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providers' news

A publication for participating providers and their office staffs

inside

Intensity modulated radiation therapy

Intensity modulated radiation therapy (IMRT) meets primary coverage criteria for a limited number of indications. Several coverage policies outlining criteria for IMRT are available online and more policies are being developed.

Multiple codes are used to bill IMRT services but the only CPT codes 77301, 77338, and 77418 are specific to IMRT.

Over the past year, there has been an increase in the number of IMRT claims that are filed with a noncovered diagnosis or coverage criteria for a covered indication is not met and yet radiation therapy is appropriate. In these situations claims will be paid based on the allowances for 3D conformal radiation therapy. This is a continuation of reimbursement policies in place since 2005.

Arkansas BlueCross BlueShield
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Policy requiring timely response to medical records requests

A. Standard and definition of timely response versus tardy response: As a condition of network participation, providers participating in the Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and the Health Advantage networks must make a timely response to all medical records requests. A response to a medical records request is deemed timely if a complete response, furnishing copies of all requested medical records as defined in the request, is made not later than 60 days after the request was sent to the provider. A tardy response is any response by a provider to a medical records request that is either (a) incomplete or (b) delivered 61 or more days after the request was sent to the provider, or (c) sent by any method other than the required fax bar-coding process described below, unless a provider has arranged in advance, by specific written agreement with the network sponsor, for special handling of the medical records request response.

B. Bar-coded request process, follow-up requests and procedures: Medical records requests are made initially via the Medical Records Request (MRR) system, which is an automated process that includes a bar-coded fax transmission of the request to the provider. Participating providers are required to respond in kind, using a fax and the same bar code to return the requested medical records. This process incorporates a tracking system (via use of the bar code) to avoid duplication of effort and loss of records in the transmission process. Providers who are unable to use the bar-coded fax process for some reason must make arrangements in advance of sending any medical records with the appropriate network sponsor (such arrangements to be evidenced by a signed, written acknowledgment of the network sponsor) for special handling of the medical records request response.

Automatic reminders of outstanding medical records requests are generated by the MRR system on the 20th day following the initial request. A third request/reminder also is generated by the system on the 40th day following the initial request.

C. Consequences of tardy responses: Any participating provider who has more than three tardy responses identified during any 30-day period (regardless of the period in which such medical records requests were made, and regardless of the passage of time involved past 60 days), will receive a warning letter from Medical Audit and Review (or any other appropriate department with knowledge), reminding such provider of the importance of timely responses, including potential implications for network participation status (initial warning letter).

Any participating provider who fails to clear up and fully address all tardy responses within 21 business days after the initial warning letter is sent will be placed on medical records probation for a period of 180 days. Medical Audit and Review will send a letter (or any other appropriate department with knowledge) to such provider, establishing the beginning and end date for such medical records probation (second warning letter).

After a provider has been placed on medical records probation, in order to remain eligible for network participation, such provider must achieve 100 percent timely responses for all medical records requests sent to such provider during the medical records probation period (the 180-day period defined in the second warning letter). A provider who successfully completes the medical records probation period with a 100 percent timely response record reverts to the pre-probation timely response standards and process, except where repeat offender status is designated, as further outlined below. Providers who fail to achieve 100 percent timely responses during the medical records probation period are subject to termination of network participation. If network participation is terminated due to failure to achieve 100 percent timely responses during the medical records probation period, a terminated provider shall be ineligible to re-apply for network participation for a minimum period of one year.

D. Repeat offender status and process: A provider who repeatedly fails to make timely responses resulting in medical records probation for such provider more often than twice during any two calendar-year

Policy requiring timely response to medical records requests (continued from page 2)

period shall be disqualified from network participation as a repeat offender, and will be ineligible to re-apply for network participation for a minimum period of three years from the date of network termination.

E. **Acceptable and unacceptable excuses for meeting timely response standard:** The network sponsors may, in their sole discretion, and upon written application by the affected provider setting forth all the relevant circumstances, including documentation satisfactory to the network sponsors, recognize certain acceptable excuses for tardy responses.

Such acceptable excuses may include

(a) power outages, natural disasters or computer systems failures not attributable to any fault of the provider and provided no reasonable alternative was available to the provider;

(b) a documented change by the provider in computer systems or transmission equipment (such as major systems replacement or upgrades), if notice of such changes is sent in advance, in writing, to the network sponsors and provided no reasonable alternative was available to the provider;

(c) relocation of the provider's practice location involving disruption to ongoing business operations, if notice of such relocation is sent in advance, in writing, to the network sponsors and provided no reasonable alternative was available to the provider; or

(d) illness or incapacity of the provider and all office staff at the same time that effectively shuts down the provider's practice and prevents timely attention to all business of the provider.

Unacceptable excuses for tardy responses include

(a) illness or incapacity of the provider, in any case where the provider has office staff, temporary staff, consultants, practice managers, agents or others available to perform administrative functions on his/her behalf; or

(b) illness or incapacity of any office staff of the provider, in any case where other office staff continue to be able to work, or in any case in which the provider's office continues to be open and operating with or without normal staffing, including but not limited to temporary staff, consultants, practice managers, agents or others available to perform administrative functions on her/his behalf;

(c) inclement weather not constituting a natural disaster that prevents operation of the provider's office;

(d) dereliction of duty, negligence, insubordination or malicious or criminal conduct of any employee, consultant, practice manager or agent;

(e) breach of contract, negligence or any other failure or omission of any office management company, practice manager, consultant, independent contractor or agent of provider; or

(f) lack of appropriate record-keeping or insufficient security and management of medical records, including but not limited to failure to keep such records updated, classified, indexed and maintained in providers' own record system or database.

F. **Applicants to networks:** Any applicant for network participation who has a history of medical records requests and responses as to any network sponsor shall be subject to this policy. If the applicant's history of responses to medical records requests fails to meet the requirements of this policy (e.g., if such applicant is then delinquent in medical records responses because of having more than three tardy responses during any 30 day period, or because of failure to completely address and clear up any tardy responses within 21 business days after the initial warning letter, or because of failure to successfully complete any medical records probation period, or because of being placed on medical records probation more than twice during any two calendar year period) such applicant shall be ineligible to participate in the network until

(a) in the case of an initial warning letter, the tardy responses are completely addressed and cleared up in not less than 21 business days after the initial warning letter;

(b) in the case of failure to successfully complete any medical records probation period, such applicant shall be ineligible to re-apply or participate in the network for a period of one year from the date of the application; or

(c) in the case of having been placed on medical records probation more than twice during any two calendar-year period, such applicant shall be ineligible to re-apply or participate in the network for a minimum period of three years from the date of the application.

Not otherwise classified/unlisted procedure codes

Effective immediately, when billing procedure codes that are defined as not otherwise classified or unlisted procedure in the CPT and/or HCPCS coding manuals, a description must be indicated on the claim form and/or electronic record for each code billed. As noted in the December 2009 Providers' News, if the description is not present on the claim form and/or electronic record, it will result in the claims being returned for this information. When the claim is re-filed, including the descriptions, it will be considered a new claim and a corrected claim form does not need to be attached.

Reminder: clinic visits billed by a facility

Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation do not recognize facility charges for clinic visits. Facility charges for services performed in a clinic should be billed under revenue codes 0510-0519. These services will be denied and charges for these services should not be collected from Arkansas Blue Cross policyholders.

Covered services performed in a clinic will be reimbursed when billed on a professional claim. (Article originally printed in the September 2008 issue of *Providers' News*.)

Medical records attached to claim and/or corrected bills

Arkansas Blue Cross and Blue Shield still is receiving medical records attached to claims and/or corrected bills. Due to an automated front-end process, there is no notification of records being attached. Therefore, as a reminder, providers should not send medical records until requested. Medical records should then faxed using the bar-coded sheet as the cover page only when requested.

It continues to be the goal of Arkansas Blue Cross to provide the most effective and efficient administration of customer service in the industry. With the assistance of our providers, Arkansas Blue Cross will reach that goal and assure that our providers' claims and requests are processed in the most efficient manner.

Secondary paper claims submission

When filing secondary paper claims, a copy of an explanation of benefits (EOB) or remittance advice (RA) showing primary payment must be attached to each individual claim. Multiple claims attached to one copy of an EOB or RA will be returned. The electronic submission of secondary claims is preferred. For assistance in filing secondary electronic claims, please contact your software vendor or by contacting AHIN at 501-378-2336.

