Arkansas Blue Cross and Blue Shield

# Providers' News

December 2005

## 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
An Independent Licensee of the Blue Cross and Blue Shield Association

# Scope of Practice:

The following information only applies to providers submitting claims to and/or providers participating in the networks of Arkansas Blue Cross and Blue Shield and its affiliate and subsidiary companies. This change applies to services rendered in a "place of service" other than an inpatient hospital setting.

Any service provided in an inpatient hospital "place of service" are typically rendered by a hospital employee. Inpatient services are reimbursed as part of the inpatient hospital reimbursement and are not billed separately.

Please note the member's benefit certificate defines services eligible for reimbursement. A member's benefit certificate and its provisions take precedence over the information below.

**Audiologist:**
- Evaluate and treat speech, language, voice, communication and auditory processing (includes aural rehabilitation);
- Vestibular function testing when testing does not include neurological function integration;
- Audiologic function testing that does not include evoked potentials or emissions;
- Hearing aid examination, selection, and follow-up;
- Diagnostic analysis and reprogramming of cochlear implants;
- Auditory rehabilitation;
- Tinnitus assessment; and
- Canolith repositioning.

**Dietician:** When ordered by a physician:
- Medical nutrition assessment; and
- Re-assessment of individuals.

**Licensed Certified Social Worker (LCSW):**
- Health and behavior assessments and interventions.

**Licensed Professional Counselor (LPC):**
- Psychotherapy that does not include an evaluation/management service; and
- Health and behavior assessments and interventions.

**Occupational Therapist (OT):**
- Occupational therapy evaluation;
- Manual muscle testing, range of motion, and physical performance testing and measurement;
- Therapeutic exercises;
- Orthotic fitting and training;
- Prosthetic training;
- Self-care, home management services;
- Therapeutic exercises, whirlpool and paraffin bath;
- Assistive technology assessment; and
- Development of cognitive skills and sensory integrative techniques.

**Orthotist:**
- Fitting, training and follow-up of orthotics ordered by a physician.

**Pharmacist:**
- Dispensing and compounding (limited) of drugs; and
- Administration of influenza and pneumonia vaccines.

**Physical Therapist (PT):**
- Manual muscle testing, range of motion and physical performance testing and measurement;
- Physical therapy evaluation;
- Physical medicine treatment modalities and therapeutic procedures;
- Simple debridement of chronic wounds, with a physician's order;
- Wheelchair management;
- Orthotic fitting and training, prosthetic training; and
- Assistive technology assessment.

**Prosthetist:**
- Prosthetic training and checkout for orthotic/prosthestic use.

*(Continued from page 2)*

**Psychological Examiner (PE):**

- Developmental, psychological, and neuropsychological testing.

**Psychologist:**

- Psychiatric diagnostic interview examination;
- Psychotherapy that does not include an evaluation/management service; and
- Developmental, psychological, and neuropsychological testing.

**Respiratory Therapy (RT):**
(With the order of a physician):

- Perform pulmonary function testing;
- Administer inhaled medications;
- Provide patient education on asthma; and
- Teach proper technique for inhaled medication.

**Speech Pathologist (SP):**

- Evaluate and treat speech, language, voice, communication and auditory processing (includes aural rehabilitation);
- Treatment of swallowing dysfunction and/or oral function for feeding (not including endoscopy);
- Evaluation of oral and pharyngeal swallowing function;
- Evaluation and therapeutic services for use of a speech-generating device;
- Evaluation for speech generating augmentative and alternative communication devices; and
- Speech therapy.

# National Provider Identifier (NPI):

As of early December 2005, reports from the Centers for Medicare and Medicaid Services (CMS) indicate only about 2,000 providers in Arkansas have been assigned an National Provider Identifier (NPI). If you have not already applied for an NPI, please apply soon. Providers can apply online for an NPI at: ***http://nppes.cms.hhs.gov*.**

In 2006, Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries will request NPI information from providers that will help populate the claims processing systems. More detailed implementation information will be communicated to providers at a later date.

Please be aware that changes are forthcoming to the 1500 and UB paper claims forms. The changes to the forms will accommodate the 10 digit NPI. Arkansas Blue Cross and its affiliates and subsidiaries are planning to require the NPI on paper claims once the new claim forms have been mandated. For information regarding:

- 1500 forms, visit www.nucc.org;
- UB04 forms, visit www.nubc.org; and
- NPI, visit the CMS web-site: http://www.cms.hhs.gov/providers/npi/default.asp.

# Arkansas Blue Cross Adopts RBRVS for 2006:

Effective April 1, 2006, Arkansas Blue Cross and Blue Shield will adopt the 2006 Resource Based Relative Value System (RBRVS) Relative Value Units (RVUs) which were published in the November 21, 2005 Federal Register Final Rule.

A new Arkansas Blue Cross and Blue Shield fee schedule using 2006 RBRVS will be available on the AHIN website bulletin board January 1, 2006. The 2006 Arkansas Blue Cross and Blue Shield laboratory fee schedule allowances will also be available on the AHIN bulletin board on January 1, 2006.

# Non-Physician Providers:

Most CPT codes are designated as **"**Physician" services and will be denied as "outside the scope of practice" for non-physician providers.

Examples of "Physician" services include CPT codes 29000 - 29799 (Casting or strapping). These CPT Codes are specifically defined as "Physician" services, are normally considered a fragmentation of other physician services, and are not payable to non-physicians.

Most CPT codes applicable to non-physician providers can be found in the "Medicine" section of the CPT book. The appropriate code from this section should be utilized for services provided by non-physician providers.

# Presbyopia- Correcting Intraocular Lens:

Effective January 1, 2006, HCPCS will add code V2788 (Presbyopia Correcting Function of Intraocular Lens). The billing and payment for Intraocular lenses (IOL) is included in facility payments for the related surgical procedure.

HCPCS Code V2788 should be used to show the **DIFFERENCE** in the cost of the regular IOL and the Presbyopia correcting IOL. A facility must obtain a waiver from the patient to bill the patient for the difference in cost. The patient waiver should explain why HCPCS Code V2788 is necessary rather than the standard IOL and the difference in cost.

If a member chooses to have multifocal lens rather than monofocal lens, the member is responsible for the cost of the multifocal lens minus the Arkansas Blue Cross allowance to the facility for the monofocal lens:

- Allowance for monofocal lens = $225 if performed in an Abulatory Surgery Center;
- Allowance for monofocal lens = $300 if performed in a hospital outpatient setting.

The Arkansas Blue Cross allowance for the monofocal lens is included in the total allowance to the facility for the procedure of extraction and replacement of the lens.

# Remittance Advice Available Online via AHIN:

Over 8,000 providers in the state of Arkansas now have access to the Advanced Health Information Network (AHIN), Arkansas Blue Cross and Blue Shield's internet portal for providers.

For approximately two years, providers have been able to view remittances for individual claims online. Effective September 1 2005, providers are now able to search for and retrieve entire remittances (Adobe Acrobat (PDF) format) identical in all respects to the paper remittances currently mailed.

