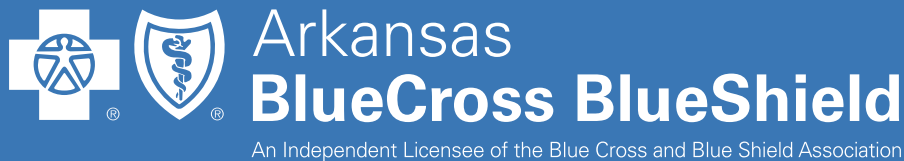


Arkansas Blue Cross Blue Shield Provider Manual

Updated April 11, 2024



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SECTION 1

Arkansas Blue Cross and Blue Shield

Welcome to the Arkansas Blue Cross and Blue Shield Provider Manual

Welcome! Thank you for becoming a participating provider with Arkansas Blue Cross and Blue Shield. Arkansas Blue Cross and Blue Shield is the largest health insurer in Arkansas. Established by a group of physicians in 1948, Arkansas Blue Cross has provided its members with quality health coverage for more than 75 years. A mutual insurance company, Arkansas Blue Cross is owned by its policyholders and operated as a not-for-profit organization.

What This Manual Is Intended to Do

Arkansas Blue Cross recognizes that, at times, the administrative requirements of managing a patients' health care can be complex. The intent of this Provider Manual is to serve as a source for answers to some of the most common questions providers have about health plan coverage and claims filing procedures, policies and other facts related to administering care to Arkansas Blue Cross members.

This Provider Manual is not intended as a complete statement of all provider-related policies, procedures, or standards of Arkansas Blue Cross and Blue Shield. The Provider Manual outlines certain, but not all, policies and procedures adopted by Arkansas Blue Cross with respect to provider participation, claims filing, and related subjects. Other policies and procedures, not reflected in this Manual, are published regularly in the Providers' News, on the Arkansas Blue Cross website for providers and members, in our member benefit certificates or health plans, or in other special publications, letters, or notices, including but not limited to credentialing standards, appeals policies and procedures, network terms and conditions, and provider contracts.

A Word about Our Affiliated Companies

This Provider Manual is created and published by USABLE Mutual Insurance Company, d.b.a Arkansas Blue Cross and Blue Shield headquartered in Little Rock, Arkansas at 601 Gaines Street. It is intended to be a guide for providers participating in the Arkansas Blue Cross and Blue Shield Preferred Payment Plan ("PPP") Network.

At the same time, however, this Provider Manual contains numerous references to networks, products or services of other companies that are affiliated with but separate and distinct from Arkansas Blue Cross and Blue Shield. Most of the participating providers are already familiar with these affiliated companies and their networks, products, and services; nevertheless, to be sure that all providers understand the references in this Manual to affiliated companies and their networks, products and services, a summary of the affiliated companies and their relationship to Arkansas Blue Cross and Blue Shield is in Section 15: Products.

Arkansas Blue Cross wants providers to understand that while these companies are affiliated with us, they are separate organizations with their own Boards of Directors, officers, and operations, as well as policies and procedures. Providers, who wish to participate in any network of these separate, but affiliated companies, must meet the terms and conditions, and execute the participation agreements, required by these separate, affiliated companies.

Disclaimer

Arkansas Blue Cross and Blue Shield makes no representations or warranties with respect to the content hereof. Further, Arkansas Blue Cross reserves the right to revise this publication without obligation of Arkansas Blue Cross to notify any person of such revision or changes.



Updates to any part of this Manual may be made by Arkansas Blue Cross at any time. Arkansas Blue Cross may give notice of such updates in a variety of ways, depending on the nature of the update, including issuance of a letter to providers, publication in the Providers' News newsletter or other publications of Arkansas Blue Cross, or posting to the Arkansas Blue Cross website, arkansasbluecross.com.

Special Note: This Manual is provided for the convenience of providers participating in any Arkansas Blue Cross network. Nothing in this manual shall be interpreted as guaranteeing coverage of any service, treatment, drugs or supplies because coverage or non-coverage is always governed exclusively by the terms of the member's health benefit plan. Accordingly, in case of any question or doubt about coverage, providers should always review the member's particular health benefit plan.

Any five-digit physician's current procedural terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright by the American Medical Association. All Rights Reserved.

Unless otherwise indicated, any reference in this Manual to "company," shall be deemed to refer to Arkansas Blue Cross and Blue Shield.

Last update: October 25, 2023

Regional Offices

The main office of Arkansas Blue Cross and Blue Shield is located at Sixth and Gaines streets in downtown Little Rock. Arkansas Blue Cross operates full-service regional office Retail Centers serving seven designated geographic areas of the state. The [Regional Offices](#) (headquartered in, Hot Springs, Little Rock, Jonesboro, Pine Bluff, and Springdale offer sales and provider relations services to counties in their parts of the state.

[View the regional map.](#)

Medical Directors

Arkansas Blue Cross and Blue Shield Corporate Office

Medical Director	Address	Phone & Fax
Chief Medical Officer Dr. Mark Jansen mtjansen@arkbluecross.com	Arkansas Blue Cross 601 South Gaines St. Little Rock, AR 72201	(501) 378-2309 (501) 378-5699 fax
Dr. Patty Gibson plgibson@arkbluecross.com	Arkansas Blue Cross 5 Allied Drive Little Rock, AR 72202	(501) 502-1049 (501) 378-2855 fax
Dr. Randal Hundley rfhundley@arkbluecross.com	Arkansas Blue Cross 5 Allied Drive Little Rock, AR 72201	(501) 688-0716 (501) 378-2720 fax
Dr. William Fiser wpfiser@arkbluecross.com	Arkansas Blue Cross 5 Allied Drive Little Rock, AR 72201	(501) 688-0723
Health Equity and Public Programs Dr. Creshelle Nash crnash@arkbluecross.com	Arkansas Blue Cross 601 South Gaines Little Rock, AR 72201	(501) 399-3986
Medicare Advantage and Senior Products Dr. Thomas Becker tebecker@arkbluecross.com	Arkansas Blue Cross 5 Allied Drive Little Rock, AR 72202	(501) 502-1362

Central Region Little Rock

Medical Director	Address	Phone & Fax
Dr. John Brineman jrbrineman@arkbluecross.com	Arkansas Blue Cross 601 South Gaines Little Rock, AR 72202	(501) 502-1330 (501) 379-4664 fax

Northeast Region Jonesboro

Medical Director	Address	Phone & Fax
Elaine Gillespie eagillespie@arkbluecross.com	Arkansas Blue Cross 2110 Fair Park Blvd, Ste 1 Jonesboro, AR 72401	501-974-5790 501-974-5713 fax

Northwest Region Springdale

Medical Director	Address	Phone & Fax
Dr. Cygnet Schroeder-Bise caschroeder-bise@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	501-527-2305 501-527-2323 fax
Vice President Clinical Strategy and Population Health Dr. Joanna Thomas jmthomas@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	(479) 973-6623 (501) 378-2855 fax
Dr. Mark Enderle maenderle@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	(479) 973-6619 (501) 378-2304 fax
Dr. Joseph Rose jrose@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	(501) 378-2311

West Central Region Fort Smith

Medical Director	Address	Phone & Fax
Dr. Cygnet Schroeder-Bise caschroeder-bise@arkbluecross.com	Arkansas Blue Cross 3501 Old Greenwood Road, Suite 3 Fort Smith, AR 72903	(479) 379-5159 (479) 648-6311 fax

Remote

Medical Director	Address	Phone & Fax
Dr. Michael Martin mrmartin@arkbluecross.com	Remote	(501) 399-3942 (870) 974-5713 fax
Dr. Kristin Lower kflower@arkbluecross.com	Remote	(479) 379-5159 (479) 648-6311 fax

Network Development Representatives

The [network development representatives](#) (NDR) serve as the point of coordination for the provider network activities in the assigned region and supports on-going network operations. The NDR is accountable for maintaining a good effective working relationship with providers in the assigned regions, which includes contracting and education regarding Arkansas Blue Cross and Blue Shield. The NDR is also responsible for assisting providers with specific inquiries and problems which have not been resolved by other inquiries.

Dental Network Managers

Effective January 1, 2020, dental administration services moved from Arkansas Blue Cross and Blue Shield to USABLE Life. Your current [dental provider network manager](#) is still available to provide the exceptional level of support you have come to expect from Arkansas Blue Cross, but their contact information has changed. Although Sheila Ward and Steven Seymour are employees of USABLE Life, they will continue to provide dental provider relations for Arkansas Blue Cross.



SECTION 2

General Information

How to contact Arkansas Blue Cross and Blue Shield

Provider Service Lines

Provider	Number	ID Number begins or formatted as
Arkansas Blue Cross Provider	501-378-2307 or 800-827-4814 (Arkansas policies only)	(examples) XCA, XCJ, XCP
BlueCard®	800-810-BLUE (2583)	AAA + up to 17 additional alphanumeric characters
The BlueLine	800-676-BLUE (2583) (benefits for all out-of-state policies)	AAA + six to nine numeric digits
The Enterprise Exchange	800-800-4298	XCB, XCG, XCR, XCQ, XCV, XCY, EXX, AEE, AXC
FEP	800-482-6655 (federal policies only)	R
State and School Employee	501-378-2364 or 800-482-8416 (state and school employee policies only)	XCS followed by 960 and a six-digit number
Health Advantage	800-843-1329 (HMO, POS and Open Access policies only)	XCH + K and eight numeric digits
BlueAdvantage Administrators of Arkansas	888-872-2531	AAA + A + eight numeric digits + a two-digit suffix
Integrated Health	800-451-7302 (pre authorization of inpatient admissions only)	

Member Service Lines

Line	Little Rock	Toll Free	TTY
Customer Service (main line)	501-378-2010	800-238-8379	
State/Public School Employees	501-378-2364	800-482-8416	
Federal Employees	501-378-2531	800-482-6655	
Medi-Pak® (Current Members)	501-378-3062	800-238-8379	
Medi-Pak (Prospective Members)	501-378-2937	800-392-2583	
Medi-Pak Advantage Customer Service		877-233-7022	888-844-5530
Medi-Pak Advantage (Pharmacy Customer Service)		866-494-6699	866-236-1069
Medi-Pak Advantage (Caremark Clinical Department Prior approvals and exceptions)		866-494-6699	866-236-1069
Medi-Pak Rx (Claims)		866-494-5829	866-236-1069
Medi-Pak Rx (Membership)		866-390-3369	800-756-4023



Line	Little Rock	Toll Free	TTY
Medi-Pak Rx (Caremark Clinical Department Prior approvals and exceptions)		866-494-5829	866-236-1069
BlueCard®		800-880-0918	
Enterprise Exchange Customer Service		800-800-4298	
Health Advantage	501-378-2363	800-843-1329	
BlueAdvantage Administrators of Arkansas	501-378-3600	888-872-2531	

Email Us

If you have questions about our products or services, you may submit a question to [Customer Service](#).

If you have any questions or comments about our Web site, you may email our [Webmaster](#).

Contact Our Regional Offices

Arkansas Blue Cross and Blue Shield is committed to providing easy access to customers on the local level. We have seven full-service regional offices to serve you.

[Regional Offices](#): Locate the regional office nearest you.

[Network Development Representatives](#): Service for health-care providers.

News Media Contact

Max Greenwood: **501-378-2131**

Our Mailing Address

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

Contact Us to Update your Provider Information

Since it is the responsibility of each provider to inform Plans when there are changes, providers are reminded to notify Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries of any changes to their demographic information or other key pieces of information, such as a change in their ability to accept new patients, street address, phone number or any other change that affects patient access to care. For Arkansas Blue Cross to remain compliant with federal and state requirements, changes must be communicated within 30 days so that members have access to the most current information in the Provider Directory.

You should routinely check your current practice information by going to arkbluecross.com and select FIND CARE near the center of the page. If your information is not correct and updates are needed, please provide the correct information as soon as possible by completing the [Provider Change of Data Form](#).

You may also receive a data verification letter from our Provider Network Operations department to provide you with an additional opportunity to confirm your information as well.

For more information, contact Provider Network Operations at **501-210-7050** or email to providernetwork@arkbluecross.com.

Definitions

These definitions are for general reference and convenience only and are subject to modification by the terms of your provider contract or member health plan or policy which shall control in the event of any conflict.

ALLOWED CHARGES or **ALLOWANCE** means the fee-per-service agreed upon in a contractual arrangement between Arkansas Blue Cross and a participating provider or the usual amount charged by the provider, whichever is less. See your provider contract for complete details.

AMBULATORY SURGERY is any procedure identified on the ambulatory-surgery list which can be done on an outpatient basis.

BENEFIT CERTIFICATE is the document which Arkansas Blue Cross provides to members that defines the scope of covered services and the terms, conditions, limitations, or exclusions that apply to such coverage.

BRAND-NAME MEDICATION means any prescription medication that has a patented trade name separate from its generic or chemical designation, and indicated as such by Medispan.

CASE MANAGEMENT is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes. Case Managers are healthcare professionals who serve as member advocates to support guide and coordinate care for members, families, and caregivers as they navigate their health and wellness journeys.

COINSURANCE is the percentage of allowed charges for covered services for which the member is responsible for payment.

COMPOUND MEDICATION means a medication that is prescribed by the physician and prepared by the pharmacist using multiple FDA approved-ingredients through any route of administration, including intravenous therapy.

CONTRACT YEAR means the twelve consecutive month period commencing on the Group Enrollment Contract effective date and renewing on the anniversary of that effective date.

COPAYMENT is an amount specified that the member is responsible for paying when receiving specified covered services.

COVERED SERVICES means those services and the attendant drugs or supplies covered under the terms of a member's health plan or policy, as amended from time to time. For complete details, see the member's applicable benefit plan or policy.

DEDUCTIBLE is the amount of eligible expenses a covered person must pay before payment of benefits is commenced by the payer under the person's health plan or policy.

EMERGENCY PRESCRIPTION means any prescription medication prescribed in conjunction with emergency services and deemed necessary by a physician to be immediately needed by the covered person. See member's applicable health plan or policy for complete definition and details.



EMERGENCY SERVICES are those services that are required when traumatic bodily injury or the sudden, unexpected onset of an illness would lead a prudent layperson (possessing an average knowledge of medicine and health) to believe that the condition requires the immediate care and attention of a qualified physician or when the condition, if not treated immediately, could reasonably be expected to result in serious physical impairment. See member's applicable health plan or policy for complete definition and details.

EVIDENCE OF COVERAGE means the certificate of insurance containing the benefits, conditions, limitations and exclusions of the Group Insurance Contract plus the Schedule of Benefits and any amendments signed by an Officer of Health Advantage.

FORMULARY means a specified list of covered prescription medications that is maintained by Arkansas Blue Cross. This list is subject to change.

GENERIC MEDICATION means any chemically equivalent reproduction of a brand-name medication whose patent has expired.

GROUP CONTRACT is the contract between a health plan or insurance policy payer and an employer which sets forth the terms of enrollment, membership, payment, coverage, terms, conditions, limitations, and exclusions under which a group may obtain a health plan or insurance policy coverage for its members.

HOSPITAL means an acute general care hospital, a psychiatric hospital or a rehabilitation hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law or approved by the Board of Directors of the company: hospitals owned or operated by state or federal agencies, convalescent homes or hospitals, homes for the aged, sanitariums, long-term care facilities, infirmaries or any institution operated mainly for treatment of long-term chronic disease. For complete details, see the member's applicable benefit plan or policy.

IMPERATIVE CARE means care a member receives while traveling outside the service area for an unexpected illness or injury that cannot wait until the member returns to the service area. The member can call **800-810-BLUE** for participating providers in their area; claims will be reviewed upon receipt to determine if they meet urgent/emergent guidelines.

INPATIENT STATUS is defined as a hospital stay greater than 24 hours or greater than 12 hours plus an overnight stay while receiving medically necessary treatment — unless the stay is related to uncomplicated ambulatory surgery.

