Arkansas Blue Cross and Blue Shield

Providers' News

June 2003

Inside the June Issue:

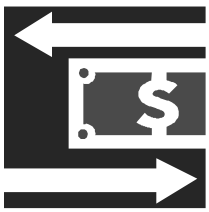
Please Note:

This newsletter contains information pertaining to Arkansas Blue Cross and Blue Shield, a mutual insurance company, its wholly owned subsidiaries and affiliates. This newsletter does not pertain to Medicare. Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

Electronic Payment Option Coming Soon:

To receive your claim payments for Arkansas Blue Cross and Blue Shield (except Federal Employee Program), Health Advantage and BlueAdvantage Administrators of Arkansas by electronic funds transfer directly to your financial institution, please call your local Provider Network Representative to request an enrollment packet.

Electronic payment option will be available in July, 2003. Arkansas Blue Cross and Blue Shield is looking forward to providing this new service to our providers.



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

Arkansas' FirstSource® PPO - Office Visit Copayments For Primary Care Physician & Specialty Care Physician:

Arkansas Blue Cross and Blue Shield is pleased to announce the addition of a specialty care physician office visit copay to our FirstSource PPO group product line. This optional rider was available for groups starting June 1, 2003.

The Primary Care Physician (PCP) and Specialty Care Physician (SCP) optional rider covers services performed in either the Primary Care Physician's office or the Specialty Care Physician's office at 100% after the appropriate copay.

Primary Care Physician Office Visit Copay:

- $20 Or $30

Specialty Care Physician Office Visit Copay

- $40 Or $50

The specialist copay rider includes a Primary PCP copay. The PCP copay covers the same services in this rider as has been covered in the PCP office visit copay rider we have been marketing. Groups may still purchase the PCP copay without the specialist copay.

The following services are covered under the PCP copay when performed in an in-network PCP's office and billed by the PCP:

- Office Visit
- Diagnostic X-Ray
- Lab Work
- Accident or Emergency Medical Care
- Surgery
- Allergy Shots
- Injections

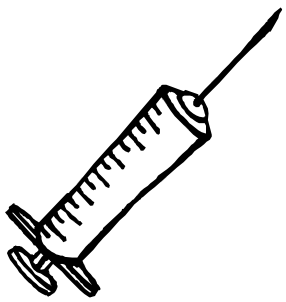
The following services are covered under the SCP copay when performed by an in-network specialist who performs a face-to-face exam or consult and bills all services on the same claim:

- Office Visit
- Lab Work
- Plain Film X-Ray
- Commonly administered injections
- Allergy Testing
- Audiology Testing

All other services performed in the PCP's or SCP's office that are covered by the medical plan will be subject to deductible and coinsurance. All services performed by out-of-network providers are subject to the deductible and coinsurance.

Arkansas' FirstSource® PPO - Specialty Care Physician Office Visit Copay: Types Of Injections Covered Under Copay:

- Anti-anxiety
- Antibiotics
- Anti-cholinergic
- Anti-convulsant
- Anti-depressive
- Anti-diuretic hormone
- Anti-dyskinetic
- Anti-emetic
- Anti-glaucoma
- Anti-gout
- Antihistamine
- Anti-hypertensive
- Anti-hypoglycemic
- Anti-psychotic
- Anti-ulcer
- Bronchodilator (injections only)
- Cardiac anti-arrhythmic
- Cholinergic
- Contraceptives
- Corticosteroids
- Diuretics
- Insulin
- Migraines - (only Dihydroergotamine Mesylt and Sumatriptan Succinate)
- Muscle Relaxants
- NSAID (parenteral)
- Opioids
- Peristaltic Stimulants
- Sedatives
- Sympathomimetic
- Vitamin D analog
- Vitamin K



Arkansas' FirstSource® - Specialty Care Physician Office Visit Copay: Type Of Injections Not Covered Under Copay:

Injections not included under the specialty care physician office visit copay include medications used primarily in the treatment of cancer, chemotherapy side effects, infertility, impotence, pregnancy problems, coagulation factor diseases, HIV, adenosine deaminase deficiency, and Gaucher's and other related diseases.Also, non-specific injection codes will not be covered under the copay.

Other types of injections not included under the copay are:

- Abortifacients,
- Alpha 1 proteinase inhibitors,
- Anabolic steroids,
- Anesthesia and those injections used to aid in other diagnostic tests, surgery, dialysis, or other injections,
- Anti-fungals,
- Anti-virals,
- Bone resorption inhibitors,
- Botox,
- Cultured chondrocytes implants,
- Hormones,
- Immunosuppressive drugs for transplants,
- Medications for filling/refilling infusion pumps,
- Pulmonary artery anti-hypertensives,
- Thrombolytic agents, or
- Tissue grafts.

ASE: USAble MCO Now Official Workers' Compensation Managed Care Organization for Arkansas State Employees:

Effective April 24, 2003, the Public Employee Claims Division (PECD) of the Arkansas Insurance Department will begin utilizing the workers' compensation managed care services of USAble Managed Care Organization.

After review of numerous bid proposals submitted by several state certified managed care organizations, the PECD chose the USAble MCO (an association of Arkansas' FirstSource PPO and Systemedic Corporation) to provide MCO services for over 49,000 Arkansas State Employees.

Total workers' compensation member access to Arkansas' FirstSource PPO will rise to over 811,000 Arkansas employees (15,000+ Arkansas employers) with the addition of the Arkansas State Employees.

Promotion of Dr. Jim Adamson to Corporate Vice President:

Arkansas Blue Cross and Blue Shield is pleased to announce that the Board of Directors of Arkansas Blue Cross recently endorsed the appointment of Dr. Jim Adamson to the position of Vice President and Chief Medical Officer. This promotion properly recognizes Dr. Adamson's position in terms of having overall responsibility for the clinical affairs of the enterprise and his contributions to the development of strategic direction.

Dr. Adamson has served as Medical Director since joining the Plan in May of 1992. In addition to providing clinical direction for our enterprise, he represents our Plan and the Blue Cross and Blue Shield system through his appointment by the American Medical Association as the Blue Cross Blue Shield Association representative to the AMA-CPT Committee. Dr. Adamson also serves on the BCBSA Medical Policy Panel, the National Committee of Physician Executives and frequently serves on ad-hoc committees at the request of the National Association.

Please join us in congratulating Dr. Adamson on this well deserved promotion.

Computed Tomographic Angiography for Acute Pulmonary Embolism (Helical/Spiral CT Angiography):

Coverage policy for this diagnostic procedure was recently reviewed. Staff consensus after this review was that current coverage policy should not be changed, but that the information gathered should be published for educational purposes.

Technique:
Computed tomographic images are obtained at mediastinal window settings after bolus contrast injection, often by peripheral IV. Image acquisition is accomplished by rapidly "spiraling" the scanner around the patient carriage from the top of the aortic arch to the base of the heart.

Seventy to eighty images are acquired over a 15-20 second breath-holding period (as feasible) during dynamic injection of contrast material (3-5 ml/sec). (Image acquisition is timed to optimal concentration of the contrast material in the pulmonary arterial system, often assisted by a scout injection of approximately 10 ml of contrast to assess circulation time.) Image reconstruction algorithms are then applied.

