Arkansas Blue Cross and Blue Shield

Providers' News

December 2004

Inside the December Issue:

Please Note:

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield, a mutual insurance company, its wholly owned subsidiaries, and affiliates. The 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.

We're on the Web!
www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com
and www.fepblue.org

The Providers' News
The Providers' News is a quarterly publication of Arkansas Blue Cross and Blue Shield. Please send your questions or comments about the Providers' News to:

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Arkansas BlueCross BlueShield
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Fraud Alert from the Special Investigations Unit — Identity Theft Scam:

A recent Provider Identify Theft Scam has surfaced in Arkansas. Scam artists are posing as Arkansas Blue Cross and Blue Shield representatives and obtaining Social Security Number and Tax Identification Numbers from providers.

In most cases, the scam artists have identified themselves to providers as "Mr. Williams". The scam artists tell providers their claims are being "held up" because their Social Security Number or Tax Identification Number is needed before the claims could be processed. The scam artists then use the stolen Social Security Number to obtain fraudulent credit cards.

If you receive such a call, please notify Arkansas Blue Cross and Blue Shield's Special Investigations Unit by dialing the fraud hotline at 1-800-FRAUD21 (1-800-372-8321).

Timely Filing Guidelines:

The following information regarding timely claims filling applies to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and Health Advantage.

Filing Original Claim:
Providers must submit claims for any service, supply, prescription drug, test, equipment, or other treatment within 180 days after such service, supply, prescription drug, test, equipment, or treatment is provided. In the case of a claim for inpatient services for multiple consecutive days, a written proof must be submitted no later than 180 days following the date of discharge for that admission.

Re-Submitting Claims:
Arkansas Blue Cross and Blue Shield and its affiliates ask that providers also use this 180 day timely filing limit for re-submitting claims for adjustments or for submitting additional information on a previously filed claim.

Adjudicated Claims/COB:
Arkansas Blue Cross and its affiliates does extend the timely filing requirements to include 180 days after the primary insurer adjudicates the claim. Timely deadline for secondary claims is 180 days from the date processed by the primary carrier.

Member Responsibility:
The 180 day timely filing provision is applicable for both providers and members. When a patient covered by Arkansas Blue Cross or an affiliate does not provide their provider with proof of coverage until after the 180 day timely filing has expired, that patient is responsible for the services and the provider should not bill Arkansas Blue Cross.

All contract holders should have a member Identification Card. Arkansas Blue Cross and Blue Shield and its affiliates encourage all providers to have patients complete insurance coverage update forms each time of service. By completing a coverage update form, patients are given every opportunity to provide insurance information.

If there is a question on coverage, refer to AHIN (Advance Health Information Network) for member eligibility and claims status or call *TheBlueLine*, our voice activated response service available 24 hours a day 7 days a week.

(This information does not apply to the Federal Employee Program (FEP).)

Hello! Hola!

Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas now offer an interpretation service for Spanish speaking members. Members can now call and ask questions concerning their coverage in Spanish and several other languages (German, French, etc.).

If a Customer Service Representative with fluency in Spanish is not available, an external interpreter who speaks Spanish may be added to the line to help with the call.

Please note that the appropriate privacy of information assurances are in place.

Coverage Policy Changes:

Since September 2004, the following policies have been added or revised in the Arkansas Blue Cross and Blue Shield Coverage Policy manual:

- Bevacizumab (Avastin);
- Detection of Circulating Tumor Cells in the Management of Patients with Cancer;
- Digital Motion X-ray (Cineradiography/Videoradiography) for Musculoskeletal Conditions;
- Genetic Testing for Screening, Detection and/or Management of Prostate Cancer;
- Genetic Testing, Canavan Disease;
- Genetic Testing, Factor V Leiden;
- Genetic Testing, Fragile X;
- Genetic Testing, Hemochromatosis;
- Genetic Testing, Melanoma, Hereditary;
- Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids;
- Left Ventricular End Diastolic Pressure (LVEDP), Non-Invasive Measurement in the Outpatient Setting;
- PET, Positron Emission Tomography for Alzheimer's;
- Sacral Nerve Stimulation;
- Vagus Nerve Stimulation for Depression; and
- Whole Body Computed Tomography Scan as a Screening Test.

Knee Braces: (Reprint from September 2003 issue of Providers' News)

In an attempt to clarify coverage for custom versus off-the-shelf knee braces, Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas made a change in the allowance for knee braces in the Durable Medical Equipment (DME) section of the current Arkansas Blue Cross fee schedule.

Now, there is one allowance for each of the three basic classes of knee braces with no adjustment for custom versus off-the-shelf braces (effective December 1, 2003).

The new HCPCS Classes and allowances for knee braces are as follows:

Description	HCPCS Codes	Allowance
Category 1	L1800 - L1825	$ 80.00
Category 2	L1830 - L1840	$ 108.00
Category 3	L1843 - L1885	$ 575.00

Please review these changes with your office staff. Should you have any questions, please contact your local Arkansas Blue Cross Network Development Representative in the regional office nearest you.

ID Card Prefix Change:

The prefix on member ID cards for employees of Prescolite, a division of Hubbell Lighting located in El Dorado, Arkansas, will change. Effective January 1, 2005, the prefix will change from HUI to the new prefix **HUE**.

Please note that it is essential for prompt claim processing to submit the current member number located on the ID card. Always ask to see a member's ID card whenever healthcare services are requested.

Pharmacy — Three Tier Formulary Changes

Rising pharmacy expenditures, which are based on increasing prescription utilization by members and soaring drug costs, continue to be a primary factor contributing to current premium increases.

The three tier copayment has become an attractive method to better align the member's coinsurance to the cost and preferred status of a particular medication. The three tier pharmacy copayment concept has now grown to cover 90% of all Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas groups.

To lessen the confusion, Arkansas Blue Cross, Health Advantage and BlueAdvantage are attempting to make changes between the second and third tiers for three tier copayment plans only once a year during January.

Exceptions will be made for the following situations:

- When a single source medication loses its patent protection and a generic drug becomes available, the brand name medication is moved to the third tier.
- When a new medication is approved by the FDA and becomes available, a decision will be made regarding whether to place the new drug in the second or third tier.

Effective January 1, 2005 Arkansas Blue Cross, Health Advantage and BlueAdvantage will implement some medication changes from second tier status to third tier. For more information, providers can access our websites:

www.ArkansasBlueCross.com
www.HealthAdvantage-HMO.com
www.BlueAdvantagearkansas.com
www.UsableAdmin.com

Pharmacy — Drug Tier Changes:

Effective January 1, 2005, the following medications will move to the third tier:

• Accuneb	• Casodex	• Elestat	• Lumigan	• Nasonex	• Salagen	• Sular
• Altace	• CeeNu	• Flomax	• Luxiq	• Olux	• Proscar	• Symbyax
• Ambien	• Chromagen	• Hyzaar	• Maxair	• Optivar	• Pulmicort	• Tarka
• Anadrol	• Clarinex	• Inderal LA	• Miacalcin	• Pacerone	• Serevent	• Tricor
• Android	• Cozaar	• Lescol	• Migranal	• Plavix	• Skelaxin	• Verelan PM
• Androxy	• Dantrium	• Lexxel	• Mobic	• Pravachol	• Solaraze	• Vivactil
• Avelox	• Didronel	• Lidoderm	• Nasacort	• Quixin	• Stalevo	• Zaditor
• Brethine	• Duoneb	• Livostin	• Nasalide	• Renacidin	• Striant	• Zantac

This change does not apply to the Federal Employee Program (FEP). For information concerning FEP pharmacy, access their website at www.fepblue.org and select "Pharmacy Programs".