MAINTENANCE MEDICATION means a specific prescription medication exceeding a one-month supply that has been designated as a maintenance medication by the company for ongoing therapy of a chronic illness. For complete details, see the member's applicable benefit plan or policy.

MAINTENANCE or **SUPPORTIVE CARE** means care that is delivered after the acute phase of a condition has passed and maximum therapeutic benefit has occurred. Maintenance care is treatment to promote optimal function in the absence of significant symptoms. Supportive care is treatment for a chronic condition for which recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continual care. For complete details, see the member's applicable benefit plan or policy.

MEDICAL DIRECTOR is a person trained and licensed as a medical doctor who works for Arkansas Blue Cross to review medical issues and help establish the Arkansas Blue Cross coverage policy. The medical director does not practice medicine or give any medical advice or counseling.

MEMBER means any person who satisfies the eligibility requirements and financial obligations to qualify for coverage of health care services under a health plan issued or administered by Arkansas Blue Cross, its subsidiaries or affiliates. Member further means and includes any person who satisfies the eligibility requirements and financial obligations to qualify for coverage of health-care services under a health plan; including, but not limited to group health, Workers' Compensation or injury-benefit plans, or any other medical payments or health-benefit plan, whose sponsor or claims administrator has entered into any PPP Network access agreement with Arkansas Blue Cross, its subsidiaries or affiliates. Member shall not include individuals covered solely by other insurance carriers, except for those individuals covered under the BlueCard Program. See your provider contract for complete definitions and details.

MEMBER APPEAL means a request to change a previous decision made by Health Advantage in which the Member is financially responsible.

NON-COVERED SERVICES Any service not covered under the terms, conditions, exclusions and limitations of a Member's Evidence of Coverage with Health Advantage.

OUT-OF-AREA SERVICES means those services provided outside the Service Area in a location outside the state of Arkansas where covered medical services are not available through In-Network Providers.

OUTPATIENT is defined as utilization of ambulatory or ancillary services for diagnosis and treatment.

PARTICIPATING HOSPITAL is a hospital with which Arkansas Blue Cross maintains contractual arrangements to provide comprehensive hospital services to all members. Please refer to the provider directory for the names of participating hospitals, physicians and providers. See your provider contract for complete definitions and details.

PARTICIPATING PHARMACY means a licensed pharmacy which has a written agreement to provide pharmacy services to Arkansas Blue Cross participants as provided in the benefit certificate.

PARTICIPATING PHYSICIAN means a licensed Doctor of Medicine or osteopathy, who has a contract with Arkansas Blue Cross to provide health services to members. Please refer to the provider directory for the names of participating hospitals, physicians and providers. See your provider contract for complete definitions and details.

PARTICIPATING PROVIDER means a health care provider [including durable medical equipment (DME), home health, etc.] who has contracted with Arkansas Blue Cross to provide or arrange for the provision of health care services to members. Please refer to the provider directory for the names of participating hospitals, physicians and providers. See your provider contract for complete definitions and details.

PHYSICIAN means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health interventions at the time and place such intervention is rendered. For complete details, see the member's applicable benefit plan or policy.

PRE AUTHORIZATION is the process whereby inpatient admissions are reviewed for an initial determination of whether hospitalization is medically necessary, or whether needed services could be provided in an outpatient or other alternative setting. Pre authorization does not guarantee payment, but means only that, based on information provided to Arkansas Blue Cross, coverage for the admission (and for the initial number of inpatient days authorized for reimbursement), will not be denied solely based on lack of medical necessity for inpatient treatment. Coverage and payment to all providers is always subject to member eligibility, payment of premiums and all other terms and conditions of the member's health plan. NOTE: Pre authorization is not required for most Arkansas Blue Cross health plans. Check your patient's ID card or health plan to determine applicability of pre authorization requirements.

PREFERRED DRUG LIST is an abridged list of covered prescription medications selected by Arkansas Blue Cross that are subject to lower copayments and coinsurance. For complete details, see the member's applicable benefit plan or policy.

PRESCRIPTION means an order for drugs, medicines or medications by a physician to a pharmacy for the benefit of and use by a covered person of Arkansas Blue Cross. For complete details, see the member's applicable benefit plan or policy.

PRESCRIPTION MEDICATION means any medication or pharmaceutical that has been approved by the U.S. Food and Drug Administration, can be obtained only by a physician order, and bears the label — "Caution: Federal Law prohibits dispensing without a prescription." For complete details, see the member's applicable benefit plan or policy.

PROVIDER means an advance practice nurse; an athletic trainer; an audiologist; a certified orthodontist; a chiropractor; a community mental health center or clinic; a dentist, a Hospital; a licensed ambulatory surgery center; a licensed certified social worker; a licensed dietitian; a licensed durable medical equipment provider; a licensed professional counselor; a licensed psychological examiner; a long-term care facility; a non-Hospital based medical facility providing clinical diagnostic services for sleep disorders; a non-Hospital based medical facility providing magnetic resonance imaging, computed axial tomography, or other imaging diagnostic testing; an occupational therapist; an optometrist; a pharmacist; a physical therapist; a physician or surgeon (M.D. and D.O.); a podiatrist; a prosthetist; a psychologist; a respiratory therapist; a rural health clinic; a speech pathologist and any other type of health care Provider which the Company, in its sole discretion, approves for reimbursement for services rendered.

SUBSCRIBER means a person who is directly employed by the employer for full-time employment. This person must reside in the United States and be paid for full-time work in the conduct of the employer's regular business. No director or officer of the employer shall be considered a subscriber unless he meets the above conditions.

Helpful Reminders

To assist physician offices in obtaining proper eligibility, coverage and benefits information regarding Arkansas Blue Cross members, a list of helpful reminders is provided below:

- When a member calls to schedule an appointment, ask about insurance information.
- When a member arrives at your office, ask to see their Arkansas Blue Cross and Blue Shield identification card.
- Maintain a current copy of the front and back of the member's identification card in their medical file.
- When possible, collect any copayments, coinsurance, and deductibles the day services are rendered.
- File claims with Arkansas Blue Cross within 180 days even if Arkansas Blue Cross is not the primary payer.

If a member does not have a valid identification card, providers may call our Customer Service department or access [Availity](#) to obtain the most current membership eligibility information available for Arkansas Blue Cross, from the employer and/or member. If you are not already registered on Availity, click [here](#) to find out how to register.

My BlueLine

The Interactive Voice Response System

Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas are happy to announce the availability of **My BlueLine**, the Interactive Voice Response System (IVR). **My BlueLine** recognizes common English to answer questions when you call. When providers call, **My BlueLine** will immediately answer. By simply responding to the questions asked by the system – with no buttons to push – providers can get questions answered quickly and easily without having to wait.

Providers can call **800-827-4814**, or locally to the Central Arkansas area **501-378-2307**, for access to information for Arkansas Blue Cross Blue Shield, Blue Advantage Administrators, Health Advantage and Federal Employees Program (FEP) members.

Note: Continue using the existing telephone numbers for the following:

- Blue Card **800-880-0918**

Arkansas Blue Cross believes this is a great enhancement for providers. Providers will no longer have to call multiple phone lines to get information on a member, depending upon whether the member's coverage is with Arkansas Blue Cross and Blue Shield, Medi-Pak®, BlueAdvantage Administrators, Health Advantage, or FEP (Federal Employees Program).

My BlueLine will be able to help providers with questions regarding member eligibility, member benefits, and claims status. During regular business hours, callers can request – at any time during the telephone call – to speak to the next available customer service representative. At that time, the caller will be given an option of visiting with a Customer Service Representative with BlueAdvantage Administrators, Health Advantage, Arkansas Blue Cross Blue Shield, or FEP (Federal Employees Program). Please note that for Blue Advantage Administrators, there are several phone lines handling self-insured employers. Therefore, it may be necessary that we direct you to a phone number on the member's ID card.

My BlueLine is there when you need quick answers to simple questions and is available 24 hours a day, seven days a week.

Items to Remember:

National Provider Identifier (NPI): A caller **must** have their 10-digit NPI and the member's ID number when calling **My BlueLine**.

Using My BlueLine

Items to Remember:

- **National Provider Identifier (NPI):** A caller must have their 10-digit NPI number and the member's ID number when calling.
- **Clear speech:** Speak clearly and avoid conversations with others while using the IVR.
- **Speaker phones:** Avoid use of speaker phone when using the IVR.
- **Headsets:** To eliminate problems with the IVR not recognizing what is spoken, avoid the use of headsets.
- **Multiple checks:** A caller can check on as many claims or members' eligibility as needed in the same call.

- **Multiple lines of business:** Callers can check on Arkansas Blue Cross and Blue Shield, Health Advantage and Blue Advantage Administrators of Arkansas patient information in the same call.
- **Main menu:** Say “Main Menu” at any time to be transferred to the main menu section.
- **Availability:** The IVR system is available 24 hours a day, 7 days a week.
- **Customer service:** Say “Customer Service” at any time to transfer to Customer Service. Customer Service Representatives are available during regular working hours.
- **Answering questions:** Once a caller is familiar with the IVR system, break in and answer the questions before the IVR is finished speaking the questions.
- **Information provided:** Eligibility information and any benefit information provided is not a guarantee of payment or coverage and is only valid if all coverage criteria is verified when we receive the claim

Where to Call for Out-of-State Members

- For benefits on out-of-state Blue Cross and Blue Shield members – **800-676-2583**.
- For claims on out-of-state Blue Cross members – **501-378-2127** or **800-880-0918**.

Helpful Web Sites

Name	Website
American Chiropractic Association	acatoday.org
American Occupational Therapy Association	aota.org
Arkansas Medicare Services	medicare.com/state/arkansas-medicare
Arkansas Chiropractic Association	archiro.org
Arkansas Chiropractic Society	archirosociety.com
Arkansas Department of Health	healthyarkansas.com
Arkansas Department of Human Services	humanservices.arkansas.gov
Arkansas Foundation for Medical Care, Inc.	afmc.org
Arkansas Hospital Association	arkhospitals.com
Arkansas Medical Society	arkmed.org
Arkansas Medicaid	https://www.benefits.gov/benefit/1089
Arkansas Physical Therapy Association	arpta.org
Arkansas State and Public School - Employee Benefits Division	dfa.arkansas.gov/employee-benefits-division/arbenefts
Arkansas State Medical Board	armedicalboard.org
Availity	apps.availity.com/availity/web/public.elegant.login
BlueAdvantage Administrators of Arkansas	blueadvantagearkansas.com
BlueCard	arkansasbluecross.com/providers/resource-center/bluecard-program
Centers for Medicare and Medicaid Services	cms.gov
Coordination of Benefits Agreement (COBA)	cms.gov/medicare/coordination-of-benefits-and-recovery/coba-trading-partners/coordination-of-benefits-agreements/coordination-of-benefits-agreement-page.html
Federal Employee Program (FEP)	fepblue.org
Federal Registers online site	ofr.gov
GPO (Government Publishing Office)	gpo.gov
Health Advantage	healthadvantage-hmo.com
Information on Medicare Manuals	cms.gov/manuals
Medical Group Management Association	mgma.com
Medicare Training	cms.gov/outreach-and-education/learn/get-training/get-training-page.html
NPPES - National Provider Identifier	https://nppes.cms.hhs.gov/#/
OIG (Office of the Inspector General)	oig.hhs.gov
SSA (Social Security Administration)	ssa.gov



SECTION 3

BlueCard

What is BlueCard?

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

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

What services and products are covered under BlueCard?

BlueCard applies to all inpatient, outpatient and professional services. BlueCard does not yet apply to the following:

- Stand-alone dental and prescription drugs
- Federal Employee Program (FEP)
- Some individual Metallic plans

How do providers identify BlueCard members?

When members from other Blue Cross and Blue Shield Plans arrive at a provider's office or facility, be sure to ask for their current membership identification card. The two main identifiers for BlueCard members are the alpha prefix and the "PPO in a suitcase" logo for eligible PPO members.

Alpha Prefix

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route out-of-area BlueCard claims. The alpha prefix identifies the independent Blue Cross and Blue Shield company ("Plan") or national account to which the member belongs.

There are two types of alpha prefixes - plan-specific and account-specific:

1. Plan-Specific Alpha Prefixes are assigned to every Plan and start with X, Y, Z, or Q. The first two positions indicate the Plan to which the member belongs, while the third position identifies the product in which the member is enrolled.
 - a. First character: X, Y, Z or Q
 - b. Second character: A-Z
 - c. Third character: A-Z
2. Account-Specific Prefixes are assigned to centrally processed national accounts. National accounts are employer groups that have offices or branches in more than one area, but offer uniform coverage benefits to all their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national-account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

International Alpha Prefixes:

International alpha prefixes can be seen on identification cards from foreign Blue Cross and Blue Shield members. These ID cards will also contain three-character alpha prefixes. For example, JIS indicates Blue Cross and Blue Shield of Israel members. The BlueCard claims process for international members is the same as that for domestic Blue Cross and Blue Shield members.

What is the “PPO in a suitcase” logo?

Providers should immediately recognize BlueCard PPO members by the special “PPO in a suitcase” logo on their membership card. BlueCard PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard Program. It is important to remember that not all PPO members are BlueCard PPO members, only those whose membership cards carry this logo. Members traveling or living outside of their Blue Plan’s area receive the PPO level of benefits when they obtain services from designated PPO providers.

What about identification cards with no alpha prefix?

Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard program. Please look for instructions or a telephone number on the back of the member’s ID card for information on how to file these claims.

It is very important to capture all ID-card data at the time of service. This is critical for verifying membership and coverage. Arkansas Blue Cross suggests that providers make copies of the front and back of the ID card and pass this key information on to their billing staff. Do not make up alpha prefixes. Incorrect or missing alpha prefixes delay claims processing. Providers who are unsure of their participation status (PPO or non-PPO) should call Arkansas Blue Cross and Blue Shield.

What about BlueCard limitations on some individual Metallic plans?

Some Arkansas Blue Cross and Blue Shield members may receive new 2018 member ID cards without the small suitcase in the corner. These health plans do not include out-of-area benefits. For these members, the provider should only refer to out-of-area providers when Arkansas True Blue PPO network providers are not available. Prior approval is required for extenuating circumstances and can be obtained by completing a Continuation of Care form. Please do not fill out a Continuation of Care form for these members unless they meet the approved parameters.

The Continuation of Care form provides benefits for continuity of care for any member who is **receiving prenatal care** or is in **active treatment for an acute or chronic condition** with a provider not in our area of coverage. This allows the member to continue through the current period of active treatment or up to 90 days, depending on the care needs and circumstances of the patient. The patient must then transition to an in-area provider.

Continuation of care only covers:

- Pregnancy in the third trimester and/or
- High-risk, newly diagnosed or relapsed cancer currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant, recent major surgeries in the acute phase and follow-up period
- Serious acute conditions in active treatment such as heart attacks or strokes.

Routine exams, vaccinations, health assessments, chronic condition care, minor illnesses and elective surgeries do not qualify for continuation of care.

How can providers find out more information about BlueCard?

For more information about BlueCard, call Arkansas Blue Cross and Blue Shield's BlueCard Customer Service toll free at **800-880-0918** or visit the BlueCard Web site at bcbs.com/healthtravel/finder.html.

BlueCard Claims

How to file claims for BlueCard members

Regardless of where a patient's Blue Cross and Blue Shield Home Plan is located, providers should follow these three easy steps to file a claim:

1. Call BlueCard® Eligibility at **800-676-BLUE** (2583) to verify the patient's eligibility and coverage.
2. Give the customer service representative the first three characters of the member's identification number (their alpha prefix number).
3. Submit the member's claim to Arkansas Blue Cross and Blue Shield using regular claims filing procedures after health care services have been provided to the patient.

