Arkansas Blue Cross and Blue Shield

Providers' News

June 2008

Inside the June Issue:

Please Note:

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company and its 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 Blue Cross and Blue Shield Radiology Provider Assessment Guidelines (updated November 2007)

Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation developed the following assessment guidelines in 2005 that are intended to promote reasonable and consistent safety standards for the provision of imaging services. Arkansas Blue Cross, Health Advantage, and USAble Corporation will accept imaging service facilities into their separate networks if the facility and its affiliated physician or hospital meet the provider assessment guidelines (in addition to all other applicable contractual requirements and terms and conditions for network participation that apply to the hospital or physician that owns or controls and operates applying imaging facility):

Plain Films:

- Facilities performing plain films must comply with the Arkansas Board of Health Rules and Regulations.
- The Arkansas Consumer-Patient Radiation Health and Safety Act (Act 1071 of 1999), requires that individuals who use radioactive materials or medical equipment emitting or detecting ionizing radiation on human beings for diagnostic or therapeutic purposes, be licensed to do so.

Providers' staff performing plain film X-rays must be in compliance with the state mandate, with one of the following licenses:

- **Licensed Technologist License:** Individuals trained on the job and licensed under the "grandfather" provision (this license is no longer issued);
- **Limited Licensed Technologist License:** Individuals who have passed the Limited Scope Examination in either chest, extremity, skull/sinus, spine and/or podiatry;
- **Radiologic Technologist License:** For individuals who have graduated from an accredited Radiologic Technology School and passed the American Registry of Radiologic Technologists (ARRT) Radiography registry examination; or
- **Temporary License:** Individuals who have trained on the job and are preparing to take the Limited Scope Examination.

For additional information on types of licenses, visit the following web site:
www.healthyarkansas.com/rtl/lic_info.html

Mammography:

- Facilities must have a current MQSA (Mammography Quality Standards Act) certificate issued by the FDA.
- Diagnostic mammography must be performed under direct supervision and interpretation of a board-certified or board-eligible radiologist who is on-site during the examination.

Nuclear Cardiology:

- Nuclear cardiology practices must meet all federal guidelines and be in compliance with the Nuclear Regulatory Commission Regulations. Nuclear cardiology practices must comply with the Arkansas Board of Health Rules and Regulations.
- Nuclear cardiology imaging systems must have the capability of assessing both myocardial perfusion and contractile function (ejection fraction and regional wall motion).
- Cardiac stress tests must be performed under the direct supervision of a licensed MD or DO who has a current Advanced Cardiac Life Support (ACLS) certification.
- It is recommended that nuclear cardiology practices employ a technologist who is certified in Nuclear Medicine through the ARRT, CNMT, or NMTCB or licensed by the state in nuclear medicine technology.
- Nuclear cardiology practices must achieve accreditation by January 1, 2009, by:
  - ICANL (Intersocietal Commission for the Accreditation of Nuclear Laboratories);
  - ACR (American College of Radiology); or

  - JCAHO (if a nuclear cardiology facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement).

Any new nuclear cardiology facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

Positron Emission Tomography(PET):

- PET facilities must meet all federal guidelines and be in compliance with the Nuclear Regulatory Commission Regulations.
- PET facilities must comply with the Arkansas Board of Health Rules and Regulations.
- Only high performance full ring PET systems will be considered for privileging.
- PET examinations must be interpreted by a licensed MD or DO who is board certified or board eligible in radiology or nuclear medicine.
- It is recommended that PET facilities employ a technologist who is certified in Nuclear Medicine through the ARRT, CNMT, or NMTCB or a technologist who is licensed by the state in nuclear medicine technology.
- PET facilities must achieve accreditation by January 1, 2009, by:
  - ICANL (Intersocietal Commission for the Accreditation of Nuclear Laboratories),
  - ACR (American College of Radiology), or
  - JCAHO (if a PET facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement.)