AI modifier

Arkansas Blue Cross and Blue Shield has not accepted consultation CPT codes 99241-99241 and 99251-99255 since April 1, 2010 as stated in the December 2009 issue of *Providers' News*. Because Arkansas Blue Cross is no longer accepting the consultation codes, it is important to be able to identify the principal physician of record. The principal physician of record should use modifier AI when billing for hospital and nursing home visits, CPT codes 99218-99336 and 99304-99306. This modifier will identify the admitting or attending physician who oversees the patient's care while in an inpatient or nursing facility setting. This is an informational only modifier. The AI modifier will not make any changes in processing or amounts payable. Therefore, append any payment modifiers before the AI modifier.

Walmart health plan changes for 2011

Effective January 1, 2011, the Walmart Associates' Health and Welfare Plan will have several changes:

- Health Care Credit (HCC) will be discontinued.
- Value plans will be replaced with HRA plans.
- Five medical plans will be available (outlined below).
- Associates participating in the HRA plans will receive a company contribution of $500 for individual coverage or $1000 for family coverage. The HRA funds pay first dollar coverage for eligible medical expenses that are applied to the deductible or coinsurance. Unused HRA funds will rollover to 2012.
- HRA plans will have an individual or family deductible.
- HDP Standard Plan is replacing the Freedom Plan currently offered. This year only one deductible level will be offered.
- Preventive care services will be reimbursed at 100 percent of the plan allowable for in-network providers. When an out-of-network provider is used, the plan reduces the benefit to 50 percent. The amount paid for out-of-network services will apply toward the annual deductible and will not apply toward the out-of-pocket maximum.
- Preventive care services will be determined using the Health Care Reform PPACA guidelines.

Below is a summary of the deductible/coinsurance options that will be available.

Health Reimbursement Account (HRA) Plans:

Plan	Associate Only	Associate and dependents
HRA Basic	• $500 HRA company contribution • $2,200 deductible responsibility • $5,000 out-of-pocket maximum	• $1,000 HRA company contribution • $4,400 deductible responsibility • $10,000 out-of-pocket maximum
HRA Enhanced	• $500 HRA company contribution • $1,250 deductible responsibility • $5,000 out-of-pocket maximum	• $1,000 HRA company contribution • $2,500 deductible responsibility • $10,000 out-of-pocket maximum
HRA Elite 5000	• $500 HRA company contribution • $750 deductible responsibility • $5,000 out-of-pocket maximum	• $1,000 HRA company contribution • $1,500 deductible responsibility • $10,000 out-of-pocket maximum
HRA Elite 3000	• $500 HRA company contribution • $750 deductible responsibility • $3,000 out-of-pocket maximum	• $1,000 HRA company contribution • $1,500 deductible responsibility • $6,000 out-of-pocket maximum

High Deductible Plan:

Plan	Associate Only	Associate and dependents
HDP Standard	• Up to $600 HSA match • $3,000 deductible • $5,950 out-of-pocket maximum	• Up to $1,200 HSA match • $6,000 deductible • $11,900 out-of-pocket maximum

Splitting claims

Providers should submit all codes for one place of service on one date of service for payment on one claim. Providers should not submit multiple claims for payment for the same date of service by splitting the codes billed on separate claims. Splitting the claims may cause the claim(s) to pend for manual processing and possibly delay payment.

Revenue code claims filing changes

Effective March 1, 2011, outpatient institutional claims containing revenue codes 0905, 0906, 0912, 0913 and 0915 will require CPT/HCPCS codes in conjunction with these revenue codes. When submitting outpatient claims with these revenue codes (both electronic and paper), facilities must also use the appropriate corresponding CPT codes 90801-90880, 90901, 96101-96120, G0176, G0177, G0396, G0397, G0410 and G0411. Claims submitted without appropriate CPT/HCPCS codes will be rejected and the member will not be responsible. This revision applies to all outpatient UB04 claims submitted to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage.

The following are the current Arkansas Blue Cross fee schedule allowances for these codes.

Code	Allowance
90801	$43.27
90802	$45.05
90804	$16.60
90805	$17.79
90806	$10.07
90807	$17.78
90808	$10.68
90809	$16.60
90810	$14.82
90811	$22.52
90812	$15.41
90813	$22.53
90814	$15.41
90815	$22.53
90816	$16.60
90817	$17.79

Code	Allowance
90818	$10.07
90819	$17.78
90821	$10.68
90822	$16.60
90823	$14.82
90824	$22.52
90826	$15.41
90827	$22.53
90828	$15.41
90829	$22.53
90846	$3.55
90847	$11.27
90849	$5.33
90853	$3.56
90857	$6.52
90862	$17.79

Code	Allowance
90870	$58.80
90880	$11.86
90901	$16.00
96101	$0.59
96102	$32.80
96103	$28.40
96118	$30.23
96119	$47.60
96120	$54.40
G0176	$0.00
G0177	$0.00
G0396	$1.80
G0397	$1.80
G0410	$0.00
G0411	$0.00

Also effective March 1, 2011, revenue code 0761 (specialty services – treatment room), will require CPT codes on outpatient claims. Please use the following appropriate CPT code when submitting revenue code 0761: 99201-99205, 99211-99215, 97597, 97598 and 97602. Outpatient claims submitted without the appropriate CPT code in conjunction with revenue code 0761 will be rejected and the member will not be responsible.

The following are the current Arkansas Blue Cross fee schedule allowances for these codes.

Code	Allowance
99201	$17.55
99202	$23.85
99203	$31.05
99204	$35.55
99205	$38.70

Code	Allowance
99211	$12.60
99212	$18.00
99213	$21.60
99214	$29.70
99215	$34.20

Code	Allowance
97597	$34.40
97598	$38.80
97602	$38.80

Supplies are often used in conjunction with services billed with revenue code 0761. When revenue code 0761 is billed, supplies in conjunction with 0761 should be billed using revenue codes 0270, 0271 or 0272.

In the presence of revenue code 0761, the codes listed below should be used when billing revenues codes 0270, 0271 or 0272. Outpatient claims submitted without these appropriate HCPCS codes will be rejected and the member will not be responsible. Below are the current Arkansas Blue Cross fee schedule allowances for these codes. Please note that these UB-04 claims filing policy revisions do not affect the benefit coverage policies of the services being billed.

Revenue code claims filing changes (continued from page 6)

Code	Allowance
A4216	$0.45
A4217	$3.13
A4244	$1.04
A4246	$3.53
A4248	$2.09
A4450	$0.09
A4452	$0.36
A4455	$1.43
A4456	$0.26
A4461	$3.29
A4462	$3.29
A4463	$0.00
A4465	$11.66
A4470	$7.81
A4480	$6.52
A4490	$8.68
A4495	$8.68
A4500	$6.52
A4510	$15.51
A4565	$5.00
A4570	$5.00
A6000	$21.80
A6010	$30.96
A6011	$2.28
A6021	$21.02
A6022	$21.02
A6023	$190.30
A6024	$6.19
A6025	$30.50
A6154	$14.38
A6196	$7.35
A6197	$16.44
A6198	$20.06
A6199	$5.29
A6200	$9.50
A6201	$20.80
A6202	$34.88
A6203	$3.35
A6204	$6.23
A6205	$7.68
A6206	$5.65
A6207	$7.34

Code	Allowance
A6208	$9.03
A6209	$7.48
A6210	$19.92
A6211	$29.37
A6212	$9.70
A6213	$10.09
A6214	$10.29
A6215	BR
A6216	$0.05
A6217	$0.43
A6218	$0.43
A6219	$0.95
A6220	$2.58
A6221	$3.17
A6222	$2.13
A6223	$2.42
A6224	$3.61
A6228	$2.60
A6229	$3.61
A6230	$3.92
A6231	$4.68
A6232	$6.88
A6233	$19.19
A6234	$6.54
A6235	$16.82
A6236	$27.25
A6237	$7.91
A6238	$22.79
A6239	$27.76
A6240	$12.24
A6241	$2.57
A6242	$6.07
A6243	$12.31
A6244	$39.28
A6245	$7.27
A6246	$9.92
A6247	$23.78
A6248	$16.24
A6250	$1.50
A6251	$1.99
A6252	$3.25
A6253	$6.34

Code	Allowance
A6254	$1.21
A6255	$3.03
A6256	$3.73
A6257	$1.53
A6258	$4.30
A6259	$10.94
A6260	$1.30
A6261	$5.22
A6262	$1.30
A6266	$1.92
A6402	$0.12
A6403	$0.43
A6404	$0.86
A6407	$1.88
A6410	$0.39
A6411	$0.43
A6412	$0.43
A6413	$0.00
A6441	$0.67
A6442	$0.17
A6443	$0.29
A6444	$0.56
A6445	$0.32
A6446	$0.41
A6447	$0.67
A6448	$1.16
A6449	$1.75
A6450	$13.74
A6451	$40.34
A6452	$5.91
A6453	$0.61
A6454	$0.77
A6455	$1.39
A6456	$1.28
A6457	$1.14
A6501	BR
A6502	BR
A6503	BR
A6504	BR
A6505	$99.55
A6506	$41.03
A6507	BR