While claims on BlueCard® members from out-of-state should be submitted in the first instance to Arkansas Blue Cross and Blue Shield for processing, the payer of all such claims is the patient/member's "Home Plan," (i.e., the separate Blue Cross and Blue Shield Licensee Company in the patient-member's home state). Arkansas Blue Cross and Blue Shield merely transmits the claim to the separate company for processing and payment (or denial), as appropriate in its discretion.

For questions regarding claims status, please call Arkansas Blue Cross and Blue Shield's BlueCard® Customer Service at **800-880-0918**.

Note: Providers should not collect payment up front from the member other than the required copayment.

Private room claims filing guidelines for all private facilities

When billing private room charges for an all private facility, value code 02 must be entered in the V002 electronic record or in the value code fields (39-41) on a UB04 claim form when submitting a paper claim. Using the value code will ensure the full DRG allowance is passed to the members Home Plan on the BlueCard claims.

Dental Claims

Regular dental claims are not handled through BlueCard® but dental-related services that are covered under the medical benefits can be filed through BlueCard® using the appropriate dental codes. The member's Blue Cross and Blue Shield plan will instruct providers to consult the member's ID card and file regular dental claims directly to them.

How to avoid misrouted BlueCard claims

In order to avoid misrouted claims and delays in claims processing, Arkansas providers should submit claims for out-of-state BlueCard members to Arkansas Blue Cross and Blue Shield for processing. Do not submit claims directly to the member's out-of-state Blue Plan as this will cause a delay in claims processing. The only exception is when an Arkansas Blue Cross provider also contracts with the out-of- state Blue Plan.

Another form of misroute notification can be received directly from a Home plan. When a provider receives a 1050 or 1051 denial notification on a remittance advice, the Home plans are notifying the provider that they hold no membership for that patient and/or the claim has been routed to them in error. At that time, providers need to obtain a current copy of the patient's ID card for correct filing instructions.

How do indirect, support, or remote providers file BlueCard claims?

Health-care provider who offers products, materials, informational reports and remote analyses or services and are not present in the same physical location as a patient are considered an indirect, support or remote provider. Examples include, but are not limited to, prosthesis manufacturers, durable medical equipment suppliers, independent or chain laboratories, or telemedicine providers.

Indirect providers for members from multiple Blue Plans should follow these claim-filing rules:

- Providers who have a contract with the member's Plan, file with that Plan;
- Providers who normally send claims to the direct provider of care, follow normal procedures;
- Providers who do not normally send claims to the direct provider of care and do not have a contract with the member's Plan should file with their local Blue Cross and Blue Shield Plan.

When and how will providers be paid for BlueCard claims?

In some cases, a member's Blue Cross and Blue Shield Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from providers, Arkansas Blue Cross and Blue Shield may either ask for the information or give the member's Plan permission to contact the provider directly.

Whom do providers call about claims status, adjusting BlueCard claims and resolving other issues?

Providers should contact Arkansas Blue Cross and Blue Shield's BlueCard Customer Service toll free at **800-880-0918**, or contact their [regional office](#).

How do providers handle calls from members and others regarding claims status or payment?

If a member contacts a provider regarding a claim, providers should tell the member to contact their Blue Cross and Blue Shield Plan. Providers should refer the member to the front or back of their ID card for a customer-service number.

The member's Plan should not be contacting a provider directly. However, if the member's Plan does ask a provider to send them another copy of the member's claim, refer them to Arkansas Blue Cross and Blue Shield's BlueCard Customer Service toll free at **800-880-0918**.

Special Note

Even though Arkansas Blue Cross and Blue Shield will serve as a sole point of contact for BlueCard claims, please understand that this does not mean that Arkansas Blue Cross and Blue Shield assumes the obligation to pay or guarantee payment of any claims for services to the members of other Blue Cross and Blue Shield Plans, i.e., the Home Plans. Sole responsibility for payment of all BlueCard claims for members covered by other Blue Cross and Blue Shield Plans (non-Arkansas Blue Cross and Blue Shield BlueCard members) shall remain at all times with the applicable Blue Cross and Blue Shield Plan, i.e., the Home Plan. Arkansas Blue Cross and Blue Shield acts merely as the Host Plan for purposes of facilitating ease-of-service to the Home Plan's members, and assisting in communications with that Home Plan.

All coverage determinations for non-Arkansas Blue Cross and Blue Shield BlueCard members are the responsibilities and decisions of the Home Plan, not Arkansas Blue Cross and Blue Shield. Providers agree to look solely to the Home Plan for non-Arkansas Blue Cross and Blue Shield BlueCard members for payment with respect to any services to such members.

Please note that Arkansas Blue Cross and Blue Shield does not share ownership or governance with any other Blue Cross and Blue Shield Plan; Arkansas Blue Cross and Blue Shield is an entirely independent, separate not-for-profit mutual insurance company, organized in the state of Arkansas and owned by its policyholders. The only association between Arkansas Blue Cross and Blue Shield and other Blue Cross and Blue Shield Plans is that each separate company has been licensed by the Blue Cross and Blue Shield Association to use the registered "Cross" and "Shield" service marks in their separate business operations.

The BlueCard Program is a cooperative effort among these separate, independent licensees of the Blue Cross and Blue Shield Association, but it does not in any way obligate Arkansas Blue Cross and Blue Shield to fund any benefits or become liable for any activities or omissions of any other Blue Cross and Blue Shield Plan. If a provider disputes the coverage or payment determination of another Blue Cross and Blue Shield plan, the provider must pursue appeals or other legal remedies with the applicable Blue Cross and Blue Shield Home Plan, not with Arkansas Blue Cross and Blue Shield.

BlueCard Coordination of Benefits (COB) and Remittance Advice (RA)

COB Questionnaire

Providers can obtain and submit Coordination of Benefits (COB) questionnaires to Arkansas Blue Cross and Blue Shield before filing a claim. Questionnaire responses should not be sent as an attachment to a claim. The two-page COB questionnaire should be printed as a one-sided document to prevent imaging problems. Do not print the COB questionnaire on the front and back of the page. If the member belongs to another Blue Plan, Arkansas Blue Cross will forward the COB questionnaire responses to the member's Blue Cross and Blue Shield Plan on the provider's behalf. The COB questionnaire is available on the Arkansas Blue Cross Web site and through the Advanced Health Information Network (Availity). Completed forms can be faxed to **501-378-2433** or mailed to:

Arkansas Blue Cross
Attn: Blue Card Support
P.O. Box 2181
Little Rock, AR 72203

Remittance Advice Balancing Instructions and Guidelines Related to COB

There has been an increase in inquiries due to the calculation on the remittance when two or more policies are involved on a claim. Below are examples of some of the more common calculations used in the coordination of benefits (COB).

However, due to the differences in COB policies and rules for other Blue Cross and Blue Shield carriers, an example cannot be provided for all instances. Therefore, when in doubt, bill the member the amount indicated in Member Liability on the remittance advice. If there is an error in payment, the member's Home Plan will initiate any necessary adjustments.

The following examples should assist providers in determining patient liability on claims.

Example 1: Charges Discount Paid Payment

Total Charges =	\$ 545.50
Less Blue Cross Discount =	(\$ 121.08)
Less Other Insurance Paid =	(\$ 126.04)
Less payment on Remittance Advice =	(\$ 97.21)
<hr/>	
Equals patient liability =	\$ 201.17
Provider bills patient \$201.17	

Note: The patient responsibility amount on the RA is \$327.21, which includes the other insurance paid amount of \$126.04.

Patient Responsibility on RA =	\$ 327.21
Less Other Insurance =	(\$ 126.04)
<hr/>	
New Patient Response =	\$ 201.17

Example 2: Charges Allowed Discount Coinsurance Payment

Total Charges = \$ 1190.85
Less Blue Cross discount = (\$ 538.48)
Less payment on Remittance Advice = (\$ 489.29)
<hr/>
Difference is coinsurance = \$ 163.08

Patient responsibility is \$163.08 which is the coinsurance amount. Providers will need to bill the patient for the coinsurance amount.

Example 3: Charges Discount Paid Payment

Total Charges = \$ 242.00
Less Blue Cross Discount = (\$ 104.68)
Less Other Insurance = (\$ 106.16)
Payment on Remittance Advice = (\$ 0.00)
<hr/>
Patient responsibility = \$ 31.16

No payment was made on this claim to subtract. Providers will need to bill the patient for \$31.16.

Note: The patient responsibility amount on RA is displayed as \$137.32 which includes the other insurance paid amount of \$106.16. $\$137.32 - \$106.16 = \$31.16$ current patient responsibility.

Example 4: Charges Discount Paid Payment

Total Charges = \$ 5,444.86
Less Blue Cross Discount = (\$ 3,782.86)
Less Other Insurance Paid = (\$ 1,662.00)
<hr/>
Patient responsibility = \$ 00.00

There is no payment from the patient on this claim. The balance is zero with nothing remaining to bill the patient. The patient responsibility amount matched what the other insurance paid \$1662.00.

Changes to remittance advice

Effective April 13, 2014, the following changes were implemented to the remittance advice

New Message Codes:

The following new message codes will now be displayed when applicable:

- 1294 – Medicare-like rate applied for Native American member with approved purchaser order seen by non-Indian Health Services Provider.
- 1305 – All diagnostic reports are needed before the claim can be processed.
- 1306 – PET/MRI/CT scan report/results are needed before claim can be processed.
- 1307 – EEG report with analysis is needed before the claim can be processed.

Discount Code 2- Sequestration Reduction Applied

When discount code 2 is displayed on the remittance advice the amount of that discount is also included in the total amount above.

New Medical Record Document Types:

There are 10 new medical record document types and three updated medical record document types. The new medical record document types will provide the capability to order specific records versus requesting 'complete' medical records. The new medical record document types are as follows:

- **AD** - Accident/Onset date
- **BG** - Blood gases report
- **DE** - Description of services/supply equipment
- **DR** - Delivery report
- **DT** - All diagnostic reports
- **ER** - EEG report with analysis
- **OA** - Ordering/referring physician name and address/NPI
- **SR** - PET/MRI/CT scan report/results
- **TN** - Tooth number
- **VS** - Vein study report

The following medical record type descriptions have been updated. They are as follows:

- **MD** - Medication Record/Administration (current letter #996)
- **ST** - Occupational, Physical, or Speech Therapy Evaluation/Report (current letter #947)
- **TP** - Treatment Plan/Notes (current letter #974)

BlueCard: Corrected Claim Submission

What is a “Corrected Claim”? A “Corrected/Replacement Claim” is a change to a claim that has been previously submitted for processing and has been finalized and reported on the Provider’s Remittance Advice (RA). Corrected claims should not be submitted unless the initial filing has been finalized and is listed on their remittance advice.

Corrected Claim submissions are to be used for claims that have finalized processing and have a claim number assigned. A Corrected Claim should be submitted when providers are changing data on the claim form such as a procedure code, diagnosis code, or charge with a thorough description of what has been changed. Corrected claims may be submitted electronically or by paper.

Electronic submission

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, the Federal Employee Program and BlueCard accept electronic corrected claims.

For both facility and professional corrected claims, in order to expedite processing time and identify the actual corrections and the reason for the correction, Arkansas Blue Cross requires a “total replacement” claim in order for a complete comparison to the original claim along with the explanation in the NTE segment.

To file corrected claims electronically for the CMS 1500 claim form, the provider must populate 2300/CLM05-3 with a value of 7 and include the ICN number or BlueCard SCCF# of the original claim. The original ICN or SCCF# (Document Control Number DCN) must be placed in the REF segment of the Loop 2300 with a qualifier of Ref 01=F8. If these are not submitted, the claim will be returned as a duplicate.

To file corrected claims electronically for the UB claim form, facilities will need to use XX7 type of bill.

Paper submissions

To submit corrected claims on paper, the provider is asked to complete the most current Corrected Bill Submission Form for both the CMS 1500 and the UB04 claim forms and attach the claim as it should have been filed originally. The claim will be returned to the provider processed, or denied as a duplicate claim, unless the form is attached. The purpose of this change is to expedite processing time by assisting in identifying the actual correction and the reason for the correction.

The preferred way to submit a corrected claim is through your clearinghouse or direct data entry on Availity. Paper claims delay processing and could result in more errors, also causing a delay. A separate form is not needed when submitting your claim through one of these methods.

The most current Corrected Bill Submission Form can be accessed and printed from the Arkansas Blue Cross and Blue Shield website at arkbluecross.com. Corrected Claim forms should not be used if providers wish to file the claim under a new identification number or different member, the claim should be filed as a new claim and Arkansas Blue Cross notified of the original incorrect submission.

Corrected Claim forms should not be used to appeal the disposition outcome of a claim or to question the processing of a claim. If providers wish to appeal a claim based on new medical information or rationale, please submit a written request with the supporting documentation to:

Arkansas Blue Cross
Attn: BlueCard Customer Service
P.O. Box 2181
Little Rock, AR 72203

Timely filing

As a reminder, Arkansas Blue Cross set a 180-day timely filing limit for first-time claims as well as corrected claims. When it is necessary to file a corrected claim, please ensure it is done within 180 days of the original paid date or the corrected claim will be rejected or returned.

If you have questions regarding Corrected Claims, contact Availity Client Services at **800-282-4548**.

Filing Original Claim

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

Re-submitting Claims

Arkansas Blue Cross and its affiliates also require providers to use this 180-day timely filing limit for re-submitting claims for adjustments, or for submitting additional information on a previously filed claim.

Adjudicated Claims/COB

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

Member Responsibility

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

All contract holders should have a member identification card and should present their member ID card prior to each service. Arkansas Blue Cross and its affiliates encourage all providers to have their patients' complete insurance coverage update forms at the time of each service. By completing an insurance coverage update form, patients are given every opportunity to provide up-to-date insurance information.

For questions regarding coverage, providers should refer to Availity for member eligibility and claims status or call The BlueLine, our voice activated response service, available 24 hours a day, 7 days a week.

Durable medical equipment, lab and specialty pharmacy

Claims filing rule reminders for durable medical equipment, lab and specialty pharmacy:

In 2004, the Blue Cross and Blue Shield Association (the Association) revised its “Blue Card” claims filing rules for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. While these revisions are several years old, the Association has only recently tightened system requirements related to these rules. These rules apply to all provider networks and claims related to Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage when claims are being submitted via the “Blue Card” process of the Association, a process used to facilitate the efficient processing of claims for members receiving services outside their local service area or state.

Claims for independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy are filed to the local Blue Cross and Blue Shield Plan (sometimes called the “Host Plan”). The local Blue Cross Plan is usually defined as the Plan in whose service area the services are rendered. The Blue Plan that issued coverage for a given member, or that contracted with their employer to administer their self-funded health plan, is referred to as the “Home Plan.” (Please note that “Host Plan” and “Home Plans” are in every case independent companies so that the “Host Plan” is not responsible for funding of any insurance issued by a “Home Plan.” The “Host Plan’s” role is limited to a claims processing and customer services assistance function with respect to the out-of-state provision of services to the “Home Plan’s” member.)

New message codes on remittance advice for misrouted claims based on filing rules for independent clinical laboratory, durable medical equipment suppliers and specialty pharmacy

New message codes have been created to handle misrouted claims for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. When claims are not filed according to the previously published filing rules (see the reprinted rules following), the claims will be rejected for one of the following reasons depending on the provider specialty:

- **Independent Clinical Laboratory** – **Message Code 1290: Claim filed to wrong Plan.** File to the Plan in the state where the specimen is drawn.
- **Durable/Home Medical Equipment and Supplies** – **Message Code 1291: Claim filed to wrong Plan.** File to the Plan in the state where the equipment was shipped to or purchased in a retail store.
- **Specialty Pharmacy** – **Message Code 1292: Claim filed to wrong Plan.** File to the Plan in the state where the ordering physician is located.

