will likely be different from your contracted rate, or different from the Medicaid rate in the state in which you practice.

How do I know that I am seeing a Medicaid member?

Members enrolled in a Blue Plan Medicaid product are issued Blue Plan ID cards. Blue Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. Blue Plan ID cards for Medicaid members:

- Will not include a suitcase logo.
- Will contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness, for example, "This member has limited benefits outside of Arkansas Blue Cross. Providers should request eligibility/benefit information. Providers should always submit an eligibility inquiry if the Plan ID card has no suitcase logo and includes a disclaimer with benefit limitations, using the same tools available for BlueCard:
- BlueCard Eligibility Line
- BlueExchange

Because Plan member ID cards will not always indicate that the member is enrolled in a Medicaid product, you should always obtain eligibility and benefit information. With an eligibility response, you should receive information on Medicaid coverage.

What amount should I expect to receive for members that reside outside of Arkansas Blue Cross service area?

When billing for services rendered to an out-of-state Medicaid member, you will be reimbursed according to the member's home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

My state does not require me to include an NPI or NDC code and many of the other data elements listed above on a Medicaid claim. Why do I have to include these codes?

Most state Medicaid programs require NPI and NDC codes and the additional data elements (when applicable) to be populated on claims submitted for Medicaid members for encounter data reporting purposes. To ensure compliance with state Medicaid requirements, providers who bill for Medicaid members should include these data elements on applicable Blue Plan Medicaid claims or the claims may be pended or denied.

I do not often see Medicaid members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members in other states?

Many state Medicaid programs require providers to enroll before reimbursement may be provided by the Blue Plan. If you do not enroll with the state where required, the claim could be denied.

Whom do I contact if I have questions?

If you have questions, please call Arkansas Blue Cross and Blue Shield toll free at 1-800-800-4298.

(Continued on page 19)

Medicaid claims handling for Medicaid members (Continued from page 18

Exhibit 1 – Medicaid Billing Data Elements

Required Data Elements for Medicaid Claims NOTE: Effective March 2016, applicable Medicaid claims submitted without these data elements will be denied.				
837 Reference	**837 Professional[1] Data Element Reference**	**837 Institutional[2] Data Element Reference**	**Professional Paper Claim Item Reference (CMS1500)[3]**	**Institutional Paper Claim Form Locator (UB04)[4]**
National Drug Code	Loop 2410 LIN03	Loop 2410 LIN03	Item Number 24 Shaded Portion	Form Locator 43
Rendering Provider Identifier (NPI)	Loop 2310B NM109 unless overridden when reported in Loop 2420A NM109 ONLY when Rendering is different from Loop 2010AA Billing Provider	Loop 2310D NM109 unless overridden when reported in Loop 2420C NM109 ONLY when Rendering is different from Loop 2310A Attending Provider	Item Number 33A NPI# or Item Number 24J (Unshaded) Rendering Provider ID#	Form Locators 78-79 Form Locator 43 Line Level
Billing Provider NPI	Loop 2010AA NM109	Loop 2010AA NM109	Item Number 33A NPI#	Form Locator 56

Other Data Elements for Medicaid Claims NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.				
837 Reference	**837 Professional[1] Data Element Reference**	**837 Institutional[2] Data Element Reference**	**Professional Paper Claim Item Reference (CMS1500)[3]**	**Institutional Paper Claim Form Locator (UB04)[4]**
Billing Provider (Second) Address Line	Loop 2010AA N302	Loop 2010AA N302	Item Number 33 Billing Provider Information and Phone Number Line 2	Form Locator 1 Line 2
Billing Provider Middle Name or Initial	Loop 2010AA NM105	Loop 2010AA NM105	Item Number 33 Billing Provider Information and Phone Number Line 1	Form Locator 1 Line 1
(Billing) Provider Taxonomy Code	Loop 2000A PRV03	Loop 2000A PRV03	Item Number 33B Other ID #	Form Locator 81
(Rendering) Provider Taxonomy Code	Loop 2310B PRV03 unless overridden when reported in Loop 2420A PRV03	Not applicable for institutional claim	Item Number 24I ID Qualifier Number	Not applicable for institutional claim