Revenue code claims filing changes (continued from page #)

Code	Allowance
A6508	BR
A6509	BR
A6510	$125.54
A6511	BR
A6512	$9.08
A6513	BR
A6530	$68.59
A6531	$43.27
A6532	$60.96
A6533	$76.80
A6534	$90.13
A6535	$54.91
A6536	$102.88
A6537	$120.14

Code	Allowance
A6538	$50.06
A6539	$116.02
A6540	$109.64
A6541	$207.81
A6542	$347.84
A6543	$122.55
A6544	$20.95
A6545	BR
A6549	$73.92
A6550	$27.42
Q4100	BR
Q4101	$35.46
Q4102	$4.60
Q4103	$4.60

Code	Allowance
Q4104	$15.65
Q4105	$10.63
Q4106	$41.71
Q4107	$98.93
Q4108	$19.99
Q4109	$83.21
Q4110	$36.44
Q4111	$7.38
Q4112	$367.51
Q4113	$367.51
Q4114	$995.83
Q4115	BR
Q4116	BR

Sleep study supplies

Supplies used during a sleep study are considered part of the reimbursement to outpatient facilities. Reimbursement for CPT codes 95805, 95806, 95807, 95808, 95810, and 95811 already include reimbursement for supplies. Therefore services billed under revenue codes 0270, 0271 and 0272 during a sleep study will not be reimbursed and the member is not responsible.

Stereotactic radiosurgery/stereotactic body radiation therapy

Stereotactic radiosurgery (SRS) is a method of delivering high doses of ionizing radiation to small intracranial targets. The technique differs from conventional radiotherapy, which involves exposing large areas of intracranial tissue to relatively broad fields of radiation over a number of sessions. SRS is typically done in one session.

Stereotactic body radiation therapy (SBRT) is highly focused radiation therapy delivered outside the cranium, typically in five or fewer sessions. Any course of therapy consisting of more than five sessions should be billed as IMRT.

Coverage policy 1997210, stereotactic radiosurgery and stereotactic body radiation therapy gamma knife surgery, linear accelerator, cyberknife, tomotherapy, provides coverage criteria that must be met in order for SRS/SBRT to be reimbursed.

Radiation therapy services billed as SRS or SBRT that do not meet coverage criteria will be reimbursed based on allowances for three-dimensional conformal radiotherapy. CPT codes specific for SRS include 77371, 77372 and 77432; codes specific for SBRT include 77373 and 77435.

Medical literature will continue to be reviewed for articles reporting results of ongoing clinical trials investigating the use of SBRT for indications that are not currently included in the coverage policy.

Blue surgical safety checklist implementation

The Blue Surgical Safety Checklist is adopted from the World Health Organization (WHO) Surgical Safety Checklist. The checklist is a tool created by leaders in surgery, anesthesia, nursing and quality improvement to reduce the number of errors and complications resulting from surgery. The checklist outlines essential standards of surgical care and is designed to be simple, be widely applicable, and address common and potentially disastrous lapses.

Every operating room team can improve the safety and efficacy of care delivered to surgical patients. WHO has created this starter kit to help providers and their facility (hospital, ambulatory surgery center, or other operative facility) implement a checklist that can identify gaps in preoperative practice and establish or confirm adherence to proven standards of care that can improve surgical results and decrease deaths and complications. The starter kit also provides a detailed explanation of strategies for putting this checklist into place, a means of identifying essential staff members and clinicians, and a guide for troubleshooting problems that are bound to arise during the process of implementation.

Arkansas Blue Cross and Blue Shield hopes these materials are useful. Provider thoughts, feedback, and experiences with implementation and this starter kit can be e-mailed to patientsafety@bcbsa.com. Provider feedback can help improve this project and the safety of surgical patients everywhere.

Background

In January of 2007 WHO began a program aimed at improving the safety of surgical care globally. The initiative, Safe Surgery Saves Lives, aims to identify minimum standards of surgical care that can be universally applied across countries and settings. By focusing attention on surgery as a public health issue, WHO is recognizing the importance of improving the safety of surgical care around the world. The initiative seeks to harness political commitment and clinical will to address important safety issues, including inadequate anesthetic safety practices, avoidable surgical infection, and poor team communications which have proved to be common, deadly, and avoidable problems across all countries and settings.

Through a two-year process involving international input from surgeons, anesthesiologists, nurses, infectious disease specialists, epidemiologists, biomedical engineers, and quality improvement experts, as well as patients and patient safety groups, WHO created a surgical safety checklist that encompasses a simple set of safety standards that can be used in any surgical setting. Each step on the checklist is simple, widely applicable, and measurable. In addition, the safety steps reduce the likelihood of serious, avoidable surgical harm and are unlikely to introduce harm or unmanageable cost.

Organizations from around the globe (including professional societies of surgery, anesthesia, nursing; patient safety groups; health provider organizations; ministries of health; and nongovernmental and relief organizations that provide surgical care) have endorsed the concept of the checklist, which was officially launched on June 25, 2008, in Washington, D.C. Surgical safety is now a priority for health care safety and quality improvement.

The checklist has been validated in eight pilot sites in diverse global settings. Initial data show that key safety standards are rarely followed in their entirety and that the checklist improves adherence to them. While the checklist is simple in concept, actually using it and implementing it in a facility may be more difficult than is immediately apparent.

This starter kit will help providers evaluate the current state of safety practices at their facility, compare them with the objectives of safe surgical care established by WHO, and identify areas for improvement. It provides suggestions for strategies to leverage changes in the process of care that can translate into improved outcomes for surgical patients. It also provides strategies for measuring changes over time, an essential component of quality improvement efforts.

With 234 million major surgical procedures occurring annually, surgical safety is now a major issue for public health. The Safe Surgery Saves Lives program aims to improve safety standards on a worldwide basis. Having a facility participate in this process brings everyone closer to meeting the objectives of improved surgical care.

This Blue Surgical Safety Checklist consists of 19 steps designed to improve communication and consistency of care within surgical teams and reduce avoidable complications.

Blue surgical safety checklist implementation (continued from page 9)

How to implement the checklist

- **Build a team:** Commitment by all clinical team members involved in surgical procedures is essential. Tell colleagues about the checklist, starting with those who are likely to be most supportive. Include colleagues from all clinical disciplines (surgery, anesthesia, and nursing) in these discussions. Identify a core group of people who are enthusiastic about the checklist while trying to involve at least one member from each of the clinical disciplines. At this early stage, work with those who are interested and willing to work with you, rather than trying to convince the most resistant people.
- **Meet with your organization's leaders:** Present the checklist to organization's leadership (see the PowerPoint presentation available at: www.safesurg.org). Emphasize the benefits of lower complication rates and the potential for cost savings. Support of this initiative by leaders in each of the clinical disciplines is critical to its success. Think about what the hospital leadership can do to promote the checklist.
- **Start small, then expand**: With the help of organization leadership, run a campaign to get the checklist implemented in specific settings, for example a single operating room or within a single department. During the original evaluation by WHO, sites that tried to implement the checklist in multiple operating rooms simultaneously or throughout the hospital faced the most resistance and had the most trouble

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Blue Safety Checklist | **Surgical Safety**

1 Sign In
(Before induction of anaesthesia)

- ◯ **Patient has confirmed:**
  - Identity
  - Site
  - Procedure
  - Consent
- ◯ **Site marked/not applicable**
- ◯ **Anaesthesia safety check completed**
- ◯ **Pulse oximeter on patient and functioning**

Does patient have a known allergy?
- ◯ No
- ◯ Yes

Difficult airway/aspiration risk?
- ◯ No
- ◯ Yes, and equipment /assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ◯ No
- ◯ Yes, and adequate intravenous access and fluids planned

2 Time Out
(Before skin incision)

- ◯ **Confirm all team members have introduced themselves by name and role**
- ◯ **Surgeon, anaesthesia professional and nurse verbally confirm:**
  - Patient
  - Site
  - Procedure

Anticipated critical events
- ◯ **Surgeon reviews:** What are the critical or unexpected steps, operative duration, anticipated blood loss?
- ◯ **Anaesthesia team reviews:** Are there any patient-specific concerns?
- ◯ **Nursing team reviews:** Has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?

Has antibiotic prophylaxis been given within the last 60 minutes?
- ◯ Yes
- ◯ Not applicable

Is essential imaging displayed?
- ◯ Yes
- ◯ Not applicable

3 Sign Out
(Before patient leaves operating room)

Nurse verbally confirms with the team:
- ◯ **The name of the procedure recorded**
- ◯ **That instrument, sponge and needle counts are correct** (or not applicable)
- ◯ **How the specimen is labelled** (including patient name)
- ◯ **Whether there are any equipment problems to be addressed**
- ◯ **Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient**

convincing staff to use the checklist effectively. Start small, testing out the checklist in one operating room with one team and moving forward after problems have been addressed and when enthusiasm builds.