Arkansas Blue Cross and Blue Shield Customer Service staff will be monitoring claims denied with these message codes and will contact the Home Plans for verification of the denial. Once the information is obtained, Customer Service will reach out to affected providers to determine the steps needed to get the claim processed.

Independent Clinical Laboratory

For clinical lab, the local Blue Cross Plan is defined as the plan in which service area the specimen was drawn. Example: a blood specimen is drawn at a physician’s office in Little Rock that participates in the Health Advantage network on a member who has Health Advantage benefit coverage. The lab is sent to New York to be processed and is billed from North Carolina. This laboratory participates in the Health Advantage network.

The claim must be billed directly to Health Advantage as the specimen was drawn in Arkansas. The claim will be processed as in network for covered services.

Another example: A blood specimen is drawn in Hot Springs on a member who has health plan coverage administered through Blue Advantage Administrators of Arkansas. The clinic where the specimen is obtained is not in any Arkansas Blue Cross provider networks. The lab specimen is sent to Denver, CO to be processed and will be billed by the lab from Denver. The lab is also not in any Arkansas Blue Cross or affiliates' provider network. The claim must be billed directly to Blue Advantage as the specimen was obtained in Arkansas. The claim will be processed as out of network for covered services.

The Referring Provider information, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission, is required on claims submitted for clinical lab. Arkansas Blue Cross and its family of companies require the referring provider on all professional service claims. Any outpatient claim submitted with a laboratory service must contain the referring provider name and NPI. The referring provider will need to be a provider registered/enrolled in the provider database of Arkansas Blue Cross or its family of companies. Listing a referring provider who is not registered with Arkansas Blue Cross will result in claim rejection or denial.

Durable/Home Medical Equipment and Supply

For durable/home medical equipment and supply, the local Blue Cross Plan is the plan in which service area the equipment was shipped to or purchased at a retail store. For example: a member with Arkansas Blue Cross and Blue Shield insurance living in Fort Smith, AR orders diabetic supplies from a mail order supplier in Ohio. The supplier participates in the Host Plan's network in Ohio but not Arkansas. The claim must be Filed directly to Arkansas Blue Cross because Arkansas is where the supplies were shipped. The claim will be processed as out of network for covered services.

The following information is required on claims submitted for durable/home medical equipment:

- Patient's Address, Field 5 on CMS 1500 Health Insurance Claim Form or in loop 2010CA on the 837 Professional Electronic Submission.
- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.
- Place of Service, Field 24B on the CMS 1500 Health Insurance Claim Form or in loop 2300, segment CLM05-1 on the 837 Professional Electronic Submission.
- Service Facility Location Information, Field 32 on CMS 1500 Health Insurance Form or in loop 2310 A (claim level) on the 837 Professional Electronic Submission.

Specialty Pharmacy

For specialty pharmacy, the local Blue Cross Plan is defined as the plan in which service area the ordering physician is located. For example: a physician whose clinic is in Pine Bluff orders specialty drugs for a Health Advantage member who lives in Stuttgart. The specialty pharmacy is located in Jackson, MS and is in the Mississippi Blue Cross and Blue Shield provider networks, but not in any Arkansas Blue Cross or affiliates' networks. The claim must be filed directly to Health Advantage as the ordering physician's practice location is in Arkansas. The claim will be processed as out of network as the specialty pharmacy is not in any Arkansas Blue Cross or affiliates' provider networks. Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form

or loop 2310A (claim level) on the 837 Professional Electronic Submission is required on claims submitted for clinical lab.

The Blue Card program has always relied on the provider agreement status and pricing of the local Blue Cross and Blue Shield Plan and that is still true. The mere fact that a claim is required to be submitted directly to certain Blue Cross Plan does not obligate any local Blue Cross Blue Plan to offer contracts to any lab, durable medical equipment supplier or specialty pharmacy.

However, the Association's rules for BlueCard have been revised to allow Blue Cross Plans to contract with out of state clinical labs, durable medical equipment suppliers and specialty pharmacies. Each local Blue Cross will make its own decisions related to provider contracting and pricing.

BlueCard: Inpatient claims financial responsibility policy revision

The Blue Cross Blue Shield Association is taking steps to ensure consistency among all Blue Plans regarding inpatient pre-service review (also known as pre-authorization or pre-certification). Beginning July 1, 2014, inpatient facilities that fail to obtain pre-authorization or pre authorization when it is required, **will be financially responsible for any covered services not paid and the member will be held harmless.**

Not all health plans require inpatient pre-authorization or pre-certification, but where it is required, inpatient providers who fail to obtain it will be financially responsible for any covered services not paid and the member will be held harmless. It will become very important for facilities to check member eligibility and pre-certification requirements, whether it be via a HIPAA 270 transaction or by calling the phone number on the member's ID card.

In order to implement the Blue Cross Blue Shield Association mandate, our provider agreement language must be revised. Please consider this notification as an amendment to the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage HMO and PPO Arkansas' (formerly USAble Corporation) True Blue PPO and Arkansas' FirstSource® PPO provider network participation agreements.

The following sections in the Hospital and PHO provider network participation agreements will now contain the additional language:

Prior Approval and Eligibility Inquiries

Non-emergency admissions

Facility understands and agrees that for Health Plans that require prior approval and Facility fails to obtain prior approval that Facility will hold Member harmless of any amounts not paid for Covered Services.

Emergency admissions

Facility understands and agrees that for Health Plans that require prior approval within 24 hours after admission or by the end of the next working day, if on a weekend or holiday and Facility fails to obtain pre-authorization or pre-notification, that Facility will hold Member harmless of any amounts not paid for Covered Services.

Electronic provider access

The Blue Cross and Blue Shield Plans offers Electronic Provider Access (EPA) to give providers the ability to access out-of-area member's Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to prior approval, amongst other pre-claim processes. Electronic Provider Access (EPA) will enable providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider will have the same access to electronic pre- service review capabilities as the Home Plan's local providers.

The availability of EPA will vary depending on the capabilities of each Home Plan. Some Home Plans will be fully implemented and have electronic pre-service review for many services, while others will not yet have implemented electronic pre-service review capabilities. Local access to the EPA is found on the Advanced Health Information Network (Availity) under the "Members" menu option.

BlueCard: Medicare Claims

Pricing claims for Medicare statutorily excluded services

The following Medicare crossover servicing updates became effective October 13, 2013 for all Blue Plans to more accurately price and process these claims:

- For services that are statutorily excluded by Medicare (i.e., home infusion therapy and hearing aids), providers should submit only those statutorily excluded services to Arkansas Blue Cross and Blue Shield with a GY modifier on each line for the service that is excluded or not covered by Medicare. The GY modifier should be used to indicate that the item or service is statutorily excluded. This will allow Arkansas Blue Cross to apply the contracted rate with the provider to accurately process the claim according to the member's benefits. Also, by submitting statutorily excluded services with a GY modifier directly to Arkansas Blue Cross, providers will receive payment for these services in a timelier manner.
- When a provider submits a claim to Medicare and the services were statutorily excluded and not covered by Medicare, however the member has benefits for those services; providers will receive notification from the Blue Plan with instruction to submit those statutorily excluded services directly to Arkansas Blue Cross. Instructions will be included in either a paper or electronic RA or in a letter from the Blue Plan.
 - Paper RAs and Letters: When receiving paper RA's or letters, providers will receive instructions similar to the message below:

"This service is excluded or not covered under Medicare. However, the service may be eligible for benefits under other coverage. Please submit this service to your local Plan."
 - Electronic RAs (835): the following HIPAA claim adjustment reason codes and remark codes will be included on the 835 responses:
 - Claim Adjustment Reason Code (CARC) 109: "Claim not covered by this payor/contractor."
 - RA Remark Code (RARC) N837: "Alert: submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information."
 - Group Code: OA

Commonly Asked Questions:

How do providers know if a service is statutorily excluded or not covered by Medicare?

Providers are responsible for including the GY modifier on only those services which are statutorily excluded by Medicare.

Where on the claim do providers put the GY modifier?

The GY modifier should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe services, a "not otherwise classified code" (NOC) must be used with the GY modifier.

The GY modifier is located in the line level procedure code modifier field(s) and the modifier can be:

- Present position 1, 2, 3 or 4.
- On the paper 1500 form, the GY modifier is located in field 24D.
- On the paper UB04 form, the GY modifier is located in field 44.
- On the 837P, the GY modifier is found at level 2400, Service Line Loop in SV101-3, SV101-4, SV101-5 or SV101-6.
- On the 837I, the GY modifier is found at level 2400, Service Line Loop in SV202-3, SV202-4, SV202-5 or SV202-6.

Duplicate claims handling for Medicare crossover

Since January 1, 2006, all Blue Plans have been required to process Medicare crossover claims for services covered under Medigap and Medicare Supplemental products through the Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare claims to the Blue secondary payer to eliminate the need for provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, this has also allowed Medicare crossover claims to be processed in the same manner nationwide.

Effective October 13, 2013, when a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting the claim to Arkansas Blue Cross and Blue Shield.

The claims providers submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 14 business days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time a provider receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for a provider to receive payment or instructions from the Blue Plan.

Providers should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit claims to Medicare to allow for the crossover process to occur and for the member's benefit policy to be applied.

Medicare primary claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date will be (returned or rejected) by Arkansas Blue Cross.

Commonly Asked Questions:

How do providers submit Medicare primary / Blue Plan secondary claims?

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that providers enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification.
- Be certain to include the alpha prefix as part of the member identification number. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When a provider receives the remittance advice (RA) from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the RA indicates that the claim was crossed over, Medicare has forwarded the claim on behalf of the provider to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to Arkansas Blue Cross.
- If the RA indicates that the claim was not crossed over, submit the claim to Arkansas Blue Cross with the Medicare RA.
- In some cases, the member identification card may contain a COBRA ID number. If so, be certain to include this number on the claim.

- For claims status inquiries, contact Arkansas Blue Cross Customer Service at **800-880-0918** or **501-378-2127**.

When should providers expect to receive payment?

The claim a provider submits to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 14 business days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time the Medicare RA is received. As a result, upon receipt of the RA from Medicare, it may take up to 30 additional business days for providers to receive payment or instructions from the Blue Plan.

What should providers do in the meantime?

If a provider submitted the claim to the Medicare intermediary/carrier and hasn't received a response to the initial claim submission, they should not automatically submit another claim. Instead, providers should:

- Review the automated resubmission cycle on the claim system.
- Wait 30 calendar days from receipt of the Medicare Remittance advice.
- Check claims status before resubmitting.

Sending another claim, or having a billing agency resubmit claims automatically, slows down the claim payment process and creates confusion for the member.

Filing Medicare Advantage Home Health Request for Anticipated Payment Claims

The Center for Medicare and Medicaid Services (CMS) allows Revenue Code 0023 for Medicare Advantage home health request for anticipated payment (RAP) claims that contain a service line with zero as the total charge, of which Medicare pays 60% of their normal allowance. Total Charges must be entered as zero on the RAP claim. This field cannot be left blank.

The claims are then re-submitted later with the actual charges. Medicare then adjusts the claims when the re-submitted bill is received and pays the remaining difference. These are identified when Medicare home health care claims are submitted with a bill type 322 or 332 along with zero charges. When the final bill is submitted, it will initiate a void only adjustment on the RAP Claim. The final bill should contain bill types 329 or 339 and actual charges.



SECTION 4

Claims Filing and Information

Accidental Injuries & Subrogation

Accidental Injuries

If an Arkansas Blue Cross and Blue Shield member is involved in an accident, bill in the usual manner, adding the place, date, time and cause of injury. Arkansas Blue Cross needs to know the cause of injury to process injury claims. By adding the cause of injury and date of injury to the original claim submission, the provider facilitates a timely and expedited claim process.

If benefits are payable under the terms of any automobile medical, automobile no-fault, homeowners, premises liability, personal injury protection or similar contract of insurance, benefits may be coordinated at the point of final determination of liability.

Subrogation

Subrogation rights are included in all Arkansas Blue Cross members' health plans or contracts. This means that if Arkansas Blue Cross pays claims for an injury or illness (whether or not it was the result of an accident or some other cause) that was caused by another person who is liable to the member for that injury or illness, Arkansas Blue Cross is entitled to recover our payments from the responsible third party or their insurance carrier.

Arkansas Blue Cross members are obligated to cooperate and to furnish all information needed to identify and pursue a third party or subrogation. If the member fails to cooperate, Arkansas Blue Cross has the right to recover claim payments and deny benefits. This means a provider's claims may be affected if the member fails to promptly return the C-110 form or otherwise fails to cooperate or seeks to avoid our subrogation interest.

Note: Subrogation investigation and recovery services may be pursued for Arkansas Blue Cross by a separate subrogation vendor, known as Healthcare Recovery Services, Inc. (HRI) or Trover.

Arkansas Blue Cross and Blue Shield Partners with Availity

Arkansas Blue Cross and Blue Shield and its family of companies entered into a strategic partnership with Availity in 2020. As part of the alliance, Availity serves as the designated EDI Gateway providing portal and clearinghouse services for Arkansas Blue Cross and Blue Shield.

Availity is the nation's largest real-time health information network with connections to more than 2,000 payers nationwide, including government payers like Medicaid and Medicare. With a full range of provider clearinghouse and revenue cycle management options, Availity may also offer ways to consolidate clearinghouse endpoints. Visit availity.com/edclearinghouse for more information.

Arkansas Blue Cross and Blue Shield offers many transactions on Availity, such as eligibility and benefits, claim submission, remit viewer, claim statuses, a dedicated payer-space with payer-specific apps and documents on a dedicated payer space, and more. Visit apps.availity.com/availity/web/public.elegant.login to access Availity registration.

Availity has created a landing page consisting of helpful information and training opportunities to assist providers through the registration and the getting started process. Providers can access the Availity landing page at availity.com/arkansasbluecross.

Providers are encouraged to become familiar with Availity chat, ticketing functions and the Availity client services team at **800-282-4584** (282-AVAILITY).

Assignment of Benefits

Providers may elect to require that members, before receiving services, execute an assignment whereby any benefits under the member's health plan or contract are assigned to the provider. Granted that a provider is a participating provider in good standing with Arkansas Blue Cross and Blue Shield (not in violation of the provider agreement, the Arkansas Blue Cross billing and coding guidelines or this Provider Manual) on the date of such assignment, and on the date of the services in question, Arkansas Blue Cross will honor such assignments and any payments due for the services will be paid directly to the provider rather than to our member.

If providers cease to be a participating provider for any reason, however, Arkansas Blue Cross reserves the right to decline to accept the assignment; and in such case Arkansas Blue Cross may, in our discretion, make payment to the member rather than to the provider. Whether or not providers elect to require and receive an assignment from an Arkansas Blue Cross member, providers agree to release the member from all financial responsibility with respect to that assigned claim, except for applicable copayment, coinsurance and deductible; i.e., providers agree to look exclusively to Arkansas Blue Cross for payment for all services to the member, except for copayment, coinsurance and deductible (or non-covered services permitted to be billed to members under the terms of your participation agreement).

Claims Filing Rule Reminders for Durable Medical Equipment, Lab and Specialty Pharmacy

In 2004, the Blue Cross and Blue Shield Association (the Association) revised its “Blue Card” claims filing rules for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty drugs not covered on the pharmacy benefit. While these revisions are several years old, the Association has only recently tightened system requirements related to these rules. These rules apply to all provider networks and claims related to Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage when claims are being submitted via the “Blue Card” process of the Association, a process used to facilitate the efficient processing of claims for members receiving services outside their local service area or state.

Claims for independent clinical laboratory, durable/home medical equipment and supply, and specialty drugs not covered on the pharmacy benefit are filed to the local Blue Cross and Blue Shield Plan (sometimes called the “Host Plan”). The local Blue Cross Plan is usually defined as the Plan in whose service area the services are rendered. The Blue Plan that issued coverage for a given member, or that contracted with their employer to administer their self-funded health plan, is referred to as the “Home Plan.”