Quality images thus depend on multiple image-acquisition "heads", and necessitate a discrete and carefully-timed contrast bolus concentrating in the pulmonary vasculature during image acquisition.

Sensitivity and specificity of this technique for pulmonary emboli have been reported to be 70-100%, but vary widely. Because of the poor predictive value of scintigraphic lung scanning, and the invasive nature of contrast pulmonary angiography, this method is enjoying rapid acceptance into diagnostic clinical algorithms, even as doubt of its accuracy and applicability continues.

Position Papers by National Medical Societies:
The American College of Radiology, in its Appropriateness Criteria, listed CT angiography in 1999 as "indicated" in the evaluation of PE. The American College of Chest Physicians Consensus Committee on Pulmonary Embolism in 1998 stated that "A normal contrast-enhanced CT scan does not exclude PE", and recommended against its widespread use until validated.

The American Thoracic Society in a clinical practice guideline in 1999 stated: "This diagnostic modality is still under investigation and no firm general conclusions can be made without more extensive experience." The technique was not included in its recommended diagnostic algorithm.

Literature Review:

1. Acute pulmonary embolism: assessment of helical CT for diagnosis. Drucker EA et al; Radiology 1998; 209: 235. Prospective comparison of helical CT to contrast angiography in 47 patients, using multiple radiologists' readings, blinded to angiographic results. "Detection of pulmonary embolism with helical CT may be less accurate than previously reported. Helical CT may not have the ideal attributes of a first-line imaging study for the diagnosis of pulmonary embolism."

2. Sensitivity and specificity of helical computed tomography in the diagnosis of pulmonary embolism: a systematic review. Rathbun SW, et al; Ann Intern Med 2000; 132: 227. A Medline review of reports from 1986 to 1999 was conducted, and the authors conclude: "Use of helical CT in the diagnosis of pulmonary embolism has not been adequately evaluated." "Definitive large, prospective studies should be done to evaluate the sensitivity, specificity, and safety of helical CT for diagnosis of suspected pulmonary embolism."

3. The role of spiral volumetric computed tomography in the diagnosis of pulmonary embolism. Mullins MD et al; Arch Intern Med 2000; 160: 293. Eleven English-language studies reviewed, with the conclusion: "Spiral volumetric computed tomography may have a role as a "rule-in" test for large central emboli, but additional research is required to establish its place in clinical practice."

4. Diagnosis of pulmonary embolism with use of computed tomographic angiography. Ryu, JH et al.; Mayo Clinic Proceedings 2001; 76:59. This is one of several publications from the Mayo Clinic group describing the use of this modality in their hands, and proposing a diagnostic algorithm centered around computed tomography.

5. Clinically suspected pulmonary embolism: Is it safe to withhold anticoagulation after a negative spiral CT? Gottsater, A, et al.; European Radiology 2001; 11: 65. This is one of a number of prospective evaluations of the clinical safety of follow-up without anticoagulation, of patients at risk for pulmonary embolism but with a negative spiral CT.

6. Spiral computed tomography for the diagnosis of pulmonary embolism in critically ill surgical patients: a comparison with pulmonary angiography. Velmahos GC, et al; Arch Surg 2001; 136: 505. Helical CT and contrast angiography were compared in 22 critically ill surgical patients with clinical suspicion of PE, all with marked pulmonary parenchymal disease at the time. Sensitivity and specificity for CT was 45% and 82% respectively, with the conclusion: "Pulmonary angiography remains the gold standard for the diagnosis of PE in critically ill surgical patients. Computed tomographic pulmonary angiography needs further evaluation in this population."

7. Current strategies for the diagnosis of pulmonary embolus. Johnson, MS. J Vasc Interv Radiol 2002; 13: 13. This recent review presents a perspective in the form of an overview of the literature on the topic, and states: "…inter-observer agreement is persistently less than that of arteriography, and the potential for significant numbers of falsely positive or negative studies remains." "Despite the preponderance of evidence showing that the diagnostic accuracy of HCT for PE continues to require validation, that modality has leapt into common use at many centers."

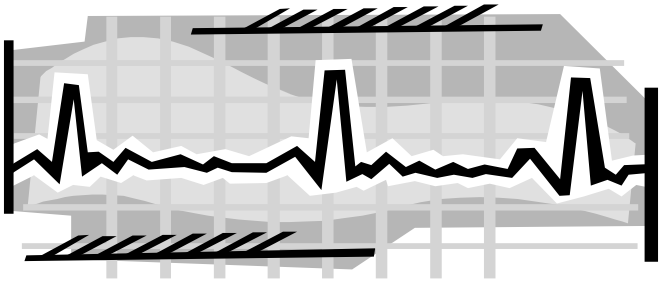
8. Overview of prospective investigation of pulmonary embolism diagnosis II (PIOPED II). Gottschalk, A, et al; Seminars in Nuclear Medicine 2002; 32: 173. This paper outlines PIOPED II, currently enrolling patients, "designed to assess the efficacy of the spiral computed tomographic pulmonary angiogram in patients suspected of having acute pulmonary embolism."

Independent Review:

The issue of the accuracy of CT angiography, and its use to diagnose or exclude acute pulmonary embolism, was sent for out-of-state independent review. Both reviewers were professors at academic centers. A radiologist disagreed with the conclusion below, while a pulmonologist agreed.

Conclusion:

Computed tomographic angiography to diagnose acute pulmonary embolism is of uncertain accuracy in clinical practice. Its incorporation as a first-line diagnostic tool has not been enthusiastically accepted by specialty societies. This conclusion may change as newer technology emerges.



Pharmacy: AdvancePCS SpecialtyRx™:

AdvancePCS SpecialtyRx™ has been selected as a preferred Specialty Medication provider of Synvisc®, Supartz®, Hyalgan®, Aldurazyme®, Fuzeon®, Synagis®, and Thyrogen® effective July 1, 2003.

AdvancePCS SpecialtyRx™ offers you and your patients, our members, a convenient way to order high-tech specialty medications and supplies at a considerable discount for the member. In addition, AdvancePCS SpecialtyRx™ offers a pharmaceutical care management program designed to provide our members with reliable pharmacy care management throughout their treatment.

Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation and affiliates recently negotiated discounted pricing with AdvancePCS SpecialtyRx™ for Synvisc®, Supartz®, Hyalgan®, Aldurazyme®, Fuzeon®, Synagis®, and Thyrogen®. AdvancePCS SpecialtyRx™ is considered the preferred participating pharmacy for specialty medications.

Since these medications are routinely administered in the physician's office, the physician choosing to order specialty medications from AdvancePCS SpecialtyRx™ for members, will continue to be reimbursed for medication administration (administration is billed with CPT 20610). The physician will not take ownership of the drug through purchase and will avoid any inventory investment under this process.

Should the physician choose to dispense these medications without using AdvancePCS SpecialtyRx™, the physician will be reimbursed for medication administration (CPT 20610) and for the medication according to the new fee schedule effective July 1, 2003. In addition, the member SHOULD be held harmless and CAN NOT be billed for the difference between the Arkansas Blue Cross allowable and the physicians' charge.