- **Use the checklist:** Make sure the core team members are using the checklist in their own operating rooms. Slowly encourage others to adopt the checklist and work through potential concerns with them. Do not hesitate to customize the checklist for your setting as necessary, but do not remove safety steps just because you are having trouble accomplishing them.
- **Track changes:** Collect data to see if the standards are being followed as the checklist is implemented in more operating rooms. Follow both process and outcome measures — e.g., in what percent of operations are we giving antibiotics at the correct time? How many patients get surgical site infections? (There are strategies and tips for data collection in the next section.)
- **Set public goals:** Once you have a sense of the data, try to improve the numbers by letting the whole hospital know about improvement goals you hope to achieve.
- **Update the hospital on progress:** Make the progress on both process and outcome measures publicly available so that staff and physicians can witness improvement.
- **Continuity is essential:** Continue to use the checklist. Data collection may become less frequent as the checklist is accepted. A periodic check on progress will ensure that process measures stay on track and complications are minimized. Following the percentage of operations that use the checklist will help ensure adherence to it and the safety steps it embodies.
- **Share experiences with the Blue Cross and Blue Shield Association and the Safe Surgery Saves Lives Program:** Tell your stories of success and challenges by emailing them at: patientsafety@bcbsa.com. Additionally, if a provider would like to be recognized on the WHO Web site, register their facility at www.who.int/patientsafety/safesurgery/hospital_form/en/index.html.

Strategy overview for implementing the checklist

This starter kit provides suggestions for implementing the checklist, understanding that different practice settings around the world will adapt it to their own circumstance. Each safety check has been included based on clinical evidence or expert opinion that its inclusion will reduce the likelihood of serious, avoidable surgical harm and that adherence to it is unlikely to introduce injury or significant cost.

The checklist was also designed for simplicity and brevity. Many of these steps are already accepted as routine practice in facilities around the world, though they have only rarely been followed in their entirety. As a result, each surgical department must practice with the checklist and examine how to sensibly integrate these essential safety steps into its normal operative workflow.

Ultimately the goal of the checklist is to help insure that teams consistently follow a few critical safety steps and thereby minimize the most common and avoidable risks that endanger the lives and well-being of surgical patients.

It will take practice for teams to learn to use the checklist effectively. Some individuals may feel it is an imposition or even a waste of time. The goal is not to produce rote recitation or to frustrate workflow. It is intended to provide teams with a simple, efficient set of high priority checks for improving effective teamwork and communication — and ensure that the safety of the patient is a top priority in every single operation that is done. The checklist enables consistency in safety for patients and introduces (or maintains) a culture that values achieving it.

Successful implementation requires adapting the checklist to local routines and expectations. This will not be possible without sincere commitment by organization leaders. For the checklist to succeed, the chiefs of surgery, anesthesia, and nursing will need to publicly embrace safety as a priority and the checklist as a worthwhile safety tool. This should include their personally using the checklist and their regularly asking others how the process of implementation is going. If there is not demonstrable leadership, then instituting a checklist of this sort may engender discontent and antagonism.

Lastly, in order to insure brevity, the checklist is not designed to be exhaustive. There must be a balance between inclusion of important items and overall length of the checklist. Each individual facility will have additional safety steps that are followed and is therefore encouraged to reformat, reorder, or revise the checklist to accommodate local practice while insuring the completion of its critical safety steps.

Blue surgical safety checklist implementation (continued from page 11)

Worksheet for Implementing the Checklist

Please fill in the following worksheet prior to beginning the intervention and continue to refer to this worksheet throughout the intervention.

1) Build a Team

Start by telling colleagues about the Checklist. Gather a team of people who are excited about the Checklist and potentially are willing to help you in your endeavor. Be sure to include members from surgery, anesthesia, and nursing. Write their names here:

_____

_____

_____

2) Meet with Organization Leaders

Meet with people in your organization who are leaders in their disciplines. Be sure to include at least the following individuals in this meeting: a leader in nursing, a leader in anesthesia, a leader in surgery, and an administrative leader of the hospital. In this meeting, present the program and how it can help your hospital. You can use the PowerPoint presentation found at: www.safesurg.org, which is designed to inform an audience with diverse educational backgrounds about what the Checklist is, the evidence that supports it, and how it can be used in your hospital. You should feel free to modify this as you see fit or to create a presentation of your own. If people at the meeting have detailed questions about the evidence behind the Checklist, there are many resources on our website that you can refer them to.

After you have presented the Checklist, be open to suggestions and constructive criticism so that you can work out the concerns that members of the group may have. This should ideally be a small enough meeting that you can understand whether people are receptive to the idea or not by allowing everybody to share their thoughts about the Checklist. At the end of your presentation, you may ask the group, “Is this an idea that you could see working at our hospital? Do you have any reservations about using the Checklist?” It may be necessary to also meet later with individual leaders who are resistant to the idea of the Checklist, but we have found that in general, most leaders are excited about innovative ideas that can potentially reduce complications and save money.

Write down which leaders are on-board for using the Checklist, as well as the departments that they represent:

_____

_____

_____

3) Collect Information

Fill out the sheet “Questions for Hospitals to Answer Prior to Implementing the Checklist” on page 14. This is designed to help you think about what data you can feasibly collect and how to collect them in your facility. Your team of leaders should review this document.

4) Assess Areas for Potential Improvement

Decide what data you want to collect with regard to the Checklist. You might decide that you want to collect additional data because you see another area for improvement beyond what is listed on our Checklist.

Note the additional data you might collect here:

_____

_____

_____

Collect data for a month. We recommend that you collect data on at least 50 cases so that you will be able to measure real improvement. People at your facility may be more willing to use the Checklist if you can prove that using it is making a difference in the health outcomes of patients. You will need data telling you where you have started in order to later evaluate with how much you have improved.

Set goals here for:
Number of cases for which you will collect data: _____

Projected date of completion of data collection: _____

Once you have finished (on the date you have entered above), write in how many cases you have collected and identify potential areas for improvement (for example, in only 57% of our procedures are patients receiving appropriately timed antibiotics) as well as data that tells you that you are doing well in a certain area (in 100% of our cases pulse oximetry is routinely used):

_____

_____

_____

5) Run a Multimedia Campaign

Make the larger community aware of the importance of the Checklist and get medical professionals using it (and perhaps even get patients asking for it to be used). This involves a publicity blitz, depending on what resources are available to you: posters, e-mails, flyers, buttons, stickers, and videos are all possible ways to make people aware of this simple tool for improving surgical outcomes. Get creative with this campaign and customize it to your community. Show the video from our Web site on how to run the Checklist to your department and publicize the video screening. The more innovative and catchy it is the better. Medical professionals often have limited time, so a succinct message can go a long way. Additionally, having solidified support from organization leaders of the Checklist during your earlier meetings will make this broader campaign much easier. With their permission, you can say that these leaders have endorsed the use of this Checklist. Ideally, they will even be willing to help publicize the Checklist within their own departments.

Write down what media you plan to use to publicize the Checklist (for example, email, posters, etc.) as well as key people who will agree to work on publicity within each medium or within each department:

_____

_____

_____

6) Use the Checklist

You don't have to wait until the multimedia campaign is over to start using the Checklist in your own operating room. Start using the Checklist as soon as realistically possible. This will allow you to both serve as a model

Blue surgical safety checklist implementation (continued from page 13)

for others, and will help you to assess early on what the challenges are when using the Checklist in your hospital. At this stage and as you receive feedback from others; feel free to customize the Checklist to your own setting. Maybe it makes more sense in your facility to switch the order of several items. You could laminate the Checklist and place it in a prominent place in the operating room, writing on it with a white-board marker which can erase between uses. Or you can use paper copies. The Checklist is meant to be flexible, so if staff are complaining of a certain issue relating to using it, try to rework either the Checklist's content or the way it is used in order to better fit your setting.

Remember that it is essential to start small with the use of the Checklist. At first you may be the only one using the Checklist. But then another surgeon from a different division likes the idea and starts to use the Checklist. Then the nurse he is working with spreads it to more operating rooms. People may be resistant initially to being asked to do another task in the operating room, yet when they see the Checklist in action, they could change their minds. Use this space to describe any challenges that you or others are having in using the Checklist:

_____

_____

_____

7) Continue Data Collection

The Checklist is much less effective if you don't know whether implementation is improving patient outcomes. Be sure that you are collecting data as you go. If your facility has the resources and is large, it may be appropriate to have someone work on collecting data full-time. If your facility doesn't have as many resources, or when you are just starting out, you may want to collect data on your own, or have people feed data to you from their own operations. Write in who you plan to put in charge of the data collection:

_____

_____

_____

Make a graph of your progress. This can be week by week, if improvements are being made that quickly, or on a monthly basis. In January, before you implemented the Checklist you might be at 57% for proper timing of antibiotics before surgery. In February, as the Checklist first started, this number went up to an average of 60%, but by March, when the Checklist was being used in about half of the operations done in the hospital, the group could have reached 85%. A graph can be a powerful visual tool for displaying this progress.