TYSABRI®: Allowance, Coverage Policy, and Claims Filing Policies & Procedures:

Biogen has recently introduced a new medication, **Tysabri®**, for the treatment of patients with relapsing forms of multiple sclerosis to reduce frequency of clinical exacerbations.

Providers should be aware this treatment is expensive. The four week treatment cost for the medication alone for one patient is approximately $2,260 for the IV route based on the listed average wholesale price.

In order to help manage the cost of this new medication for members, Arkansas Blue Cross and Blue Shield has established a preferred pharmacy relationship. Arkansas Blue Cross established a specific allowance and coverage policy and specific claims filing policies and procedures for **Tysabri®** when administered by physicians.

In order for providers to be reimbursed for charges related to **Tysabri®**, it is important for providers to understand Arkansas Blue Cross's preferred process for dispensing the medication through our preferred pharmacy. Providers will bill Arkansas Blue Cross for only the administration of the medication.

Under the Preferred Payment Plan ("PPP") participation agreement, Arkansas Blue Cross has established an allowance for **Tysabri®** administered by physicians. Under all other Arkansas Blue Cross insured health plans and policies that include prescription drug benefits, prescription medications must be obtained from a participating pharmacy in order to be covered.

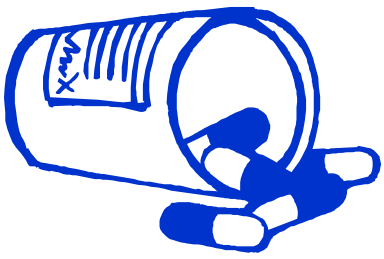
Arkansas Blue has established the following coverage policy and claims filing policies and procedures for **Tysabri®** when administered by physicians:

1. Prior approval of coverage is required. Call the prior authorization number for eligibility verification and to arrange the pharmacy contact for dispensing the medication at (501) 378-3392.
2. Upon receipt of a prescription, the preferred pharmacy provider, ***Caremark Specialty Pharmacy***, will dispense and ship the medication to the physician's office under the patient's name prior to the scheduled administration.
3. ***Caremark Specialty Pharmacy*** will bill Arkansas Blue Cross (or one of its affiliates, or by a self-funded group health plan accessing an affiliate's network) for the cost of the medication. Providers will then bill only for administration. The provider will not take ownership of the drug and will avoid any inventory investment under this process.

The procedures should reduce the financial risk to providers from a claim denial or payment delay that may occur for whatever reason and prevent the provider's need to maintain an inventory of this expensive medication.

Please note: The affiliates and subsidiaries of Arkansas Blue Cross, specifically Health Advantage and BlueAdvantage Administrators of Arkansas, have elected to receive the benefit of the PPP agreement with respect to the allowance for **Tysabri®**, as well as the claims filing policies and procedures for **Tysabri®** outlined above.

The administration of **Tysabri®** should be billed using the new "G" codes through 2005. Please use G0359 for the first hour and G0360 for any required subsequent hour.



New Member ID's for All Members of Health Advantage and BlueAdvantage Administrators of Arkansas:

In a continuing effort to protect the privacy of our members, Health Advantage and Blue-Advantage Administrators of Arkansas will complete the reissue of new ID cards for all members during December 2004. The new member ID cards replace the current social security based member ID number with a new unique identifier.

Health Advantage completed converting member ID numbers over the Labor Day week-end. The format of the new Health Advantage randomly assigned contract number is as follows: XCHK00067367

The Health Advantage conversion **excluded** all active members of Arkansas State Employees (ASE) and Public School Employees (PSE). The Arkansas State Employees Benefit Division will be assigning the main portion of the member ID number for ASE and PSE and Health Advantage will add the prefix of XCHY00.

The new member ID numbers for PSE became effective October 1, 2004. The new member ID numbers for ASE will be effective January 1, 2005. The format of the ASE/PSE contract number is as follows: XCHY00123456

BlueAdvantage reissued member cards in four phases: July, August, September, and December, 2004. Wal-Mart members will be included in this final phase scheduled for December 2004.

By January 2005, all current members of BlueAdvantage will possess ID cards that do not utilize social security numbers as part of their member ID number. Member numbers will however continue to begin with a three-character prefix.

Please note that it is essential for prompt claim processing to submit the current member ID number. Always ask to see a member's ID card whenever healthcare services are requested.

If there is any question regarding the correct member ID for claim filing, the Advanced Health Information Network (AHIN) workstation will always display the correct member number and eligibility information.

Health Advantage Provider Appeals Procedures:

If a provider wishes to appeal a claim denial, the provider must submit an appeal, in writing, within 180 days of the denial of the provider's claim. Providers may appeal an administrative decision or coverage policy decision made by Health Advantage. All appeals are reviewed based on the additional information supplied by the provider at the time of the appeal before a final decision is made.

A review of the appeal will be conducted within 30 working days after the receipt of the provider's written appeal. The appeal will be reviewed by one of Health Advantage's Member Response Coordinators for administrative issues or a Health Advantage Medical Director for coverage policy issues.

The purpose of the Health Advantage coverage policies is to inform members and physicians why certain medical procedures may or may not be covered under Health Advantage health plans.

Health Advantage requests that before a provider appeals a claim denial, the provider access and review the applicable Health Advantage coverage policy. The coverage policies are available on the Health Advantage website at **www.HealthAdvantage-hmo.com**.

Health Advantage — Member Satisfaction Survey For 2004:

Health Advantage participates in an annual ***Membership Satisfaction Survey*** that meets the requirements to the National Committee of Quality Assurance (NCQA). The membership survey not only includes information on the administrative services such as customer service, claims timeliness, and accuracy, but also request information on how members feel about their physicians.

Health Advantage is happy to report for 2004 members continue to indicate they are highly satisfied with Health Advantage and their personal physician and/or specialists, higher than the national and regional responses of other health maintenance organizations and others participating in the survey.

The following are highlights from this year's survey.
Of the members returning the survey:

- 96% thought their claims were handled correctly by Health Advantage.
- 94% felt they were treated with courtesy and respect by the provider's office staff.
- 92% felt that the provider's office staff was as helpful as they thought they should be.

Of those returning the survey, members felt:

- More than 9 out of 10 doctors (or other health care providers,) were perceived as "usually" or "always" listened carefully to their patients, explained things in a way that the patient could understand, and showed respect for what the patient had to say.
- Almost 9 out of 10 doctors (or other health care providers) were reported as "usually" or "always" spent sufficient time with their patients.

Overall, on a scale of 0 to 10, where 10 is the best possible:

- 95% of respondents gave their health care a 6 or higher.
- 88% of respondents gave their health plan a rating of 6 or higher.
- 94% gave their personal doctor or nurse a 6 or higher.
- 91% gave their specialist doctor or nurse a 6 or higher.

What counts most to members? Based upon additional analysis of the survey results, the following service factors were determined to be the biggest predictors and drivers of members' overall satisfaction with their health plan and their physician:

1. Physicians, specialists, and other health care professionals that listen carefully and explain things in an understandable way.
2. Member's claims are handled correctly.

Details of the results with comparisons for the last five years are on the Health Advantage Web site.