Please note that “Host Plan” and “Home Plans” are in every case independent companies so that the “Host Plan” is not responsible for funding of any insurance issued by a “Home Plan.” The “Host Plan’s” role is limited to a claims processing and customer services assistance function with respect to the out-of-state provision of services to the “Home Plan’s” member.

New message codes on remittance advice for misrouted claims based on filing rules for independent clinical laboratory, durable medical equipment suppliers and specialty pharmacy:

New message codes have been created to handle misrouted claims for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. When claims are not filed according to the previously published filing rules (see the reprinted rules following), the claims will be rejected for one of the following reasons depending on the provider specialty:

- Independent Clinical Laboratory – **Message Code 1290: Claim filed to wrong Plan.** File to the Plan in the state where the specimen is drawn.
- Durable/Home Medical Equipment and Supplies – **Message Code 1291: Claim filed to wrong Plan.** File to the Plan in the state where the equipment was shipped to or purchased in a retail store.
- Specialty Pharmacy – **Message Code 1292: Claim filed to wrong Plan.** File to the Plan in the state where the ordering physician is located.

Arkansas Blue Cross Customer Service staff will be monitoring claims denied with these message codes and will contact the Home Plans for verification of the denial. Once the information is obtained, Customer Service will reach out to affected providers to determine the steps needed to get the claim processed.

Independent Clinical Laboratory

For clinical lab, the local Blue Cross Plan is defined as the plan in which service area the specimen was drawn. Example: a blood specimen is drawn at a physician’s office in



Little Rock that participates in the Health Advantage network on a member who has Health Advantage benefit coverage. The lab is sent to New York to be processed and is billed from North Carolina. This laboratory participates in the Health Advantage network. The claim must be billed directly to Health Advantage as the specimen was drawn in Arkansas. The claim will be processed as in network for covered services.

Another example: A blood specimen is drawn in Hot Springs on a member who has health plan coverage administered through Blue Advantage Administrators of Arkansas. The clinic where the specimen is obtained is not in any Arkansas Blue Cross provider networks. The lab specimen is sent to Denver, CO to be processed and will be billed by the lab from Denver. The lab is also not in any Arkansas Blue Cross or affiliates' provider network. The claim must be billed directly to Blue Advantage as the specimen was obtained in Arkansas. The claim will be processed as out of network for covered services.

The Referring Provider information, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission, is required on claims submitted for clinical lab.

Durable/Home Medical Equipment and Supply

For durable/home medical equipment and supply, the local Blue Cross Plan is the plan in which service area the equipment was shipped to or purchased at a retail store. For example: a member with Arkansas Blue Cross and Blue Shield insurance living in Fort Smith, AR orders diabetic supplies from a mail order supplier in Ohio. The supplier participates in the Host Plan's network in Ohio but not Arkansas. The claim must be Filed directly to Arkansas Blue Cross because Arkansas is where the supplies were shipped. The claim will be processed as out of network for covered services.

The following information is required on claims submitted for durable/home medical equipment:

- Patient's Address, Field 5 on CMS 1500 Health Insurance Claim Form or in loop 2010CA on the 837 Professional Electronic Submission.
- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.
- Place of Service, Field 24B on the CMS 1500 Health Insurance Claim Form or in loop 2300, segment CLM05-1 on the 837 Professional Electronic Submission.
- Service Facility Location Information, Field 32 on CMS 1500 Health Insurance Form or in loop 2310 A (claim level) on the 837 Professional Electronic Submission.

Specialty Pharmacy

For specialty pharmacy, the local Blue Cross Plan is defined as the plan in which service area the ordering physician is located. For example: a physician whose clinic is in Pine Bluff orders specialty drugs for a Health Advantage member who lives in Stuttgart. The specialty pharmacy is located in Jackson, MS and is in the Mississippi Blue Cross and Blue Shield provider networks, but not in any Arkansas Blue Cross or affiliates' networks. The claim must be filed directly to Health Advantage as the ordering physician's practice location is in Arkansas. The claim will be processed as out of network as the specialty pharmacy is not in any Arkansas Blue Cross or affiliates' provider networks. Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission is required on claims submitted for clinical lab:

The Blue Card program has always relied on the provider agreement status and pricing of the local Blue Cross and Blue Shield Plan and that is still true. The mere fact that a claim is required to be submitted directly to certain Blue Cross Plan does not obligate any local Blue Cross Blue Plan to offer contracts to any lab, durable medical equipment supplier or specialty pharmacy.

However, the Association's rules for BlueCard have been revised to allow Blue Cross Plans to contract with out of state clinical labs, durable medical equipment suppliers and specialty pharmacies. Each local Blue Cross will make its own decisions related to provider contracting and pricing.

Contiguous Counties

Claims filing rules for counties bordering Arkansas

This is a reminder on the claims filing rules for health care providers located in counties of states that border Arkansas.

If a member has insurance coverage with Arkansas Blue Cross and Blue Shield and if that member receives services from a healthcare provider located in a bordering county who is contracted to be in the provider networks of Arkansas Blue Cross or its affiliates, the provider must submit the claim directly to Arkansas Blue Cross or its affiliates, as applicable. In this scenario, Arkansas Blue Cross essentially fills both the “Host” and “Home” Plan function, based on the peculiar circumstances of border county proximity and the network participation agreement in place with the out-of-state provider. This rule also applies to Health Advantage, its members and contracted providers, as well as to health plans administered by Blue Advantage Administrators of Arkansas.

An example would be a physician in Memphis, TN, who provides care to a patient with health plan coverage from Health Advantage. If that physician is in the Health Advantage provider network, the claim must be submitted to Health Advantage in Little Rock. If a health care provider in a bordering county is not in the provider networks of Arkansas Blue Cross and its affiliates but is participating in the networks of the Blue Cross and Blue Shield plan where the provider is located, and that provider renders services to a member with coverage from Arkansas Blue Cross and its affiliates, the provider must file claims to the local Blue Cross Blue Shield plan as the “Host Plan.”

An example would be a physician in Memphis, TN, who provides care to a patient with health plan coverage from Health Advantage. This physician is NOT in the Health Advantage provider network but is in the Blue Cross Blue Shield of Tennessee provider networks. This claim must be submitted to Blue Cross Blue Shield of Tennessee. If a health care provider located in a county bordering Arkansas, who participates in the provider networks of Arkansas Blue Cross and its affiliates renders care to a member with insurance from a Blue Cross Blue and Shield Plan other than Arkansas Blue Cross and its affiliates, the provider must file the claim to the local Blue Cross and Blue Shield Plan, as the “Host Plan.”

An example would be a physician in Branson, MO (located in a county bordering Arkansas) who provides care to a member with insurance coverage from Blue Cross Blue Shield of Montana. This claim must be submitted to the local Blue Plan which, for a place of service location in Branson, MO is Anthem Blue Cross and Blue Shield of Missouri. It does not matter whether the physician is in the Anthem Blue Cross and Blue Shield of Missouri provider networks, the claim still must be submitted to the local or “Host Plan.”

The exceptions to these rules apply to health care providers for lab, durable medical equipment/medical supplies and specialty pharmacy.

Coordination of Benefits

When Arkansas Blue Cross is the secondary carrier, the benefits will be reduced by the amount paid by the primary carrier. The allowable expense is a service that is covered in full or in part by any of the plans covering the person. Non-covered expenses are not coordinated.

Ultimately, it is the member's responsibility to ensure delivery of the EOB from the primary carrier to Arkansas Blue Cross. However, if the provider receives the EOB from the primary carrier, he or she may forward it to Arkansas Blue Cross for processing.

When Arkansas Blue Cross is secondary, a provider has the right to collect the copayment deductible, or coinsurance and then coordinate benefits with the other carrier.

Please note: If Arkansas Blue Cross and Blue Shield is the secondary payer, providers should not submit a claim until they have received the primary payer's payment.

If the provider receives payment in excess of actual charges and has collected a copayment, deductible or coinsurance from the member, the provider should reimburse the member up to but not exceeding the amount of the copayment, deductible or coinsurance. Any additional overpayment for that date of service should be refunded to the secondary carrier.

If the provider contractually participates with other health plan(s), the privilege to collect a copayment may be affected by the agreement with the other health plan(s).

To file secondary claims electronically, reference [Filing Claims Electronically](#).

Dual Arkansas Blue Cross Coverage

When a member has two Arkansas Blue Cross policies, the copayments and coinsurance amounts are paid by the secondary plan. If one plan has a pre-existing clause, the member could have an amount that would not be paid in full. Services that are not covered by both the primary and secondary carriers are not coordinated.

If the provider does not participate with the primary carrier but does participate with Arkansas Blue Cross, all secondary payments will be made directly to the provider as opposed to paying the member.

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 contact EDI Operations is **501-378-2336**.

Corrected Claims

The Arkansas Blue Cross definition of a corrected claim is a claim that has been processed, whether paid or denied, and was refiled with additional charges, a different diagnosis, or any information that would change the way that claim was originally processed. Placing the “Corrected Claim” indication on the claim form when it has not been previously processed will cause a delay in claim adjudication.

Claims returned requesting additional information are NOT to be refiled as corrected claims. These claims have been processed; however additional information is needed to finalize payment. Inappropriate usage of the Corrected Claim form will result in information being returned to the provider.

Do not use the Corrected Claim form for the following:

- New claims
- Appeals
- Medical records
- Invoices
- Inquiries
- Adjustments

Corrected Claims can be used for all lines of business including BlueCard and FEP. For a Corrected Claim form, click on the following link: [Provider Forms](#). Filing claims electronically or by using direct data entry on Availity prevents the need for an additional form and is the preferred method for submitting a corrected claim.

To file corrected claims electronically, reference the [Filing Claims Electronically](#) section of this manual.

Electronic Corrected Claims Are Accepted

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, FEP and BlueCard accept electronic corrected claims.

Electronic Submission: To file corrected claims electronically for the CMS 1500 claim form, providers should enter the number 7 in 2300/CLM05-3 and include the ICN number or BlueCard SCCF# of the original claim. The original ICN or SCCF# (Document Control Number - DCN) should be placed in the REF segment of the Loop 2300 with a qualifier of Ref01=F8. If these are not submitted, the claims will be returned as a duplicate.

Providers need to ask their software vendor to open an area within the 2300 loop for the remarks in the NTE segment as to what was corrected on the claim. Arkansas Blue Cross would appreciate receiving a total replacement claim in order for a complete comparison to the original claim along with the explanation in the NTE segment. This will expedite processing time and identify the actual corrections and the reason for the correction for both facility and professional corrected claims. To file corrected claims electronically for the UB claim form, the facility will need to use XX7 type of bill.

If you have questions regarding corrected claims, please contact Availity Client Services at **800-282-4548** (292-AVAILITY).

Filing Claims Electronically

EDI is the acronym for Electronic Data Interchange. EDI is the exchange of information using routine business transactions in a standardized computer format; for example, data interchange between an insurance carrier and a provider. Electronic Data Interchange will save providers time and money. Providers may reach Arkansas Blue Cross and Blue Shield EDI Services at **501-378-2336** or via e-mail at edi@arkbluecross.com.

How to Enroll

Providers must have appropriate software to transmit claims electronically. Software for the transmission of electronic claims may be included in the provider's current practice management or EHR system. If a provider

currently has a practice management system, contact the software vendor. Otherwise, providers must choose a HIPAA compliant software vendor, billing agent or clearinghouse. Availity also has solutions for providers. Providers can contact Availity to inquire: **800-282-4548** (282-AVAILITY).

Provider Changes

Changes within a provider's office are both necessary and inevitable. As an electronic submitter, providers will need to notify EDI Services of any changes that may occur at a provider's office by sending an e-mail to edi@arkbluecross.com or faxing the information to **501-378-2265**.

- **Address Changes** – Address changes for electronic submitters must be reported to Provider Enrollment Services (to update a provider number address) and EDI Services (to update an electronic submitter file address).
- **Changes in Contact Person** – EDI must know who to speak to in a provider's office regarding electronic claims.
- **Changes in Physician Staff** – Please notify EDI Services, as well as Provider Network Operations, when a doctor leaves a practice so that he/she can be deleted from the electronic billing information retained in a provider's office. Likewise, if new physicians are added, please let EDI know so the doctor may be added to the electronic billing information retained in the provider's office.

Initial hospital visits billed by multiple physicians

In March 2012, Arkansas Blue Cross and Blue shield sent notice to providers that only the admitting physician could bill the hospital admission CPT Codes 99221-99223. All other physicians seeing the patient, even if for the first time, were instructed to bill the subsequent hospital CPT Codes 99231-99233. However, most physicians continue to bill the hospital admission codes.

After data analysis and understanding that the consult CPT Codes are not available for providers to use, Arkansas Blue Cross agrees that the physicians providing 'consults' to the hospital patient may bill the first visit using the hospital admission CPT Codes 99221-99223 provided the service meets the requirements set forth by the Centers for Medicare & Medicaid Services (CMS) for this use.

The admitting physician should add Modifier A1 for reporting purposes only. Consulting physicians and subsequent attending physicians should not use the Modifier A1.

Medical Facts Letter

Certain claim submissions trigger a front-end claim edit that creates a request for additional information. This information is obtained using a medical facts letter that is sent to the provider. Listed below are guidelines for completing the medical facts letter.

Guidelines

- Complete all questions on the medical facts letter regarding pre-existing conditions and answer all questions on our form letter.
- Use the appropriate diagnosis procedure codes and try to avoid using vague or unspecified diagnosis and V codes.
- Use the appropriate E&M code for the service rendered and avoid upcoding.
- Do not use modifier 25 with office visit codes unless there is really a separate identifiable service provided.
- Provide both operative reports if billing as cosurgery.
- Provide the lab results with neutrophil count or a formula to calculate the neutrophil count when we request information for the use of Neupogen.
- Psychiatrists' and psychologists' office staff should enter the correct number of services on the claim depending on the service provided. Some "psych" codes do not have time units and entering the incorrect number of services will result in incorrect payment.
- Submit ALL requested information when requested.

Note: Arkansas Blue Cross and Blue Shield relies on the accuracy, truthfulness and completeness of all information supplied to us on the medical facts letter to properly adjudicate the claim and the member's benefits. Failure to supply Arkansas Blue Cross with full, accurate information may constitute fraud. The person completing the medical facts letter is required to sign the form. The signature on the medical facts letter is required and is looked upon by Arkansas Blue Cross as an assurance that the information provided is true and correct in all respects and does not present a misleading picture.

Member Cooperation

How Member Cooperation Affects Provider Reimbursement

Arkansas Blue Cross and Blue Shield's member health plans and contracts outline certain areas in which we need the member's cooperation to adequately process their claims or provide good customer service. If the member fails to provide that cooperation, in some instances Arkansas Blue Cross will not be able to determine benefits or may decide to deny benefits for lack of cooperation. The charges for services would then become the member's responsibility.

Because provider reimbursement by Arkansas Blue Cross is always subject to the terms of the member's health plan or contract, providers should be aware of the terms of the health plan or contract, including those terms that require member cooperation. Providers should encourage our members who are your patients to fully cooperate in furnishing all information needed to properly evaluate and adjudicate their claims.

When Members Fail to Cooperate

If the member fails to cooperate and Arkansas Blue Cross must deny claims on that basis, providers will not be entitled to any reimbursement from Arkansas Blue Cross for the services in question. Areas in which we commonly need and request member cooperation include but are not limited to:

- Obtaining medical records or other claims-related information
- Obtaining information regarding other coverage the member may have (coordination of benefits)
- Obtaining information regarding the status of a dependent, such as a disabled child or a college student
- Obtaining information regarding third party liability (e.g., auto accident), subrogation or work-related injuries

Member Fraud or Misrepresentation

If Arkansas Blue Cross and Blue Shield discovers that a member obtained coverage initially by means of an application that misrepresented the member's past medical history or other relevant background, or that a member has filed fraudulent insurance claims, Arkansas Blue Cross may elect at our discretion to terminate the member's health plan coverage or insurance contract, or to rescind the coverage.