The online remittances can be printed, saved to a local machine, and replicated for use by multiple billers. Remittances are available approximately two days sooner on AHIN as compared to receipt by mail. Remittances will be maintained online for a period of six months.

For more information, please consult the bulletin board section of AHIN. Complete instructions on how to use this new function are listed.

# Depo-Provera—Injection Code J1055:

Code J1055: Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Depo-Provera).

Arkansas Blue Cross and Blue Shield has received numerous complaints regarding the pricing of medroxyprogesterone acetate. This drug is provided in a pre-filled 150 mg syringe and in a 400 mg vial. The pre-filled 150 mg syringes are more convenient but much more expensive than taking the 150 mg dosage from a 400 mg vial. The Arkansas Blue Cross payment is based on the cost of 150 mg taken from the 400 mg vial.

Arkansas Blue Cross contracts support this pricing methodology. The Primary Coverage Criteria in the Arkansas Blue Cross contracts includes the following language:

"…the Primary Coverage Criteria require that if there are two or more effective alternative health interventions, the Plan should limit its payment to the Allowable Charge for the most cost effective intervention."

# Sign Up Now For Electronic Payment Option:

To receive a claim payments via electronic funds transfer directly to a financial institution from Arkansas Blue Cross and Blue Shield, BlueCard, BlueAdvantage Administrators of Arkansas, Health Advantage, USAble Life Group Health, and USAble Administrators, please contact the local Provider Network Representative to request an enrollment packet. As a general rule, providers can receive payments one or two days sooner by EFT versus a paper check.

Note: The EFT payment option is not offered for the Federal Employee Program at this time.

# Coverage Policy Manual Update:

The following policies have been added or revised in the Arkansas Blue Cross and Blue Shield Policy Coverage Manual:

- Single Photon Emission Computed Tomography;
- Immune Globulin, Intravenous;
- Tumor Antigen, CA 125;
- Auditory Evoked Potential;
- Magnetic Innervation Therapy for Urinary Incontinence;
- Single Photon Emission Computed Tomography (SPECT);
- Virtual Colonoscopy / CT Colonography;
- Neuromuscular Stimulation, Functional;
- Extracorporeal Shock Wave Therapy For Plantar Fasciitis and Other Musculoskeletal Conditions;
- Extracranial-Intracranial Bypass Surgery in Cerebrovascular Disease;
- Sacroplasty; and
- Intrauterine Systems, Progesterone or Progestogen-Releasing.

# Flu Vaccine Supply:

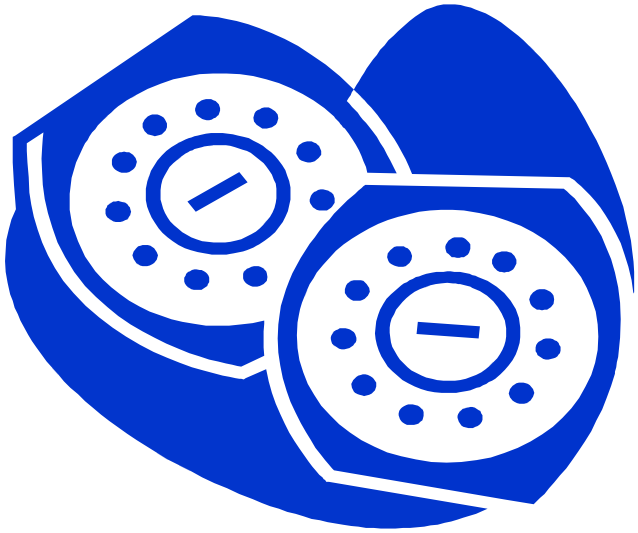
Many providers have been unable to obtain any flu vaccine again this year. Last year when it was time to order, Adventis took orders for 2 days at which time Adventis filled their quota and did not take anymore vaccine orders.

For next year, here is what providers need to do! Call Sanofi-Pasteur (1-800-vaccine) and create an account. Once an account has been created, Sanofi-Pasteur will contact providers when it is time to order next years vaccine. If a provider is on the list, the flu vaccine should be available.

# Pharmacy — Multi-Source Ortho Products No Longer Covered:

Effective January 1, 2006, **Arkansas Blue Cross and Blue Shield** will **no longer cover** the following brand name oral contraceptives. Generic equivalents will be covered.

| | |
|---|---|
| Loestrin | Ortho-Novum 1/50 |
| Loestrin FE | Ortho-Novum 1-35 |
| Novum 10/11 | Ortho-Novum 7-7-7 |
| Ortho-Cept | Ortho-Tri-Cyclen |
| Ortho-Cyclen | Tri-Norinyl |
| Ortho-Micronor | |



Arkansas Blue Cross and Blue Shield **will cover** the following Oral Contraceptives on the 2006 Oral Contraceptive Formulary:

| **First Tier** | |
|---|---|
| All Generic Oral Contraceptives | |
| **Second Tier** | |
| Yasmin | Ortho-Tricyclen-LO |
| Ortho-Evra Patch | Seasonale (3-copays) |
| **Third Tier** | |
| Estrostep FE | |

Note: This pharmacy change does not apply to the Federal Employee Program (FEP). For FEP pharmacy information, please contact the Prescription Drug Program at 1-800-624-5060 or the Mail Service Prescription Drug Program at 1-800-262-7890.

# Pharmacy — 2006 Formulary Changes:

The following medications will move to the third tier effective January 1, 2006 and will have a higher copayment thereafter. If a member is currently taking one of these medications, the member may choose to pay the higher copayment or the member may change to a comparable medication in the first or second copayment tier. This change applies to Arkansas Blue Cross and its affiliate and subsidiary companies.

A list of preferred or second-tier medications can be found the following websites:

www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com

Note: This pharmacy change does not apply to the Federal Employee Program (FEP). For FEP pharmacy information, please contact the Prescription Drug Program at 1-800-624-5060 or the Mail Service Prescription Drug Program at 1-800-262-7890.

| | | | |
|---|---|---|---|
| Actonel | Colocort | Gelclair | Natacyn |
| All Duet Products | Crestor | Gengraf Liquid Only | Natafort |
| Avandamet | Depen | I CAR Prenatal | Natelle |
| Avandia | Diamox | Inversine | Natelle-EZ |
| Cantil | Dipentum | Levaquin | Paxil CR |
| Carac | Effexor | Metrogel Vaginal | Procanbid |
| Cleocin Vaginal Ovules | Effexor XR | Motofen | |
| Clindamax Vaginal | Flexeril | Nascobal | |

# Pharmacy — Dose Titration:

As an effort to control rapidly rising drug costs, Arkansas Blue Cross and Blue Shield and its affiliate and subsidiary companies will implement a dose titration policy effective December 15, 2005.

The following brand medications (including their generic equivalents and dosage strengths) are most affected by this titration policy:

- Geodon
- Gleevec
- Keppra
- Lamictal
- Mirapex
- Neurontin
- Requip
- Topamax

If a member is currently taking any of the medications listed above, the member will be able to receive the same strength and quantity until December 15, 2005. After the effective date and the 60 day titration period is completed, it will be necessary to increase the strength and lower the quantity of the medication that they are currently taking.