Health Advantage — Update for Routine Gynecology Diagnoses:

Health Advantage has updated the list of routine/wellness diagnoses for gynecological care to include codes V72.31 and V72.32.

For further information, please call Customer Service at 800-843-1329.

Speech Therapy—CPT Code 92507:

Arkansas Blue Cross and Blue Shield has identified a billing problem with CPT code 92507 (Treatment of speech, language, voice, communication, auditory processing, and/or aural processing disorder [includes aural rehabilitation, individual]). This procedure does not include a time designation and is restricted to one service per day, regardless of the amount of time spent with the patient.

According to the American Speech-Language Hearing Association (ASHA) analysis of the 2004 Medicare Fee Schedule, "All CPT codes represent a single treatment session or one evaluation unless a specific time is designated in the CPT descriptor."

The ASHA analysis restates the above in a separate paragraph: ""The CPT/HCPCS procedures for speech-language pathology do not include time designations. Each procedure is intended to represent a typical visit rather than a 15-minute session."

Billings for more than one service per day will be denied.

Ultrasound Studies of Pelvic Anatomy:

When a transmural and transvaginal ultrasound of the pelvic anatomy are billed on the same day, multiple procedure rules will be applied for both the technical and professional components of the CPT codes. The lesser procedure code will be allowed at 50% of the Arkansas Blue Cross and Blue Shield fee schedule allowance.

CPT Code 76830 — ultrasound, transvaginal.
CPT Code 76856 — ultrasound, pelvic (non-obstetric), B-scan and/or real time with image documentation; complete.
CPT Code 76857 — ultrasound, pelvic (non-obstetric), B-scan and/or real time with image documentation; limited or follow-up (eg, for follicles).

BlueCard News—New Publication for Arkansas Blue Cross and Blue Shield:

Arkansas Blue Cross and Blue Shield has a new publication, ***BlueCard News***. ***BlueCard News*** is a publication that contains detailed information about claims submission, changes in procedures and other information related solely to BlueCard and the BlueCard Program. The first issue was printed and distributed during November, 2004.

The BlueCard links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for professional outpatient and inpatient claims processing and reimbursement. The program allows participating Blue Cross and Blue Shield providers in every state to submit claims for Indemnity and PPO patients who are enrolled through another Blue Plan to their local Blue Cross and Blue Shield Plan.

Through the BlueCard program, providers can submit claims for Blue Cross and Blue Shield members (including Blue Cross only and Blue Shield only) visiting providers from other areas directly to Arkansas Blue Cross and Blue Shield. Arkansas Blue Cross is the sole contact for all Blue Cross and Blue Shield claims submissions, payments, adjustments, services and inquiries.

Arkansas Blue Cross and Blue Shield Moves to the 2005 Medicare Relative Value Units:

(Reprint from October 2004 Special Issue of *Providers' News*.)

Effective January 31, 2005, Arkansas Blue Cross and Blue Shield will move to the 2005 Medicare Relative Value Units for **most** codes. The fee schedule for codes with relative value units will be available on the Advanced Health Information Network (AHIN).

Most providers will experience an increase in allowance primarily due to a $1.00 increase in the conversion factor for **most** codes.

The allowances for Computerized Tomography (CT) scans will be reduced based on a change in the allowance for the practice expense for the technical component of these services. The fee schedule change is similar to the reduction for MRI's that was effective October 1, 2001.

For the most up-to-date Arkansas Blue Cross and Blue Cross fee schedule, visit the AHIN website. Don't have access to AHIN? Please call (501) 378-2419 or toll-free (866) 582-3247 for provider enrollment information.

Code Review Reminders:

(Reprint from the September 1998 issue of Providers' News)

The following items are reminders of how to submit claims to ensure appropriate adjudication by the Code Review software:

- Please do not bill bilateral procedures on one line. Submit the primary site and amount charged on one service line without Modifier 50 on the second site and amount charged on another service line with Modifier 50.
- Review the CPT code description to determine if specific time parameters are incorporated and submit the appropriate unit count. For example, it the CPT code's description is for services in a 30 day span and you are billing for one month, the correct unit count on this service line would be one. Another example is when the code specifies the amount of time, such as "...45 to 50 minutes…", the correct number of services to submit is one.
- CPT codes 97001 through 97028 do not describe time parameters. The appropriate unit count is one per day.
- Almost all codes beginning with 00100 through 69999 have some type of global period defined where pre-op and/or post–op days are included in the reimbursement for the procedure. (There are also other global package codes outside of this range.) The number of days varies per procedure but almost always includes the day the procedure was performed. If there are extenuating circumstances that result in a service being performed that should be included in the global package concept for the procedure, please submit the appropriate modifier for this service.

Code Review Change for Health Advantage only: CPT code 99000 is not accepted unless the specimen is being sent to an outside independent laboratory. If applicable, please submit the appropriate modifier. The collection of the specimen is also included in any office visit and/or evaluation and management code submitted for that date of service.

Arkansas Blue Cross and Blue Shield Named a "Top Innovator" in Information Technology:

Arkansas Blue Cross and Blue Shield has been named by ***Information Week*** magazine as one of the 500 "Top Innovators" in Information Technology (IT) in the country. Only two other Arkansas companies were named to the list (Acxiom and Wal-Mart).

From the September 20, 2004 publication, ***Information Week*** said that companies named to its list demonstrate a pattern of technological and organizational innovation, striking a favorable balance between investment and cost effectiveness.

"This is a significant achievement for Arkansas Blue Cross and Blue Shield to be listed among such national giants of technology as Verizon, Xerox, Dell, Marriott, FedEx, Panasonic, General Motors, Acxiom and Wal-Mart," said Robert L. Shoptaw, Chief Executive Officer of Arkansas Blue Cross. "It's also a tribute to the technology investments we've made that directly benefit our policyholders and our providers," Shoptaw said.

Shoptaw attributed the national recognition to several strategic innovations made by Arkansas Blue Cross in recent years:

Advanced Health Information Network:
The Advanced Health Information Network **(**AHIN) provides doctors and hospitals with free, secure, online access to patient eligibility and claims information, helping to speed up the delivery of care. By connecting electronically to all 41 Blue Cross and Blue Shield Plans across the country, Arkansas Blue Cross can deliver electronic eligibility verification to Arkansas physicians for any person insured by Blue Cross anywhere in the United States, in as little as 8 to 10 seconds.

AHIN also allows direct claims submission and real-time correction of claims. As a result, more than 80 percent of all provider claims are submitted electronically, speeding up the process of claims payment. By combining AHIN with an innovative electronic "reading" of paper claims, all claims are paid in an average of six days after receipt. "Clean" claims, where all information is correct and complete, are paid in as little as two days after receipt.

Consumer-Driven Health-Care Tools:
Consumer-driven health-care tools give greater control over health-care spending to the policyholders who want to take advantage of Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or Flexible Spending Accounts (FSAs).

Arkansas Blue Cross has developed a unique "one-to-many" integrated settlement engine that facilitates the automatic transfer of health-care related payments between the policy-holder, Arkansas Blue Cross, medical providers and any recognized financial services company that policyholders may choose to administer their HSAs, HRAs or FSAs. This simplifies and speeds the payment process for all parties involved.