If coverage is rescinded, that action is retroactive to the first date that the member's coverage became effective, even if that date was months or even years before Arkansas Blue Cross discovered the fraud or misrepresentation. This means that the member, in effect, never had any coverage because the coverage was obtained through fraudulent or material misrepresentation.

Accordingly, providers may be asked to refund prior claims payments made with respect to such a member, and any pending claims with respect to such a member will be denied by Arkansas Blue Cross on grounds that no coverage existed on the date of service.

Therefore, it is in a provider's best interest to assist Arkansas Blue Cross in identifying any member fraud or misrepresentation as early as possible, not only to protect all members and the public at large from the costs of such improper activity, but also to protect providers.

Most Common Claim Denials

Of all the claims submitted to Arkansas Blue Cross and its affiliates, almost twenty-five percent are denied on the first submission because of a problem with the way the claims are filed or due to the lack of necessary information. The top denial reasons are listed below. To help prevent these types of denials, please review the suggestions with each reason for denial:

- Additional information requested from another provider to verify completion/accuracy of enrollment information – Failure to return any information requested in a timely manner may result in a denial.
- Duplicate charge - Providers should check each EOP/RA when received. If a provider resubmits the same claim without any changes or corrections, the resubmission will cause a duplicate-claim error. Before resubmitting a claim, check the claims status by calling My BlueLine or check Availity online.
- Information requested from policyholder not received - Providers should have the member call customer service to provide requested information.
- Medical information required to determine benefits - For some claims, providers may receive a Bar-Coded fax or letter requesting additional information. Please refer to the bar-coded fax or letter for details on what information is needed. Fax the Bar-Coded letter along with the requested information to Arkansas Blue Cross. The claim will remain closed for the reason noted on the EOP/RA until Arkansas Blue Cross or its affiliates receive the requested information.
- No prior approval on file – Services that require prior approval must be authorized prior to the delivery of services. Approval numbers must be indicated in Block 23 of the CMS 1500 claim form.
- Patient account number missing – The patient’s account number must be listed on the claim, or the submission will fail in Availity.
- Service not submitted within required filing period - All claims for services must be submitted within 180 days of the date the service is rendered to be eligible for reimbursement. NOTE: If providers fail to file a claim within the required 180-day period, providers cannot bill the member for that claim and providers will not receive payment from Arkansas Blue Cross.
 - If the member fails to provide insurance information within the required 180-day filing period, providers should not file the claim. Providers should hold the member responsible for the payment of the services.
- Service part of an allowance on this or a previous claim – If the claim for service is considered part of an allowance acknowledged on the claim or a previous claim, the claims will be denied for fragmented charges.

Paper Claims

Providers are encouraged to utilize the much faster, easier electronic claims processing capabilities available through Availity. However, if a provider must use paper claims, the following guidelines apply.

Guide to CMS-1500 Paper Claim Form for Professional Providers

These guidelines will help providers prepare claims for Optical Character Recognition (OCR) scanning when filing paper claims for Arkansas Blue Cross and Blue Shield, Health Advantage, and Blue Advantage Administrators.

- **Align the Form:** Please align the claim form carefully so that all data falls within the blocks on the claim form. The provider will be able to keep the form aligned if they center an “X” in the boxes at the top right and left corners of the claim. Please be sure that all line-item information appears on the same horizontal line. Claims will be returned if they are not properly aligned.
- **Dates:** Use an 8-digit format for all dates on the claim. For example, enter June 1, 2006 as 06012006. All dates must be valid dates. Some fields require an entry such as DOS, while others are optional.
- **Dollars and Cents:** Please do not use dollar signs (\$) in any block. Separate dollars and cents with a blank space. For example, enter \$1,322.00 as 1332 00.
- **Forms:** Please don’t fold, staple, or tape claims. Please separate all forms carefully. Forms must be original red and white forms. Copies of forms or forms with light print cannot be accepted and will be returned to the provider.

For providers using bursting equipment, adjust the splitters to precisely remove the pin feed edges. Claims must be submitted on the 08/05 version of the CMS-1500 claim form printed with red “drop out” ink.

Providers may obtain copies of the CMS-1500 claim form through various vendors such as the American Medical Association or the U.S. Government Printing Office.

- **Keep It clean:** Don’t print, write, or stamp extra data on the claim form. When correcting errors, use white correction tape only and not white correction fluid.
- **Lines of Service (block 24):** Limit the lines of service to six lines on each claim filed. Placing information in the shaded areas as shown on the NUCC site should be as “FYI” only since the data may not image properly. Arkansas Blue Cross and Blue Shield does not recommend the use of this free form line. However, if it is used, it is critical that the right qualifiers be used.
- **Names:** For all blocks requiring names, please omit any titles, such as Mr. or Mrs. Enter the last name first, followed by a comma, and then the first name - Last Name, First Name. (For example: Doe, James).
- **Print quality:** Providers can help ensure that paper claims are accurately processed by checking the quality of the print carefully. Faint printing can cause scanning problems. Please replace printer ribbons or toner regularly and be sure to use the highest quality print setting available.
- **Ribbons and Fonts:** Use only black ribbons in typewriters or printers and change the ribbons frequently. Although claims can be accepted using a 12-pitch setting, please use a 10-pitch setting. If software supports fonts, please use Courier 10 Monospace font.

By following these guidelines, providers will assist Arkansas Blue Cross and Blue Shield in meeting its goal of efficient, accurate claims processing.

Rejected Claims

As part of the change in claims processing, all paper claims are now processed through “front-end” edits that verify eligibility information. Claims that cannot be scanned by OCR will be returned to the provider with an accompanying explanation. Providers will receive a letter for claims that the OCR rejects. Please verify the information on the patient’s insurance card prior to submission.

Submit the unacceptable claims as New claims. Do not resubmit unacceptable claims as “corrected” claims. Unacceptable claims are rejected prior to acceptance into Arkansas Blue Cross adjudication system(s), therefore there is no “original” claim to correct on the Arkansas Blue Cross systems.

Common causes of paper claim delays or returns

- National Provider Identifier missing in blocks 17B, 32A and 33A
- Invalid Place of Service and Type of Service Codes
- Invalid CPT or ICD–9 codes
- Misaligned information on the form. Make sure your information is inside the form blocks
- Narrative text in numeric fields on the CMS-1500 (HCFA) form
- Hand-written claims
- Alpha characters in numbers fields
- Invalid member number
- Un-scannable forms or copied forms that are not of good print quality

Reminder of printing guidelines for paper claims

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and Health Advantage encourage providers to file claims electronically since electronic claims are processed faster and more accurately than paper claims. However, in the event that a paper claim form is used, certain guidelines must be followed before the paper claim can be accepted. To ensure the paper claim is accepted and the claims data is read accurately, providers should adhere to the following guidelines:

- Use only red Form CMS-1500 08/05 and red Form UB-04 that conform to CMS guidelines.
- Align the form carefully so that all data falls within the blocks on the claim form. Please be sure that all line-item information appears on the same horizontal line.
- Do not hand write claim information. Claim information must be printed or typed with black ink. Remember to regularly change your printer ribbon or ink cartridges.
- Keep the form clean by not printing, writing, or stamping extra data on the form. Please refrain from using correction fluid or correction tape. If an error occurs while completing the claim, please complete a new, red claim form for submission.
- Use only UPPERCASE letters for alphabetical entries. Don’t mix fonts or use italics, script, percent signs, question marks or parentheses.
- The recommended font for Form CMS-1500 08/05 is 12-point Courier New set at 10 characters per inch (10-pitch), 6 lines per inch. The recommended font for Form UB-04 is 10-point Courier New set at 10 characters per inch (10-pitch) and 6 lines per inch.

- Please separate all forms carefully. Do not fold, staple, or tape claims. Do not place any stickers on the claim form. Remove any pin-feed edges from any continuous feed forms.

Since Optical Character Recognition (OCR) technology is used to convert paper claims to electronic data, paper claim forms that do not comply with these guidelines or are printed too light to be successfully read by OCR equipment may be rejected.

Paper Claims: Step-By-Step Instructions

The following information is designed to help providers complete the new CMS-1500 claim form which is mandated by the National Uniform Claim Committee (NUCC) to meet the requirement for all providers to have a NPI number. Only submit paper claims if electronic claim submission isn't possible.

Note: Effective January 1, 2007, all fields indicated as **REQUIRED** in the following guide must be completed or the claim will be returned to the provider.

Block 1 – Type of Insurance:

Indicate the type of health insurance coverage applicable to this claim: Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA Black Lung, or Other.

Block 1A - Insured's I.D. # (REQUIRED):

Enter the patient's current identification number exactly as it appears on their identification card, including the appropriate three letter alpha prefix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in the processing or denial of the claim.

Block 2 - Patient's Name (REQUIRED):

Enter the patient's last name followed by a comma and the first name in all capital letters. An entry in this block is required. Do not include any apostrophes, hyphens, suffixes (like Jr. or Sr.), or titles (such as Mr. or Mrs.) any other marks of punctuation besides the comma. For example, enter Mrs. Mary O'Hara as "OHARA, MARY."

Block 3 - Patient's Date of Birth and Sex (REQUIRED):

Enter the patient's birth date (MM DD CCYY) and sex. A space must be reported between month, day, and year. **Entry in both the date of birth and sex is required.**

Block 4 - Insured's Name (REQUIRED):

Enter the last name of the policyholder or subscriber, followed by a comma and the first name. Please enter this name exactly as it appears on their card. Do not include any apostrophes, hyphens, suffixes (like Jr. or Sr.), or titles (such as Mr. or Mrs.) any other marks of punctuation besides the comma. For example, enter Mary O'Hara as "OHARA, MARY." Using the terms "same" or "self" may result in a claim being rejected.

Block 5 - Patient's Address (REQUIRED):

Fill out this block only if the patient's address is different from the insured's address, in Block 7, and please enter no more than 28 characters in this field.

Block 6 - Patient's Relationship to Insured (REQUIRED):

Check the appropriate box for patient's relationship to insured. Enter an "X" in one of the following boxes:

- Self - the patient is the subscriber or insured
- Spouse - the husband or wife or qualified partner as defined by the insured's Plan.
- Child - minor dependent as defined by the insured's Plan.
- Other - stepchildren, student dependents, handicapped children, & domestic partners.

Block 7 - Insured's Address and Telephone (REQUIRED):

Enter the Insured's address and telephone number.



Block 8 – (reserved for NUCC use).**Block 9 - Other insured's Name (REQUIRED):**

If the patient is covered under another health benefit plan including Arkansas Blue Cross and Blue Shield, BlueAdvantage, or Health Advantage, please enter the full name of the policyholder.

Block 9A - Other insured's Policy or Group Number (REQUIRED):

Enter Other Insured's Policy or Group Number (**Note: Do not use a hyphen or space within the policy or group number.**)

Block 9B - (reserved for NUCC use)**Block 9C - (reserved for NUCC use)****Block 9D - Other Insured's Plan Name or Program Name (REQUIRED):**

Enter the other insured's plan name or program name. If recipient has Medicare coverage, enter the word Medicare followed by the Medicare plan name (e.g., Medicare Senior Dimensions, Medicare Senior Care Plus).

Block 10 (A - C) - Patient's condition related to?

For each category (employment, auto accident, other), insert an "X" in either the **YES** or **NO** fields. If any "YES" fields are selected, Block 14 must be populated with the accident date. The appropriate postal abbreviation for the STATE must be supplied if an AUTO ACCIDENT.

Block 10D - This field is reserved for local use**Block 11 - Insured's Policy, Group, or FECA Number (REQUIRED):**

Enter the insured's current identification number exactly as it appears on their identification card, including the appropriate three-letter alpha prefix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in processing or denial of the claim.

Block 11A - Insured's Date of Birth, Sex (REQUIRED):

Enter the 8-digit date of birth (MM/DD/CCYY) of the insured and an "X" to indicate the sex of the insured.

Block 11B – Other Claim ID (Designated by NUCC). Block 11C – Insurance Plan Name of Program Name:

Enter the insured's plan name or program name as it appears on their identification card.

Block 11D - Is there another health benefit plan?

Enter an "X" in the appropriate box. If marked "Yes", complete 9 and 9 A-D.

Block 12 – Patient's or Authorized Person's signature.**Block 13 – Insured's or Authorized Person's signature.****Block 14 - Date of Current Illness, injury or Pregnancy:**

Injury - Enter date the accident occurred; if any YES fields are marked with an "X" in Block 10 (A - C) then Block 14 must be populated with the accident date.

- **Illness** - Enter for acute medical emergency only and include onset date of condition;
- **Injury** – Enter the date of the accident
- **Chiropractic** – Enter the date of the first treatment.
- **Pregnancy** - Enter date of the last menstrual period (LMP) as the first date.

Block 15 – Other Date:

If patient has had the same or similar illness, enter the date of the onset of illness.

Block 16 – Dates Patient Unable to Work in Current Occupation:

Enter the date range where patient is unable to work in current condition.

Block 17- Name of Referring Physician or Other Source (REQUIRED):

Enter the name (First Name, Middle Initial, and Last Name) and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim. Do not use periods or commas within the name.

Block 17B - National Provider Identifier (NPI) (REQUIRED):

Enter the NPI of the referring provider, ordering provider, or other source in 17B. **(Note: Now required for claims filed May 23, 2007 or later.)**

Block 18 - Hospitalization Dates Related to Current Services:

Enter admission and discharge dates (MM DD YY format) for inpatient hospitalization related to current services.

Block 19 – Additional Claim Information (Reserved for local use). Block 20 - Outside lab charges:

If laboratory work was performed outside a provider’s office, enter the laboratory’s actual charge to the provider. If the laboratory bills Arkansas Blue Cross directly, enter an “X” in the “NO” box.

Block 21(A-L) - Diagnosis and/or Nature of Illness or Injury (REQUIRED):

Enter the appropriate ICD-9 diagnosis code (up to five digits) for the services performed. Enter up to twelve (12) ICD-9 codes in the spaces indicated A through L. Enter the codes across each line, not down **Do NOT use any punctuation such as a decimal.**

Block 22 – Resubmission Code:

Complete the field to adjust or void a previously paid claim. Otherwise, leave this field blank.

- In the Code area, enter an adjustment or void reason code
- In the Original Reference Number area, enter the last paid Internal Control Number (ICN) of the claim.

Block 23 – Prior Approval Number:

Enter only one approval number per claim form. Enter any of the following as assigned by the payer for the current service:

- Prior approval number,
- Referral number, or
- Mammography prior approval number.

Block 24 - Supplemental Information:

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24.

National Drug Codes (NDC) for drugs – must have N4 qualifier followed by 11 digit NDC code – do not put a space between the qualifier and code; do not use hyphens in the code.

Placing the following information in the shaded areas as shown on the NUCC site should be as “FYI” only since the data may not image properly. Arkansas Blue Cross does not recommend the use of this free form line. However, if it is used, it is critical that the right qualifiers be used.

Narrative description of unspecified codes must have a “ZZ” qualifier followed by the code description – do not put a space between the qualifier and the code.

From the NUCC website:

“To enter supplemental information, begin at Block 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.”

Block 24A-Date(s) of Service (REQUIRED):

Enter date(s) of service, from and to. If only one date of service, enter that date under “From.” Leave “To” blank or re-enter “From” date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is only allowed for services on consecutive days. The number of days must correspond to the number of units in 24G.

Block 24B - Place of Service (POS) Code (REQUIRED):

Enter the appropriate two-digit code from the “Place of Service” list from the CMS web site for each item used or service performed. The “Place of Service” identifies the location where the service was rendered. POS 11 = Office

Block 24C - EMG Emergency Indicator:

Enter “N” for NO and “Y” for YES in the bottom, unshaded area of this field.