8) Set Public Goals

Where do you want to be in a month? In a year? Your goals will depend entirely on your specific setting and how easy it is to make changes in your institution. Sit down with the leadership of the organization before widespread implementation begins and think about specific numeric goals that you have. For example, in January, you decide that you want the Checklist to be used in 50% of operations by June. Make sure that the goals are feasible yet ambitious. You can also have specific goals for items on the Checklist that your hospital especially needs to work on. For example, "As our facility currently has the correct timing for antibiotics in about 57% of its operations, our goal is that we raise this number to 80% within six months and to 95% within one year."

Be sure to come up with goals that include the different disciplines. For example, rather than only setting goals that the surgeons, nurses, and anesthesiologists have direct control over, aim to set specific goals for the hospital CEOs — such as having every upper-level administrator witness the use of a Checklist in an operation or having staff accountants calculate the amount of money that has been saved thus far through the Checklist's prevention of costly surgical complications

Blue surgical safety checklist implementation (continued from page 14)

You can encourage the use of the Checklist by bringing out the competitive side of people. Once the use of the Checklist is well-established, you can post Checklist adherence rates of different divisions to see which are more consistently using the Checklist. Write down several specific goals for your facility, department, or surgical team:

_____

_____

_____

_____

9) Update on Progress

It is important to let the staff members and physicians know how the facility or their specific department is doing with regard to the Checklist. Make graphs and tables of your current Checklist performance and outcomes available in public spaces, on your website, or in an organization-wide e-mail. These numbers can be a source of pride for the surgical teams and such announcements act as an additional ongoing component of the multimedia campaign, reminding surgical teams to use the Checklist. Write in a schedule for updating the staff and physicians on progress (every month? every two weeks?):

_____

_____

_____

_____

10) Repeat

Continue to collect data, set goals, and publicly announce successes with regard to the Checklist's uptake and specific items, as well as overall surgical complication rates. In time, the Checklist should become a standard part of life in your facility. Continue to meet with leadership to think about ways to improve use of the Checklist, and ask for feedback from all levels about challenges related to the Checklist. Finally, in addition to publicly announcing the successes of the Checklist, celebrate these successes by acknowledging those who have taken key roles in the Checklist's uptake or having a celebration for the group or department with the largest uptake or best percentages of a certain measure.

11) Share

You've had some positive experiences and some challenges with using the Checklist. Now is the time to let others hear about your experiences. Whether you are a surgeon or an administrator, a nurse or a CEO, you now have valuable insight into how to implement and use the Checklist. Many other hospitals and surgical facilities across the globe in very different settings are using the Checklist as you read this. They can benefit from your new expertise. We encourage you to email us with questions, to discuss how you overcame challenges, or to share advice at: patientsafety@bcbsa.com.

Blue surgical safety checklist implementation (continued from page 15)

Questions for Facilities to Answer before Implementing the Checklist

You may fill in this form prior to using the Checklist in your facility. This is a proposed guide that will allow you to ensure that appropriate leadership and the ability to collect data are in place before you begin using the Checklist. This document will also provide baseline numbers to compare to later data.

We would also appreciate your registering your facility as one that is interested in participating in this work: www.who.int/patientsafety/safesurgery/testing/hosp_form/en/index.html.

General Information

Your name _____

Your position at hospital/facility _____

E-mail address_____

Hospital/facility _____

Location _____

Number of beds in hospital (n.a. if ASC) _____

Number of staff surgeons operating in hospital/facility_____

Number of staff anesthetists (MD and RN) _____

Number of operating rooms _____

Leadership

Who are key leaders in each of the following departments who you would like to help get the Checklist in place?

Anesthesia _____

Nursing _____

Surgery_____

Administration_____

Baseline Data

How many operations were performed in the past week in your facility? _____ In the past month? _____

In the past year? _____ Do you currently use a surgical checklist? _____

Is the following documented and/or completed at the following appropriate times? _____
Fill out the first column based on your current perceptions, then collect data for about one week (or even one day) in order to fill out the second column.

Before Induction of Anesthesia	Perceived to be part of current process (Y/N)	% of time actually completed based on data (or write unable to collect)
Verbal confirmation with patient of identity, procedure, and consent		
Site marked by surgeon		
Anesthesia safety check of machine and medications		
Airway evaluated and score documented		

Blue surgical safety checklist implementation (continued from page 16)

Before Skin Incision	Part of current process (Y/N)	% of time completed (or write Unknown)
Team introduction by name & role		
Verbal confirmation of patient, site and procedure immediately before incision with all team members present ("time out")		
Anesthesia safety check of machine and medications		
Airway evaluated and score documented		

Before Patient (and Surgeon) Leave Operating Room	Part of current process (Y/N)	% of time completed (or write Unknown)
Team introduction by name & role		

Antibiotics

Who is responsible for the selection and administration of antibiotics?_____

_____

Where are antibiotics administered (e.g. in the OR, in the holding area, on the patient floor)?_____

_____

What is the target time for administration of antibiotics in relation to the surgery start time? _____

_____

Pick a manageable number of patient records to look at and determine how many had the following outcomes:

Total number of patient records you are examining_____

How many surgical site infections did these patients have? _____

How many major complications did these patients have? (See below for examples of major complications)

_____

(Wound disruption, CVA/Stroke, Graft/Prosthesis/Flap Failure, Pneumonia, Coma, Deep Vein Thrombosis, Unplanned Intubation, Cardiac Arrest Requiring CPR, Sepsis or septic shock, Pulmonary Embolism, Myocardial Infarction, Prolonged Ventilation, Major Peripheral or Cranial Nerve Injury, Return to Operating Room, Acute Renal Failure, Bleeding)

How many patients died in the within 30 days of surgery for any reason (even if not surgical)? _____

_____

For a single service, find the surgical site infection rate for the previous reporting period. _____

_____

How is this collected? _____

_____

Plan of Timeline for Implementation

Fill in how many operating rooms or surgeons (you may choose either or both) you plan to have using the Checklist by each date.

Blue surgical safety checklist implementation (continued from page 17)

Time Elapsed	Operating Rooms	Surgeons
1 Week		
1 Month		
2 Months		
4 Months		
6 Months		

Reviewed by:

_____ _____
(Preparer) Date

_____ _____
(Administrator) Date

_____ _____
(Leader in Nursing) Date

_____ _____
(Leader in Anesthesiology) Date

_____ _____
(Leader in Surgery) Date

Clinical Tips

Sign In

- **When should the "Sign In" be performed? Who must be in the room?** The "Sign In" should be completed right before the induction of anesthesia in order to confirm the safety of proceeding. It requires the presence of the anesthesia provider and nursing personnel at the very least.
- **How are the steps on the checklist confirmed?** Every step of the checklist should be performed out loud and in conjunction with the other team members in the room. While not all items need to be performed right before induction, CONFIRMATION of every step is essential to avoid errors of omission.
- **How should we confirm the patient's identity when the patient is a child or is incapacitated?** When confirmation by the patient is impossible, a guardian or family member can assume this role. In emergencies to save life and limb, if a guardian or family member is not available, this step can be skipped.
- **Does the staff surgeon need to mark the operative site?** The site of operation should ideally be marked by the surgeon of record, but can be marked by an independent practitioner as long as that practitioner will be involved in providing care at the time of skin incision.
- **What if the site is not marked by the time the patient is transferred to the operating room?** It is imperative that the site be verified while the patient is awake and alert (when possible) and this is required in the JCAHO Universal Protocol. If it is discovered that the site has not been marked and the patient has not been medicated, the verification can occur in the operating room. However if the patient has been medicated then the surgery may need to be delayed until the patient is able to participate in the process.
- **What should be included in the anesthesia safety check?** In addition to confirming that the patient is fit for surgery, the anesthesia team should ensure that all necessary equipment is functioning and medications readily available, including the airway equipment, breathing system, suction, and assistance as needed.
- **What should be done if the patient is found to have a risk factor like a difficult airway or a risk of aspiration?** If the patient is found to have such a risk factor, the anesthesia team must prepare for problems that may arise as a result. For example, in the case of a difficult airway, the team should, at a minimum, adjust the

Blue surgical safety checklist implementation (continued from page 18)

approach to anesthesia (for example, using a regional anesthetic, if possible) and have emergency equipment accessible. A capable assistant — whether a second anesthetist, the surgeon, or a nursing team member — should be physically present to help with induction of anesthesia. For a patient recognized as having any of the possible risk factors, the box should be marked (and induction of anesthesia begun) only after the anesthetist confirms that he or she has the adequate equipment and assistance present at the bedside.