If there are any questions regarding appropriate dosage, Arkansas Blue Cross recommends the member consult their prescribing physician. If the member or prescribing physician need further clarity or have any questions, please contact the Pharmacy customer service at the following numbers:

Arkansas Blue Cross — 1-800-863-5561

Health Advantage — 1-800-863-5567

BlueAdvantage/USAble — 1-888-293-3748

Note: This pharmacy change does not apply to the Federal Employee Program (FEP). For FEP pharmacy information, please contact the Prescription Drug Program at 1-800-624-5060 or the Mail Service Prescription Drug Program at 1-800-262-7890.

# Pharmacy — Medicare Part D:

Beginning January 1, 2006, senior citizens will have the first opportunity to use their new Medicare Prescription Drug Plans. Initial enrollment for Medicare Prescription Drug Plans began on November 15, 2005 and will continue until May 15, 2006.

Arkansas Blue Cross and Blue Shield is an approved sponsor of the Medicare Part D program. Arkansas Blue Cross will be offering three products to Medicare beneficiaries.

If a beneficiary would like to request a Medi-Pak Rx kit or have questions regarding the new drug plans, they should call customer service 1-800-392-2583.

Any pharmacy interested in joining the Medi-Pak Rx network may call 1-800-237-6184. Additional pharmacy information is also available on the Arkansas Blue Cross website at www.ArkansasBlueCross.com.

Note: This pharmacy change does not apply to the Federal Employee Program (FEP). For FEP pharmacy information, please contact the Prescription Drug Program at 1-800-624-5060 or the Mail Service Prescription Drug Program at 1-800-262-7890.

# Pharmacy — DAW 1 Code:

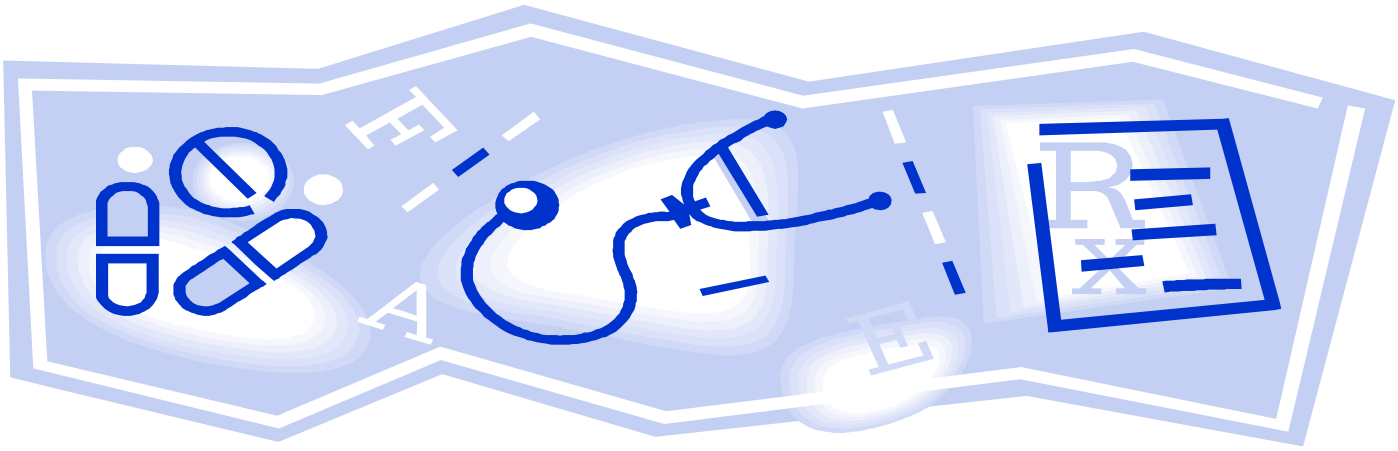
Arkansas Blue Cross and Blue Shield and its affiliate and subsidiary companies are committed to providing members with a high quality prescription drug program with medication therapies that are safe, effective, and affordable. As a result, beginning December 15, 2005, Arkansas Blue Cross and its affiliates will implement a prior authorization on the Brand name medications listed below. The generic versions will be available without a prior authorization.

Members will be able to receive the Brand Name medication without a prior authorization if the member is willing to pay the difference in the price between the brand name and generic medications (DAW 2).

Once the new prior authorization is in place, a prescriber must send justification, including complete medical records, that will validate the medical necessity for requiring the use of the branded medication rather than generic.

Note: This pharmacy change does not apply to the Federal Employee Program (FEP). For FEP pharmacy information, please contact the Prescription Drug Program at 1-800-624-5060 or the Mail Service Prescription Drug Program at 1-800-262-7890.

| | | | |
|---|---|---|---|
| Adoxa | Dynacin | Minocin | Valium |
| Ativan | Fioricet | Monodox | Vibramycin |
| Darvocet | Fiorinal | Myrax | Vibra-tabs |
| Darvon | Flexeril 10mg | Periostat | Xanax |
| Doryx | Lomotil | Soma (all forms) | |



# Federal Employee Program (FEP) 2006 Benefit Changes:

For FEP members enrolled in the Standard Option, members may seek care from any covered provider. However, members will receive the highest level of benefits when services are rendered by a Preferred provider.

For FEP members enrolled in the Basic Option, members must use a Preferred provider to receive benefits. If members receive care from a non-Preferred physician, members will not receive reimbursement for treatment.

For a complete list of changes, please refer to the FEP website at **www.fepblue.org**.

**The following changes apply to both the Standard and Basic Options:**

- Preventive care benefits for colonoscopies are available when performed for cancer screening.
- Preventive care benefits for ultrasound screenings are available for aortic abdominal aneurysms.
- Preventive care benefit for children who receive meningococcal vaccines is available.
- Outpatient cognitive rehabilitation therapy when performed by a licensed therapist or physician is available.
- Penile prosthesis is available to treat erectile dysfunction resulting from prostatectomy to treat prostate cancer.
- Outpatient nutritional counseling is limited to 4 visits per year when billed by a covered provider. This visit limitation does not apply to outpatient nutritional counseling provided for the treatment of anorexia or bulimia.
- Coverage for organ/tissue transplants now includes coverage for additional diagnoses. In addition, FEP has clarified the benefits provided for transplant support services.
- Pulmonary rehabilitation performed and billed by the outpatient department of a hospital or freestanding ambulatory facility is available for benefits.

**Changes to the Standard Option only**

Chiropractor limited benefits are available for ten spinal manipulations, an initial exam and a set of X-rays performed by a Chiropractor each year. Benefits for these services will be paid in full based on the FEP allowance, after the member pays a $15 copayment, for Preferred provider. Benefits are paid subject to the coinsurance and calendar year deductible for a Non-preferred provider.

**Changes to the Basic Option only**

Outpatient hospital or ambulatory surgical center for diagnostic tests are paid in full based on our allowance.

Inpatient Preferred facility Maternity is now limited to $100 per admission copayment. Previously, members paid a copayment of $100 per day, up to $500 for the admission.

**Legible attachments.**

Helpful hints: All documents attached to a claim (such as an explanation of benefits or Medicare Summary Notice) are scanned to maintain valid records. Claim attachments that are not legible or dark enough to be scanned will be returned.