(Continued on page 20)

Other Data Elements for Medicaid Claims NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.				
837 Reference	**837 Professional[1] Data Element Reference**	**837 Institutional[2] Data Element Reference**	**Professional Paper Claim Item Reference (CMS1500)[3]**	**Institutional Paper Claim Form Locator (UB04)[4]**
(Service) Laboratory or Facility Postal Zone or Zip Code	Loop 2310C N403 unless overridden when reported in Loop 2420C N403	Loop 2310E N403	Item Number 32 Service Facility Location Information Line 3	Form Locator 1 Line 3
(Ambulance) Transport Distance	Loop 2300 CR106 unless overridden when reported in Loop 2400 CR106	Loop 2400 SV205 with applicable revenue code	Not reportable on 1500 form	Form Locator 42 with applicable revenue code
(Service) Laboratory Facility Name	Loop 2310C NM103 unless overridden when reported in Loop 2420C NM103	Loop 2310E NM103	Item Number 32 Service Facility Location Information Line 1	Form Locator 1 Line 1
(Service) Laboratory or Facility State or Province Code	Loop 2310C N402 unless overridden when reported in Loop 2420C N402	Loop 2310E N402	Item Number 32 Service Facility Location Information Line 3	Form Locator 1 Line 3
Value Code Amount	Not applicable for professional claim	Loop 2300 HI in 5th position within the composite data element (Value Information HI) Up to 24 value codes may be reported with a corresponding amount	Not applicable for professional claim	Form Locators 39-41 Up to 12 value codes may be reported with a corresponding amount Form Locator 81 after above are exhausted
Value Code	Not applicable for professional claim	Loop 2300 HI in 2nd position within the composite data element (Value Information HI) Up to 24 value codes may be reported	Not applicable for professional claim	Form Locators 39-41 Up to 12 value codes may be reported Form Locator 81 after above are exhausted
Condition Code	Loop 2300 HI in 2nd position within the composite data element (Condition Information HI) Up to 24 condition codes may be reported	Loop 2300 HI in 2nd position within the composite data element (Condition Information HI) Up to 24 condition codes may be reported	Item Number 10d	Form Locators 18-28 Up to 11 condition codes may be reported Form Locator 81 after above are exhausted

(Continued on page 21)

Other Data Elements for Medicaid Claims NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.				
837 Reference	**837 Professional[1] Data Element Reference**	**837 Institutional[2] Data Element Reference**	**Professional Paper Claim Item Reference (CMS1500)[3]**	**Institutional Paper Claim Form Locator (UB04)[4]**
Occurrence Codes and Dates	Not applicable for professional claim	Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Information HI) Up to 24 occurrence codes and associated dates may be reported	Not applicable for professional claim	Form Locators 31-34 Up to 8 occurrence codes and associated dates may be reported Form Locators 35-36 (FROM field) may be used when available Form Locator 81 after above are exhausted
Occurrence Span Codes and Dates	Not applicable for professional claim	Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Span Information HI) Up to 24 occurrence codes and associated dates may be reported	Not applicable for professional claim	Form Locators 35-36 Up to 4 occurrence span codes and associated dates may be reported Form Locator 81 after above are exhausted
Referring Provider Identifier and Identification Code Qualifier	Loop 2310A NM108/09 or REF01/02 unless overridden when reported in Loop 2420F NM108/09 or REF01/02	Loop 2310F NM108/09 or REF01/02 unless overridden when reported in Loop 2420D NM108/09 or REF01/02	Item Number 17a Other ID# or 17b NPI #	Form Locators 78-79
Ordering Provider Identifier and Identification Code Qualifier	Loop 2420E NM108/09 or REF01/02 when a different from the service line Rendering Provider	Not applicable for institutional claim	Item Number 17a Other ID number or 17b NPI number	Not applicable for institutional claim
Attending Provider NPI	Not applicable for professional claim	Loop 2310A NM109	Not applicable for professional claim	Form Locator 76 Line 1
Operating Physician NPI	Not applicable for professional claim	Loop 2310B NM109 unless overridden when reported in Loop 2420A NM108/09	Not applicable for professional claim	Form Locator 77 Line 1
Claim or Line Note Text	Loop 2300 NTE02 unless overridden when reported in Loop 2400 NTE02 (Line Note NTE)	Loop 2300 NTE02	Item Number 19 Additional Claim Information	Form Locator 80