Coverage and claims filing policies for Synvisc®, Supartz®, Hyalgan®, Aldurazyme®, Fuzeon®, Synagis®, and Thyrogen® administered in a physician's office are as follows:

- Prior approval of coverage is required . Call the prior authorization number, (501) 378-3392, for eligibility verification and to arrange the pharmacy contact for dispensing the medication to your office.
- Upon receipt of a prescription, AdvancePCS SpecialtyRx™ can dispense and ship the medication to the physician's office under the patient's name PRIOR to the scheduled administration date.
- AdvancePCS SpecialtyRx™ will file a medication claim with ABCBS or affiliate. The physician will then submit a medical claim for medication administration only (administration is billed with CPT 20610).

These provisions applies to Arkansas Blue Cross and Blue Shield, Health Advantage, and members accessing the Arkansas' FirstSource network of USAble Corporation.

Pharmacy - Important Prior Authorization Changes:

Effective **June 20, 2003**, the Pharmacy Prior Authorization phone number will change. Please note the changes.

The new phone number will be **(501) 378-3392** and the fax number will be **(501) 378-6980**.

Outpatient Facility Claims with Surgery Billed:

All outpatient facility claims submitted with a surgical procedure must also have a corresponding ICD9 Procedure Code indicated on the UB92 claim form in field 80.

Pharmacy - Copay Changes in Three Tier Plans:

Arkansas Blue Cross and Blue Shield, Health Advantage, Blue Advantage Administrators of Arkansas, USAble Life, and USAble Administrators will make several copay changes on June 15, 2003 in the non-sedating antihistamine class and ADD/ADHD class of medications for fully insured and self-insured plans that have the three tier copay plan design.

Tier 1: Generic prescription drugs which have the lowest co-payment.
Tier 2: Brand-name prescription drugs with the mid-range co-payment.
Tier 3: Brand-name prescription drugs which have the highest co-payment.

Non-Sedating Antihistamines:
On June 15 all dosage forms of Singulair®, Allegra®, and Allegra-D®, which are currently on second tier copay status in three tier copay plans, will move to third tier copay status. This will place all NSAs on the third tier copay level in three tier copay plans.

Letters will go out to all members currently taking Singulair® and Allegra® products to notify them of this action.

ADD/ADHD Medications:
Also, on June 15, 2003, the following copay changes will be made in the ADD/ADHD class of drugs in three tier copay plans.

1. Straterra® is a preferred medication and will move from third tier copay to second tier.
2. Concerta® will remain preferred and remain on second tier copay status.
3. The following medications will change from second tier copy to third tier copay status:
   - Adderall®
   - Adderall XR®
   - Cylert®
   - Dexedrine®
   - Dextrostat®
   - Metadate CD®
4. All generic medications in this class will remain at first tier copay status.

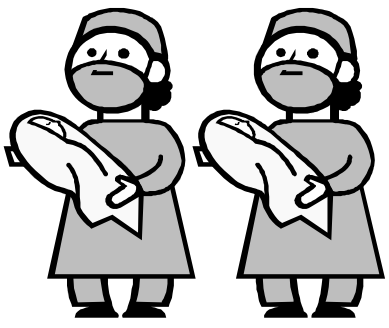
Delivery of Twins:

Traditionally Arkansas Blue Cross and Blue Shield and its affiliates have not made additional reimbursement for the delivery of a second baby. It is our intention to allow additional reimbursement only when the delivery of the second infant is complicated.

The Arkansas Blue Cross and Blue Shield and its affiliates will bundle CPT 59409 (vaginal delivery only) or 59514 (cesarean delivery only) when billed with primary codes 59400 and 59510 (antepartum, delivery, and postpartum care for the respective type of delivery).

The complicated vaginal delivery of twins should be billed with 59400 and 59409 with Modifier-59. Records will be requested for these claims to document a complicated delivery, and if payment is allowed for the second delivery it will be paid at 50%. If one infant is delivered vaginally and one via cesarean then 59510 should be reported for the second and 59409 with Modifier-51 should be reported for the first infant.

According to CPT Assistant, if both infants are delivered via cesarean section then report only CPT 59510. If the cesarean delivery of the second infant is significantly more difficult, add Modifier-22 to this code. Physicians need to submit an operative note and a special report with the claim.



Multiple/Assistant/Team Surgery:

We have noted increased billing of procedures by surgeons of the same specialty in the same operative setting. Some procedures are billed consecutively, some concurrently.

In general, it is our intent that the overall payment for one or more procedures during the same operative setting will be no more than if the procedures had been done by one physician. It is our intent to apply multiple surgery guidelines to all procedures done during a single operative setting.

Examples:
When two surgeons of the same specialty perform concurrent procedures through the same incision, one will be paid as the primary surgeon and the other will be paid as an assistant, and modifier 51 is applicable (e.g., two neurosurgeons doing a difficult acoustic neuroma).

When two surgeons of the same or different specialties perform consecutive procedures through the same incision, each surgeon will be paid for his procedure(s) but modifier 51 will be appended to procedure codes where applicable (e.g., diskectomy and cervical fusion).

Exceptions may be recognized for urgent or emergent circumstances for physicians of different specialties.

When two surgeons of different specialties work concurrently to perform a single procedure (reported by a single CPT code), each should use the same procedure code with modifier 62 (e.g., surgeon and electrophysiologist for ICD placement).

When surgeons of different specialties do different procedures through separate incisions they are considered team surgeons, and each are paid for the procedures they perform and bill.

When surgeons of the same specialty perform same or similar procedures concurrently, multiple surgery and/or bilateral surgery guidelines will be appended (e.g., bilateral knee replacement; radical mastectomy on one side, simple mastectomy on the other side).

BlueCard - Hearing and Vision Claims:

Effective June 1, 2003, Plans are required to handle hearing and vision claims through BlueCard including claims for eyeglasses. The change requires Host Plans to transmit hearing and vision claims to Home Plans, and Home Plans will be required to accept and process these claims through BlueCard.

The procedure for filing claims for eyeglasses will be as follows:

- Regular eyeglass frames, billed with HCPCS procedure code V2020, will be priced at the Arkansas Allowance and the difference placed in provider write off column of the remittance advice.
- Deluxe frames, billed with HCPCS procedure code V2025 and all other vision procedure codes (V2100-V2799), will be priced as charged. Any reduction in the allowance will be determined by the members Home Plan and any difference will be the member's responsibility.

Office visits should be filed on the first line of the claim and frames should be filed on the second line of the **SAME CLAIM** with the appropriate CPT / HCPCS codes. If frames are filed with other vision services, the claim will be rejected with instructions to 're-file frames on a line separate from the other vision services'.

Timely Filing Rules For Medi-Pak Claims:

Recent issues of *Providers' News* (June 2002 and December 2002) made providers aware of Arkansas Blue Cross and Blue Shield's "timely filing" rules regarding claims filing deadlines.

Providers should note that these rules apply to Medi-Pak, Arkansas Blue Cross and Blue Shield's Medicare supplement plan. Providers have 180 days from the Medicare remittance paid date to file Medi-Pak claims with Arkansas Blue Cross.

Medi-Pak claims for services that are **not** covered by Medicare – at-home recovery, foreign travel and prescription drug claims – must be filed within 180 days of the date of service.