Any new PET facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

Computed Tomography (CT) and Magnetic Resonance (MR) Imaging — General Facility Requirements:

- All CT facilities utilizing equipment producing ionizing radiation must be in compliance with federal and state guidelines and be in compliance with the Arkansas State Board of Health Rules and Regulations for the Control of Sources of Ionizing Radiation.
- All CT facilities must have a documented Radiation Safety/ALARA Program.
- All MR facilities must meet all state and federal guidelines and comply with the Arkansas Board of Health Rules and Regulations.
- All CT and MR providers must provide a written report within 10 business days from the date of service to the ordering provider. [Mammography reports must be completed within 30 days, per Mammography Quality Standards Act (MQSA) guidelines.]
- All CT and MR facilities must have a documented Quality Control Program inclusive of both imaging equipment and film processors.
- All CT facilities must achieve accreditation by January 1, 2009, by the American College of Radiology (ACR), Intersocietal Commission for the Accreditation of Computer Tomography (CT) Laboratory Operations, or JCAHO (if a CT facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement.)
- MR facilities must achieve accreditation by January 1, 2009, by:
  - American College of Radiology (ACR),
  - Intersocietal Accreditation Commission for Magnetic Resonance Labs (IACMRL), or
  - JCAHO (if a MR facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement.)

Any new CT or MR facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

Medical and Technical Staff Requirements:

- It is recommended that CT and MR facilities employ an appropriately licensed or certified technologist (state licensed, ARRT, ARDMS, NMTCB).
- Contrast enhanced procedures must be performed under the direct supervision of a licensed physician who has current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certification.

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- The interpreting physician is responsible for examining all of the visualized structures, and must report any clinically relevant abnormalities of these adjacent structures. In some cases, these structures may be seen only on the localization (scout) images. The technical parameters of a CT or MR examination may be tailored to evaluate specific anatomy or function, but the images obtained also demonstrate adjacent anatomy. For example, cardiac CT or MR examinations include portions of the lungs, mediastinum, spine, and upper abdomen, and the evaluation of these structures must be included in the interpreting physician's written report.
- CT and MR studies must be interpreted by a licensed MD or DO, who is board certified or board eligible in radiology or nuclear medicine, or a licensed MD or DO, who has had exposure, training, and experience in the interpretation of CT and MR examinations in their area of expertise, including knowledge of the physics of CT and MR, understanding of radiation generation and exposure, knowledge of scanning principles and modes, knowledge of principles for intravenous contrast administration for safe and optimal imaging, knowledge of recognitions and treatment of adverse reactions to contrast administration, knowledge of principles of image post processing, and knowledge of normal anatomy and pathologic changes of the area being examined.

Instrumentation Requirements:

- If offering cardiac CT applications, a multi-detector row helical CT with at least 16 detector rows and CT slice thickness of 1.5 cm or less, or an electron beam CT scanner is a requirement. If offering CT coronary artery angiography, a 32 or greater multi-detector row, helical CT with sub-millimeter slices is a requirement.
- MR systems with field strength of 0.7 Tesla or greater will be considered high field systems.
- MR systems with field strength less than 0.7 Tesla will be considered low field strength systems.
- MR systems with field strength of less than 0.4 Tesla will not be covered.

Additional Provisions and Considerations — Hospital Based /Owned and Physician Based /Owned Imaging Facility:

Hospital based/owned and Physician based/ owned outpatient diagnostic imaging facilities must be associated / owned by a participating in-network hospital or physician.

Data Storage:

The acquired images, post-processed and reconstructed images, and the data set must be stored and available for review according to the state guidelines for maintenance of patient medical records:

Records must be kept for a period of five years from the ending date of service or until all audits, appeal hearings, investigations, or court cases are resolved, whichever period is longer. (See AR ADC 016 06 024, Section 204.000B.)

Leased Services:

Leased equipment must meet the provider assessment guidelines for the imaging services provided, as described in this document.

Providers who perform diagnostic imaging services on imaging equipment that is leased on a part time or intermittent basis (e.g. two days per week) will not be eligible for reimbursement of such services by Arkansas Blue Cross and Blue Shield.

Mobile Services:

Mobile services must meet the Provider Assessment Guidelines for imaging services provided as described in this document.

Note: Transportable Services – Medical practices that maintain multiple facilities or locations may transport their own equipment

from one location to another. This must be clearly detailed on the Privileging Application. The equipment must be owned, managed, and operated by that facility. Use of mobile service providers and/or equipment that is not owned by the privileged facility will not be considered.

Site Inspections:

All imaging providers are subject to un-announced site inspections. Providers who are found to have misrepresented information on their Privileging Application or to be non-compliant with any of the above Guidelines may be subject to removal from the imaging network.

Multi-Specialty Group Practice:

- A Multi-Specialty Group Practice (MSGP) is defined as a provider group operating at one or multiple locations and consisting of various provider specialty types. The MSGP is organized as a legal entity. Practices with affiliations (but no legal relationship) with other provider practices or groups do not qualify as MSGP.
- MSGP Privileging Applications will be reviewed on a case-by-case basis.
- The MSGP must meet the specific modality guidelines as defined in the Privileging Guidelines.