HIPAA Compliance strategy:
The HIPAA compliance strategy, developed by Arkansas Blue Cross, was particularly innovative in meeting the wide array of Electronic Data Interchange (EDI) and the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA):

- Arkansas Blue Cross was one of the few "Covered Entities" in the country to be ready on time to achieve HIPAA compliance with EDI transactions (claims, eligibility and claims status) at the original required date of October 16, 2002.

(Continued on page 11)

(Continued from page 10)

- Arkansas Blue Cross was able to hold its overall cost of HIPAA compliance to 40 percent less than the national average of Health Plan compliance costs reported by the Gartner Group, a national advisory group. Arkansas Blue Cross was able to hold down costs because of its long-term strategic IT investments and advanced involvement in national standards-setting organizations.

- By positioning AHIN as an independent "single-source clearinghouse," Arkansas Blue Cross was able to make the total claims-filing process easier for medical providers. This clearinghouse concept allows providers to send all of their claims for payment, regardless of which health insurance company they should go to. AHIN sorts the claims electronically, performs several editing functions and forwards the claims on to the appropriate insurance company for payment.

- If a provider's claims billing system, typically referred to as a Practice Management System (PMS), does not generate claims in the HIPAA-required format, AHIN also offers the service of translating those claims into the required format. Translating claims enables providers to add situational data elements where needed and forward claims on to any insurance company. This service is offered free of charge for any claim involving Arkansas Blue Cross, Health Advantage, BlueAdvantage Administrators of Arkansas, Medicare, or Medicaid. For any other commercial insurance company, the small fee charged is far less than any other available.

- Many providers were faced with substantial new fees being imposed by PMS vendors to generate HIPAA-complaint transactions before passing them on to insurance companies for payment. Many providers were troubled with those major new fees and approached Arkansas Blue Cross for assistance to find alternative IT approaches.

- In addition to the AHIN solutions, Arkansas Blue Cross found three other HIPAA-compliant billing options that were far less expensive than what the PMS vendor offered, demonstrated their effectiveness with some pilot locations, and then communicated these options to all providers across Arkansas. Working with other Blue Cross and Blue Shield Plans nationwide to find lower-cost and more effective options, Arkansas Blue Cross shared these options and its own unique design concept with providers and medical societies across the country, so that additional options could also be built.

"Being named among the 500 best Information Technology innovators in Corporate America is a preeminent achievement," said Joseph S. Smith, Arkansas Blue Cross Vice President and Chief Information Officer. "Without question, this is a major corporate milestone delivered by a vast array of dedicated IT professionals, enabled by a supportive Board of Directors and Senior Leadership Team," Smith said.

Information Week magazine reviewed thousands of companies spanning 21 industries to compile its list of top 500 innovators. ***Information Week*** magazine evaluated the companies on their IT strategies, innovative programs, staffing, training and investment in technology.

Arkansas' FirstSource PPO Access Only Groups — As of January 2005:

Group Name	Group Name
• Aalf's Manufacturing Inc / Midland's Choice	• Howard Memorial
• ACF Industries Inc / American Railcar	• James Hardie / Bryar Gypsum
• Anchor Packaging / Hermann Co.	• KLA Benefits / Klipsch LLC
• AR Carpenters Health & Welfare Fund	• LA Darling
• AR Sheet Metal Workers -Local #36-L	• Levi Hospital
• Arkansas State University Athletes	• Magnolia Hospital
• Arvest Bank	• Marshalltown Tools
• Ashley County Medical Center	• Maverick Tube Corp
• Atlantic Research	• Motor Appliance Corporation
• Basler Electric	• Nestle USA
• BEKAERT - Rogers, AR Location	• Newport Hospital
• BEKAERT - Van Buren, AR Location	• Odom's Tennessee Pride Sausage
• Boar's Head Provisions Co	• Paxton Media / Jonesboro Sun
• Brentwood Industries, Inc	• Peterson Manufacturing / Mission Plastics
• Bridgestone - Firestone	• REA Magnet Wire
• Bryce Corporation	• Siegel-Robert Inc
• Columbia Forest Products	• Siplast Inc
• Defiance Metals	• Southern Painters Welfare
• Diocese Of Little Rock / Christian Brothers	• St. Michael Healthcare-Hospital
• FedEx Freight East, Inc / (American Freightways)	• St. Michael Healthcare-Rehabilitation
	• St. Michael Healthcare-COBRA
• Franklin Electric	• Town & Country Grocers / Price Chopper
• Genmar - Ranger Boats	• Townsend Foods
• Harding University	• UFCW (Kroger & Consumer Market)
• Harps Food Stores	• Wabash National / Cloud Corp
• Hot Spring County (HSC) Medical Center	• Wallace & Owens

NOTE: Claims for Access Only groups may be submitted electronically to Arkansas Blue Cross and Blue Shield.

Arkansas' FirstSource PPO Access Only Groups — Terminations since Jan 2004:

Group Name	Termination Date	
• Alcoa	1/1/2004	
• American Greetings	1/1/2004	
• Ball Corp	1/1/2004	
• Eastern Ozark Regional Healthcare	1/1/2004	To Blue Card
• Emerson Electric, Kennett, MO	1/1/2004	
• Emerson Electric/US Electric Motors - Mena	1/1/2004	
• Emerson Motors - Rogers	4/1/2004	
• Emerson White Rogers - Harrison	9/1/2004	To Blue Card
• HealthScope Benefits—Employees	1/1/2005	
• Magna International Retirees	5/1/2004	
• Norandal USA	1/1/2004	To Blue Card
• Quebecor World	1/1/2004	To Blue Card
• Reynolds	1/1/2004	
• Wal-Mart	1/1/2004	To Blue Advantage
• Whirlpool	1/1/2005	

CPT Code 61795:

CPT Code 61795 is an add-on code describing a computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal.

Computer assisted surgery encompasses three key activities:

1. Planning,
2. Registration, and
3. Navigation.

Arkansas Blue Cross and Blue Shield has seen CPT Code 61795 billed routinely with some sinus procedures and requested clarification of the code from the ***CPT Information Services.***

Arkansas Blue Cross was informed that the vignette supplied by RUC described one to two hours of pre-operative planning, a major component of the code.
Claims for procedures which does not meet this definition will be denied, or if determined on a post-pay basis does not meet criteria, over-payment will be requested.

Significant Changes for Arkansas State Employees (ASE):

Effective January 1, 2005, the Arkansas State Employees covered by Arkansas Blue Cross and Blue Shield or Health Advantage will have preventive services covered at 100% of the allowable charges. No deductible, coinsurance or co-payments will be charged to the patient if one of the following procedures codes is filed with the diagnosis codes specified in the chart below. **Please note that the new CPT codes for gynecology visits have been added to the chart.**

In a continuing effort to protect the privacy of our members, Arkansas Blue Cross and Health Advantage will reissue new ID cards for all members replacing the current social security-based member number with a new unique identifier. The new ID card will also contain a new group number. Providers will need to obtain a copy of the new member ID card and update their billing system to ensure claims are submitted with the new group and ID numbers.

Providers should call 1-800-482-8416 to verify benefits and check claims status for ASE/PSE members. The number will route providers and members through the IVR. If the caller opts out of the IVR, the call will be directed to the ASE/PSE Customer Service Division.