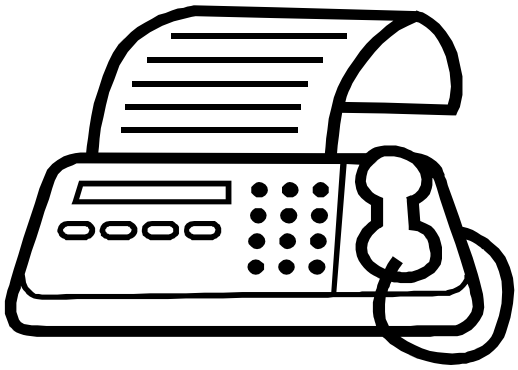
Medi-Pak Plan I members – the only Medi-Pak members who have prescription drug coverage – do not need to file prescription drug claims as long as they show the pharmacist their Medi-Pak Plan I identification card at the time the prescription is filled.

Faxing Medical Records:

Recently, there has been some discussion about HIPAA regulations allowing medical records to be faxed. The Office of Civil Rights for the U.S. Department of Health and Human Services has clarified that the HIPAA Privacy Rule does allow for use of telefaxes to transmit protected health information (PHI) between covered entities for purposes of treatment, payment or healthcare operations, so long as minimal safeguards are in place to avoid risk of unauthorized access to the telefax machine and messages.

Covered entities must have in place reasonable and appropriate administrative, technical and physical safeguards to protect the privacy of PHI that is disclosed using a fax machine, or any other method of disclosure. Examples of measures that could be used in such a situation include the sender confirming that the fax number is correct for the receiving office, and placing the fax machine in a secure location to prevent unauthorized access to the information. [See 45 CFR 164.530 (c)]

Any covered entity (health provider, health plan, or health care clearinghouse) can share PHI for treatment, payment, or health care operations with another covered entity if both covered entities have or had a relationship with the person. [See 45 CFR 164.506(c) (4)]



Additional HIPAA references for more details are:

1. Clarification on using a Fax machine, OCR HIPAA Privacy guidance document published December 3, 2002, in the section titled, "Miscellaneous Frequently Asked Questions about the HIPAA Privacy Rule."
2. Other clarifications and FAQ can be found in the OCR HIPAA Privacy guidance document published December 3, 2002.
3. Definitions of covered entity, electronic media, protected health information can be found in 45 CFR 160.103(3)

As a reminder: Starting in mid-July, medical record request letters will have a new bar-code and tracking number. Please return this letter, as the first sheet, with the requested medical record information or fact sheet. The bar-coded letter will allow the information you send us to be tracked and processed faster. The bar-coded letter is unique for each medical record request and cannot be reused. Therefore, please DO NOT use the bar-coded letter for other patients.

Corrections - 2003 CPT Code Deletions:

The previous issue of the Providers' News (March 2003) incorrectly reported deleted CPT Codes for 2003. For you convenience, corrections are highlighted below.

PROCEDURE	REPLACE WITH
99297	99296
00869	00921
21041	21040
36520	36511-36512
36521	36516
44209	44238
53670	51701, 51702
53675	51703
58551	58545, 58546
80090	
85021	
85022	
85023	**85007 and 85027 (not 86027)**
85024	85025
85031	85014, 85018, 85032
85585	85008

PROCEDURE	REPLACE WITH
85590	85032
85595	85049
86915	38210-38213
88144	
88145	
90709 (not 90700)	
92525	92610-92611
92598	
92599	92709
94650	
94651	
94652	
94665	
99508	95806-95811
99539	99600

CPT Code and HCPCS Code Changes:

HCPCS Codes S0302 & S0310:

Effective May 7, 2003, HCPCS codes S0302 and S0310 have been changed from "BR" to $0.00 in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT Code 82274:

Effective April 29, 2003, CPT code 82274 was changed in the Arkansas Blue Cross and Blue Shield Fee Schedule from "BR" to the below:

Total	Prof	Tech	SOS Total	SOS Prof	SOS Tech
$7.10	$0.50	$6.60	$7.10	$0.50	$6.60

Corrections - 2003 Deleted HCPCS Codes:

The March 2003 Providers' News reported the deleted HCPCS Codes for 2003. However, the following changes were made to the Arkansas Blue Cross and Blue Shield Fee Schedule and incorrectly reported in the March 2003 publication. The "2003 Deleted HCPCS Codes" should include:

- **A4460 (not A4462)**
- **C1778 (omitted)**
- **A4801 (omitted)**
- **C1780 (omitted)**

Neulasta Reimbursement:

Pegfilgrastim (Neulasta), S0135, is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

Reimbursement for pegfilgrastim has been based on invoice price since it became available in 2002. Reimbursement is being changed to $2,400.00 for 6 mg of pegfilgrastim. An invoice copy will no longer be requested or required.

With this change in reimbursement comes a change in the coverage policy. Pegfilgrastim will now be subject to the same coverage criteria required for granulocyte colony stimulating factors filgrastim and sargramostim. Granulocyte colony stimulating factors are not covered to maintain the schedule or dose-intensity of a chemotherapy regimen.

Effective July 1, 2003, Q4053 will be a new HCPCS code for pegfilgrastim. This code describes 1 mg for the dosage. The number of units will need to be changed to indicate the dose administered.

Genetic Testing for Cystic Fibrosis:

The American College of Obstetrics and Gynecology has recommended that cystic fibrosis screening should be made available to all couples, whatever their risk for carrying the cystic fibrosis gene.

Services related to genetic testing are a contract exclusion. If a couple requests genetic testing to screen for the CF gene they should be asked to sign a waiver that they are responsible for the charges for the testing.

New Accounts Receivable Reconciliation System:

During the next several months, Arkansas Blue Cross and Blue Shield will be implementing a new Accounts Receivable Reconciliation System (ARRS) for our Group Claims Processing System (GCPS) and Medipak System. This new functionality will allow Arkansas Blue Cross to capture the results of claim adjustments and report them to providers in a more timely manner.

If an additional payment is required, this transaction will be reflected on your remittance advice. If an overpayment is determined, a refund request letter will be sent identifying all pertinent patient and claim information. The financial control number will be located in the upper right corner of the letter along with the system indicator (either GCPS or Medipak as appropriate), the affected claim number, and contract number.

It will be important that providers respond immediately to the refund request letter by:

1. Notifying us of any question about the over-payment/refund request or
2. Refunding the amount requested.

In the event your refund is not received within thirty (30) days from the date of the letter, an automated offset/recovery will occur much like it does today for the BlueCard program.

This activity will also be reflected on your payment and remittance advice and will reference again the pertinent data for the over-payment being recovered: patient name, letter date and original overpayment amount along with the financial control number which has ICN and patient ID/contract number.

At this time, offsets will be taken only against the GCPS Remittance Advice but may be for GCPS and/or Medipak overpayments.

Claims Payment Issues:

While one of Arkansas Blue Cross and Blue Shield's ongoing goals is to minimize the number of claims paid incorrectly, errors may occasionally be made. Some of these error conditions can affect 1099 earnings and/or patients' claim history, deductibles, and benefit limits. These situations can result in incorrect information being reported to the IRS and/or incorrect patient benefit determination.