High-Tech Radiology Provider Assessment

National Imaging Associates (NIA) mailed packets to non-hospital based imaging centers during February, 2008. Please complete the assessment information requested and return the packet immediately to:

National Imaging Associates, Inc.
11050 Olson Drive, Suite 200
Rancho Cordova, CA 95670

The provider assessment information may also be completed on-line at **www.RadMD.com**.

Imaging Centers must meet the terms and conditions and high-tech radiology guidelines (see page 2-5 of this newsletter) in order to remain a participating provider in the provider networks of Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation. Imaging Centers who do not meet the guidelines based on the information provided in the assessment will be terminated from the provider networks effective January 1, 2009.

Providers who have not completed and returned the assessment information, please do so immediately. Site visit surveys may also be required in order to remain a participating provider in the networks. Providers who have not received a provider assessment packet should contact their regional Network Development Representative immediately.

RBRVS Effective May 1, 2008 — High-Tech Radiology

Arkansas Blue Cross and Blue Shield has identified some erroneous calculations on some High-Tech Radiology procedures. These calculations are being corrected and in most, if not all, cases, will result in an increased allowance. Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, and Health Advantage will automatically adjust all claims paid at the incorrect fee.

Arkansas Blue Cross and Blue Shield Ended the NPI Contingency Period on May 23, 2008

Arkansas Blue Cross and Blue Shield and its family of companies ended all HIPAA National Provider Identifier (NPI) contingencies on May 23, 2008. As of that date, all claims must identify providers by their NPI. This process change applies to electronic, paper and direct entry claims. Additionally, My BlueLine and Customer Service will be requiring the NPI in order to access information on eligibility, benefits, and claims status.

The ending of the CMS NPI contingency plan was met with very few processing exceptions. Arkansas Blue Cross would like to commend the providers of Arkansas for the successful implementation of this National Provider Identifier mandate.

Proof of Timely Filing:

Article from the June 2005 issue of the Providers' News

Documents submitted as proof of timely filing will only be accepted if computer generated and contain the following information:

- Physician or Facility Name;
- Patient's name and member ID#;
- Date of service;
- Charged amount;
- CPT code;
- Date claim was originally filed/resubmitted;
- Insurance filed is listed as Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, or Health Advantage (Insurance codes are not acceptable unless a memo accompanies the print out describing the code.); and
- If the insurance filed shows a plan other than Arkansas Blue Cross, BlueAdvantage, or Health Advantage, a memo should be attached indicating when the provider was notified that the member had other insurance and any circumstances that caused the delay in filing with the correct or the delay in checking the status of the claim. These cases will be reviewed. If the member did not notify the provider of the correct insurance plan, the claim should not be filed and the member can be billed.

If a provider attached a claim correction form to the claim with proof of timely filing, this can expedite the process since the scanning system should halt the claim for review.

The following will not be accepted as proof of timely filing:

- Hand written notes indicating date the claim was filed;
- Computer notes with incomplete information;
- Insurance codes with no explanation;
- Proof of timely filing with a date of service past 180-days from the current date; (Extenuating circumstances may be reviewed by attaching a memo.)
- Dates on the bottom of the claim submitted as proof; or
- Arkansas Blue Cross, BlueAdvantage, or Health Advantage is secondary, 180-day timely filing starts from the primary carrier's Remittance Advice date of payment or denial.

AHIN Announces New and Improved Member Benefit Displays

Article from the March 2008 issue of the Providers' News

Arkansas Blue Cross and Blue Shield is pleased to announce enhancements in the Advanced Health Information Network (AHIN) display of Member Benefits. For providers already accessing AHIN for Eligibility and Benefit information for Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, and Health Advantage patients, Arkansas Blue Cross thanks you.

For providers who are not currently using AHIN, Arkansas Blue Cross would like to encourage them to begin using AHIN for all of their Eligibility and Benefit inquiries. **This is the same Member Eligibility and Benefit information that Arkansas Blue Cross Customer Service Representatives are viewing.**

For faster service when checking on member benefits and claim status, Arkansas Blue Cross recommends always access AHIN first or providers may also call MyBlueLine (Voice Response Unit) systems. MyBlueLine is an automated system available for use by a provider via the telephone.