- **What constitutes "adequate intravenous access"?** If there is a significant risk of substantial blood loss (>500 ml in adults, >7 ml/kg in children), at least two large-bore intravenous lines or a central venous catheter should be placed prior to skin incision. In addition, the team should confirm the availability of fluids or blood for resuscitation.

Time Out

- **When should the "Time Out" be performed? Who must be in the room?** The "Time Out" is a momentary pause taken by the team just before skin incision in order to confirm that several essential safety checks are undertaken.
- **Can we perform the "Time Out" without the staff surgeon?** No. The Time Out must involve every member of the team, including the surgeon of record.
- **My team often stays together for the whole day. Must we introduce ourselves before every surgery?** The most critical time for introductions is at the beginning of an operative day. There is no need to repeat an introduction if everyone has already done so. However, if new members join a room, they should introduce themselves as should every member of the team present. Even if everyone knows each other, introductions are important as they serve to reinforce team communication (and can help avoid embarrassment at having to ask someone's name with whom one has been working for a prolonged period of time!).
- **Does confirming the patient, site, and procedure as noted on the Checklist comply with the surgical pause we're already required to perform?** Yes, this step is the standard "time out" or "surgical pause" and meets the standards of many national and international regulatory agencies. Just before the surgeon makes the skin incision, the person coordinating the Checklist or another team member will ask everyone in the operating room to stop and verbally confirm the name of the patient, the surgery to be performed, the site of surgery and, where appropriate, the positioning of the patient in order to avoid operating on the wrong patient or the wrong site. Visual confirmation with a hospital identification bracelet or other form of identification is extremely important.
- **How lengthy should our discussion of anticipated critical events be?** What if it is a routine procedure? The team should take as much time as needed to effectively communicate important issues for the team to be aware of. In routine procedures without any unanticipated events or steps, the surgeon can simply state, "This is a routine case of X duration," and then ask the anesthetist and nurse if they have any special concerns. Complex cases, or those requiring equipment or implants, should be adequately discussed, but critical steps in even the most complex cases can often be discussed in under 2 minutes and may save time during the procedure by avoiding delays in securing equipment, instruments, or implants.
- **What if antibiotic prophylaxis was administered more than 60 minutes before the first incision? And what should we do if we have to administer vancomycin or another long-acting antibiotic that takes time to infuse?** If prophylactic antibiotics have been administered more than 60 minutes earlier, the team should consider redosing the patient. If you are reporting measures for the Surgical Care Improvement Project (SCIP) the measure will still fail so study the issues to learn how the process might be improved. Antibiotics such as vancomycin and many fluoroquinol ones need time to infuse and SCIP allows for these up to 120 minutes before incision. The Checklist should prompt a confirmation of appropriate antibiotic administration, including compliance with SCIP measures.

Sign Out

- **When should the "Sign Out" be performed? Who must be in the room?** This should be completed before removing the patient from the operating room but is ideally performed just before or during wound closure. The aim is to facilitate the transfer of important information to the clinical teams responsible for the care of the patient after surgery. The Sign Out can be initiated by the circulating nurse, surgeon or anesthetist and should be

Blue Surgical Safety Checklist Implementation (continued from page 19)

accomplished before the surgeon has left the room.

- **Why must we confirm the name of the procedure yet again?** The procedure may have changed or expanded during the course of an operation, and appropriate communication of this fact is important for all team members.
- **What do you mean by "key concerns for recovery and management"?** The surgeon, anesthetist and nurse should review the postoperative recovery and management plan, focusing in particular on intraoperative or anesthetic issues that might affect the patient. Events that present a specific risk to the patient during recovery and that may not be evident to all involved are especially pertinent. The aim of this step is the efficient and appropriate transfer of critical information to the entire team. This may include issues such as what medications the patient may need (such as restarting beta-blockers or aspirin, stopping antibiotics within 24 hours, etc.), what diet the patient should be on, what to do with drains, or what their activities should be.
- **We use a paper Checklist and check off all the boxes as we go. What should we do with the Checklist when we're done?** The Checklist is not intended to be an audit tool and can be discarded after the operation. However, if a facility wishes to use it as one, it can be placed in the patient record or retained for quality assurance review.

New health care electronic transaction formats

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility, and claims status requests and responses.

Over 99 percent of Medicare Part A claims and over 96 percent of Medicare Part B claims transactions are received electronically. The current versions of the standards used in these health care transactions lack certain functionality required by the health care industry. Therefore, it is necessary for providers to prepare for new standards in order to continue submitting claims electronically. Please insure your vendor and/or clearinghouse is aware of these changes.

Mandated changes to the electronic transaction formats for claims and other transactions will be effective January 1, 2012. All electronic transactions will be changing from the current X12 4010A1 format to the X12 5010 format. The changes are a result of the adoption of the 5010 X12 as the standard for medical care and affect the following transactions:

- Eligibility (270/271) – version 005010X279A1
- Remittance advice (835) - version 005010X221A1
- Claims (837) professional - version 005010X222A1
- Claims (837) institutional - version 005010X223A2
- Report (999) Acknowledgment - version 005010X231A1
- Claim Status (276/277) - version 005010X212
- Dental Claims (FEP only) version 005010X224A2

After December 31, 2011 only the new formats for claims and other transactions will be accepted. 5010 standards can be purchased at www.wpc-edi.com.

Testing schedule for new formats:

- **Beginning Today:** Arkansas Blue Cross and Blue Shield is encouraging providers who are ready to test the X12 5010 837 claim transaction(s) to do so now. Contact EDI Services at 501-378-2419 or email at edi@arkbluecross.com for more information.
- **January 1, 2011:** Providers may begin testing of the X12 5010 transactions for 270/271 eligibility and 276/277 claim status.
- **April 2, 2011:** Providers may begin testing of the X12 5010 transaction for 835 (electronic RA).
- **July 1, 2011:** Providers who have successfully completed the X12 5010 transaction testing may move into production.

Testing the new X12 5010 formatted transactions is a provider's responsibility and must be completed prior to December 31, 2011. Due to the required changes, the time line for 5010 testing is condensed and providers should be discussing the 5010 changes with their vendors now. Providers may obtain more information regarding the X12 5010 transition at http://www.arkansasbluecross.com/providers/5010resourcecenter.aspx.

FEP

Federal employee program (FEP) 2011 benefit changes

Changes to both the Standard and Basic options:

- **Eligibility:** Children up to age 26 will be eligible for coverage under "self" and "family" enrollment beginning January 1, 2011.
- **Hearing Aids:** FEP will now pay up to $1,000 per hearing aid per ear for hearing aids. The member is responsible for any amount billed above the $1,000 per ear regardless of provider participation status. Children needing hearing aids , up to age 22, can receive the $1,000 per hearing aid per ear every calendar year. Adults needing hearing aids, age 22 and over, can receive the $1,000 per hearing aid per ear every 36 months.
- **Mental Health and Substance Abuse:** New Directions is the new behavioral health vendor effective January 1, 2011. Prior approval is no longer required for outpatient professional or outpatient facility care for mental health and substance abuse treatment. Previously, prior approval was required. Precertification for admission to an inpatient facility is still required within 48 hours of admission. Residential treatment centers are treated as non-covered providers unless case management has granted an exception. For admission to an inpatient mental health facility, or to contact New Directions, call 1-800-367-0406.
- **Maternity Care:** FEP will now provide benefits to cover up to four mental health visits per year at 100 percent for treatment of maternity-related depression. The member must use a preferred provider in order to receive these benefits. FEP will now provide benefits for breast feeding education and individual coaching on breast feeding by a physician, physician assistant, nurse midwife, nurse practitioner/clinical specialist or registered nurse certified lactation consultant covered at 100 percent.
- **Pharmacy:** Providers should prescribe generic drugs when possible. Generic drugs are less costly for the member. Pharmacy services rendered by a Veteran's Affairs (VA) outpatient facility on or after January 1, 2011, will be processed by the Retail Pharmacy Benefit Manager, Caremark.
- **Preventive Care:** FEP will now provide preventive care benefits covered at 100 percent to cover preventive services for adults and children recommended under the Affordable Care Act. The member must use a preferred provider in order to receive these benefits. The member's office visit copayment will still apply if the primary purpose of the visit is other than preventive care. Pneumococcal, DPT, and MRR have been added to the list of routine immunizations that are now covered at 100 percent for adults. The following services are included in this change and are subject to diagnosis code limitations noted:
  - Immunizations (Adult) – covered regardless of diagnosis code.
  - Cancer Screenings – covered regardless of diagnosis code.
  - Abdominal Aortic Aneurysm – covered regardless of diagnosis code.
  - Colonoscopy – covered for diagnosis code V10.00, V10.03, V10.04, V10.05, V10.06, V10.07, V12.72, V160, V19.8, V76.41, V76.50, V76.51 or V84.09.
  - All other preventive services – covered for any diagnosis code on the preventive/medical listing.
- **Smoking Cessation:** FEP will now provide preventive care benefits for smoking cessation treatment covered at 100 percent. The member must use a preferred provider in order to receive these benefits. Previously, these services were subject to a copayment.
- **Speech-Generating Devices:** FEP will now pay up to $1,000 per calendar year for speech-generating devices. The member is responsible for any amount over the $1,000 regardless of

FEP 2011 benefit changes (continued from page 21)

provider participation status.