Please note:

- Amounts of issued provider payee checks are recorded as increases to the 1099 earnings;
- Amounts of voided provider payee checks are recorded as decreases to the 1099 earnings;
- Amounts received from providers (claims refunds) are recorded as decreases to the 1099 earnings.
- 1099 earnings are accumulated under the Tax Identification Number (TIN) of the payee, as recorded in our files at the time of the transaction.
- Providers must notify Arkansas Blue Cross promptly if your TIN or your name changes in order to ensure accurate reporting to the IRS. If the IRS sends Arkansas Blue Cross a B-Notice indicating that the Taxpayer Name and TIN we filed does not match their records, Arkansas Blue Cross will be required to withhold, and remit to the IRS, 28% of future amounts payable to you if corrected data is not received within the mandated time frame. Once withheld amounts are remitted to the IRS, they cannot be refunded to you, but will be reported on your 1099 as Federal Income Tax Withheld.

Notes to physicians:

- Paper Claims: As the provider of service, you should always enter your individual provider number in box #24K of the CMS 1500 claim form. If you want your-self to be the payee, you must enter your individual provider number in box #33 behind "PIN". If you want a clinic to be the payee, you must enter the clinic's provider number in box #33 behind "GRP".
- NSF Electronic Claims: As the provider of service, you should always enter your individual provider number beginning in position 93 of field 23 on the FA0 record.
- Non-Medicare Claims: For non-Medicare claims, enter the "pay to" provider number beginning in position 105 of field 14 on the BA0 record.
- Medicare Claims: For Medicare claims, the "pay to" provider number must be entered beginning in position 48 of field 9 on the BA0 record.
- ANSI 837, Version 4010A1 Electronic Claims: Please refer to the ANSI X12N 837 Implementation Guide for instructions regarding the use of Loop 2010AA, REF02 or Loop 2010AB, REF02 for the "pay to" provider and Loop 2310B, REF02 or Loop 2420A, REF02 for the rendering provider number.
- Deductibles, benefit limits, out-of-pocket maximums, and lifetime maximums are accumulated by individual member. If erroneous claims are not adjusted appropriately and promptly, subsequent claims may be incorrectly adjudicated.
- Please verify that the payee is correct on all checks that you receive prior to negotiating them.

Listed below are examples of some situations that can occur along with procedures recommended to facilitate correction of the data:

- If you receive payment for a claim for services that you did not provide: Please refund the amount paid in error. Even if you know to whom the payment should have been made, do not forward the amount to that party. Your 1099 can only be corrected if the money is returned so that the claim can be re-processed to the appropriate party.
- If the patient was paid and payment should have been made directly to you: Please advise the patient to return the check, or refund the amount paid, along with a request to re-process the payment to the provider. If you accept payment from the patient, we could subsequently discover the error and send a request for refund to the patient since our records will reflect that patient received the payment.
- If you were paid and payment should have been made to the patient: Please refund the payment to Arkansas Blue Cross (rather than to the patient) along with a request to re-process the payment to the patient. A provider's 1099 can only be corrected if the money is returned and the claim can be re-processed to the appropriate party.
- If a check is made payable to an individual physician but should have been made payable to the clinic: Please return the check to Arkansas Blue Cross (rather than depositing the check in the clinic's account) with a request to re-process the payment to

the appropriate provider. A provider's 1099 can only be corrected if the money is returned and the claim can be re-processed to the appropriate party. NOTE: If the check is made payable to an individual physician, the 1099 will be generated in the physician's name, even if the provider is an employee of the clinic.

Arkansas Blue Cross and Blue Shield recommends providers endorse and deposit all checks as soon as possible after confirming that the payee is correct. Most of our checks have a pre-printed stale date message indicating that the check will be void if not cashed within a specific time frame (usually six months). After that time, the check must be re-issued or, in some cases, the claim must be re-processed.

As a deterrent to fraud and to enhance the quality of copies of cleared checks that might be requested in the future, Arkansas Blue Cross and Blue Shield also recommends that provider endorsements be made in black ink and include the bank account number into which the deposit is being made.

To minimize the time required to process a claim refund and to ensure your 1099 earnings are adjusted accurately:

- When sending us a requested refund: Please return the remittance copy of the refund request letter along with your check.
- When sending us an unrequested refund: It is not necessary to return the original check and the entire remittance advice or explanation of payment if just one or two patient claims are paid incorrectly. Please enclose copies of the remittance advice or explanation of payment pages with the claims paid in error highlighted and a notation of the reason for the refund or enclose the following information for each claim paid in error:
  1) Reason for the refund,
  2) Patient name,
  3) Patient ID number,
  4) Date of service,
  5) Amount,
  6) Provider name (pay to),
  7) Provider number (pay to), and
  8) TIN (pay to).

A separate refund check for each claim is preferred, if you are not returning the original check.

A provider's 1099 earnings can only be corrected if Arkansas Blue Cross has the specific provider name, number, and TIN. If a provider uses the services of a third party for these financial transactions, please instruct third party administrator to provide this information on each refund.

Please do not combine refunds for Arkansas Blue Cross Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas, USAble Administrators, USAble Life Group Health, or Medicare. Please do not issue refund checks to Arkansas First Source. The check should be payable to the original claim payer with a copy of the remittance advice/explanation of payment

Note: Federal Employee Program (patient ID# begins with "R") refunds should not be combined with others to Arkansas Blue Cross and Blue Shield in order to comply with new timeliness standards even though the refunds are sent to the same processing location.

The following are the correct addresses to use for claims refund:

Arkansas Blue Cross Blue Shield
P.O. Box 2099
Little Rock, AR 72203 - 2099

ABCBS/Federal Employee Program
P.O. Box 2099
Little Rock, AR 72203 - 2099

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203 - 1460

Health Advantage
P.O. Box 8069
Little Rock, AR 72203 - 8069

USAble Administrators
P.O. Box 1460
Little Rock, AR 72203 - 1460

USAble Life Group Health
P.O. Box 1151
Little Rock, AR 72203 - 1151

Medicare (part A or B)
P.O. Box 8075
Little Rock, AR 72203 - 8075

Health Advantage - Denial Codes:

A provider may bill a member the usual charge amount of each service denied for "Not a contract benefit" or "Member has exceeded benefit limitations".

With the new re-design of the Explanation of Payment, a design flaw was found in the programming logic which caused part of the amount to incorrectly appear on the Explanation of Payment as a provider write off.. Since the same information appears on the member's Explanation of Benefits, the member may call and question their statement.

The design problems have been identified and Health Advantage is working diligently to correct the error.

Health Advantage - Home Health:

When a provider or member request Home Health benefit information from Health Advantage, other related benefits may also be given to ensure accurate information is given to both providers and members.

Some charges billed by a Home Health provider might fall under a benefit other than Home Health which could affect the member's financial responsibility. For example: therapy billed by a Home Health provider will be applied to the therapy benefit which usually has a higher copay and a yearly maximum.

Since Health Advantage does not know what services will be billed prior to receiving the claim we normally quote the following benefits: **Home Health, DME, Therapy, and Pharmacy.**

Thank you for allowing Health Advantage to quote all benefits that could be related to the member's claim.

Health Advantage - Multiple Claim Status Checks:

Health Advantage Customer Service wants to be able to assist providers with problems in a timely manner. In order to do this, Health Advantage Customer Service must have adequate phone coverage.

If your provider office is connected to AHIN and you have a bundle of claim status checks or are working from a report, please check the claim status in AHIN prior to calling customer service.

If access to AHIN is not an option for your provider office at this time and your submitted claims have not been processed, please check the information on the claim form before contacting customer service. If the claims are filed correctly, they are processed in a timely manner.