# BlueCard - Claims Denied for Timely Filing:

If a claim is denied for timely filing and a provider wishes to have an exception to reconsider the denial, an inquiry should be initiated through BlueCard Customer Service.

Once the inquiry is initiated, the customer service representative will request proof of timely filing. After the documentation is received, the member's home plan will be contacted for reconsideration.

If the member's home plan approves the request, an adjustment will be initiated and the provider will be notified. If the request is not approved, a BlueCard customer service representative will also contact the provider.

# BlueCard - Corrected Claims Submissions and Timely Filing:

Beginning January 1, 2006, BlueCard will enforce the timely filing provision for all corrected claims submissions.

Currently, for any claim that is received more than 180 days past the date the services were rendered, the claim is denied and the provider is prohibited from balance billing members for services that would otherwise be covered.

Beginning January 1, 2006, any additional charges that were not included on the initial claim submission that are included on a corrected bill submission received more than 180 days from the date the services were rendered will be denied under the timely filing provision in the provider contract and will not be billable to the patient.

This policy will not impact a provider's ability to appeal payments made when claims for such services were received within 180 days from the date services were rendered.

# BlueCard - Corrected Claims Submission Form:

BlueCard providers may use the revised Corrected Claim Submission Form (located on page 13) which also includes a section for timely filing review. Providers need to attach the supporting documentation with the form.

The Corrected Claim Submission Form is now available on the Arkansas Blue Cross website at **www.ArkansasBlueCross.com**. Select the "Provider" page and then click on the "Forms for Providers" link.

Arkansas BlueCross BlueShield
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P.O. Box 2181
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Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 8069
Little Rock, AR 72203-8069

BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 1460
Little Rock, AR 72203-1460

# Physician/Supplier

- **CORRECTED BILL (must attach corrected claim)**
  - ***Diagnosis Code*** • ***Billed Charges*** • ***Procedure Code*** • ***EOB Attached*** • ***Interim/Final Bill***
- **TIMELY FILING REVIEW (must attach proof of timely filing)**

*This form should not be used for submitting medical information, any medical information submitted with this form will be returned.*

*Please complete and return this form to the address of the applicable health plan check below.*
*See bottom of form for important information*

Please check (•) one • ABCBS • BlueCard • Health Advantage • Blue Advantage • FEP

| SECTION 1 - PROVIDER INFORMATION | | |
|---|---|---|
| Physician/Supplier Name | Provider # | Date |
| Address | Telephone # | |
| City, State and Zip Code | Provider Contact Name | |

| SECTION 2 - PATIENT INFORMATION | |
|---|---|
| Patient Name | |
| Policyholder's Name | Policyholder's ID *(Please include alpha prefix)* |
| Address | City, State and Zip Code |

| SECTION 3 - ORIGINAL CLAIM INFORMATION | | |
|---|---|---|
| Date of Service on Original Claim | Original Claim # | Total Charges on Original Claim $ |
| | BlueCard SCCF# | |

| SECTION 4 - CORRECTED CLAIM INFORMATION | |
|---|---|
| Date of Service on Corrected Claim | Total Charges on Corrected Claim $ |
| Reason for Submission | |
| | |
| | |
| | |
| | |
| Provider Contact Signature | |

Please Note: Claims which have been rejected/returned as UNPROCESSABLE (due to claims filing, eligibility or coding issues, etc.) or for which no claim number has been assigned, are not subject to Corrected Billing. Those claims should be filed as original claims and should not have this form attached.

# National Imaging Associates (NIA) :

As a provider, you are no doubt aware of the escalation in the cost of health care. The National Manufacturing Association has concluded that America's standard of living will decrease in the coming years due to the transfer of jobs overseas. One major reason cited for this job loss is the cost of health care borne by American employers.

Most physicians are not aware that the fastest growing area in health care is medical imaging. Arkansas Blue Cross and Blue Shield currently pays approximately the same amount in claims for imaging as for pharmacy, and imaging costs are increasing at a much faster rate.

In 2005, Arkansas Blue Cross members will receive one CT or MRI for every three people. In addition to the increased financial burden this places on those paying health insurance premiums, the rapid acceleration in radiological imaging is exposing patients to worrisome doses of radiation. For example, each cranial CT scan with and without contrast delivers the radiation equivalent of 200 chest X-rays, while a chest CT provides 350 chest X-ray equivalents. For these reasons, Arkansas Blue Cross, BlueAdvantage, Health Advantage, and USAble Corporation have entered into an agreement with National Imaging Associates, Inc., (NIA) for outpatient imaging management services.

A prior authorization program for outpatient diagnostic imaging procedures will be implemented beginning February 1, 2006. Providers will have from February 1 to May 1, 2006, to become familiar with the requirements of the program prior to the full implementation date of May 1, 2006. This correspondence serves as notice of changes to the Utilization Review Programs under the Arkansas Blue Cross and Blue Shield provider agreement.

Effective February 1, 2006, the prior authorization program will apply to all Arkansas Blue Cross members, including those who access the True Blue PPO network, as well as all Health Advantage members.

Customers of BlueAdvantage Administrators of Arkansas can elect to add this program on a group-by-group basis, which would be indicated on the member's ID card. These services do not apply to members of the Federal Employee Program (FEP) at this time.

Under terms of the agreement, Arkansas Blue Cross, Health Advantage and BlueAdvantage will retain ultimate responsibility and control over claims adjudication and all coverage policies and procedures. NIA will manage out-patient imaging/radiology services through existing contractual relationships. **Claims for imaging services will continue to be processed based upon the terms of the Arkansas Blue Cross Preferred Payment Plan, Health Advantage, Usable Corporation Arkansas' FirstSource, and True Blue provider agreement(s).**

# Provider Workshop Schedule for Radiological Services:

**Conway**
Thursday, January 12, 2006 at 1:30 pm
University of Central Arkansas
Brewer- Hegeman Conference Center

**Fayetteville**
Wednesday, January 18, 2006 at 10:00 am
Springdale Holiday Inn

**Fort Smith**
Tuesday, January 17, 2006 at 10:00 am
St. Edward's Mercy Medical Center
Hennessey Room

**Hot Springs**
Wednesday, January 25, 2006 at 3:00 pm
National Park Medical Center
Fordyce Room

**Jonesboro**
Friday, January 20, 2006
Session 1 - 8:30 am; Session 2 -10:00 am
Session 3 - 1:00 pm; Session 4 - 3:00 pm
St Bernard's Auditorium

**Little Rock**
Monday, January 9, 2006 at 1:30 pm
Baptist Health Medical Center
Gilbreath Conference Center, Room 22

**Mountain Home**
Thursday, January 19, 2006 at 1:00 pm
Baxter County Regional Medical Center
Cafeteria

**Pine Bluff**
Thursday, January 26, 2006
Session 1 - 10:00 am & Session 2 - 1:00 pm
Pine Bluff Convention Center

**Russellville**
Tuesday, January 10, 2006 at 9:00 am
St. Mary's Regional Medical Center
Annex Room

**Searcy**
Wednesday, January 11, 2006 at 9:00 am
White County Medical Center
Hubach Conference Center

**Texarkana**
Tuesday, January 24, 2006 at 10:00 am
Holiday Inn (5401 N. State Line Avenue)
Patton Room

# Radiology Management Reference Guide:

## Prior Authorization Fact Sheet:

- A prior authorization program for outpatient diagnostic imaging procedures will be implemented beginning February 1, 2006. Providers will have from February 1 to May 1, 2006, to become familiar with the requirements of the program prior to the full implementation date of May 1, 2006. This correspondence serves as notice of change to the Utilization Review Programs under the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage, True Blue, and the USAble Corporation Arkansas' FirstSource provider agreements.