1. AHIN access for patient eligibility and benefits available for provider's front office staff and admissions office staff. AHIN is **not** just for submitting claims! AHIN allows a provider's front office staff and admission office the ability to retrieve patient eligibility and benefit information. To access AHIN, go to the Arkansas Blue Cross and Blue Shield web site at www.arkbluecross.com, click on the Provider Page and Select the AHIN link. If an office, facility or hospital already uses AHIN, providers can have immediate access to eligibility, claims and claim-status information.

AHIN is available for more than a million Arkansas Blue Cross, Health Advantage, BlueAdvantage Administrators of Arkansas and USAble Administrators members and former members. AHIN access is free of charge and is EASY to use. For more information on setting up a front office staff or admissions staff to have this easy access to AHIN, please call **501-378-2336.** AHIN can limit access to only eligibility and benefit information.

2. My BlueLine, Arkansas Blue Cross and Blue Shield's Provider Service line is available 24/7 (1-800-827-4814). Use a natural, conversational voice to ask for patient specific information. Just pick up the phone, dial 1-800-827-4814 during business hours and talk. With My BlueLine, it really is that simple and it frees up Customer Service Staff to answer more complicated inquiries.

My BlueLine provides several choices:

- Eligibility and Benefits
- Claim Status
- Addresses

Please note that all eligibility and benefits information is conditional upon verification ***when the claim is received and processed***, and should not be relied upon as assurance of payment of the claim. While Arkansas Blue Cross strives to provide the most current information via AHIN and My BlueLine, Arkansas Blue Cross cannot guarantee that all information has been furnished timely or that computer entries have been updated at the time of the inquiry. All eligibility or benefits information given, via AHIN, My BlueLine or otherwise, is subject to the terms, conditions, exclusions, and limitations of the applicable member's health plan or insurance contract and the participating provider agreement, which take precedence over any inconsistent or contrary oral or written representations.

Electronic Funds Transfer (EFT)

Over 62% of Arkansas Blue Cross participating providers are now using the Electronic Funds Transfer (EFT) payment method for Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, USAble Administrators, USAble Life Group Health, and Wal-Mart payments.

The following is a handy reference for Check / EFT identifiers and payment frequencies to assist providers in identifying where EFT payments originate.

Arkansas BlueCross BlueShield:

- **I T 01** — BlueCard;
- **BC 01** — Arkansas Blue Cross and Blue Shield commercial business; and
- **MP 01** — Arkansas Blue Cross Medicare Supplement (Medipak) business.

BC 01 and MP 01 pay twice weekly with schedule adjustments for holiday and month-end processing. BlueCard (IT 01) pays weekly.

The Arkansas Blue Cross codes for hard copy check payments are:

- **HO** — BlueCard,
- **GA** — Commercial business, and
- **MA** — Medipak.

BlueAdvantage Administrators of Arkansas:

- **US 0 1** — Cross & Shield branded self-funded groups;
- **US US** — USAble Administrators (non-branded self-insured groups)
- **US CH** — Arkansas Comprehensive Health Insurance Plan;
- **US 5 5** — USAble Life Group Health; and
- **US WM** — Wal-Mart.

All BlueAdvantage groups pay weekly, except Wal-Mart which pays twice weekly, and have schedule adjustments for holiday and month-end processing. Since each self-insured group generates a separate EFT, there could be multiple US 01 transactions on any given day. The EFT codes for BlueAdvantage are the same as on hard copy check payments.

Health Advantage:

- **HA S I** — Self-insured;
- **HA AR** — Arkansas State and Public School Employees; and
- **HA ST** — Commercial.

Each type of Health Advantage payment is made weekly with schedule adjustments for holiday and month-end processing. Payments for Arkansas State and Public School Employees is released upon receipt of funding. The Health Advantage EFT codes are the same as on hard copy check payments.

Federal Employee Program (FEP):

Arkansas Blue Cross does not make Federal Employee Program (FEP) payments via EFT at this time. Arkansas Blue Cross will be adding EFT payments for FEP before the end of the year. The identifiers are FS (Standard Option) and FB (Basic Option).

In a continuing **'GO GREEN'** business strategy, Arkansas Blue Cross hopes many more providers will sign up for EFT soon. Contact an Arkansas Blue Cross network development representative for an EFT enrollment package. On-line EFT enrollment will be coming soon!