If letters or numbers are transposed, information is printed off the line, information is omitted, or is incorrect, the claim will be rejected.

If the claim is still not processed within thirty days, include a memo indicating the dates the claim was filed and send an original claim form to:

Claims Department
Health Advantage
26 Corporate Hill Drive
Little Rock, AR 72205

By including a memo, claim filing problems can be identified and your staff member will not be on the phone in great length. The claim will be submitted for processing or returned to you if there is incorrect information on the claim form.

Health Advantage - POS vs. Open Access POS :

An easy way for providers to identify the referral requirements for their patients, is to look at the member's ID card.

Point of Service Plan (not Open Access Plans): Referrals are required in order for the member's claims to be paid on the in-network benefit level. If no referral is obtained, the claims will be processed on the member's out-of-network benefit level. Some benefits such as mental health, therapy and adult routine exams are not covered on the out-of-network level.

Open Access POS: If the member's card reads "POS OA", the member is on an Open Access POS Plan. Referrals are not required for members with open access point of service plan. The claims will be processed on the in-network or out-of-network benefit level based solely on the participation status of the billing provider.

Health Advantage - Pre-Certifications:

Health Advantage DOES NOT require pre-certification for in-network hospitals for inpatient or outpatient services. Admission to any out-of-network facility must have prior approval from Health Advantage except for emergency care.

For Open Access Point-of-Service, a referral is not needed for in-network providers. If the member has Open Access Point-of-Service coverage, the admitting PCP must be the ordering physician for the hospital services in order for the claim to be processed on the in-network guidelines.

If an in-network specialist is the ordering physician, the specialist must have a current, non-restricted referral in place from the primary care physician (or covering PCP). No "referral" should be issued to the hospital. The hospital however, should give the referral information to all ancillary providers (i.e. Pathology, Radiology, Anesthesiology, etc.).

Health Advantage - Modifiers:

Billing the incorrect modifier may cause a claim to process incorrectly or deny. Before calling Customer Service regarding a claim that processed incorrectly, please check the modifier billed. If the modifier is incorrect, the Customer Service Representative cannot request an adjustment.

A corrected claim with a *Claim Correction Form* must be submitted to Health Advantage Claims Department for adjustment review. If you have billing questions regarding modifiers, please let your Network Development Representative know and billing education can be provided.

Health Advantage - Injectable Medication:

When calling to verify benefits for injectable medications, please be prepared to give the Customer Service Representative the name of the medication. Most injectable drugs are coordinated through Advanced Specialty RX and the physician is only allowed the reimbursement for the administration of the injection.

After the Customer Service Representative verifies benefits, your call may be transferred to the pharmacy area so that the authorization for the injectable medication can be promptly obtained.

HIPAA – Will Your Claims be Paid After October 16, 2003?

This question seems to be on everyone's mind with less than 6 months before the compliance deadline for the HIPAA Administrative Simplification transaction rule. Recall from previous notices that insurers will be prohibited from accepting electronic claims in formats other than ANSI 837 version 4010A1 after October 16, 2003.

Obviously, Arkansas Blue Cross and Blue Shield cannot accept production claims in this new format without sufficient testing. If you are ready to test HIPAA compliant claims, please contact EDI Services at 501-378-2419 or toll free at 866-582-3247, and more detailed information will be provided at that time. **A HIPAA Test Schedule form must be completed and returned before provider-to-insurer testing can be initiated.**

As required by law, Arkansas Blue Cross and Blue Shield will no longer accept NSF or UB electronic claim formats beginning October 16, 2003. If your organization will not be completely converted to the ANSI format, there are several viable options available.

First, your practice management system (PMS) vendor may have a release upgrade available to support HIPAA requirements. If that is the case, make sure to test with Arkansas Blue Cross prior to implementing the new release into production. If not, please question your vendor as to why their software is not compliant with federal-mandated formats. If you utilize a billing agent, inquire as to when they will begin HIPAA testing.

Some PMS vendors are initially not making all changes required to support HIPAA formats, rather, they are requiring providers to use new clearinghouse services. If your PMS vendor is one of these, please make sure you understand all the new incremental costs and implications that you are facing. You do have some options to consider.

Second, our enterprise clearinghouse, AHIN, is available to convert your current electronic claim format into the new standard format. Those providers that have not begun testing by August will receive an enrollment form to use AHIN as your HIPAA clearinghouse. Please complete and return the enrollment form promptly if you wish to utilize that service. This service is offered free of charge for claims filed to Arkansas Blue Cross Blue Shield, Health Advantage, BlueAdvantage Administrators, Medicaid and Arkansas Medicare Parts A & B.

AHIN will also accept claims being routed to any other Blue plan at no cost. However, there is a 10 cent per claim fee for any other commercial carrier claim handling.

Alternatively, there are several proven vendor solutions that interact with major PMS systems to generate HIPAA-formatted claims:

- Companion Technologies (Craig Klein 800-999-0788),
- Payerpath (Kathleen Kennedy 804-560-2409),
- RMSystems (Randy Matthews 479-756-2310), and
- Webify (Lang Smith 804-288-1690).

Lastly, there are other clearinghouses available to translate claim formats, but expect to pay a significant fee for that service.

At a national level, there has been much discussion about providers reverting to paper on October 16, 2003 to avoid complying with HIPAA transactions requirements. We urge you to contact us prior to making this decision since there would most likely be negative cash flow implications for Medicare claim payments. In fact, current Medicare regulations prohibit the submission of paper claims after October 16, 2003 except in narrowly defined circumstances. Arkansas Blue Cross will assist you in determining if a more efficient option would work for your organization and still be permissible under HIPAA.

In an upcoming communication to assist with HIPAA Transactions & Code Set requirements, Arkansas Blue Cross will be distributing a Provider HIPAA Implementation Guide. This document explains the implementation rules and includes a worksheet to assist providers with a compliance strategy as well as a work plan.

HIPAA - Request for Medical Records:

Over the past several months, all of us in the healthcare industry have been working to understand the requirements of the Privacy Rule and the impact of implementing changes to the way we do business. One significant issue surrounds when authorizations are needed and what form those authorizations must be in to be HIPAA compliant.

Since April 14, 2003, the effective date of the new HIPAA Privacy requirements, several providers questioned the authorizations that accompany our requests for medical records. Generally, there are two circumstances when Arkansas Blue Cross and Blue Shield will request medical records and only one triggers the need for a signed authorization form.

Arkansas Blue Cross will request medical records to perform **medical underwriting for individuals applying for coverage.** In this circumstance, the Privacy Rule requires the individual requesting coverage to complete a HIPAA-compliant authorization specifically to request medical records for underwriting purposes.

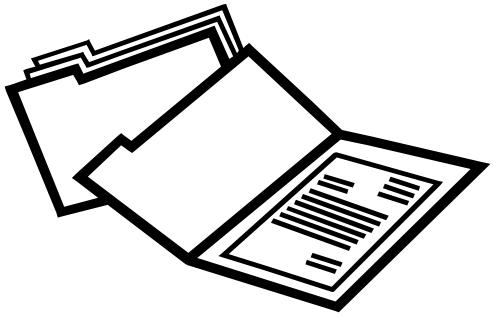
To help in this effort, Arkansas Blue Cross has developed an Authorization Form for the individual to complete as part of the application process. This form was developed based on the detailed requirements of the Privacy Rule and is HIPAA-compliant. The individual completes this form and Arkansas Blue Cross will forward it to provider offices to request the appropriate medical record information.