New Patient - Well Baby Visits

CPT Codes	Ages	Diagnosis Code Required
99381	Under 1 year	Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Under 18 years of age)

CPT Codes	Ages	Diagnosis Code Required
99382	Age 1-4	Early Childhood--Must be billed with diagnosis code V20.2
99383	Age 5-11	Late Childhood--Must be billed with diagnosis code V20.2
99384	Age 12-17	Adolescent--Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Over 18 years of age)

CPT Codes	Ages	Diagnosis Code Required
99385	Age 18-39	Must be billed with diagnosis codes V72.3, V70, V70.0, V7231, V7232, or V7612.
99386	Age 40-64	
99387	Age 65+	

Established Patient - Well Baby Visits (Under 18 years of age)

CPT Codes	Ages	Diagnosis Code Required
99391	Under 1 Year	Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Under 18 years of age)

CPT Codes	Ages	Diagnosis Code Required
99392	Age 1-4	Early Childhood--Must be billed with diagnosis code V20.2
99393	Age 5-11	Late Childhood--Must be billed with diagnosis code V20.2
99394	Age 12-17	Adolescent--Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Over 18 years of age)

CPT Codes	Ages	Diagnosis Code Required
99395	Age 18-39	Must be billed with diagnosis codes V72.3, V70, V70.0, V7612, V7231, or V7232.
99396	Age 40-64	
99397	Age 65+	

Newborn Care -Well Baby Visits (Under 18 years of age)

CPT Codes	Ages	Diagnosis Code Required
99432	Under 1 Year	Must be billed with diagnosis code V20.2

Preventive Care—Adult (members age 18 and over)

Description	CPT Codes	Ages	Diagnosis Code Required
Annual Physical		Age 18+	Must be billed with diagnosis codes V72.3, V70, V70.0, V7612, V7231, or V7232.
Office Visit	99385 & 99395	Age 18-39	
Office Visit	99386 & 99396	Age 40-64	
Office Visit	99387 & 99397	Age 65 +	
Laboratory Services	81000-81005, 80051, 80053, 80061, 85018, 85014, 85025, or 85027	Age 18+	

Screening Mammogram (including breast exam)

Description	CPT Codes	Ages	Diagnosis Code Required
Mammogram, unilateral	76090, 76092 and G0202, or Revenue Code 403	Age 40 +	Allowable with any diagnosis code.
- with computer-aided detection	76083	Age 40 +	

Pap Smear

CPT Codes	Ages	Diagnosis Code Required
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174-88175	Age 18+	Allowable with any diagnosis code.

Prostate Specific Antigen (PSA)

CPT Codes	Ages	Diagnosis Code Required
84152, 84153, 84154	Age 40 +	Allowable with any diag code.

Colorectal Cancer Screening (Choice of the following beginning at age 50)

Description	CPT Codes	Age /Frequency	Diagnosis Code Required
Fecal occult blood test and one of the following:	82270, 82274	Annually	Allowable with any diagnosis code.
- Flexible sigmoidoscopy	45330—45339	Every 5 years	
- Colonoscopy	45378—45385	Once every 10 yrs	
- Double contrast barium enema	74280	Once every 5 yrs	

Cholesterol and HDL Screening

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Males Age 35+	82465, 83718-83721	Once every 5 yrs	Allowable with any diagnosis code.
Females Age 45+	82465, 83718-83721	Once every 5 yrs	

Immunizations – Adult (members age 18 and over)

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Diphtheria	90719	Every 10 years	Allowable with any diagnosis code.
Diphtheria and Tetanus toxoid (Td) ages over seven	90718	Every 10 years	
Hepatitis B (Hep B)	90740, 90747, 90746	Once Per Lifetime	
Influenza	90658	Annually	
Pneumococcal Conjugate	90732	Adults over 55 or immunosuppressed	

Preventative Care—Child

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
All childhood immunizations		Under age 18	Allowable with any diag code.

2005 Coding Changes:

Medicare will not recognize the following drug/ chemotherapy administration codes in 2005: 90780, 90781, 90782, 90784, 96400, 96408, 96410, 96412, and 96414. The codes have been replaced by more descriptive 'G' codes: G0345-G0363. With implementation of the 2005 RVU's effective January 31, 2005, Arkansas Blue Cross and Blue Shield and its' subsidiaries will recognize the new 'G' codes and will NOT recognize the following administration codes.

Proc Mod	Description
90780	Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour
90781	Intravenous infusion for therapy/diagnosis, admin. by physician or under direct supervision of physician; each additional hour, up to 8 hrs (List separately in add. to code for primary proc)
90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular
90784	Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous
96400	Chemotherapy administration, subcutaneous or intramuscular, with/without local anesthesia
96408	Chemotherapy administration, intravenous; push technique
96410	Chemotherapy administration, intravenous; infusion technique, up to one hour
96412	Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

The appropriate 'G' codes are:

Crosswalk From CPT to New 'G' Codes

CPT	HCPCS	Description
Hydration		
90780	G0345	Intravenous infusion, hydration; initial, up to one hour
90781	G0346	Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)
Injections and Infusions (Non-chemotherapy; Other than hydration)		
90780	G0347	Intravenous infusion, for therapeutic/diagnostic (Specify substance or drug); initial, up to one hour
90781	G0348	Intravenous infusion, for therapeutic/diagnostic (Specify substance or drug); each additional hour, up to 8 hours (List separately in addition to code for primary procedure & report in conjunction with G0347)
90781	G0349	Additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)
N/A	G0350	Concurrent infusion (List separately in addition to code for primary procedure report only once per substance/drug regardless of duration, report G0350 in conjunction with G0345
90782	G0351	Therapeutic or diagnostic injection (Specify substance or drug); subcutaneous or intramuscular

Crosswalk From CPT to New 'G' Codes

CPT	HCPCS	Description
Injections and Infusions (Non-chemotherapy; Other than hydration) continued		
90783	N/A	Intra-arterial
90784	G0353	Intravenous push, single or initial substance/drug
N/A	G0354	Intravenous push, single or initial substance/drug; each additional sequential intravenous push (List separately in addition to code for primary procedure)
90788	N/A	Intramuscular injection of antibiotic
90799	N/A	Unlisted injection or infusion
Chemotherapy Administration		
96400	G0355	Chemotherapy admin, subcutaneous or intramuscular non-hormonal antineoplastic
96400	G0356	Hormonal antineoplastic
96405	N/A	Chemotherapy administration, intralesional, up to and including 7 lesions
96406	N/A	Chemotherapy administration, intralesional, more than 7 lesions
96408	G0357	Intravenous, push technique, single or initial substance/drug
96408	G0358	Intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)
96410	G0359	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
96412	G0360	Chemotherapy administration, intravenous infusion technique; each additional hour, up to 8 hours (List separately in addition to code for primary procedure) Use G0360 in conjunction with G0359
96414	G0361	Initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump
96412	G0362	Each additional sequential infusion (different substance/drug), up to 1 hour (use with G0359)
96420	N/A	Chemotherapy administration, intra-arterial; push technique
96422	N/A	Chemotherapy administration, intra-arterial; infusion technique, up to one hour
96423	N/A	Chemotherapy administration, intra-arterial; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)
96425	N/A	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96440	N/A	Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96445	N/A	Chemotherapy admin into peritoneal cavity, requiring & including peritoneocentesis
96450	N/A	Chemotherapy admin, into CNS (eg, intrathecal), requiring & including spinal puncture
96520	N/A	Refilling and maintenance of portable pump
N/A	G0363	Irrigation of implanted venous access device for drug delivery systems (Do not report G0363 if an injection or infusion is provided on the same day)
96530	N/A	Refilling & maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)
96542	N/A	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

Fee Schedule Updates:

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule regarding Home Health Agencies effective **September 1, 2004**.