Block 24D - Procedures, Services or Supplies (REQUIRED):

Enter the CPT/HCPCS code(s) and applicable modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description unless it is an ‘unlisted’ procedure code. If ‘unlisted’ an NDC or description must be shown in the shaded area for that line.

Block 24E - Diagnosis Pointer (REQUIRED):

Enter the line-item diagnosis code pointer(s) referencing the appropriate diagnosis code(s) reported in Block 24D. Do not use a range, list primary diagnosis for the service line first. (1, 2, 3 not 1-3).

Block 24F - Charges (REQUIRED):

Enter the charge for each listed service.

Block 24G - Days or Units (REQUIRED):

Enter the units of service rendered for the procedure. Anesthesia services and “special” procedure codes require time units format. **(Note: Must be whole number).**

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in block 24G of the CMS-1500 claim form. If no units are indicated on the claim, the claim will be denied.

Block 24H – EPSDT/Family Plan (Situational):

For providers that bill Family Planning services, enter “Y” if services were family planning and “N” if they were not.

Block 24I – ID Qualifier (REQUIRED):

- Using NPI in field 24J: Enter “ZZ” in the top, shaded half of the claim line.
- Using API in Field 24J: Enter “N5” in the top, shaded half of the claim line.

Block 24J - Rendering Provider ID Number (REQUIRED):

The individual provider rendering the service should be reported in Block 24J. **The original fields for Block 24J and 24K have combined and re-numbered as Block 24J.** Enter the NPI number in the un- shaded area of the field. **(Note: NPI is required on claims filed on May 23, 2007 or later).**

Block 25 - Federal Tax ID Number:

Enter the provider of service’s or supplier’s federal tax ID (employer identification number) or Social Security number. Enter “X” in the appropriate box to indicate which number is being reported. Only one box can be marked.

Block 26 - Patient’s Account Number (REQUIRED):

Enter the patient’s account number assigned by the provider of service’s or supplier’s accounting system.

Block 27 - Accept Assignment? (REQUIRED):

Enter an “X” in the correct box. Only one box can be marked. “Accept Assignment” indicates the provider agrees to accept assignment under the terms of the Medicare Program.

Block 28 - Total charge (REQUIRED):

Enter the sum of all line charges.

Block 29 - Amount Paid:

Enter the total amount the patient or other payers paid on the covered services only. Attach a copy of the other insurer’s explanation of benefits (EOB) and complete Block 9.

Please note: If Arkansas Blue Cross is the secondary payer, providers should not submit a claim until payment is received from the primary payer.

Block 30 – Balance Due (reserved for NUCC use):**Block 31 - Signature of Physician / Supplier:**

Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter the eight-digit date (MM/DD/CCYY), or alphanumeric date (e.g. January 1, 2006) the form was signed.

Block 32 - Service Facility Location:

Enter the name, address, city, state, and zip code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, zip code, and state when billing for purchased diagnostic tests. When more than one supplier is used, a separate CMS-1500 claim form should be used for each supplier. **Leave blank if this is a sub-part of the location entered in Block 33.**

Block 32A National Provider Identifier (NPI) (REQUIRED):

Enter the National Provider Identifier (NPI) number of the service facility. **(Note: NPI is required for claims filed on May 23, 2007 or later).**

Block 33 - Physician's or Supplier's Billing Name, Address, and Phone:

Enter the provider's or supplier's billing name, address, zip, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

- 1st line – Name
- 2nd line – Address
- 3rd line – City, State, and Zip Code

Block 33A - National Provider Identifier (NPI) (REQUIRED):

Enter the "pay to" National Provider Identifier (NPI) number of the billing provider in Block 33A. **(Note: The NPI is required for claims filed May 23, 2007 or later).**

Prepay Review of High-Dollar Inpatient Claims Changes for 2021 Services

The Blue Cross Blue Shield Association made changes to the high-dollar inpatient claims review for 2021. These changes were adopted by Arkansas Blue Cross and Blue Shield and its family of companies effective January 1, 2021.

The Association, in 2019, began requiring itemized bills for high dollar inpatient claims that were \$250,000 or greater. Arkansas Blue Cross was required to adopt that policy and subsequent updates to the policy. For 2020 the amount was lowered to \$200,000, and upon reviewing the findings and results of this policy, the Association lowered the threshold for 2021 to \$100,000. Therefore, please remit itemized bills for all inpatient claims of \$100,000 or more if the claim will have a payment that is tied to the billed charge (i.e., not paid wholly by per diem, case rate or diagnosis-related group). To avoid unnecessary delays or interruption of payments of these claims, providers are asked to submit an itemized bill with any claim that meets these criteria.

Arkansas Blue Cross and its family of companies use the CMS Provider Reimbursement Manual and the UB Editor for guidance, as well as the services of Optum (formerly known as Equian) to conduct this prepay review. Arkansas Blue Cross and the Blue Cross Blue Shield Association will continue to evaluate the results of the prepay review to determine whether the billed amount subject to review should be adjusted.

To minimize the administrative work this change will create for the providers, Arkansas Blue Cross is working to automate an electronic submission format to allow the providers to bill the electronic claim and other supporting documentation simultaneously.

Please contact your network development representative for specifics about submitting itemized bills with the claims.

Note: For questions involving a report's findings, we ask that providers work with Equian/Optum directly. Please review the report and contact Equian/Optum to discuss any inquiries regarding review findings and/or the documentation and explanation necessary to clarify the questioned charges:

Claims Resolution

Email: claimsresolution@equian.com

Direct: **888-895-2254**

Additionally, providers may formally dispute a report's findings. Please identify the correspondence as a formal dispute, include the documentation and explanations necessary to clarify the questioned charges, and send the formal written dispute to:

Claims Disputes / Reconsiderations

Email: reconsiderations@equian.com

Fax: **866-700-5769**

Mail: Equian, LLC / Attention: Claims Disputes / 600 12th St / Suite 300 / Golden, CO 80401



Provider “Third Party Liability” or “Subrogation” Activities and Member Claims

Arkansas Blue Cross and Blue Shield would like to provide the following notice regarding applicable claims filing policies and procedures of Arkansas Blue Cross and its affiliate, Health Advantage, in situations in which a third party or their liability carrier are responsible for the injuries an Arkansas Blue Cross or Health Advantage member sustains (generally referred to for shorthand convenience as “Third Party Liability” or “Subrogation” matters). These policies and procedures have been in place for many years but are being restated for emphasis due to increasing Third Party Liability or Subrogation activities of some providers.

Providers are reminded that their network participation agreements obligate them to comply with all claims filing policies and procedures, including those published in Providers’ News.

1. Arkansas Blue Cross and Blue Shield and Health Advantage encourage providers to file all claims, rather than holding such claims to pursue Third Party Liability or Subrogation. Filing the claim allows quick provision of any available health plan or insurance contract benefits to our members and provides the fastest payment to providers.
2. Although filing of claims is strongly encouraged and preferred, Arkansas Blue Cross and Health Advantage provider contracts do not require that claims be filed with them and recognize that state law specifically grants a lien to providers for Third Party Liability (i.e., providers can claim a part of any third party recovery the member may otherwise seek or be entitled to recover).
3. While Arkansas Blue Cross and Health Advantage understand this state lien law, and do not purport to change or challenge it, Arkansas Blue Cross and Health Advantage do require as an express term of their network participation agreements that participating providers must not pursue the member for any amounts in excess of the Arkansas Blue Cross or Health Advantage payment (“Excess Amounts”) although participating providers may collect applicable member deductible, coinsurance or copayments. This means that while a provider can go after the third party or their carrier without violating their network participation agreement, the provider cannot attempt to recover “Excess Amounts” from the member. Any attempt to bill the member or collect against the member or their assets for Covered Services will be deemed a violation of the network participation agreement.
4. Providers are reminded that network participation agreements impose a 180-day timely filing requirement for all claims, and expressly bar collection – either from Arkansas Blue Cross or Health Advantage or the member – on claims not filed within 180 days. Thus, if a provider elects not to file a claim in favor of exclusively pursuing Third Party Liability or Subrogation, if that effort causes a delay in filing the claim past the 180-day filing deadline, providers cannot thereafter bill either the member or Arkansas Blue Cross or Health Advantage for any amount on such claims.
5. Providers are also reminded that while they may elect not to file a claim, members may still file the claim with Arkansas Blue Cross or Health Advantage based on the provisions of their member certificate or evidence of coverage. If the member files a claim that a provider has withheld, Arkansas Blue Cross or Health Advantage will attempt to develop and process that member- submitted claim. Providers are contractually obligated in such circumstances to provide to Arkansas Blue Cross and Health Advantage information needed to evaluate and process the claim. Any payments determined due on such claims will be paid to the provider. Providers may not decline to accept the Arkansas Blue Cross or Health Advantage payment in such

situations. If a provider does breach the participation agreement by declining to accept payment, Arkansas Blue Cross or Health Advantage will then make payment to the member. In either case, whether the payment is accepted or declined, and whether payment is made to the provider or the member (following provider refusal to accept), the provider cannot pursue collection against the member for Excess Amounts.

6. Arkansas Blue Cross and Health Advantage do not take a position regarding a provider's option to
 - a. File claims and receive the Arkansas Blue Cross or Health Advantage payment and also
 - b. Pursue Third Party Liability or Subrogation for the remaining portion of their bills (the Excess Amounts).

The only interest for Arkansas Blue Cross and Health Advantage is in ensuring that providers understand that once they become a participating provider in these networks, they cannot pursue the member for amounts beyond the Arkansas Blue Cross or Health Advantage payments.

7. To the extent that any of the preceding rules of network participation have not been clearly understood or interpreted by any provider or party, this Providers' News article shall be deemed to constitute notice of an amendment to the network participation agreement of Arkansas Blue Cross and Health Advantage participating providers.

With respect to Arkansas' FirstSource[®] PPO and True Blue PPO networks of PPO Arkansas, the same policies and procedures as referenced above shall apply, with the only variation being that PPO Arkansas is not a payer of any claims of self-funded groups that access these networks; accordingly, payment of all such self-funded group claims is always subject to funding and direction of the employer-sponsor as Plan Administrator of such plans.

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.

Cloned Medical Record Documentation Policy

All Arkansas Blue Cross and Blue Shield, Health Advantage and PPO Arkansas (“ABCBS”) network provider participation agreements require that all providers create and maintain a standard, contemporaneous medical record for each Member receiving services. The medical records shall be created and maintained in compliance with, and shall contain the information required by state and federal laws and regulations, including requirements of the Medicaid and Medicare programs, and shall be retained for such time periods required by law or regulation, but in any event not less than seven years after the date of service.

All documentation in the medical record must be specific to the individual patient and specific to the individual encounter.

The word ‘cloning’ refers to documentation that is worded exactly like previous medical record entries. Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). The United States Department of Health and Human Services, Office of Inspector General strongly discourages cloning of medical records and continues to monitor it closely.

Cloning of documentation which fails to consider patient specific variations will be considered a misrepresentation of the medical necessity requirement for coverage of services. In other words, it will be considered a breach of the required terms of each ABCBS provider agreement. Any claim connected to medical record cloning described herein may be denied, and further, providers will not be allowed to bill or seek to collect from the Member any charges described in the cloned medical records.

Timely Filing Guidelines

As a reminder, the following information regarding timely claims filing applies to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage and includes claims for members of other Blue Cross Plans.

Filing Original Claim

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

Re-submitting Claims

Arkansas Blue Cross and its affiliates also require providers to use this 180-day timely filing limit for re-submitting claims for adjustments, or for submitting additional information on a previously filed claim.

Adjudicated Claims/COB

Arkansas Blue Cross and its affiliates extends the timely filing requirements to include 180 days after the primary insurer adjudicates the claim. Timely deadline for secondary claims is 180 days from the date processed by the primary carrier.

Member Responsibility

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

All contract holders should have a member identification card and should present their ID card prior to each service. Arkansas Blue Cross and its affiliates encourage all providers to have their patients complete insurance coverage update forms at the time of each service. By completing an insurance coverage update form, patients are given every opportunity to provide up-to-date insurance information.

For questions regarding coverage, providers should refer to the tool on Availity or call The BlueLine, our voice activated response service, available 24 hours a day, 7 days a week.

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

Timely Filing Requirements

Members covered under health plans sponsored by Arkansas Blue Cross and Blue Shield usually have limitations to the time for which benefits are available after services are rendered. This stipulation, called a “timely-filing” provision, makes prompt submission of claims critical to getting the claim paid.

In most cases, to be eligible for benefits, a claim must be submitted within 180 days of the date services are rendered. Corrected claims must be submitted within 180 days of the original payment date.

Timely Filing Requirements

- COB - In the case of coordination of benefits when Arkansas Blue Cross is the secondary payer, the claim must be filed within 180 days of the primary payer’s determination.
- Medi-Pak® - The claim must be filed within 180 days from the date Medicare paid.
- BlueCard® - Timely filing requirements are determined by the home plan.
- Medicare Advantage - Timely filing requirements are the same as Medicare.

Proof of Timely Filing

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 acceptance or 999 report is the preferred documentation and should be submitted for best practice to qualify for timely filing review.
- If the insurance filed shows a plan other than Arkansas Blue Cross, 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 within the timeframe to comply with timely filing, the claim should not be filed and the member can be billed.

If a provider attached a claim correction form to a paper 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

If Arkansas Blue Cross and Blue Shield is secondary, the 180-day timely filing starts from the primary carrier's Remittance Advice date of payment or denial.

UB-04 Facility Claims

Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their web site at nubc.org.

Rule and Regulation 43, Clean Claims, and Section 14 Claims

The Arkansas Insurance Department Rule and Regulation 43 sets standards for timely processing of health insurance claims. Rule and Regulation 43 establishes the maximum number of days that insurance carriers have to process “clean claims” and “non-clean claims” or “Section 14 Claims” without incurring penalties. All claims to insurance carriers are subject to this regulation.

Rule and Regulation 43

Rule and Regulation 43 requires that:

1. All clean claims submitted electronically must be processed (paid or denied with notification to provider or member) within 30 days. Clean claims submitted on paper must be processed within 45 days.
2. For Section 14 Claims, the claim must be determined to be non-clean and returned to the provider or member within 30 days. After the correct information has been provided to the insurance carrier, the insurance carrier then has 30 days to process the claim.

If the insurance carrier does not process a clean claim within 60 days, the insurance carrier must then pay a penalty beginning on the 61st day after the claim was filed. The penalty is the amount of the claim multiplied by 12 percent per annum multiplied by the number of days delinquent divided by 365.

If the insurance carrier does not process a Section 14 Claim within 45 days of receipt of necessary information, the insurance carrier must then pay a penalty beginning on the 46th day after the correct information is received. The penalty is the amount of the claim multiplied by 12 percent per annum multiplied by the number of days delinquent divided by 365.

For information and guidelines on filing the CMS-1500 claim form and CMS-1500 anesthesia claim form and for filing guidelines for Wellness services, please read the following information.

R&R 43 Exceptions: This rule does NOT apply to the Federal Employee Program and some groups administered by BlueAdvantage Administrators of Arkansas.

Clean Claims

Clean Claims are claims submitted with all information necessary for payer adjudication and that do not require further investigation. A “Clean Claim” does not include claims on expenses incurred during a period of time when premiums were delinquent or for benefits under a Medicare supplement policy if the claim is not accompanied by an explanation of Medicare benefits or the Explanation of Medicare Benefits (EOMB) has not been otherwise received by the insurance carrier.