(Continued on page 22)

Other Data Elements for Medicaid Claims NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.				
837 Reference	**837 Professional[1] Data Element Reference**	**837 Institutional[2] Data Element Reference**	**Professional Paper Claim Item Reference (CMS1500)[3]**	**Institutional Paper Claim Form Locator (UB04)[4]**
Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT))	Loop 2300 CRC02, CRC03 (EPSDT Referral CRC)Loop 2300 CRC04 and CRC05 are used when additional conditions apply	Loop 2300 CRC02, CRC03 (EPSDT Referral CRC)Loop 2300 CRC04 and CRC05 are used when additional conditions apply	Item Number 24H EPSDT/Family Plan	Form Locators 18-28
Service Facility Name and Location Information	Not applicable for professional claim	Loop 2310E	Not applicable for professional claim	Form Locator 1
Ambulance Transport Information Patient Weight Ambulance Transport Reason Code Round Trip Purpose Description Stretcher Purpose Description	Loop 2300 CR102 CR104 CR109 CR110	Not applicable for institutional claim	Not reportable on 1500 form	Not applicable for institutional claim

Endnotes

[1]ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222, Type 1 Errata to Health Care Claim: Professional (837), June 2010, ASC X12N/005010X222A1 and Errata to Health Care Claim: Professional (837), January 2009, ASC X12N/005010X222E1.

[2]ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, Type 1 Errata to Health Care Claim: Institutional (837), October 2007, ASC X12N/005010X223A1, Type 1 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12N/005010X223A2 and Errata to Health Care Claim: Institutional (837), January 2009, ASC X12N/005010X223E1.

[3]National Uniform Claim Committee (NUCC). 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12. Version 2.0. July 2014.

[4]National Uniform Billing Committee (NUBC). Official UB-04 Data Specifications Manual 2015. Version 9.00. July 2014.

Fee schedule: additions and changes

The following additions and changes were made to Arkansas Blue Cross and Blue Shield's fee schedule:

CPT / HCPS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
80339	$27.06	$1.89	$25.17	$0.00	$1.89	$0.00
80340	$27.06	$1.89	$25.17	$0.00	$1.89	$0.00
80341	$27.06	$1.89	$25.17	$0.00	$1.89	$0.00
90736	$187.89	$0.00	$0.00	$0.00	$0.00	$0.00
A7048	$69.98	$0.00	$0.00	$0.00	$0.00	$0.00
C9025	$510.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9026	$16.06	$0.00	$0.00	$0.00	$0.00	$0.00
C9027	$43.16	$0.00	$0.00	$0.00	$0.00	$0.00
C9113	BR	$0.00	$0.00	$0.00	$0.00	$0.00
C9121	$22.70	$0.00	$0.00	$0.00	$0.00	$0.00
C9248	BR	$0.00	$0.00	$0.00	$0.00	$0.00
C9254	$0.27	$0.00	$0.00	$0.00	$0.00	$0.00
C9257	$0.25	$0.00	$0.00	$0.00	$0.00	$0.00
C9275	$832.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9290	$15.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9293	$260.45	$0.00	$0.00	$0.00	$0.00	$0.00
C9442	$30.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9443	$29.80	$0.00	$0.00	$0.00	$0.00	$0.00
C9444	$24.17	$0.00	$0.00	$0.00	$0.00	$0.00
C9446	$1.18	$0.00	$0.00	$0.00	$0.00	$0.00
C9447	BR	$0.00	$0.00	$0.00	$0.00	$0.00
C9450	$90.81	$0.00	$0.00	$0.00	$0.00	$0.00
C9451	BR	$0.00	$0.00	$0.00	$0.00	$0.00
C9452	$0.08	$0.00	$0.00	$0.00	$0.00	$0.00
C9453	$23.98	$0.00	$0.00	$0.00	$0.00	$0.00
C9454	$269.23	$0.00	$0.00	$0.00	$0.00	$0.00
C9455	$85.80	$0.00	$0.00	$0.00	$0.00	$0.00