While several provider offices have developed a version of this form, the impact on the application process of attempting to administer numerous, provider-specific forms is significant. To benefit both the enrollment process and potential members, Arkansas Blue Cross is encouraging providers to accept our form as a valid authorization for the release of medical records. Arkansas Blue Cross has worked closely with our legal staff to ensure that our release form for medical underwriting is HIPAA compliant and offers protection for both us and the provider community.

Medical records will also be requested to support claim payment and other health care operations. A covered entity (health provider, health plan, or health care clearinghouse) can share protected health information for treatment, payment, or health care operations with another covered entity, with specific exceptions, **without an authorization** if both covered entities have or had a relationship with the individual. Determination of claim payment falls within the scope of these activities.

Arkansas Blue Cross is encouraging providers to release this information in accordance with the Privacy Rule to support timely payment of claims for services you provide to your patients. HIPAA Privacy regulations do not require a signed authorization for payment purposes and to require an authorization further increases administrative costs, payment delays, and hassles for your patients. Plus, your provider contract requires release of medical records to support claims payment and healthcare operations. Arkansas Blue Cross has been working for nearly two years to implement HIPAA compliant privacy practices and processes.

Arkansas Blue Cross looks forward to continuing to work closely with the provider community to resolve critical service issues and to meet the responsibility we all have to protect health information.



HIPAA Claims Submission – Quick Survey:

Arkansas Blue Cross Blue Shield is very interested in the HIPAA compliance status of Arkansas providers and is working to help ensure the transition is as smooth as possible. Please take a minute to email our HIPAA Project Office at predwards@arkbluecross.com and let us know how your organization is coping with these regulations.

What is your anticipated implementation strategy for HIPAA claim submission?

- Practice Management System (PMS) vendor or Billing agent will upgrade to ANSI
- Utilize AHIN as a clearinghouse
- Will submit claims on paper
- Will use another clearinghouse
- Don't know at this time

When do you plan to test HIPAA-formatted Claims?

- Already testing
- Will test after 10/16/03
- Will begin testing before 10/16/03
- Don't know or Have no plans

What is the biggest obstacle your organization is facing with HIPAA claims compliance?

- Need approval from management or project is low priority
- Budget limitations
- Claims are rejecting during tests
- Vendor or Clearinghouse not ready
- Other (please list)

Please include demographic information – Provider name, Classification (e.g. Hospital, Clinic, Individual), current PMS vendor, and Clearinghouse (if applicable). Thanks in advance for your participation and we will post the results in the next *Provider News*. Please feel free to send additional comments or information regarding your compliance effort.

HIPAA - Confidentiality:

Due to HIPAA requirements, Arkansas Blue Cross and Blue Shield, Health Advantage, or BlueAdvantage Administrators of Arkansas may not be able to provide providers with all information requested. Please note that a member's address, phone number, social security number, employer name, diagnosis and other confidential information will not be released.

If a member is in a provider's office and wants to change their Primary Care Physicians to a physician in your clinic, please have the member call their health plan. Arkansas Blue Cross and Blue Shield, Health Advantage, or BlueAdvantage Administrators of Arkansas must have verbal confirmation from the member to make a change to the member's confidential information.

Default Modifier for Anesthesiologists:

The Relative Value Guide published by the American Society of anesthesiologist states under Anesthesia Modifiers:

> *"All anesthesia services are reported by use of the anesthesia five-digit procedure code plus the addition of a physical status modifier. These modifying units may be added to the basic values. The use of other optional modifiers may be appropriate."*

The CPT-4 manual under Anesthesia Guidelines states:

> *"Services involving administration of anesthesia are reported by the use of the anesthesia five digit procedure code (00100-01999) plus modifier codes (defined under "Anesthesia Modifiers" later in these Guidelines)."*

When submitting claims with anesthesia services (codes 00100-01999) a modifier is required. These guidelines apply to Arkansas Blue Cross and Blue Shield and it's affiliates.

HIPAA - Most Frequent Testing Errors:

As an increasing number of providers, clearing-houses, and billing agents are testing their transition to the new HIPAA-standard electronic claims format (ANSI 837 version 4010A1), the Electronic Data Interchange (EDI) Services department at Arkansas Blue Cross and Blue Shield is reporting some errors that are occurring with high frequency. If you have not yet begun testing, it would save time by reviewing these items to see if they could be prevented prior to the first test.

It should be noted that all of these errors could have been eliminated by first comparing the test file against the Arkansas Blue Cross EDI Users Guide and Companion Document which can be found at www.arkmedicare.com. Please relay this information to the appropriate claims billing department to help speed your HIPAA testing.

The most common errors seen during HIPAA testing are:

- Failing to include the rendering provider.
  --Per the HIPAA Implementation Guide, the rendering provider (2310B loop) is required when different from the Billing or "Payto" provider. Failure to include the rendering provider may cause claim denials.
- Mixing Medicare and Private claims in the same submission.
- Claims submissions should include only one ST loop per SE loop.
- Sending an incorrect qualifier.
  --The EDI User's Guide will clarify proper submission.
- Failing to include "Inkeys".
  --Inkeys are required to ensure a smooth Medicare Crossover.

It will also speed testing to include a good mix of production-type claims data. For instance, use actual provider information and patient information during tests and include claims from each specialty that would normally be performed in a live setting.

The actual procedure submitted during a test does not have to be one that was actually performed, but should be a valid and one that is typically performed. A good mix of test claims will help ensure that testing closely mimics the live environment. mix of test claims will help ensure that testing closely mimics the live environment.

FEP - Dental Fee Schedule (correction):

The March 2003 issue of the Providers' News incorrectly printed the heading for the Standard Option FEP Dental Network Fee Schedule by omitting "to Age 13" and "13 and Over". Please note the corrected headings listed below.

Dental Code	Service	FEP Fee Schedule Amount Up to Age 13	FEP Fee Schedule Amount Age 13 and over	MAC

Corrected Bill Form:

Please do not use the Corrected Bill Form to submit BlueCard Inquiries. This form is to be used to submit changes to previously processed and finalized claims only. Use of this form for other purposes will slow process time for inquiries and corrected bills.

2003 Fee Schedule Update:

Effective March 26, 2003 the following changes have been made to the Arkansas Blue Cross and Blue Shield Fee Schedule.