- The following outpatient services require the new prior authorization*:
  - CT Scan
  - MRI/MRA
  - Nuclear Cardiology
  - PET Scan

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

- Emergency room, observation department of a hospital, and inpatient imaging procedures do not require prior authorization.

- These services will apply to all Arkansas Blue Cross and Blue Shield members, including those who access the Arkansas' FirstSource and True Blue PPO network, as well as Health Advantage members.

- Customers of BlueAdvantage Administrators of Arkansas can elect to add this program on a group-by-group basis, which would be indicated on the member's ID card.

- These radiology services do not apply to members of the Federal Employee Program (FEP) at this time.

- The ordering physician is responsible for obtaining the prior authorization number for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call.

- Call center hours of operation are Monday through Friday, 7 a.m. to 7 p.m.

- Providers may obtain prior authorization by calling NIA at 1-877-642-0722. (Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact NIA within five business days of the date of service and before the claim is submitted to obtain proper authorization for the studies, which will still be subject to review.)

- Average calls are completed within five minutes. Peak call volume occurs between the hours of 1 p.m. to 6 p.m.

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

- Prior authorization is not a guarantee of coverage. The radiology services are subject to the member's eligibility and benefit plan provisions.

**The Prior Authorization Implementation Recommendations for Ordering Physicians and Participating Facilities:**

As a participating provider of diagnostic imaging services that require prior authorization, it is essential that providers develop a process to ensure the appropriate authorization number(s) is obtained. The following recommendations are offered for review and consideration in developing a procedure that will be effective for each facility. These recommendations are for informational purposes only.

## Ordering Physician:

It is the responsibility of the physician ordering the imaging examination to call NIA for prior authorization. A separate authorization number is required for each procedure ordered.

Emergency room, observation department of a hospital and inpatient imaging procedures do not require prior authorization.

To expedite the authorization process, please have the following information ready before calling the NIA Utilization Management staff **(*Information is required):**

- Name and office telephone number of ordering physician*****;
- Member name and ID number*****;
- Requested examination*****;
- Name of provider office or facility where the service will be performed*****;
- Anticipated date of service (if known); and
- Details justifying examination:*****
  - Symptoms and their duration;
  - Physical exam findings;
  - Conservative treatment patient already has completed (for example: physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications);
  - Preliminary procedures already completed (for example: X-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation); and
  - Reason the study is being requested (for example: further evaluation, rule out a disorder);

If requested, please be prepared to fax the following information:

- Clinical notes;
- X-ray reports;
- Previous CT/MRI reports;
- Specialist reports/evaluation; and
- Ultrasound reports;

## Participating Imaging Facilities:

It is the responsibility of the ordering physician to ensure that prior authorization is obtained. The rendering facility should not schedule procedures without prior authorization. For urgent tests, the rendering facility can begin the process, and NIA will follow up with the ordering physician to complete the process.

Procedures performed that have not been properly authorized will not be reimbursed, and the member cannot be balance billed. A separate authorization number is required for each procedure ordered.

Emergency room, observation department of a hospital and inpatient imaging procedures do not require prior authorization. If an emergency clinical situation exists outside of a hospital emergency room, providers should proceed with the examination and call NIA the next business day at 1-877-642-0722 to proceed with the normal review process.

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

- Communicate to all personnel involved in outpatient scheduling that prior authorization is required for the listed procedures.
- If a physician office calls to schedule a patient for a procedure requiring prior authorization, request the authorization number.
- If the provider has not obtained prior authorization, inform the provider of the requirement and advise them to call NIA at the toll-free number, 1-877-642-0722. Facilities may elect to institute a time period in which to obtain the authorization number (for example, one business day).
- If a patient calls to schedule a procedure that requires prior authorization and the patient does not have the authorization number, the patient should be directed back to the referring physician who ordered the examination.

*(Continued on page 18)*

*(Continued from page 17)*

## Frequently Asked Questions:

The following are the most common questions with answers regarding the prior authorization changes from NIA .

**Q.1. Is prior authorization from NIA required for all radiological procedures?**

A.1. No. Only outpatient CT, MRI/MRA, PET and Nuclear Cardiology procedures require prior authorization.

**Q.2. Who is responsible for obtaining prior authorization from NIA?**

A.2. The ordering physician is always responsible for obtaining authorization from NIA prior to scheduling procedures.

**Q.3. Are there situations that do not require prior authorization from NIA?**

A.3. Yes, there are three situations that do not require prior authorization from NIA when billed with the applicable location code:

- When the procedure is ordered as part of emergency room services.
- When the procedure is ordered as part of an observation bed stay.
- When the procedure is ordered as part of an inpatient stay.

**Q.4. Is prior authorization required for an emergency situations?**

A.4. No. Patients who are directed to the emergency room are exempt from prior authorization. It is not necessary for anyone to call NIA retrospectively to authorize any imaging procedure performed during an emergency room visit.

**Q.5. How is Observation/Rapid Treatment handled?**

A.5. Imaging services occurring in the Observation / Rapid Treatment area of a hospital do not require prior authorization nor do these services require the ordering physician to contact NIA within the next business day of rendering the service. These services are easily identifiable in the Companies' claims systems and will be paid without an authorization from NIA.

**Q.6. What information does the ordering physician need to expedite a prior authorization call to NIA?**

A.6. To expedite the process, please have the following information ready before calling the NIA Utilization Management staff (*Information is required):

- Name and office telephone number of ordering physician*;
- Member name and ID number*;
- Requested examination*;
- Name of provider office or facility where the service will be performed*;
- Anticipated date of service (if known);
- Details justifying examination:*
  - Symptoms and their duration;
  - Physical exam findings;
  - Conservative treatment patient already has completed (for example: physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications);
  - Preliminary procedures already completed (for example: X-rays, CT's, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation);
  - Reason the study is being requested (for example: further evaluation, rule out a disorder).

**Q.7. What kind of response time can the ordering physicians expect for prior authorization?**

A.7. In many cases, especially when the caller requesting the review has sufficient clinical documentation, authorization can be obtained during the first telephone call. In general, approximately 60-65 percent of the requests will be approved during the initial telephone call. Generally, within two business days after receipt of request, a determination will be made. In certain cases, the review process may take longer if additional clinical information is required to make a determination.

**Q.8. Can NIA handle multiple authorization requests per telephone call?**

A.8. Yes.