Fee schedule: injection codes

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

CPT/ HCPCS Code	Allowed
90371	$124.76
90375	$254.52
90376	$264.19
90585	$127.34
90586	$127.34
90675	$244.33
90691	$93.96
90714	$20.74
90715	$31.58
90732	$85.81
A9575	$0.19
A9578	$2.06
A9579	$1.98
A9581	$14.59
A9583	$15.29
A9585	$0.41
J0129	$37.25
J0130	$931.70
J0132	$2.13
J0135	$708.40
J0153	$0.84
J0171	$0.12
J0180	$164.25
J0207	$373.44
J0221	$159.74
J0256	$4.56

CPT/ HCPCS Code	Allowed
J0257	$4.28
J0278	$1.17
J0280	$10.04
J0285	$19.09
J0287	$12.50
J0290	$1.10
J0295	$2.16
J0348	$0.64
J0360	$5.16
J0400	$0.77
J0401	$4.26
J0456	$3.67
J0461	$0.06
J0470	$46.82
J0475	$170.65
J0476	$78.98
J0480	$2,959.25
J0485	$3.95
J0490	$42.16
J0500	$56.66
J0515	$23.99
J0558	$6.21
J0561	$7.88
J0583	$3.88
J0585	$5.96
J0586	$7.85

CPT/ HCPCS Code	Allowed
J0587	$12.10
J0588	$4.82
J0592	$3.01
J0594	$34.54
J0595	$2.27
J0597	$42.15
J0598	$56.54
J0600	$5,385.47
J0610	$1.79
J0630	$1,209.34
J0636	$0.43
J0637	$13.04
J0638	$95.14
J0640	$3.73
J0641	$1.81
J0670	$2.40
J0690	$0.89
J0692	$2.69
J0694	$5.01
J0697	$2.60
J0698	$1.80
J0702	$6.09
J0712	$2.22
J0713	$2.10
J0717	$6.23
J0725	$19.31

CPT/ HCPCS Code	Allowed
J0735	$18.19
J0740	$568.63
J0743	$4.25
J0744	$1.68
J0770	$12.54
J0775	$39.57
J0780	$12.22
J0840	$2,644.72
J0850	$1,105.88
J0878	$0.79
J0881	$4.22
J0882	$4.22
J0885	$12.63
J0886	$12.63
J0894	$25.26
J0895	$9.23
J0897	$15.74
J1000	$13.00
J1020	$3.08
J1030	$3.73
J1040	$6.72
J1100	$0.14
J1110	$160.82
J1120	$21.88
J1160	$24.07
J1162	$2,453.48

CPT/ HCPCS Code	Allowed
J1165	$0.68
J1170	$1.90
J1190	$143.74
J1200	$0.57
J1205	$141.89
J1212	$93.67
J1230	$10.22
J1240	$5.35
J1245	$0.82
J1250	$6.18
J1260	$7.88
J1265	$0.68
J1267	$0.70
J1270	$1.26
J1290	$390.40
J1300	$222.48
J1325	$16.05
J1335	$40.85
J1364	$53.17
J1380	$11.58
J1410	$215.68
J1430	$390.09
J1438	$323.17
J1442	$1.04
J1446	$4.10
J1450	$4.08
J1458	$381.50
J1459	$39.81
J1460	$30.27