CODE	TOTAL	PROF	TECH	SOS TOTAL	SOS PROF	SOS TECH
95027	$ 6.31			$ 6.31		
G0030	$ 1,170.99	$ 120.47	$ 1,050.52	$ 1,170.99	$ 120.47	$ 1,050.52
G0031	$ 1,203.80	$ 153.28	$ 1,050.52	$ 1,203.80	$ 153.28	$ 1,050.52
G0032	$ 1,171.16	$ 120.64	$ 1,050.52	$ 1,171.16	$ 120.64	$ 1,050.52
G0033	$ 1,203.80	$ 153.28	$ 1,050.52	$ 1,203.80	$ 153.28	$ 1,050.52
G0034	$ 1,171.16	$ 120.64	$ 1,050.52	$ 1,171.16	$ 120.64	$ 1,050.52
G0035	$ 1,203.80	$ 153.28	$ 1,050.52	$ 1,203.80	$ 153.28	$ 1,050.52
G0036	$ 1,170.58	$ 120.06	$ 1,050.52	$ 1,170.58	$ 120.06	$ 1,050.52
G0037	$ 1,203.80	$ 153.28	$ 1,050.52	$ 1,203.80	$ 153.28	$ 1,050.52
G0210	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0211	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0212	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0213	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0214	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0215	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0215	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0216	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0217	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0218	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0220	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0221	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0222	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0223	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0224	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0225	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0226	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0227	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0228	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0229	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0230	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00
G0253	$ 2,124.00	$ 124.00	$ 2,000.00	$ 2,124.00	$ 124.00	$ 2,000.00

Effective January 1, 2003 the following changes were made to the Arkansas Blue Cross and Blue Shield Fee Schedule for Home Infusion Therapy Providers.

2002 HCPCS Codes	Nomenclature	Allowance
J0000, J3490, J9999, or any Rx J Code	Drug specific codes by NDC number	AWP less 10% based on Redbook pricing of NDC
	Nursing Services	
S9445	Patient education, not otherwise classified, non physician provider, individual, PER SESSION	$ 75.00
S9524	Nursing Services related to Home IV Therapy, PER DIEM	$ 75.00
99506	Home Visit for IM	$ 75.00
S9800	Home therapy, provision of infusion, specialty drug administration and/or associated nursing services & procedures, by highly technical RN PER HOUR (do not use with code 9524)	$ 30.00
	Hydration Therapy	
S9373	Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment PER DIEM. (Drugs and nursing visits coded separately.) (do not use with hydration therapy codes S9374-S9377 with daily volume scales)	$ 25.00
S9374	Home Infusion therapy, hydration therapy; ONE LITER PER DAY,	$ 25.00
S9375	Home Infusion therapy, hydration therapy; MORE THAN ONE LITER BUT NO MORE THAN TWO LITERS PER DAY.	$ 25.00
S9376	Home Infusion Therapy, hydration therapy; MORE THAN TWO LITERS BUT NOT MORE THAN THREE LITERS PER DAY.	$ 25.00
S9377	Home infusion therapy, hydration therapy, MORE THAN THREE LITERS PER DAY,	$ 25.00
	TPN	
S9365	Home infusion therapy, total parenteral nutrition (TPN); ONE LITER per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (includes standard TPN formula, lipids, specialty amino acid formulas. Drugs and nursing visits coded separately,) per diem	$140.00
S9366	Home infusion therapy, total parenteral nutrition (TPN); more than One liter but no more than TWO LITERS per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (includes standard TPN formula, lipids, specialty amino acid formulas. Drugs and nursing visits coded separately,) per diem	$190.00
S9367	Home infusion therapy, total parenteral nutrition (TPN); more than TWO LITERS but no more than THREE LITERS per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (includes standard TPN formula, lipids, specialty amino acid formulas. Drugs and nursing visits coded separately,) per diem	$240.00
S9368	Home infusion therapy, total parenteral nutrition (TPN); more than THREE LITERS per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (includes standard TPN formula, lipids, specialty amino acid formulas. Drugs and nursing visits coded separately,) per diem	$290.00
	Midline Catheter Insertion	
S5521	Home infusion Therapy, all supplies (including catheter) necessary for a midline catheter insertion. Per kit per day. Additional kits must be approved by RCM. Can only be billed with S5523.	$ 50.00
S5523	Home infusion therapy, insertion of Midline Central venous Catheter, nursing services only (no catheter or supplies included), per day. Should use S5521 with this code.	$ 75.00

Effective January 1, 2003 the following changes were made to the Arkansas Blue Cross and Blue Shield Fee Schedule for Home Infusion Therapy Providers.

2002 HCPCS Codes	Nomenclature	Allowance
	Antibiotic, Antiviral or Antifungal Therapy	
S9347	Home infusion therapy, uninterrupted, long-term, controlled rate intravenous infusion therapy (e.g. epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	$ 60.00
S9357	Home Infusion therapy, enzyme replacement intravenous therapy, (e.g. imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	$ 65.00
S9494	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (Drugs and nursing visits coded separately), per diem.	$ 35.00
S9497	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; ONCE EVERY 3 HOURS.	$ 35.00
S9500	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; ONCE EVERY 24 HOURS	$ 35.00
S9501	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; ONCE EVERY 12 HOURS.	$ 35.00
S9502	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; ONCE EVERY 8 HOURS.	$ 35.00
S9503	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; ONCE EVERY 6 HOURS.	$ 35.00
S9504	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; ONCE EVERY 4 HOURS.	$ 35.00
	Chemotherapy	
S9330	Home Infusion Therapy; CONTINUOUS Chemotherapy Infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem.	$ 25.00
S9331	Home Infusion Therapy; INTERMITTENT Chemotherapy Infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem.	$ 35.00
	Continuous Home Infusion Therapies	
S9336	Home infusion therapy, Continuous Anticoagulant Infusion therapy (e.g., Heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00
S9345	Home infusion therapy, anti-hemophilic agent infusion therapy (e.g., Factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00
S9346	Home infusion therapy, alpha-1-proteinaseinhibitor (e.g. Prolastin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00
S9348	Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g. Dobutamine); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00
S9351	Home infusion therapy, continuous anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00
S9353	Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00
S9355	Home infusion therapy, chelation therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00

Effective January 1, 2003 the following changes were made to the Arkansas Blue Cross and Blue Shield Fee Schedule for Home Infusion Therapy Providers.

2002 HCPCS Codes	Nomenclature	Allowance
S9359	Home infusion therapy, anti-tumor necrosis factor intravenous therapy; (e.g., infliximab) administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately,) per diem	$ 25.00
	Intermittent Home Infusion Therapy Injection, IM, SubQ , IV Push Therapies	
S9363	Home infusion therapy, anti-spasmodic intravenous therapy; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	$ 25.00
	Pain Management	
S9325	Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (do not use this code with S9326,S9227 or S9328)	$ 25.00
S9326	Home infusion therapy, continuous pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem.	$ 25.00
	Catheter Care Supplies	
S5497	Home infusion therapy, catheter care/maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem only. Billable when no other therapy per diem is involved with the exception of the "J" codes for Heparin and Saline flush.	$ 10.00
S5498	Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem only. Billable when no other therapy per diem is involved with the exception of the "J" codes for Heparin and Saline flush.	$ 10.00
S5501	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem only. Billable when no other therapy per diem is involved with the exception of the "J" codes for Heparin and Saline flush.	$ 10.00
S5502	Home infusion therapy, catheter care/maintenance, implanted access device, lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem only. Billable when no other therapy per diem is involved with the exception of the "J" codes for Heparin and Saline flush.	$ 10.00
S9538	Home Transfusion of blood products; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (blood products, drugs, and nursing visits coded separately), per diem	$ 25.00
S9546	Home infusion of blood products, nursing services, per visit	$ 75.00
SH	Second concurrently administered infusion therapy. MODIFIERS TO BE ATTACHED TO OTHER CODES	$ 25.00
SJ	Third or more concurrently administered infusion therapy. MODIFIERS TO BE ATTACHED TO OTHER CODES	$ 25.00

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