AHIN: Two Additional Tools Now Available

Article from the September 2006 issue of the Providers' News

Providers have already seen how AHIN (Advanced Health Information Network) has increased their efficiency by providing eligibility, claims viewing and status, online filing and correcting, as well as other features. Now, two additional tools are available for providers and their staff:

1. Electronic Remittance Advice (ERA)
2. Electronic Funds Transfer (EFT)

Electronic Remittance Advice (ERA):

Quit the paper chase and have Remittance Advices delivered electronically. Providers can post payments without leafing through the stacks of paperwork that came in the past.

ERA's save providers time and filing space — while exceeding demands for accuracy and dependability. The ERA system allows the provider's practice management system to operate at peak efficiency which adds to their bottom line and frees their staff to do other task.

If a paper copy is needed, providers can print any Remittance Advice. A history of a provider's Remittance Advice is maintained on-line through AHIN and is always available for viewing.

Electronic Funds Transfer (EFT):

When do providers like to be paid? Today? Tomorrow? Two weeks from now? Why wait for the mailman? A payment can be deposited directly into a provider's bank account and the provider is notified when the payment has been made. Just like a personal on-line account, providers control their financial information and their privacy and confidentially are assured.

Getting Started is Easy:

Contact your Arkansas Blue Cross regional Network Development Representative who can provide more information and show providers the way to a more efficient, productive office.

At this time, Electronic Fund Transfer is not available for the Federal Employee Program (FEP) or Medi-Pak® Advantage .

Durable Medical Equipment Billing

- Rentals of Durable Medical Equipment (DME) should be billed using the beginning date of rental (not a date range), units of service of 1, and the Modifier RR.
- Ten monthly rental payments of DME equipment will be considered the same as a purchase of the equipment. Additional DME billings for rental and/or purchase of the item will be denied as duplicate billings.
- Low cost DME items will require purchase rather than rental.
- Satisfaction of the Primary Coverage Criteria is required for high cost DME items.
- Purchase of covered home supplies will be limited to a 90 day supply. The Medicare limitations will be used as a guide.

Arkansas State and Public School Account Services/Codes that Require Pre-Certification

Several services, including but not limited to, high-tech radiology, physical and occupational therapy, speech therapy, and some outpatient surgeries require pre-certification by American Health Holding (AHH). Below are the specific codes and descriptions for services that have been identified as requiring the pre-certification. Provider who have questions about these services, please call American Health Holding at 800-592-0358 or fax to 866-317-0166.

Code Description	CPT and HCPCS Codes
High-Tech Radiology	
Head / Neck	70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 0042T
Chest	71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555
Spine & Pelvis	72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 77084
Upper Extremities	73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225
Lower Extremities	73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725
Abdomen	74150, 74160, 74170, 74175, 74181, 74182, 74183, 74185, 0066T, 0067T, S8037
Heart	75557, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 0144T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T, 0151T
Vascular	75635
Breast	77058 ,77059
Nuclear Medicine—Nervous System	78608, 78609
Nuclear Medicine—Cardiovascular System	78459, 78491, 78492
Nuclear Medicine—Other	78811, 78812, 78813, 78814, 78815, 78816, G0235
CT Scan, Limited	76380
Magnetic Resonance Spectroscopy	76390
MRI Low Field	S8042

ASE/PSE Account Services/Codes that Require Pre-Certification (continued):

Code Description	CPT, HCPCS, and Revenue Codes
Physical and Occupational Therapy	
Muscle and Range of Motion Testing	95831-95834, 95851-95852,
Physical Medicine And Rehabilitation	97001-97546,
Wound Care Management	97597-97755,
Orthotic And Prosthetic Management	97760- 97799
Decompression/Repositioning	S9090, S9092
Electrical Stimulation	G0283
Services In A Home Setting	G0151, G0152, S9129, S9131
Revenue Codes	240, 420, 421, 422, 423, 424, 429, 430, 431, 432, 433, 434, 439
Speech Therapy	
Otorhinolaryngologic Services	92506-92508
Services In Home Setting	S9128, G0153
Revenue Codes	440, 441, 442, 443, 444, 449
Outpatient Surgical Services	
Intradiscal Electrothermal Therapy (IDET)	0062T, 0063T, 22526, 22527
Palatopharyngoplasty	42145
Varicose Vein Excision and Ligation	36475, 36476, 36478, 36479, 37700, 37718, 37722, 37760, 37765, 37766, 37785
Blepharoplasty and/or Brow Lift	15820,15821,15822,15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908
Gynecomastia Reduction	19300
Mammoplasty (Reduction or Augmentation)	19316, 19318, 19324, 19325
Rhinoplasty	30400, 30410, 30420, 30430, 30435, 30450
Ventral Hernia Repair	49560, 49561, 49565, 49566, 49568
Scar Revision	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Septoplasty	30520