CPT/ HCPCS Code	Allowed
J1556	$40.57
J1557	$37.99
J1560	$302.74
J1561	$41.39
J1566	$33.54
J1568	$40.21
J1569	$40.34
J1570	$77.83
J1571	$55.99
J1572	$36.14
J1580	$1.32
J1602	$25.01
J1610	$183.11
J1626	$0.41
J1630	$1.87
J1631	$21.02
J1640	$22.45
J1644	$0.21
J1645	$13.18
J1650	$1.41
J1652	$3.71
J1670	$350.85
J1720	$7.40
J1740	$118.67
J1742	$144.98
J1743	$517.31
J1750	$12.57
J1800	$2.69
J1815	$0.76

CPT/ HCPCS Code	Allowed
J1817	$7.65
J1885	$0.72
J1930	$49.28
J1931	$30.63
J1940	$1.54
J1950	$851.41
J1955	$11.03
J1956	$2.32
J1980	$25.80
J2010	$10.79
J2020	$40.13
J2150	$1.55
J2175	$4.70
J2210	$4.69
J2270	$1.51
J2274	$8.70
J2278	$7.36
J2280	$6.27
J2300	$2.61
J2310	$27.01
J2315	$3.31
J2323	$17.06
J2353	$162.74
J2354	$1.28
J2355	$402.75
J2357	$30.01
J2360	$4.85
J2400	$25.71
J2410	$3.00

CPT/ HCPCS Code	Allowed
J2425	$16.21
J2426	$8.69
J2430	$10.86
J2469	$21.67
J2501	$1.39
J2503	$1,073.44
J2504	$287.36
J2505	$3,825.76
J2507	$1,213.71
J2510	$21.97
J2515	$39.45
J2540	$0.88
J2543	$2.23
J2545	$113.29
J2550	$1.66
J2560	$29.98
J2562	$318.05
J2597	$7.91
J2675	$1.09
J2680	$24.89
J2690	$50.43
J2700	$1.83
J2720	$1.03
J2724	$15.94
J2730	$95.58
J2760	$165.36
J2765	$0.71
J2770	$311.90
J2778	$409.27

CPT/ HCPCS Code	Allowed
J2780	$1.12
J2783	$236.51
J2785	$54.73
J2788	$24.58
J2790	$86.79
J2791	$4.94
J2792	$19.61
J2794	$7.17
J2796	$59.13
J2800	$56.80
J2805	$94.24
J2810	$0.30
J2820	$33.00
J2916	$2.74
J2920	$2.52
J2930	$3.68
J2997	$75.98
J3000	$13.11
J3010	$0.51
J3070	$120.13
J3095	$5.04
J3101	$91.96
J3105	$3.57
J3230	$24.62
J3240	$1,488.94
J3243	$2.41
J3250	$24.64
J3260	$2.38

CPT/ HCPCS Code	Allowed
J3262	$4.02
J3300	$3.84
J3301	$1.84
J3315	$212.41
J3357	$171.09
J3360	$6.43
J3370	$3.67
J3385	$363.26
J3396	$11.33
J3410	$1.82
J3411	$3.42
J3415	$7.71
J3420	$4.57
J3430	$3.24
J3465	$4.43
J3473	$0.36
J3480	$0.14
J3485	$1.55
J3486	$14.07
J3489	$33.53
J7030	$1.63
J7040	$0.82
J7042	$0.65
J7050	$0.41
J7060	$1.44
J7070	$2.67
J7120	$1.53
J7180	$7.71