**Q.9. What is the process for obtaining prior authorization from NIA for CT, MRI/ MRA, PET or Nuclear Cardiology procedures ordered outside of normal business hours?**

A.9. The rendering facility should proceed with the study. The ordering physician should contact NIA within five business days from the date of service and before the claim is submitted and proceed with the authorization process.

**Q.10. What is the process for obtaining prior authorization from NIA for emergency procedures ordered at a location other than a hospital emergency room?**

A.10. The authorization process will be the same. Studies conducted outside an emergency room setting will require prior authorization.

**Q.11. Do physicians have to obtain the prior authorization before they call to schedule an appointment?**

A.11. Yes. Physicians should obtain the prior authorization before scheduling the patient.

**Q.12. Does NIA ask for a date of service when authorizing a procedure?**

A.12. At the end of the authorization process, the NIA authorization representative asks where the procedure is being performed and the anticipated date of service. The exact date of service is not required.

**Q.13. How long is an authorization number valid?**

A.13. The authorization number is valid for 60 days. When a procedure is authorized, NIA will use the date of determination as the starting point for the 60-day period in which the examination must be completed.

**Q.14. What if my office staff forgets to call NIA and then goes ahead to schedule an imaging procedure requiring prior authorization?**

A.14. It is important to notify office staff and educate them about this new policy. This policy is effective February 1, 2006. Claims for CT, MRI/MRA, PET and Nuclear Cardiology procedures that are not prior authorized will not be paid, and the members must be held harmless if the service is provided by a participating provider.

**Q.15. Can the participating rendering facility obtain authorization in the event of an urgent test?**

A.15. Yes, if they begin the process, NIA will follow up with the ordering physician to complete the process.

*(Continued on page 20)*

*(Continued from page 19)*

**Q.16. Who will receive the authorization number from NIA?**

A.16. On completion of the process, NIA will automatically send a fax to the ordering physician and the servicing provider indicating the procedure, the facility, and the period for which prior authorization is valid. NIA will also provide the prior authorization number that will serve as a means of tracking the status of the process. If the ordering physician does not complete the prior authorization process, the status will be "**transaction denied for prior authorization non-compliance, no member liability**."

**Q.17. How can the NIA authorization number be identified?**

A.17. The NIA authorization number consists of eight or nine alphanumeric characters (for example: 1234M567).

**Q.18. If two authorization numbers are associated with the patient encounter, which one should be printed on the claim?**

A.18. Any of the two authorization numbers should appear on the claim form. The authorization number not entered on the claim form will be captured internally within the claims system.

**Q.19. Which provider(s) are responsible for putting the prior authorization number on the claim(s)?**

A.19. The rendering facility and/or clinic and the provider who reads the test.

**Q.20. Is an NIA prior authorization number needed for a CT-guided biopsy?**

A.20. Yes.

**Q.21. Which PET scans require a prior authorization?**

A.21. All PET scans performed in physician offices or on an outpatient basis (non-ER or observation departments) require prior authorization by NIA.

**Q.22. What happens if a patient is prior authorized for a CT of the abdomen, and the radiologist or rendering physician feels an additional study of the pelvis is needed?**

A.22. The radiologist or rendering physician should proceed with the pelvic study. If this occurs, the provider should notify the patient's ordering physician of the additional test the same day, as a matter of courtesy and appropriate medical procedure. The original ordering physician should call NIA after the study is provided to proceed with the normal review process to get an additional authorization number.

**Q.23. If a patient needs a CT in preparation for radiation therapy, is a prior authorization necessary?**

A.23. Yes.

**Q.24. After receiving a prior authorization from NIA, can the ordering physician change the planned procedure, the servicing facility, or the date of the procedure?**

A.24. Yes, but the NIA Call Center must be contacted if the planned procedure or the servicing provider changes. The date of the procedure can take place on any date within the 60 days that the authorization number is valid. If the date of service is rescheduled beyond the 60 days, the NIA Call Center must be contacted.

*(Continued from page 20)*

**Q.25. Is a prior authorization necessary when Arkansas Blue Cross, Health Advantage or BlueAdvantage (if applicable) is not the member's primary insurance?**

A.25. Yes.

**Q.26. How are procedures that do not require an NIA prior authorization handled?**

A.26. These procedures should be handled as they are today.

**Q.27. If NIA denies the prior authorization of an imaging study, does a provider have the option to appeal the decision?**

A.27. Yes, through normal appeal procedures as directed in the denial letter. If NIA makes the decision to deny the request at the end of the telephone call, and the physician does not agree with the decision made by NIA, the physician should request an appeal of the decision from NIA.

**Q.28. Is there a way to bypass the NIA recorded announcement?**

A.28. When dialing into the toll-free number, callers will hear a seven-second system greeting that identifies the NIA Imaging Authorization Service. The short announcement will instruct callers to press option one to initiate a new request for authorization on an imaging exam or option two for the status of a case that was previously called in for authorization. The announcement also will provide information that emergency procedures do not require a prior authorization. The entire greeting may be bypassed by immediately pressing the desired option whenever the announcement starts.

**Q.29. If NIA approves prior authorization of an imaging study, does this guarantee payment of the claim?**

A.29. No. A prior authorization does not guarantee payment or ensure coverage; it means only that the information furnished to NIA at the time indicates that the imaging study that is the subject of the prior authorization meets the Primary Coverage Criteria. A claim receiving prior authorization must still meet all other coverage terms, conditions, and limitations. Coverage for any such prior authorized claim may still be limited or denied if, when the claimed imaging study is completed and Arkansas Blue Cross, BlueAdvantage, and Health Advantage receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date imaging study services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the patient's health plan applies to limit or exclude payment of the claim.

**Q.30. What is the toll-free telephone number and hours of operation for the NIA Call Center?**

A.30. Providers can reach the NIA Call Center by calling the toll-free number 1-877-642-0722, Monday through Friday, from 7 a.m. to 7 p.m.

# Introducing ARHealth:

Arkansas Blue Cross and Blue Shield has designed a new product, ARHealth, for the Arkansas State Retirees and Public School Retirees. ARHealth is co-branded by the State of Arkansas and Health Advantage as indicated on the identification cards.

ARHealth has two plan designs - one plan for members with Medicare and one for members not yet Medicare eligible. Both plan designs are 'open access' - no referrals are required for in-network services.

For members with "Medicare Primary Eligible" at the bottom of the ID card, providers should file first with Medicare. The "Medicare Primary Eligible" plan will pay the members coinsurance and deductibles not covered by Medicare. There are no additional benefits such as case management or health education programs available for these members. **These members <u>will not</u> owe a copayment for office visits at the time of service.**

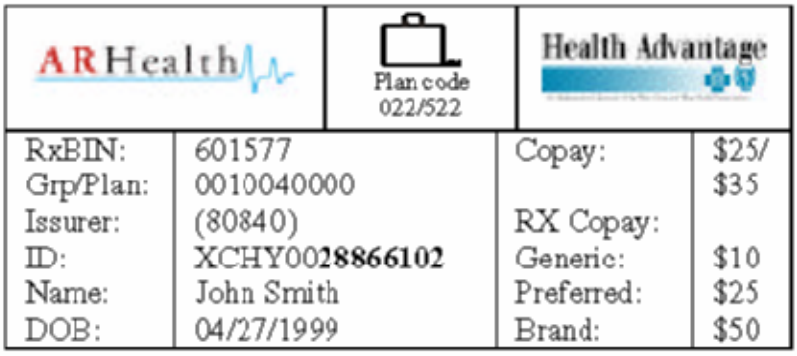
For those retirees and their dependents not Medicare eligible, there is an abbreviated plan design available (see page 5). These members <u>will owe a copayment</u> at the time of service.