Claims Denials:
Inquiries regarding claims denied by Health Advantage for '**No Valid AHH/EBD Pre-Certification for this Procedure**' should be directed as follows:

1. If Precertification has been obtained: contact customer service at 800-482-8416; e-mail customer service from the Health Advantage customer service link on AHIN or e-mail customer service directly at customerservicepse@arkbluecross.com. E-mail inquiries will be answered in one business day.
2. If no pre-certification was obtained for the service: call AHH at 800-592-0358 to request a retro-review. Inquiries may also be faxed to AHH at 866-317-0166.

Chiropractic Services:
Pre-certification is not required for services (modalities, manipulations or therapies) rendered by a chiropractor. However, all services provided by or billed by a chiropractor are limited to the 15 annual visits.

Arkansas State and Public School Employees Preventive Benefits (updated June 2008)

CPT Codes	Ages	Diagnosis Code Required
New Patient - Well Baby Visits:		
99381	Under 1 year	Must be billed with diagnosis code V20.2
New Patient - Annual Preventive (Under 18 years of age):		
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):		
99385	Age 18-39	Must be billed with diagnosis codes: V70.0, V72.31, or V76.10 thru V76.19.
99386	Age 40-64	
99387	Age 65+	
Established Patient - Well Baby Visits (Under 18 years of age):		
99391	Under 1 Year	Must be billed with diagnosis code V20.2
Established Patient - Annual Preventive Care (Under 18 years of age):		
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):		
99395	Age 18-39	Must be billed with diagnosis codes: V70.0, V72.31, or V76.10 thru V76.19.
99396	Age 40-64	
99397	Age 65+	
Newborn Care -Well Baby Visits (Under 18 years of age):		
99432	Under 1 Year	Must be billed with diagnosis code V20.2

Description	CPT Codes	Ages	Diagnosis Code Required
Preventive Care—Adult (members age 18 and over):			
Annual Physical		Age 18+	Must be billed with Diagnosis codes: V70.0, V72.31, or V76.10 thru V76.19.
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)**			
Mammogram - with computer-aided detection	77055, 77056 billed with 77051 77057 billed w/ 77052	Age 40 + Annually	Allowable with any diagnosis code.
Digital Mammogram - Computer-aided detection add-on codes are ineligible when billed with a digital mammogram.	G0202, G0204, G0206 or Revenue code 403	Age 40 + Annually	

ASE /PSE Preventive Benefits continued:

CPT Codes		Age/Frequency	Diagnosis Code Required
- Pap Smear			
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174-88175, G0101, Q0091		Age 18 + Annually	Allowable with any diagnosis code.
- Prostate Specific Antigen (PSA)			
84152, 84153, 84154, G0102, G0103		Age 40 + ; Annually	Allowable w/any diag code.
Description	**CPT Codes**	**Age/Frequency**	**Diagnosis Code Required**
- Colorectal Cancer Screening (Choice of the following beginning at age 50)			
Fecal occult blood test and one of the following:	82270, 82274, G0107, G0328	Annually	Allowable with any diagnosis code.
- Sigmoidoscopy	45300—45339, G0104	Every 5 years	
- Colonoscopy	45378—45385, G0105 or G0121	Once every 10 yrs	
- Double contrast barium enema	74280, G0106	Once every 5 yrs	
- Cholesterol and HDL Screening			
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):			
Diphtheria and Tetanus toxoid	90718-90719	Every 10 years	Allowable with any diagnosis code.
Hepatitis A & B (combined)	90636	Once Per Lifetime	
Hepatitis A (Hep A)	90632	Once Per Lifetime	
Hepatitis B (Hep B)	90740, 90747, 90746	Once Per Lifetime	
Human papilloma virus (HPV)	Gardasil 90649	Age 19 - 26	
Influenza	90658	Annually	
Pneumococcal Conjugate	90732	Age 18 and over	
Meningitis	90733, 90734	Age 18 - 24	
Herpes Zoster (or a $30 copay at pharmacy)	90736	Adults 60 and over	
Preventive Care — Child:			
All childhood immunizations	Mandated services	Under age 18	Allowable with any diagnosis code.
Hepatitis A (Hep A)	90633—90634	Once Per Lifetime	
Hepatitis B (Hep B)	90743—90744	Once Per Lifetime	
Human papilloma virus (HPV)	Gardasil 90649	Age 9 - 18	
Rotavirus	Rota Teq 90680	Age 8 - 32 weeks	
Meningitis	90733, 90734	Age 11 - 18	
Pneumococcal Conjugate Vaccine	90732, 90657—90660	Codes specific for age	