CPT Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
S9122	$ 16.00			$ 16.00		
99500	$ 128.00			$ 128.00		
99501	$ 128.00			$ 128.00		
99502	$ 128.00			$ 128.00		
99503	$ 128.00			$ 128.00		
99504	$ 128.00			$ 128.00		
99505	$ 128.00			$ 128.00		
99506	$ 128.00			$ 128.00		
99507	$ 128.00			$ 128.00		
99509	$ 128.00			$ 128.00		
99510	$ 128.00			$ 128.00		
99511	$ 128.00			$ 128.00		
99512	$ 128.00			$ 128.00		
99600	$ 128.00			$ 128.00		

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule regarding Home Health Agencies effective **October 1, 2004**.

CPT Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
G0329	BR			BR		
G0341	BR			BR		
G0342	BR			BR		
G0343	BR			BR		

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule regarding Medical and Surgical Supplies effective **October 1, 2004**.

HCPCS Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
A6550	$ 27.42	$ 0.00	$ 0.00			
A6551	$ 24.53	$ 0.00	$ 0.00			

Fee Schedule Updates:

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule effective **October 20, 2004**.

CPT Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
52234	$ 655.65			$ 383.48		
92950	$ 483.72			$ 292.57		

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule regarding Durable Medical Equipment effective **October 27, 2004.**

HCPCS Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
K0627	$ 515.31	$ 0.00	$ 0.00	$ 515.31	$ 0.00	$ 0.00

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule to include facility allowances effective **October 27, 2004**.

CPT Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
96100	$ 113.65			$ 111.90		
96105	$ 113.65			$ 111.90		
96110	$ 21.56			$ 16.32		
96111	$ 224.38			$ 168.43		

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule to include facility allowances effective **October 27, 2004**.

CPT Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
59020	$ 98.49	$ 62.36	$ 36.13	$ 65.36	$ 98.49	$ 0
59025	$ 65.27	$ 50.12	$ 15.15	$ 50.12	$ 65.27	$ 0

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule regarding Home Health Agencies allowances effective **October 27, 2004**.

HCPCS Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
S9123	$ 30.00			$ 30.00		

Fee Schedule Updates:

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule allowances effective **November 10, 2004**.

HCPCS Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
L1830	$ 108.00			$ 108.00		
L1831	$ 108.00			$ 108.00		
L1832	$ 108.00			$ 108.00		
L1834	$ 108.00			$ 108.00		

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule allowances effective **November 10, 2004.**

CPT Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
93018	$ 25.06	$ 25.06	$ 0	$ 25.06	$ 25.06	$ 0
93307	$ 315.88	$ 76.93	$ 238.95	$ 76.93	$ 76.93	$ 0

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule allowances effective **November 17, 2004.**

HCPCS Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
B9002	$ 1,112.50	$ 111.25	BR	$ 1,112.50	$ 111.25	BR
S2250	$ 0.00	$ 0.00	$ 0.00	$ 1,465.16	$ 0.00	$ 0.00

The following updates were made to the Arkansas Blue Cross and Blue Shield Fee Schedule allowances effective **November 17, 2004.**

CPT Code	Total / Purchase	Prof / Rental	Technical	Total / Purchase SOS	Prof / Rental SOS	Technical SOS
93042	$ 12.82	$ 12.82	$ 0.00	$ 12.82	$ 12.82	$ 0.00
93600	$ 301.31	$ 179.50	$ 121.81	$ 179.50	$ 179.50	$ 0.00
93602	$ 249.44	$ 180.09	$ 69.35	$ 180.09	$ 180.09	$ 0.00
93603	$ 283.82	$ 178.92	$ 104.90	$ 178.92	$ 178.92	$ 0.00
93609	$ 609.61	$ 441.18	$ 168.43	$ 441.18	$ 441.18	$ 0.00
93610	$ 340.94	$ 255.85	$ 85.09	$ 255.85	$ 255.85	$ 0.00
93612	$ 356.67	$ 255.85	$ 100.82	$ 255.85	$ 255.85	$ 0.00
93615	$ 95.58	$ 75.76	$ 19.82	$ 75.76	$ 75.76	$ 0.00
93616	$ 135.21	$ 115.39	$ 19.82	$ 115.39	$ 115.39	$ 0.00
93618	$ 607.28	$ 361.34	$ 245.94	$ 361.34	$ 361.34	$ 0.00
93619	$ 1,117.81	$ 639.33	$ 478.48	$ 639.33	$ 639.33	$ 0.00

2005 Federal Employee Program Changes:

The following information pertains only to the FEP program and it's members.

FEP Benefit Changes — Standard Option Only:

The following benefit changes are effective under the Standard Option coverage beginning January 1, 2005. (Enrollment code 104 or 105)

Physical Therapy, Speech Therapy and Occupational Therapy:
The visit limitations for Physical Therapy, Speech Therapy, and Occupational Therapy have changed to a combined total of 75 visits per person per year. When services are performed by a Preferred Provider, benefits are paid in full based on the Arkansas Blue Cross and Blue Shield allowance after the members' $15 copayment per date of service per provider.

In 2004, benefits were limited to 50 Physical Therapy services per person per year. Benefits for Speech and Occupational Therapy were limited to a combination of 25 therapy services per person per year.

Benefits for non-preferred providers have not changed for 2005. Those benefits are subject to the $250 calendar year deductible and paid at 75% of the Arkansas Blue Cross allowance.

Eye Examinations:
Benefits for eye examinations performed by covered professional providers to treat a specific medical condition are paid in full based on the Arkansas Blue Cross allowance after the members' $15 copayment. Previously, benefits for these eye exams were paid at 90% of the plans' allowance, after the calendar year deductible.

Benefits for eye examinations performed by non-participating providers to treat a medical condition have not changed for 2005.

Routine Physical Examinations:
Benefits for a routine physical exam for adults are available annually from a preferred physician regardless of the patient's age. Routine physical exams from a preferred provider have a $15 copayment. All other services listed below are paid in full based on the Arkansas Blue Cross allowance.

In 2004, benefits were provided for one routine physical exam every three calendar years for members under the age of 65 and one each calendar year for members age 65 and older. Benefits for a routine physical with a routine diagnosis, such as V70.0, include:

- History and risk assessment,
- Chest x-ray,
- EKG,
- Urinalysis,
- General health panel,
- Basic or comprehensive metabolic panel test,
- CBC, and
- Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides).

Note: Benefits are still available for all preventive care for children with a routine diagnosis (example V20.2). The guidelines are based on the recommendations of the *American Academy of Pediatric Guidelines* up to age 22. Benefits are paid in full based on the Arkansas Blue Cross allowance. No copayment or deductible applies.

Cancer Screenings:
The frequency and age limits for cancer screenings performed by participating and non-participating providers have been eliminated.

FEP Benefit Changes — Basic Option Only:

The following benefit changes are effective January 1, 2005 for the Basic Option coverage. (Enrollment code 111 or 112) **Reminder: Members covered under Basic Option must use Preferred providers.**

Routine Physical Examinations:
In 2005, benefits for a routine physical exam for adults from a preferred physician are available annually, regardless of the patient's age. Benefits for a routine physical with a routine diagnosis (example V70.0) include:

- History and risk assessment,
- Chest x-ray,
- EKG,
- Urinalysis,
- General health panel,
- Basic or comprehensive metabolic panel test,
- CBC, and
- Fasting lipoprotein profile (total cholesterol, LDL, HDL and/or triglycerides) when performed by a Preferred provider.