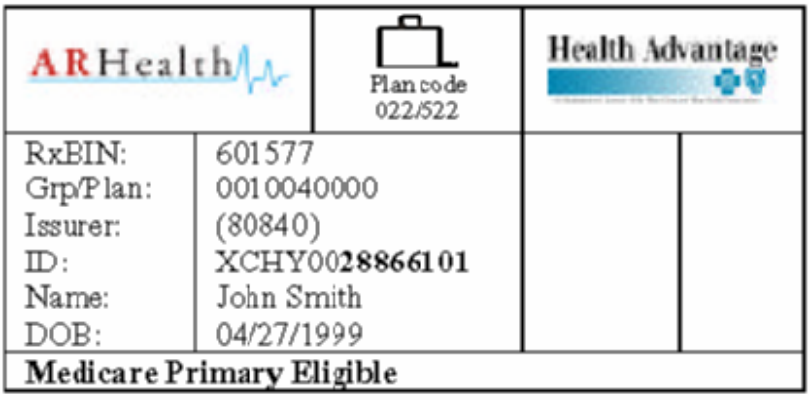
The ARHealth plan is the same for both the Arkansas State and the Public School Retirees and their dependents will continue to have the state sponsored prescription drug coverage.

However, Public School Retirees with Medicare as their primary coverage will not have the state sponsored drug card. These retirees are encouraged to purchase a Medicare Part D Prescription Drug Plan.

Any dependents of Public School retirees not on Medicare, will have the state sponsored prescription drug card. All members with the prescription drug coverage will have the RX copayment information on their identification card.

If you have benefit or claim questions regarding the ARHealth plan, call the Arkansas State and Public School Employees Customer Service area at 1-800-482-8416 .



ARHealth

For Retirees
and their dependents
Without Medicare

Health Advantage

| | In-Network | | Out-of-Network |
|---|---|---|---|
| Deductible - Individual | None | None | $500 |
| Deductible - Family | None | None | $1,000 |
| | **Copayment** | **Coinsurance** | **Coinsurance** |
| Annual Individual Out-of-Pocket | Unlimited | $1,250 | $4,000 |
| Annual Family Out-of-Pocket | Unlimited | $2,500 | $8,000 |
| **Preventive Care Services** | | | |
| Physical Exams, Adults (visit only) | $0 | 0% | 30% after deductible |
| Well Baby/Child Care /immunizations | $0 | 0% | 30% after deductible |
| Annual Gynecological /Mammogram | $0 | 0% | 30% after deductible |
| **Physician Services** | | | |
| PCP Visits | $20 | 0% | 30% after deductible |
| Specialist Visits | $30 | 0% | 30% after deductible |
| Inpatient Medical Care | $0 | 15% | 30% after deductible |
| Outpatient Surgical Care | $0 | 15% | 30% after deductible |
| **Outpatient Services** | | | |
| Diagnostic Testing (lab and X-ray) | $0 | 15% | 30% after deductible |
| Surgical Services (facility charge) | $100 | 15% | 30% after deductible |
| Emergency Room Visit | $100 (waived if admitted to same hospital) | 15% | $100 copayment 15% coinsurance |
| Urgent Care Center/ER After-hours Clinic Visit | $100 (waived if admitted to same hospital) | 15% | $100 copayment 15% coinsurance |
| Observation Services | $100 (waived if admitted to same hospital) | 15% | $100 copayment 15% coinsurance |
| **Ambulance (Land or Air)** | | | |
| ($1,000 maximum per year for transport services) | $0 | 15% | 30% after deductible |
| **Physical, Occupational, Speech Therapy, Cardiac Rehab and Chiropractic Services** | | | |
| (60 visits per member per year combined) | $0 | 20% | 30% after deductible |
| **Inpatient Hospital** | | | |
| (unlimited days at semiprivate room rate) | $400 copayment per admission (max: 3 copays per year, per person) | 15% | 30% after deductible |
| **Durable Medical Equipment** | | | |
| ($10,000 maximum per year) | $0 | 20% | 30% after deductible |
| **Prosthetics** | | | |
| ($15,000 maximum per year) | $0 | 20% | 30% after deductible |

# Crosswalk from 'G' Codes to 2006 CPT Codes:

**Hydration**

| HCPCS 2005 | CPT 2006 | Description |
|---|---|---|
| G0345 | 90760 | Intravenous infusion, hydration; initial, up to one hour. |
| G0346 | 90761 | 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)**

| HCPCS 2005 | CPT 2006 | Description |
|---|---|---|
| G0347 | 90765 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour. |
| G0348 | 90766 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure); (Report in conjunction with 90765, 90767); (Report 90766 for additional hour(s) of sequential infusion); (Report 90766 for infusion intervals of greater than 30 minutes beyond 1 hour increments). |
| G0349 | 90767 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure); (Report 90767 in conjunction with 90765, 90774, 96409, 96413 if provided as a secondary or subsequent service after a different initial service. Report 90767 only once per sequential infusion of infusate mix). |
| G0350 | 90768 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure); (Report 90768 only once per encounter); (Report 90768 in conjunction with 90765, 96413). |
| G0351 | 90772 | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial (90772-90774 do not include injections for allergen immunotherapy. For the allergen immunotherapy injections, see 95115-95117). |
| | 90773 | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial (90772-90774 do not include injections for allergen immunotherapy. For the allergen immunotherapy injections, see 95115-95117). |
| G0353 | 90774 | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug; (90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117). |
| G0354 | 90775 | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure); (Use 90775 in conjunction with 90765, 90774, 96409, 96413); (Report 90775 to identify intravenous push of a new substance/drug if provided as a secondary or subsequent service after a different initial service is provided). |