FEP Dental Claims: Helpful Hints and New Billing Requirements Effective August 1, 2008

When dental services for Federal Employee Program (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 a claim, obtain the FEP member identification number from the member ID card. The FEP member identification number begins with an R followed by 8 digits (example: R12345678).

When treating patients with cancer of the mouth: Please submit the dental claims with the cancer related diagnosis code on the claim form. Cancer related ICD-9 diagnosis codes are 140-208.99 or 230-239.99. For the exact diagnosis code, please refer to the ICD-9 Diagnosis Code book for the year the services were rendered. Please place the ICD-9 diagnosis code in field 35 on the 2006 ADA dental claim form.

New billing requirements for FEP Dental claims effective August 1, 2008: Submit all FEP dental claims using the 2006 American Dental Association (ADA) Claim Form. Claims submitted on any other dental claim form after August 1, 2008, will be rejected. Additional information on how to obtain the new dental claim form can be found at the ADA website at www.ada.org. (A sample of the 2006 ADA claim form is located on the following page.)

National Provider Identifier (NPI): All dental providers must file claims with their National Provider Identifier. All claims received without a NPI after the CMS deadline of May 23, 2008 number will be rejected.

For providers who have not obtained an NPI, please do so as soon as possible. The most expeditious way to obtain an NPI is to apply online by visiting:

https://nppes.cms.hhs.gov/NPPES

Filing dental claims as a CLINIC on the 2006 ADA claim form using the clinic and performing provider NPI numbers:

- Field 48 - Name, Address, City State, Zip Code: Enter the clinic's name and address.
- Field 49 - NPI: Enter the 10-digit NPI of the clinic.
- Field 52A - Additional Provider ID: Enter the clinic's 5-digit Arkansas Blue Cross provider number. (not required)
- Field 54 - NPI: Enter the NPI of the servicing dental provider.
- Field 58 - Additional Provider ID: Enter the 5-digit Arkansas Blue Cross number of the servicing dental provider. (not required)

Filing dental claims as the PERFORMING PROVIDER (not part of a clinic) on the 2006 ADA claim form using the performing provider NPI number:

- Field 48 - Name, Address, City State, Zip Code: Enter the billing provider's name and address.
- Field 49 - NPI: Enter the 10-digit NPI of the billing provider.
- Field 52A - Additional Provider ID: Enter the billing provider's 5-digit Arkansas Blue Cross provider number. (not required)
- Field 54 - NPI: Enter the NPI of the servicing dental provider.
- Field 58 - Additional Provider ID: Enter the 5-digit Arkansas Blue Cross number of the servicing dental provider. (not required)

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Flow Cytometry

CPT Codes 88184 and 88185 are for the technical component of flow cytometry. These codes may be billed by an outpatient facility or by a physician when performed on a patient in place of service office. Arkansas Blue Cross and Blue Shield have identified inappropriate billings for these procedures by physicians for patients in a facility setting. Arkansas Blue Cross will be requesting overpayments on these claims.

CPT codes 88187—88189 are the interpretation codes for flow cytometry. These are the appropriate codes for a physician to bill for interpretation in any place of service.

Coverage Policy Manual Updates

The following policies have been added to the Arkansas Blue Cross and Blue Shield Coverage Policy Manual or coverage has changed since March 2008. Other revised policies are not listed here because no change was made in coverage/non-coverage. To view the entire policy, providers can access the coverage policies at www.arkbluecross.com.