- **Nutritional Counseling:** FEP will now provide preventive care benefits covered at 100 percent for nutritional counseling visits for adults and children. The member must use a preferred provider in order to receive these benefits.
- **Transplants:** FEP will now provide benefits for donor screening tests and donor search expenses related to blood or marrow stem cell transplants when performed on three potential non-full siblings. Previously, benefits were only available for donor screening tests and donor search expenses for full siblings and the actual donor. Members now have benefits for additional types of organ/tissue transplants. Arkansas Blue Cross has enhanced its organ/tissue transplant prior approval procedures for members and providers.
- **Surgery for Morbid Obesity:** The member must now meet specific pre-surgical criteria before receiving surgery for morbid obesity. Pre-surgical requirements include:
  - Diagnosis of morbid obesity for a period of two years prior to surgery.
  - Participation in a medically supervised weight-loss program, including nutritional counseling, for at least three months prior to the date of surgery.
  - Pre-operative nutritional assessment and nutritional counseling about pre- and post operative nutrition, eating and exercise.
  - Evidence that attempts at weight loss in the one-year period prior to surgery have been ineffective.
  - Psychological assessment of the member's ability to understand and adhere to the pre- and post-operative program, performed by a psychiatrist, clinical psychologist, psychiatric social worker or psychiatric nurse.
  - Patient has not smoked in the six months prior to surgery.
  - Patient has not been treated for substance abuse for one year prior to surgery.
- **Chiropractors:** FEP will now provide benefits for osteopathic and chiropractic manipulative treatment, including extra spinal manipulations performed by chiropractors, limited to a combined total of 12 manipulation visits per year under the Standard Option and 20 manipulation visits per year under the Basic Option.
- **Routine Osteoporosis Screenings:** Preventive benefits will be provided for osteoporosis routine screening tests and associated office visits for women age 60 and over, when the primary diagnosis code is V82.81 (special screening for osteoporosis). This benefit will be available to eligible FEP members once per contract year for Standard and Basic Option professional and outpatient facility claims.
- **Outpatient Intensity-Modulated Radiation Therapy (IMRT):** Prior approval is no longer required for outpatient intensity-modulated radiation therapy (IMRT) related to the treatment of head, neck, breast or prostate cancer. Previously, prior approval was required for all outpatient IMRT services.
- **Genetic Counseling and Evaluations:** Preventive care benefits will be provided for the coverage of genetic counseling and evaluations for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes. Genetic counseling and evaluations will be covered for services on or after January 1, 2011. Preventive care benefits are not available for BRCA screening or prophylactic surgeries.

Changes to Standard Option:

- **Mail Service Prescription Drug Program:** A member may be eligible to receive their first four generic prescriptions filled (and/or refills ordered) at no charge through the Mail Service Prescription Drug Program when the member changes from certain brand-name drugs to a corresponding generic drug replacement.
- **Deductible:** The member's calendar year deductible is now $350 per person and $700 per family. Previously, the deductible was $300 per person and $600 per family.
- **Inpatient Care:** Members now pay $250 per admission for inpatient care, including inpatient hospice care, at preferred facilities, and $350 per admission, plus 35 percent of the plan allowance for inpatient care, including inpatient hospice care, at preferred facilities. Previously, members paid $200 per admission to preferred facilities and $350 per admission to preferred facilities.
- **Outpatient Surgery:** The member's benefits for outpatient surgery and related services performed and billed for by a hospital or freestanding ambulatory facility are now subject to the calendar-year deductible.

FEP 2011 benefit changes (continued from page 22)

Previously, members were not required to meet the deductible for these services.

- **Mental Health and Substance Abuse Care:** The member's copayment for certain outpatient mental health and substance abuse services performed by both preferred primary care and specialist providers is now $20 per visit. Previously, members paid $20 per visit for services performed by preferred primary care providers and $30 per visit for preferred specialist services. The FEP will now provide benefits covered at 100 percent for inpatient mental health and substance abuse services received from preferred professional providers. Previously, members paid 15 percent of the plan allowance after meeting the calendar-year deductible for these types of services.
- **Emergency Room Care:** Members now pay 15 percent of the plan allowance for medical emergency treatment provided by preferred and non-preferred professional providers when the services are performed in the emergency room. Previously, members were responsible for 35 percent of the plan allowance for professional emergency room care by preferred providers and a maximum of $350 per visit for professional emergency room care provided by non-preferred providers. Members now pay 15 percent of the plan allowance for medical emergency treatment provided by preferred and non-preferred when services are performed in the emergency room. Previously, members were responsible for 35 percent of the plan allowance for medical emergency treatment in preferred and non-preferred facilities.
- **Preventive Care:** FEP will now provide preventive care benefits for all covered adult preventive care when performed by preferred or non-preferred providers. Previously, certain preventive services were only covered when performed by a preferred provider. The member's coinsurance amount for preventive care services for children performed by preferred and non-preferred providers is now 35 percent of the plan allowance after the calendar year deductible is satisfied. Previously, preventive care services for children performed by preferred and non-preferred providers were paid in full up to the plan allowance.

Changes to Basic Option:

- **Dental Services:** The member's copayment for dental services performed by participating providers is now $25 per evaluation. Previously, members paid $20 per evaluation.
- **Diagnostic Services:** The member's copayment for EEGs, ultrasounds, and X-rays is now $25. Previously, members had no copayment for these services. The member's copayment for CT scans, MRIs, PET scans, diagnostic bone density tests, nuclear medicine, diagnostic angiography, and diagnostic genetic testing is now $75. Previously, members had no copayment for these services.
- **Mental Health and Substance Abuse Care:** The member's copayment for certain outpatient mental health and substance abuse services performed by both preferred primary care and specialist providers is now $25 per visit. Previously, members paid $25 per visit for services performed by preferred primary care providers and $35 per visit for preferred specialist services. The member's copayment for outpatient mental health and substance abuse services provided and billed by a preferred facility is now $25 per day per facility. Previously, members paid $75 per day per facility.
- **Emergency Room and Urgent Care:** The member's copayment for emergency-room care related to an accidental injury or medical emergency is now $125 per visit. Previously, the member's copayment was $75 per visit. The member's copayment for care provided at preferred urgent care centers related to accidental injuries and medical emergencies is now $50 per visit. Previously, the member's copayment was $30 per visit.
- **Preferred retail pharmacies:** The member's copayment for preferred brand-name drugs purchased at a preferred retail pharmacy is now $40 per prescription for up to a 34-day supply. In addition, the minimum amount the member's pay for non-preferred brand-name drugs is now $50 for each 34-day supply, or $150 for a 90-day supply.
- **Professional Charges:** The member's copayment for professional charges for intensive outpatient treatment in a provider's office or other professional setting is now $25 per visit. Previously, members paid $30 per visit for these services. The member's copayment for surgery is now $150 per performing surgeon per day. Previously, members paid $100 per performing surgeon.

Medi-Pak®

2011 pharmacy formularies - four-tier standard & four-tier enhanced

Beginning January 1, 2011, Arkansas Blue Cross and Blue Shield will move from one formulary to two formularies. Medi-Pak® Rx (PDP) Basic, Medi-Pak® Advantage (PFFS), and Medi-Pak® Advantage (PPO) will all use the Four-Tier Standard Formulary. Medi-Pak® Rx (PDP) Premier plan will use the Four-Tier Enhanced Formulary. Arkansas Blue Cross has made utilization management changes to both formularies. More specific details are listed in the table below.