## Chemotherapy Administration

| HCPCS 2005 | CPT 2006 | Description |
|---|---|---|
| | 90779 | Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion; (For allergy immunizations, see 95004 et seq); (90780 and 90781 have been deleted. To report, see 90760, 90761, 90765-90768); (90782 has been deleted. To report, use 90772); (90783 has been deleted. To report, use 90773); (90784 has been deleted. To report, use 90774); (90788 has been deleted. To report, use 90772); (90799 has been deleted. To report, use 90779). |
| G0355 | 96401 | Chemotherapy administration, subcutaneous or intramuscular; non-hormonal antineoplastic |
| G0356 | 96402 | Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic. |
| | 96405 | Chemotherapy administration; intralesional, up to and including 7 lesions. |
| | 96406 | Chemotherapy administration; intralesional, more than 7 lesions. |
| | | (96408 has been deleted. To report, use 96409). |
| G0357 | 96409 | Intravenous, push technique, single or initial substance/drug. |
| | | (96410 has been deleted. To report, use 96413). |
| G0358 | 96411 | Chemotherapy administration; intravenous, push technique, each additional substance/ drug (List separately in addition to code for primary procedure); (Use 96411 in conjunction with 96409, 96413); (96412 has been deleted. To report, use 96415). |
| G0359 | 96413 | Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug; (96414 has been deleted. To report, use 96416). |
| G0360 | 96415 | Chemotherapy administration, intravenous infusion technique; each additional hour, 1 to 8 hours (List separately in addition to code for primary procedure); (Use CPT Code 96415 in conjunction with 96413); (Report 96415 for infusion intervals of greater than 30 minutes beyond 1-hour increments); (Report 90761 to identify hydration, or 90766, 90767, 90775 to identify therapeutic, prophylactic, or diagnostic drug infusion or injection, if provided as a secondary or subsequent service in association with 96413). |
| G0361 | 96416 | Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump (For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521-96523). |
| G0362 | 96417 | Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure); (Use 96417 in conjunction with 96413); (Report only once per sequential infusion. Report 96415 for additional hour(s) of sequential infusion). |

# Arkansas' FirstSource PPO Access Only Groups Effective January, 2006:

| GROUP NAME | COMMENTS |
|---|---|
| AALF's Manufacturing Inc / Midland's Choice | Arkansas' FirstSource PPO |
| Anchor Packaging / Hermann Co. | Changing to True Blue PPO |
| Ark Sheet Metal Workers -Local #36-L | Arkansas' FirstSource PPO |
| Arkansas Carpenters Health & Welfare Fund | Arkansas' FirstSource PPO |
| Arkansas Pipe Trades Health & Welfare | New Group effective 01/06 True Blue PPO |
| Arkansas State University Athletes | Arkansas' FirstSource PPO |
| Arvest Bank | Changing to True Blue PPO |
| Ashley County Medical Center | Arkansas' FirstSource PPO |
| Basler Electric (Caraway) | Terminating 12/31/05 going to BlueCard |
| Basler Electric (Corning) | Terminating 12/31/05 going to BlueCard |
| BEKAERT - Rogers, AR Location | Arkansas' FirstSource PPO |
| BEKAERT - Van Buren, AR Location | Arkansas' FirstSource PPO |
| Boar's Head Provisions Co | Arkansas' FirstSource PPO |
| Brentwood Industries, Inc | Arkansas' FirstSource PPO |
| Bridgestone - Firestone | Arkansas' FirstSource PPO |
| Bryce Corporation | Arkansas' FirstSource PPO |
| Columbia Forest Products | Changing to True Blue PPO |
| Defiance Metals | Arkansas' FirstSource PPO |
| Diocese Of Little Rock / Christian Brothers | Arkansas' FirstSource PPO |
| FedEx Freight East, Inc.<br>(Formerly American Freightways) | Arkansas' FirstSource PPO |
| Franklin Electric | Arkansas' FirstSource PPO |
| Genmar - Ranger Boats | Arkansas' FirstSource PPO |

| GROUP NAME | COMMENTS |
|---|---|
| Harding University | Arkansas' FirstSource PPO |
| Harps Food Stores | Arkansas' FirstSource PPO |
| KLA Benefits / Klipsch LLC | Arkansas' FirstSource PPO |
| LA Darling | Changing to True Blue PPO |
| Levi Hospital | Arkansas' FirstSource PPO |
| Magnolia Hospital | Arkansas' FirstSource PPO |
| Marshalltown Company | Arkansas' FirstSource PPO |
| Maverick Tube Corp | Changing to True Blue PPO |
| Motor Appliance Corporation | TPA Name change |
| Nestle USA | Changing to True Blue PPO |
| Odom's Tennessee Pride Sausage | Arkansas' FirstSource PPO |
| Paxton Media / Jonesboro Sun | Terminating 12/31/05 going to BlueCard |
| Peterson Manufacturing / Mission Plas | Arkansas' FirstSource PPO |
| Rea Magnet Wire Co | Arkansas' FirstSource PPO |
| Siplast Inc | Arkansas' FirstSource PPO |
| Southern Painters Welfare | Arkansas' FirstSource PPO |
| St. Michael Healthcare - Cobra | Arkansas' FirstSource PPO |
| St. Michael Healthcare - Hospital | Arkansas' FirstSource PPO |
| St. Michael Healthcare - Rehabilitation | Arkansas' FirstSource PPO |
| Stephens Media Group | New Group 01/2006 True Blue PPO |
| Town & Country Grocers / Price Chopper | Arkansas' FirstSource PPO |
| Townsend Foods | Changing to True Blue PPO |
| UFCW (Kroger & Consumer Market) | Changed to True Blue PPO 10/01/05 |
| Wabash National / Cloud Corp | Arkansas' FirstSource PPO |
| Wallace & Owens | Changing to True Blue PPO |

# Fee Schedule Additions and Updates:

Effective September 21, 2005 the following update was made in the Arkansas Blue Cross and Blue Shield Fee Schedule:

| HCPCS Code | Total | Prof | Tech | Total SOS | Prof SOS | Tech SOS |
|---|---|---|---|---|---|---|
| J7302 | $377.50 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

Effective September 28, 2005:

| HCPCS Code | Total | Prof | Tech | Total SOS | Prof SOS | Tech SOS |
|---|---|---|---|---|---|---|
| J7300 | $332.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

Effective October 1, 2005.

| CPT Code | Total | Prof | Tech | Total SOS | Prof SOS | Tech SOS |
|---|---|---|---|---|---|---|
| 90658 | $11.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

Effective October 12, 2005:

| CPT Code | Total | Prof | Tech | Total SOS | Prof SOS | Tech SOS |
|---|---|---|---|---|---|---|
| 37765 | $737.44 | $0.00 | $0.00 | $737.44 | $0.00 | $0.00 |
| 37766 | $894.54 | $0.00 | $0.00 | $894.54 | $0.00 | $0.00 |
| 92391 | BR | | | BR | | |

Effective October 19, 2005:

| CPT Code | Total | Prof | Tech | Total SOS | Prof SOS | Tech SOS |
|---|---|---|---|---|---|---|
| A9512 | $0.25 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

Effective October 26, 2005:

| HCPCS Code | Total | Prof | Tech | Total SOS | Prof SOS | Tech SOS |
|---|---|---|---|---|---|---|
| J1055 | $24.06 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| J1051 | $8.02 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

The following changes have been made to the fee schedule :

| CPT Code | Total | Prof | Tech | Total SOS | Prof SOS | Tech SOS |
|---|---|---|---|---|---|---|
| 78814 | $1,947.81 | $97.81 | $1,850.00 | $0.00 | $97.81 | $0.00 |
| 78815 | $1,970.93 | $120.93 | $1,850.00 | $0.00 | $120.93 | $0.00 |
| 78816 | $1,975.08 | $125.08 | $1,850.00 | $0.00 | $125.08 | $0.00 |

Providers' News

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

Presorted Standard
U.S. Postage Paid
Little Rock, AR
Permit #1913