Benefits are paid in full based on our allowance after a $20 copayment for a preferred primary care provider per visit or $30 preferred specialist copayment per visit. In 2004, benefits were provided for one routine physical exam every three calendar years for members under the age of 65 and one each calendar year for members age 65 and older.

Note: Benefits are still available for preventive care for children with a routine diagnosis (example V20.2). These guidelines are based on the recommendations of the American Academy of Pediatric guidelines up to age 22. Benefits are paid in full based on our allowance after a $20 copayment for a preferred primary care provider per visit or $30 preferred specialist copayment per visit.

Maternity Benefits:
Maternity benefits for deliveries are paid in full based on the Arkansas Blue Cross and Blue Shield allowance in 2005. In 2004, benefits for the delivery were paid in full after the member paid a $100 copayment.

Benefits for the inpatient hospital care related to the delivery have not changed and are paid in full after a $100 per day copayment up to $500.

Laboratory Tests and X-Rays:
The copayment for laboratory tests and x-rays performed by a preferred physician or independent laboratory will be eliminated. In the past, benefits for these diagnostic tests were paid in full after a $20 copayment.

Outpatient Facility Services:
In 2005, benefits for outpatient facility care and medical supplies will be paid in full based on the Arkansas Blue Cross allowance subject to a $40 per day per facility copayment. In 2004, outpatient facility services were subject to a $30 per day per facility copayment. Benefits for medical supplies were subject to a 30 percent of the Plan allowance paid by the member.

Standard & Basic Option — Mail Order Pharmacy:

Effective January 1, 2005, the administrator for the mail service pharmacy will change from Medco Health Solutions to **Caremark**. Existing refills at Medco will automatically transferred to **Caremark** with the exception of compounds and controlled substances.

To order a refill for compound or controlled substances, providers should contact **Caremark** by using the new physician telephone number 1-800-378-5697.

FEP — Clarification of Offset Guidelines:

Federal Employee Program (FEP) Customer Service has received numerous questions regarding their offset process. Listed below are the guidelines:

- When the amount due to FEP is for $10 or less, a refund letter will not be sent. FEP will automatically offset this amount from future claims made payable to providers through Arkansas Blue Cross and Blue Shield Federal Employee Program.
- For refunds over $10, FEP uses two different refund request letters.
  a. when requesting amounts of at least $10 but not more than $50, or
  b. when requesting amounts of more than $50.

If a provider receives a letter and does not agree with the overpayment determination, FEP request providers call within 10 days of the letter date.

If the amount requested is over $10 but less than $50, please do not send a check to FEP. For the convenience of our providers, FEP will offset future claims made payable through the Arkansas Blue Cross and Blue Shield Federal Employee Program.

If the amount requested is more than $50, providers may remit the amount by check, along with a copy of the refund letter within 30 days; or if you prefer, FEP will offset future claims made payable through the Arkansas Blue Cross and Blue Shield Federal Employee Program.

Important

When an overpayment amount is initially offset, the Remittance Advice will indicate a negative amount along with data related to the claim for which the overpayment was made. Please keep the Remittance Advice for future reference.

If the overpayment is greater than the amount of claims payable that day, the Remittance Advice will indicate an "Amount Applied to FEP Carryover" equal to the balance still due and no check will be generated. The next time claims are paid, the amount being offset for a the previous overpayment will be displayed at the end of the Remittance Advice and a "Amount applied from FEP Carryover" and will be deducted from the claims payment amount for that day. For large overpayments, this carry-over process could continue for several days until the full amount is recovered.

FEP suggest that providers retain copies of all Arkansas Blue Cross and Blue Shield Federal Employee Program refund request letters and Remittance Advices that have a negative amount in a common file. Post offsets to the Remittance Advice as they occur to facilitate reconciliation of remittances and overpayment recoveries to your records.

FEP — Corrected Bill Submission Form:

Arkansas Blue Cross and Blue Shield developed a new form for Arkansas providers to use when submitting corrected bills, the Corrected Bill Submission Form. Implemented March 1, 2002, the Corrected Bill Submission Form must be completed and attached to all corrected bills submitted by Arkansas providers.

What is a “Corrected Bill”? A Corrected Bill is a claim that has been previously submitted to the plan for processing and has been finalized (paid or denied). A Corrected Bill Submission Form should be attached to the claim.

If a Corrected Bill Submission Form is not attached, the claim will be denied as a duplicate. Providers can access the Corrected Bill Submission Form on the Arkansas Blue Cross website (www.ArkansasBlueCross.com).

FEP — CMS 1500 Paper Anesthesia Time

Arkansas Blue Cross and Blue Shield has received anesthesia service claims with the anesthesia time billed in a wide variety of ways. In the past, Arkansas Blue Cross manually reviewed all anesthesia claims and corrected the time. However, this practice only perpetuated problems. Providers were never given feedback on the correct way to record this element.

Arkansas Blue Cross would prefer providers to file anesthesia services electronically. However, if providers file anesthesia services on CMS 1500s paper claim, please follow these guidelines:

- Claims submitted for anesthesia services by anesthesiologists or CRNA's must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in block 24g of the CMS 1500 form.
- When time minutes are not indicated on the claim the claim will be denied.

FEP — Durable Medical Equipment Claims Medicare Primary:

Effective August 1, 2004, FEP began receiving electronic crossover claims from Palmetto for Durable Medical Equipment (DME). When providers receive the Medicare remittance advice with the following remarks, it is not necessary to submit paper claims to FEP for secondary payment coordination:

- "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them."

Also the Medicare remittance advice will state:

- "Claim information forwarded to: BCBS OF ARKANSAS — FEP."

Please allow 30 days for FEP to process secondary payments claims based on the date Palmetto paid the original claim. Continuing to file paper claims for secondary payments only causes additional processing and paperwork.

FEP — Dental Changes:

Effective January 1, 2005, the FEP Dental Maximum allowable charge will be updated. (Please refer to the exhibits on pages 25-27)

When dental claims for FEP members are rendered in the state of Arkansas, claims should be sent to Arkansas Blue Cross and Blue Shield for processing. Please submit FEP dental claims to:

Arkansas Blue Cross and Blue Shield
Attention FEP
P O Box 2181
Little Rock AR 72203.

Note: To ensure proper payment of claims:

- Obtain the ID number from the member's identification card. The FEP identification number beginning with an "R" followed by 8 digits. (Example R12345678)
- Type your 5 digit Arkansas Blue Cross and Blue Shield provider number by your name in the middle of the dental claim form.

Note for Standard Option enrollment code 104 or 105: The FEP Dental fee schedule is not intended to be payment in full, but a benefit to offset the provider's charge. When the member uses a Preferred network dentist, the member pays the difference between the FEP fee schedule amount and the (MAC) Maximum Allowable Charge.

FEP — Basic Option Dental Fee Schedule:

Listed below is a complete list of all FEP dental services covered under the Basic Option Plan effective January 1, 2005.

Members pay a $20 copayment for each evaluation charge. FEP pays 100% of the Maximum Allowable Charge (MAC) for all other covered dental services.