Policy ID#	Policy Name
1997018	Cardioverter Defibrillator, Implantable
1997087	Growth Hormone, Human
1997190	Stem Cell Growth Factors, Epoetin
1997200	Seasonal Affective Disorder (SAD), Use of Phototherapy
1997251	Pain Management, Transforaminal Nerve Block
1998105	Transplant, Lung and Lobar Lung
1998106	Transplant, Heart/Lung
1998161	Infliximab (Remicade)
1998163	Stem Cell Growth Factors, Epoetin Alfa for Preoperative Elective Surgery
2000016	Apheresis, Lowering LDL Cholesterol (Lipid Apheresis)
2001028	Magnetic Resonance Imaging, Breast
2002014	Extracranial-Intracranial Bypass Surgery in Cerebrovascular Disease
2002025	Donor Leukocyte Infusion
2004027	Stem Cell Growth Factor, Darbepoetin
2008010	Advanced Nurse Practitioners
2008013	Certified Nurse Midwives
2008014	Physician Assistants
2008015	Clinical Nurse Specialist
2008017	PathFinderTG® Molecular Testing
2008018	Stem Cell Growth Factors, pegfilgrastim

Fee Schedule Updates

The following CPT / HCPCS codes were updated on the Arkansas Blue Cross fee schedule.

CPT/ HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
82274	$11.45	$0.80	$10.65	$0.00	$0.80	$0.00
90649	$125.55	$0.00	$0.00	$0.00	$0.00	$0.00
90680	$69.59	$0.00	$0.00	$0.00	$0.00	$0.00
90704	$22.24	$0.00	$0.00	$0.00	$0.00	$0.00
90706	$19.15	$0.00	$0.00	$0.00	$0.00	$0.00
93613	$0.00	$0.00	$0.00	$623.03	$623.03	$0.00
99605	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00
99606	$17.50	$0.00	$0.00	$0.00	$0.00	$0.00
99607	$15.00	$0.00	$0.00	$0.00	$0.00	$0.00
0066T	$233.36	$73.65	$159.71	$0.00	$73.65	$0.00
0067T	$233.36	$73.65	$159.71	$0.00	$73.65	$0.00
G0179	$67.50	$0.00	$0.00	$0.00	$0.00	$0.00
G0181	$147.60	$0.00	$0.00	$0.00	$0.00	$0.00
G0398	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G0399	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G0400	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J1642	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00
J7307	$523.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7611	$0.07	$0.00	$0.00	$0.00	$0.00	$0.00
J7612	$0.13	$0.00	$0.00	$0.00	$0.00	$0.00
J7613	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00
J7614	$0.29	$0.00	$0.00	$0.00	$0.00	$0.00
K0672	BR	$0.00	$0.00	$0.00	$0.00	$0.00
L3806	$358.40	$0.00	$0.00	$0.00	$0.00	$0.00
Q4096	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q4097	$35.55	$0.00	$0.00	$0.00	$0.00	$0.00
Q4098	$12.06	$0.00	$0.00	$0.00	$0.00	$0.00
Q4099	$5.13	$0.00	$0.00	$0.00	$0.00	$0.00
S3628	BR	$0.00	$0.00	$0.00	$0.00	$0.00

Home Infusion Therapy Services

The following HCPCS codes for Home Infusion Therapy Services will be updated on the Arkansas Blue Cross and Blue Shield fee schedule effective September 1, 2008.

HCPCS Code	Description	Updated Fee (per diem)
S9325	Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately). (Do not use this code with S9326,S9327 or S9328.)	$ 32
S9326	Home infusion therapy, **continuous** (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment per diem (drugs and nursing visits coded separately).	$ 32
S9330	Home Infusion Therapy; **continuous** (24 hours or more) chemotherapy Infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment per day (drugs and nursing visits coded separately).	$ 38
S9331	Home Infusion Therapy; **intermittent** (less then 24 hours) chemotherapy Infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment per day (drugs and nursing visits coded separately).	$ 38
S9373	Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately). (Do not use with hydration therapy codes S9374-S9377 with daily volume scales.)	$ 32
S9374	Home infusion therapy, hydration therapy; **one liter per day**	$ 32
S9375	Home Infusion therapy, hydration therapy; **more than one liter but no more than two liters per day**	$ 32
S9376	Home Infusion Therapy, hydration therapy; **more than two liters but not more than three liters per day**	$ 32
S9377	Home infusion therapy, hydration therapy; **more than three liters per day**	$ 32

(Continued from page 18)

Home Infusion Therapy Services (continued)

HCPCS Code	Description	Updated Fee (per diem)
S9494	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately). (Do not use with home infusion codes for hourly dosing schedules S9497—S9504.)	$ 45
S9497	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every three hours**	$ 45
S9500	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 24 hours**	$ 45
S9501	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 12 hours**	$ 45
S9502	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 8 hours**	$ 45
S9503	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 6 hours**	$ 45
S9504	Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; **once every 4 hours**	$ 45

Providers' News

Arkansas Blue Cross and Blue Shield
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