CPT/ HCPCS Code	Allowed
J7183	$1.03
J7185	$1.24
J7189	$2.12
J7190	$1.01
J7192	$1.21
J7194	$1.20
J7195	$1.53
J7197	$3.41
J7198	$1.90
J7201	$2.92
J7311	$19,156.71
J7312	$208.94
J7321	$92.88
J7323	$158.95
J7324	$177.21
J7325	$13.23
J7326	$584.64
J7336	$2.91
J7500	$0.26
J7502	$3.10
J7504	$1,074.13
J7506	$0.08
J7507	$0.97
J7509	$0.53
J7510	$0.10
J7511	$646.14
J7515	$0.87
J7516	$38.20

CPT/ HCPCS Code	Allowed
J7517	$1.32
J7518	$3.13
J7520	$13.72
J7525	$155.42
J7527	$7.35
J7605	$7.46
J7606	$8.82
J7608	$5.05
J7612	$0.27
J7613	$0.06
J7614	$0.09
J7626	$5.40
J7631	$0.83
J7639	$40.09
J7644	$0.23
J7682	$70.56
J7686	$526.69
J8501	$9.74
J8510	$13.15
J8520	$6.57
J8521	$21.43
J8530	$4.27
J8540	$0.26
J8560	$62.16
J8600	$11.21
J8610	$1.02
J8700	$3.05
J8705	$104.51

CPT/ HCPCS Code	Allowed
J9000	$2.83
J9017	$61.43
J9019	$390.64
J9025	$3.39
J9027	$143.51
J9031	$127.34
J9033	$25.09
J9035	$72.39
J9040	$22.31
J9041	$48.62
J9042	$124.60
J9043	$152.54
J9045	$4.00
J9047	$31.79
J9050	$2,444.28
J9055	$55.71
J9065	$20.61
J9070	$57.83
J9098	$595.30
J9100	$0.92
J9120	$965.99
J9130	$4.08
J9150	$28.28
J9155	$3.72
J9171	$3.94
J9178	$1.60
J9179	$106.00
J9181	$0.67

CPT/ HCPCS Code	Allowed
J9185	$76.81
J9190	$2.30
J9200	$62.65
J9201	$8.53
J9207	$75.05
J9208	$32.23
J9209	$3.39
J9211	$40.40
J9214	$23.52
J9217	$229.71
J9218	$7.74
J9225	$3,071.97
J9226	$21,329.83
J9228	$142.43
J9230	$242.24
J9245	$1,357.98
J9250	$0.24
J9260	$2.35
J9261	$152.72
J9263	$0.56
J9264	$10.24
J9267	$0.18
J9268	$1,567.89
J9293	$32.97
J9301	$56.36
J9302	$50.93
J9303	$104.36
J9305	$63.79

CPT/ HCPCS Code	Allowed
J9307	$220.86
J9310	$777.47
J9315	$301.63
J9320	$342.14
J9328	$6.52
J9330	$64.30
J9351	$1.54
J9355	$90.73
J9357	$1,144.40
J9360	$2.87
J9370	$4.95
J9371	$2,317.75
J9390	$10.42
J9395	$95.86
J9400	$8.60
Q0138	$0.84
Q0139	$0.84
Q0162	$0.05
Q0163	$0.25
Q0164	$0.05
Q0166	$1.86
Q0167	$1.75
Q0169	$0.04
Q0180	$104.77
Q2043	$34,216.84
Q2050	$502.15
Q3027	$40.24
Q4074	$113.85

CPT/ HCPCS Code	Allowed
Q4081	$1.26
Q4101	$32.53
Q4102	$11.27
Q4104	$34.04
Q4105	$19.62
Q4106	$35.73
Q4107	$100.55
Q4108	$32.73
Q4110	$38.69
Q4111	$7.22
Q4112	$265.23
Q4113	$265.23
Q4114	$1,572.66
Q4115	$7.26
Q4116	$33.79
Q4121	$37.63
Q4123	$13.78
Q4131	$209.62
Q9956	$36.83
Q9957	$55.24
Q9960	$0.20
Q9961	$0.22
Q9965	$0.98
Q9966	$0.20
Q9967	$0.15

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PROVIDERS' NEWS STAFF

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