Under the Basic Option Plan, a preferred provider must perform the service. If the provider is a participating dentist with Arkansas Blue Cross and Blue Shield, the provider is considered a Preferred provider under Basic Option.

Service and ADA code		MAC
0120	Periodic oral evaluation	$26.00
0140	Limited oral evaluation	$35.00
0150	comprehensive oral evaluation	$36.00

Note: Benefits are limited to a combined total of 2 evaluations per person per calendar year for 0120 and 0150

Radiographs		MAC
0210	Intraoral- complete series including bitewings (limited to 1 complete series every 3 years)	$85.00
0270	Bitewing- single film	$18.00
0272	Bitewing- two films	$26.00
0274	Bitewing - four films	$35.00

Note: Benefits are limited to a combined total of 4 films per person per calendar year for 0270, 0272, and 0274.

Preventive		MAC
1110	Prophylaxis - adult (up to 2 per calendar year)	$47.00
1120	Prophylaxis - child (up to 2 per calendar year)	$32.00
1201	Topical application of fluoride (including prophylaxis) -child (up to 2 per calendar year)	$50.00
1203	Topical application of fluoride (prophylaxis not included) -child (up to 2 per calendar year)	$18.00
1351	Sealant- per tooth, first and second molars only (once per tooth for children up to age 16 only)	$28.00

Note: Benefits are limited to a combined total of 2 visits per person per calendar year for 1120 and 1201.

Not covered: Any service not specifically listed above.

FEP — Standard Option Dental Fee Schedule:

Below is a list of dental services covered under Standard Option effective January 1, 2005.

Dental Code	Service	Up to Age 13	Age 13+	MAC
Clinical oral evaluations				
D0120	Periodic oral evaluation*	$12.00	$8.00	$26.00
D0140	Limited oral evaluation	$14.00	$9.00	$35.00
D0150	Comprehensive oral evaluation	$14.00	$9.00	$36.00
D0160	Detailed and extensive oral evaluation	$14.00	$9.00	$50.00
Radiographs				
D0210	Intraoral complete	$36.00	$22.00	$85.00
D0220	Intraoral periapical-single first film	$7.00	$5.00	$18.00
D0230	Intraoral periapical-each additional film	$4.00	$3.00	$15.00
D0240	Intraoral -occlusal film	$12.00	$7.00	$25.00
D0250	Extraoral-single film	$16.00	$10.00	$30.00
D0260	Extraoral-each additional film	$6.00	$4.00	$20.00
D0270	Bitewing-first film	$9.00	$6.00	$18.00
D0272	Bitewing-two film	$14.00	$9.00	$26.00
D0274	Bitewing-four film	$19.00	$12.00	$35.00
D0277	Bitewings-vertical-seven or eight films	$12.00	$7.00	$50.00
D0290	Posterior-anterior or lateral skull and facial bone survey film	$45.00	$28.00	$60.00
D0330	Panoramic film	$36.00	$23.00	$65.00
Tests and laboratory exams				
D0460	Pulp vitality tests	$11.00	$7.00	$25.00
Palliative treatment				
D9110	Palliative (emergency) treatment of dental pain minor procedures	$24.00	$15.00	$45.00
D2940	Fillings (sedatives)	$24.00	$15.00	$37.00
Preventive				
D1120	Prophylaxis-Child *	$22.00	$14.00	$32.00
D1110	Prophylaxis-Adult*		$16.00	$47.00
D1201	Topical application of fluoride child* (including prophylaxis)	$35.00	$22.00	$50.00
D1203	Topical application of fluoride child (excluding prophylaxis)	$13.00	$8.00	$18.00
D1205	Topical application of fluoride adult* (including prophylaxis)		$24.00	$66.00
D1204	Topical application of fluoride adult (excluding prophylaxis)		$8.00	$18.00
Space maintenance (passive appliances)				
D1510	Space maintainer-fixed-unilateral	$94.00	$59.00	$160.00
D1515	Space maintainer-fixed-bilateral	$139.00	$87.00	$200.00
D1520	Space maintainer-removable-unilateral	$94.00	$59.00	$160.00
D1525	Space maintainer-removable-bilateral	$139.00	$87.00	$200.00
D1550	Space maintainer-recementation of space maintainer	$22.00	$14.00	$40.00

*** Limited to two per person per calendar year**

Dental Code	Service	Up to Age 13	Age 13+	MAC
Amalgam restorations (including polishing)				
D2140	Amalgam-one surface, primary or permanent	$25.00	$16.00	$65.00
D2150	Amalgam-two surfaces, primary or permanent	$37.00	$23.00	$80.00
D2160	Amalgam-three surfaces, primary or permanent	$50.00	$31.00	$94.00
D2161	Amalgam-four surfaces, primary or permanent	$56.00	$35.00	$115.00
Filled or unfilled resin restorations				
D2330	Resin--one surface, anterior	$25.00	$16.00	$75.00
D2331	Resin--two surfaces, anterior	$37.00	$23.00	$95.00
D2332	Resin-three surfaces, anterior	$50.00	$31.00	$112.00
D2335	Resin--four or more surfaces or involving the incisal angle	$56.00	$35.00	$160.00
D2391	Resin Based Composite - one surface posterior	$25.00	$16.00	$90.00
D2392	Resin Based Composite - two surfaces posterior	$37.00	$23.00	$120.00
D2393	Resin Based Composite - Three surfaces posterior	$50.00	$31.00	$150.00
D2394	Resin Based Composite - Four or more surfaces posterior	$50.00	$31.00	$165.00
Inlay restorations				
D2510	Inlay--metallic--one surface, permanent	$25.00	$16.00	$380.00
D2520	Inlay--metallic--two surfaces, permanent	$37.00	$23.00	$480.00
D2530	Inlay--metallic--three surfaces, permanent	$50.00	$31.00	$520.00
D2610	Inlay--porcelain/ceramic--one surface	$25.00	$16.00	$450.00
D2620	Inlay--porcelain/ceramic--two surfaces	$37.00	$23.00	$500.00
D2630	Inlay--porcelain/ceramic--three surfaces	$50.00	$31.00	$600.00
D2650	Inlay--composite/resin--one surface	$25.00	$16.00	$425.00
D2651	Inlay--composite/resin--two surfaces	$37.00	$23.00	$445.00
D2652	Inlay--composite/resin--three surfaces	$50.00	$31.00	$500.00
Other restorative services				
D2951	Pin Retention--per tooth, in addition to restoration	$13.00	$8.00	$45.00
Extractions- includes local anesthesia and routine post-operative care				
D7140	Extraction Erupted Tooth or Exposed Root	$30.00	$19.00	$75.00
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth	$43.00	$27.00	$168.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$71.00	$45.00	$189.00
D9220	General Anesthesia in connection w/covered extractions	$43.00	$27.00	$250.00

FEP Fee Schedule Amount is the amount Standard Option Pays toward a covered dental service.

MAC (Maximum Allowable Charge) is the maximum amount Preferred network dentists will charge the FEP member for a covered dental service. The MAC may be updated periodically and is subject to change. For providers who sign a participating agreement with Arkansas Blue Cross and Blue Shield agree to accept the Arkansas Blue Cross Dental Fee schedule. (Note: This is the FEP Maximum Allowable charge.) When members use a Preferred network dentist, the member pays the difference between the FEP fee schedule and the MAC charge.

Providers' News

Arkansas Blue Cross and Blue Shield
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