Four-Tier Standard Formulary	Four-Tier Enhanced Formulary
Closed formulary	Closed formulary
Not all generics will be covered	Not all generics will be covered
Multi-source brands are not covered	Multi-source brands are covered
Extensive utilization management edits	Considerable utilization management edits
Very restrictive formulary	Very similar to 2010 formulary

Medi-Pak® advantage (PFFS) changes for 2011

Arkansas Blue Cross and Blue Shield's Medi-Pak® Advantage Private Fee-For-Service (PFFS) plan has had significant membership growth during 2010 in large part because of our network of doctors and hospitals. Arkansas Blue Cross has more than 7,000 participating providers in the Medi-Pak® Advantage PFFS network. Providers who are interested in participating in the Medi-Pak® Advantage PFFS network should contact their regional network development representative (NDR).

Arkansas Blue Cross is committed to providing timely and accurate claims processing. Providers should not hesitate to call Medi-Pak® Advantage customer service with any claims issues and your NDR with any complex unresolved issues. Providers who are paid based on interim rates can help by making sure their NDR has their most current interim rate letter.

Finally, Arkansas Blue Cross has added extra plan options for members. In today's economy, Arkansans are looking for value so Arkansas Blue Cross made every effort to keep premiums as low as possible. Arkansas Blue Cross will be offering a $0 premium Medi-Pak® Advantage plan in 52 counties. With the funding cuts to these programs, Arkansas Blue Cross kept premiums low for members by reducing some benefits. The following premiums and benefits are being offered:

Common In-Network Benefits:

- Skilled Nursing Facility - $0 copay days 1-20, $137.50 copay days 21-100;
- Home Health - $0 copay;
- ER - $50 copay per visit;
- Ambulance - $250 copay ground, $500 copay air;
- Diagnostic labs and x-rays - $0 copay;
- Medicare covered preventive services - $0 copay;
- DME/Prosthetic/Diabetic Supplies, Therapeutic Rad, Part B Drugs, ESRD - 20% coinsurance.

Out-of-Network Benefits:

$500 deductible then 30% coinsurance. Emergency room and ambulance services are always considered in-network.

Proton pump inhibitors & hypnotics: quantity limit changes

Quantity limits have been added to proton pump inhibitors (PPIs) and hypnotics. Beginning January 1, 2011, all PPIs will be limited to a 90-day supply per calendar year. All hypnotics will be limited to a 180-day supply per calendar year.

Medi-Pak® advantage private fee-for-service (PFFS) 2011 variable benefits - in-network

Service Area/ Product	Premium	Combined Out-of-Pocket Max	Inpatient Hospital Copayments	Office Visits Copayments	Physical, Occupational, and Speech Therapy	Outpatient Hospital/ Surgery/ Adv Imaging Copayments
Area 1: MA	$0.00	$5,000	$220 days 1-6, $0 additional days	$15 PCP; $30 SCP; $20 Chiro & Podiatrist	$30 copay	$250
Area 1: MA-PD Option 1	$0.00	$5,750	$265 days 1-6, $0 additional days	$15 PCP; $35 SCP; $20 Chiro & Podiatrist	$35 copay	$285
Area 1: MA-PD Option 2	$26.90	$4,750	$175 days 1-6, $0 additional days	$15 PCP; $35 SCP; $20 Chiro & Podiatrist	$35 copay	$200
Area 2: MA	$0.00	$6,700	$265 days 1-6, $0 additional days	$25 PCP; $40 SCP; $20 Chiro & Podiatrist	$40 copay	$250
Area 2: MA-PD	$48.70	$6,700	$265 days 1-6, $0 additional days	$15 PCP; $35 SCP; $20Chiro & Podiatrist	$35 copay	$250
Area 3: MA	$40.50	$6,700	$265 days 1-6, $0 additional days	$25 PCP; $40 SCP; $20 Chiro & Podiatrist	$40 copay	$250
Area 3 : MA-PD	$74.30	$6,700	$265 days 1-6, $0 additional days	$15 PCP; $35 SCP; $20 Chiro & Podiatrist	$35 copay	$250
PPO Pulaski County	$0	$6,700	$265 days 1-6 $0 additional days	$20 PCP; Urgent Care $15; SCP $40; $20 Chiro & Podiatrist	$ 40 copay	$280

- **Area 1:** Baxter, Benton, Boone, Carroll, Conway, Crawford, Franklin, Fulton, Johnson, Lee, Lincoln, Logan, Madison, Marion, Newton, Ouachita, Perry, Phillips, Pope, Randolph, Scott, Searcy, Sebastian, St. Francis, Stone, Van Buren, and Washington.
- **Area 2:** Ashley, Bradley, Cleveland, Craighead, Crittenden, Dallas, Faulkner, Grant, Howard, Izard, Jefferson, Lonoke, Miller, Monroe, Montgomery, Nevada, Pike, Poinsett, Polk, Pulaski, Sevier, Sharp, Union, Woodruff, and Yell.
- **Area 3**: Arkansas, Calhoun, Chicot, Clark, Clay, Cleburne, Columbia, Cross, Desha, Drew, Garland, Greene, Hempstead, Hot Spring, Independence, Jackson, Lafayette, Lawrence, Little River, Mississippi, Prairie, Saline, and White.

Coverage policy manual updates

The following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy Manual since September 2010. To view entire policies, access the coverage policies located on the Arkansas Blue Cross Web site at arkansasbluecross.com.

New Policies:

Policy ID	Policy Name
1997036	Cognitive rehabilitation
1997041	Continuous passive motion device in the home setting
1997082	Stem cell growth factors, granulocyte macrophage colony stimulating factor (sargramostim)
1997113	Immune globulin, intravenous and subcutaneous
1997248	Pain management, facet joint block
1998070	Cochlear implant
1998155	Respiratory syncytial virus, immune prophylaxis with palivizumab (synagis)
1998158	Trastuzumab
1999001	Nerve Conduction Studies (NCS), Electromyography (EMG)
1999017	Molecular diagnostic tests for infectious diseases
2002005	Biventricular pacemakers for the treatment of congestive heart failure
2002007	Varicose veins: endoluminal radiofrequency or laser ablation
2003021	Dermatoscopy
2004007	Radiofrequency ablation of renal tumors
2004038	Genetic test: inherited susceptibility to colon cancer including microsatellite instability
2006020	Abatacept (orencia) for rheumatoid arthritis
2006024	Ranibizumab (lucentis) for wet age-related macular degeneration and retinal vein occlusion
2009032	Genetic test: heart transplantation rejection, allomap testing
2009040	Radioimmunotherapy in the treatment of non-hodgkin lymphoma
2010028	Sipuleucel-t (provenge) for the treatment of prostate cancer
2010035	Lyme disease, intravenous antibiotic therapy and associated diagnostic testing
2010037	Interventions for progressive scoliosis
2010038	Lymphedema pumps (pneumatic compression devices) for the treatment of lymphedema
2010039	Biomarker, Serum Human Epididymis Protein 4 (HE4)
2010040	Genetic Test: Non-small cell lung cancer, KRAS mutation for predicting sensitivity to erlotinib

Fee Schedule

Fee schedule updates

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

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
37766	$936.03	$0.00	$0.00	$936.03	$0.00	$0.00
38792	$64.02	$0.00	$0.00	$64.02	$0.00	$0.00
75571	$99.19	$30.60	$68.59	$0.00	$30.60	$0.00
90657	$12.75	$0.00	$0.00	$0.00	$0.00	$0.00
90658	$12.75	$0.00	$0.00	$0.00	$0.00	$0.00
90736	$161.50	$0.00	$0.00	$0.00	$0.00	$0.00
93297	$28.46	$0.00	$0.00	$28.46	$0.00	$0.00
93299	$40.00	$0.00	$0.00	$40.00	$0.00	$0.00
J0743	$16.23	$0.00	$0.00	$0.00	$0.00	$0.00
0160T	BR	BR	BR	BR	BR	BR
0161T	BR	BR	BR	BR	BR	BR
E2373	BR	BR	BR	BR	BR	BR
E2374	BR	BR	BR	BR	BR	BR
E2375	BR	BR	BR	BR	BR	BR
E2376	BR	BR	BR	BR	BR	BR
E2377	BR	BR	BR	BR	BR	BR
E2388	BR	BR	BR	BR	BR	BR
E2389	BR	BR	BR	BR	BR	BR
E2390	BR	BR	BR	BR	BR	BR
E2391	BR	BR	BR	BR	BR	BR
E2392	BR	BR	BR	BR	BR	BR
E2393	BR	BR	BR	BR	BR	BR
E2394	BR	BR	BR	BR	BR	BR
E2395	BR	BR	BR	BR	BR	BR
E2397	BR	BR	BR	BR	BR	BR
J1055	$29.00	$0.00	$0.00	$0.00	$0.00	$0.00
S0195	$30.04	$0.00	$0.00	$0.00	$0.00	$0.00

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providers' news staff

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Please Note

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies. 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.

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