Section 13 Claims

Section 13 Claims are claims that have been submitted but must be suspended from processing until the insurance carrier receives more information. They are called “Section 13 Claims” because the rules for processing these claims are found in Section 13 of Rule and Regulation 43. Under the terms of Rule and Regulation 43, an insurance carrier must notify the claimant (provider or member) within 30 days of receiving a Section 13 Claim of the need for additional information to process the claim correctly. Necessary information may include any of the following:

- Information to determine if contract limit or exclusion applies



- Medical information to determine price of medical procedure
- Information to determine eligibility of claimant
- Information to determine if claim is covered by another carrier, government program, workers' compensation or third party
- Information to determine coordination of benefits (COB) obligation
- Information to determine if there is fraud or material misrepresentation
- Payment of premiums that were delinquent at the time of claimed services



SECTION 5

Claims Payment, Refunds, & Offsets

Appeals and Re-reviews

All re-review and appeal requests should be submitted in writing within 180 days of the denial of benefits on a claim and should include: the issue being appealed, the date of service, the patient's name and ID number, the provider's name, and reasons why the provider/member believes that the claim was incorrectly denied in whole or in part. The request should also include any medical records relevant to the appeal. For greater efficiency, providers are encouraged to pursue resolution with customer service prior to filing a re-review or appeal with Arkansas Blue Cross. An appeal or re-review request should not be submitted with a Corrected Claim form; this will only delay the appeal or re-review response.

1. Appeals and Re-review requests on Arkansas Blue Cross and Blue Shield Covered Members:

- a. Provider Re-reviews:** Arkansas Blue Cross and Blue Shield requires providers to request a re-review of a denied claim (in whole or in part) prior to the submission of an appeal. Re-reviews should be submitted to:

Arkansas Blue Cross and Blue Shield
Attn: Medical Re-Review
P.O. Box 3688
Little Rock, AR 72203

- b. Provider Appeals:** If the denial of the service continues to be disputed after the re-review is completed, an appeal may be submitted within 180 days of the original denial of the service. An appeal request on an Arkansas Blue Cross and Blue Shield member should be submitted to:

Arkansas Blue Cross Blue Shield Appeals Department
Attn: Appeals Coordinator
P.O. Box 2181
Little Rock, AR 72203

Fax: 501-378-3366

Email: appealscoordinator@arkansasbluecross.com

- c. Member Appeals:** Members should submit appeal requests in writing to the Appeals Coordinator at the above referenced address within 180 days of the denial of the service. The same information listed above under provider appeals is required for a member appeal.

2. Appeals and Re-review requests on out-of-state Blue Cross and Blue Shield Plan Members (BlueCard):

Each Blue Cross Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association. Therefore, each Plan develops their own certificates and policies and controls benefits for their members. Arkansas Blue Cross and Blue Shield acts as the Host Plan for other Blue Cross Plans when Arkansas Providers are used for services. Arkansas Blue Cross and Blue Shield only prices the claim when the member is covered under a Blue Cross Plan other than Arkansas Blue Cross, and the provider is in Arkansas. The member's Home Plan determines if benefits are due. Providers who disagree with the way a claim was processed or paid may contact BlueCard Customer Service at **800-880-0918** for assistance.

- a. Provider Re-review of the allowance for a service:** Providers should send their request in writing to:

Arkansas Blue Cross and Blue Shield
Attn: Medical Re-review
P.O. Box 3688
Little Rock, AR 72203



If the provider continues to dispute the allowance for a service after the re-review response, a written appeal may be filed with the Arkansas Blue Cross and Blue Shield Appeals Coordinator. (Address listed above.)

- b. Provider Appeals related to benefits available under another Blue Cross Plan:** The provider should send their written appeal to:

Arkansas Blue Cross and Blue Shield
Attention: BlueCard Correspondence 601 Gaines St.
Little Rock, AR 72203

Arkansas Blue Cross and Blue Shield will forward the appeal to the member's correct Home Plan for response by the other Blue Cross Plan.

- c. Member Appeals:** Members should submit their appeals directly to their own Blue Cross Plan.

Claims Payment Issues

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

- Amounts of issued provider payee checks are recorded as increases to the 1099 earnings.
- Amounts of voided provider payee checks are recorded as decreases to the 1099 earnings.
- Amounts received from providers (claims refunds) are recorded as decreases to the 1099 earnings.
- 1099 earnings are accumulated under the Tax Identification Number (TIN) of the payee, as recorded in our files at the time of the transaction.

Changes in Name or EIN (Employer Identification Number)

Providers must notify Arkansas Blue Cross and Blue Shield promptly with changes in their EIN or name to ensure accurate reporting to the IRS. If the IRS sends Arkansas Blue Cross a "B-Notice" indicating that the Taxpayer Name and EIN does not match the IRS records, Arkansas Blue Cross will be required to withhold, and remit to the IRS, 28% of future amounts payable to providers if corrected data is not received within the mandated time frame. Once withheld amounts are remitted to the IRS, they cannot be refunded to providers but will be reported on the 1099 as "Federal Income Tax Withheld."

Deductibles, Benefit Limits, Out-of-Pocket Maximums, and Lifetime Maximums

Deductibles, benefit limits, out-of-pocket maximums, and lifetime maximums are accumulated by individual members. If erroneous claims are not adjusted appropriately and promptly, subsequent claims may be incorrectly adjudicated.

Please verify that the payee is correct on all checks received prior to negotiating them.

Examples of Payment Errors

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

- If a provider receives payment for a claim for services that they did not perform: Please refund the amount paid in error. Even if you know to whom the payment should have been made, do not forward the amount to that party. A provider's 1099 can only be corrected if the money is returned and the claim reprocessed to the appropriate party.
- If the patient was paid, and payment should have been made directly to the provider: Please advise the patient to return the check, or refund the amount paid, along with a request to reprocess the payment to the provider. If a provider accepts payment from the patient, Arkansas Blue Cross could subsequently discover the error and send a request for refund to the member since our records will reflect the member received the payment.
- If a provider was paid, and payment should have been made to the patient: Please refund the payment to Arkansas Blue Cross and Blue Shield (rather than to the patient) along with a request to reprocess the payment to the patient. A provider's 1099 can only be corrected if the money is returned and the claim reprocessed to the appropriate party.

- If a check is made payable to an individual physician but should have been made payable to the clinic: Please return the check to Arkansas Blue Cross (rather than depositing the check in the clinic's account) with a request to reprocess the payment to the appropriate provider. A provider's 1099 can only be corrected if the money is returned and the claim reprocessed to the appropriate party.

Note: If the check is made payable to an individual physician, the 1099 will be generated in the physician's name, even if they are an employee of the clinic.

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

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

Minimize the Time Required to Process a Claim Refund

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

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

If the provider is not returning the original check, a separate refund check for each line of business is preferred.

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

Please do not combine refunds for Arkansas Blue Cross, Health Advantage, BlueAdvantage, USABLE Administrators, and Medicare. Please do not issue refund checks payable to Arkansas' FirstSource®. Refund

checks pertaining to FirstSource members should be made payable to the appropriate check issuer (which may sometimes be a third party administrator for a self-funded plan): Arkansas Blue Cross and

Blue Shield, BlueAdvantage, USABLE Administrators, Health Advantage or another outside carrier that accesses the FirstSource® PPO Network with a copy of the remittance advice/explanation of payment.

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

The following are the correct addresses to use for claim refunds:

Arkansas Blue Cross and Blue Shield

P.O. Box 2099
Little Rock, AR 72203

Health Advantage

P.O. Box 8069
Little Rock, AR 72203

BlueAdvantage Administrators of Arkansas

P.O. Box 1460
Little Rock, AR 72203

USABLE Administrators

P.O. Box 1460
Little Rock, AR 72203

Medicare (part A or B)

P.O. Box 8075
Little Rock, AR 72203

Copayments, Coinsurance, and Deductibles

Copayments, coinsurance and deductibles are all vital components of not only actuarial calculations of premium, but also cost incentives to the member. As required by our provider participation agreements, providers should always bill and collect all copayments, coinsurance and deductibles directly from the member. As the provider looks solely to Arkansas Blue Cross and Blue Shield for payment of **covered services**, providers should not bill or collect any amount in excess of the Arkansas Blue Cross payment except for the applicable copayments, coinsurance and deductibles.

Providers may collect any amount from members for services that are deemed not meeting the Primary Coverage Criteria (e.g., deemed experimental/investigational) if, and only if, the provider obtains a written statement from the member before any services are provided, acknowledging that the services are not covered by the member's health plan or contract, and the statement specifies the amount of charges for the services. This statement must be signed by the member in advance of any applicable services. This statement will be referred to as a [waiver of health plan liability](#).

Electronic Funds Transfer (EFT)

All applicants (excluding dental) are required to enroll in EFT, regardless of whether this is a new or an existing practice, to receive claim payments. This payment method is effective for Arkansas Blue Cross and Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas, Federal Employee Program (FEP), USABLE Administrators and USABLE Life Group Health payment types inclusively. Contact your local [Network Development Reps \(NDRs\) - Arkansas Blue Cross and Blue Shield](#) for an **EFT** enrollment package.

A separate appendix - Provider's Bank Information - is required for each of the assigned provider/ NPI numbers to whom payments are routinely directed: individual doctor / sole practitioner, facility, clinic, emergency room, etc. This is true even when the same bank information applies to all providers in the 'group.' For example, if a new physician is applying to participate in any of the networks mentioned above, and the physician is applying to join an already established clinic, that clinic must be paid via **EFT**.

After receipt of the **EFT** information, there is a waiting or pre-notification period during which time Arkansas Blue Cross and Blue Shield performs a validation process to ensure bank routing and account information is valid.

In the event a provider changes banking information to which claim payments should be directed, a new Appendix – Provider's Bank Information - is required and a new pre-notification period is established. During this pre-notification period, the provider will receive paper checks. A single contract may be completed for affiliated entities such as a facility which also maintains an outpatient clinic and the like.

Claim payments are validated by Financial Services daily and released to a servicing bank for transfer through the Automated Clearing House (**ACH**) Network to the provider's bank. Payments are released two days prior to the effective date of the **EFT** which is the same as the paper check date. Consequently, with EFT payments, your payments reach you faster.

Remittance information is posted to Availity no later than the **EFT** effective date. If you are registered on Availity, paper remittances will not be mailed. Otherwise, a cover sheet indicating that funds have been sent electronically to the provider's financial institution accompanies the paper remittance. The electronic remittance advice (**835**) is available by accessing Availity Essentials remittance viewer.

For additional information see the "Claims Payments, Refunds & Offsets" section of the Arkansas Blue Cross and Blue Shield Provider Manual at arkansasbluecross.com/providers.

Electronic Funds Transfer (EFT) Requirements

EFT submissions may come through Availity or submitted via email to your local [Network Development Rep \(NDR\)](#). **EFT** requirements include the following:

1. A complete **EFT** agreement packet which includes the following:
 - a. Authorized signature on the agreement page
 - b. Authorized signature on the Electronic Funds Transfer (**EFT**) Form
2. Valid bank letter which includes the following:
 - a. Bank letterhead

- b. Provider name
- c. Bank routing and account numbers
- d. Signature of bank official

An e-mail notification is sent to the provider advising the approximate start date of **EFT** payments. The **EFT notice does not guarantee network approval. If provider has applied for network participation, a separate welcome letter will be sent once approved through the credentialing process at which time, claims should be submitted. Please avoid submitting claims before the welcome letter is received.** Included in this notice is the current "Payment Address" to which the paper remittance will be sent. If this address is incorrect, please submit a [Provider Change of Data Form](#) . A copy of your **EFT** contract will be returned after being executed by the Vice President of Financial Services.

The Availity platform has much better security processes than email and paper. While Arkansas Blue Cross and Blue Shield realizes some providers may not have Availity, we encourage you to sign up as we believe the Availity platform offers more protective measures in this day and time of cybercrime.

Arkansas Blue Cross and Blue Shield endeavors to maintain the privacy of the provider's financial information and, to that end, has limited all screens containing such information to selected Provider Network Operations and Financial Services staff.

If you have questions about EFT enrollment or changes, contact your local **NDR** (Network Development Representative).

Electronic Funds Transfer (EFT) Identifiers

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

Arkansas BlueCross BlueShield (EFT Payments)

Identifier	Line of Business	Payment Schedule
IT 01	BlueCard	Weekly
BC 01	Arkansas Blue Cross and Blue Shield commercial business	Twice weekly*
MP 01	Arkansas Blue Cross and Blue Shield Medicare Supplement (Medipak) business	Twice weekly*

Arkansas BlueCross BlueShield (Hard Copy Check Payments)

Identifier	Line of Business
HO	BlueCard
GA	Arkansas Blue Cross and Blue Shield commercial business
MA	Arkansas Blue Cross and Blue Shield Medicare Supplement (Medipak) business

*Includes scheduled adjustments for holiday and month-end processing.

BlueAdvantage Administrators of Arkansas

Identifier	Line of Business	Payment Schedule
US 01**	Cross & Shield branded self-funded groups	Weekly*
US US	USABLE Administrators (non-branded self-insured groups)	Weekly*
US CH	Arkansas Comprehensive Health Insurance Plan	Weekly*
US 55	USABLE Life Group Health	Weekly*
US WM	Walmart	Twice weekly

*Includes scheduled 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.

Note: The EFT codes for BlueAdvantage are the same as on hard copy check payments.

BlueAdvantage Administrators of Arkansas

Identifier	Line of Business	Payment Schedule
HA SI	Self-insured	Weekly*
HA AR	Arkansas State Employees and Public-School Employees	Weekly**
HA ST	Commercial	Weekly*

*Includes scheduled adjustments for holiday and month-end processing.

**Payments for Arkansas State Employees and Public-School Employees are released upon receipt of funding.

Note: The Health Advantage EFT codes are the same as on hard copy check payments.

Federal Employee Program (FEP)

FEP (EFT Payments)

Identifier	Line of Business
ES	FEP Standard Option
EB	FEP Basic Option
EF	FEP Blue Focus Option

FEP (Hard Copy Check Payments)

Identifier	Line of Business
FS	FEP Standard Option
FB	FEP Basic Option
FF	FEP Blue Focus Option



Member Financial Obligations

In most situations, Arkansas Blue Cross members will be responsible for part of a provider's bill for services; and, as the provider agreement with Arkansas Blue Cross outlines, providers will not waive these member financial responsibilities, (i.e., the member copayment, coinsurance and deductible) as specified in the member's health plan or contract.

Non-Covered Services

Members will generally be exclusively responsible for any non-covered services provided. As specified in the provider agreement, providers may not bill members for services that do not meet Primary Coverage Criteria (e.g., experimental/investigational), unless a member waiver is first obtained. See Provider Rights and Responsibilities for instructions on member waivers and the documentation required before billing members for such non-covered services.

Please note that except for applicable copayment, coinsurance or deductible, providers are **not** permitted to request or require payment in advance by any of Arkansas Blue Cross members or from anyone else as a condition of providing services to members.

Billing

Providers are **not** permitted to balance bill a member for amounts in excess of the Arkansas Blue Cross and Blue Shield allowance (member copayment, coinsurance and deductible are deemed part of the allowance for this purpose and should be billed to the member) for covered services. Providers are also responsible for any billing or collection service activities that they may engage, or to whom a provider may assign any accounts receivable or other claims against Arkansas Blue Cross members.

If Arkansas Blue Cross finds that a provider, billing service, collection agency, or other agent engaged by a provider has improperly attempted to bill any member or collect any amounts from members in violation of the provider agreement or the guidelines in this Provider Manual, providers are obligated to promptly take all necessary steps to halt any such activity, to ensure that it is not repeated, and to reimburse Arkansas Blue Cross and the member for any expenses or losses incurred in responding to or defending against the claims or collection actions of any such billing service, collection agency or other agent. Providers may also be excluded from the network for failure to adhere to the member "hold harmless" agreement.

Refunds

While all parties strive for accurate claim adjudication on the first pass, occasionally adjudication mistakes are detected that result in the need to adjust the amount paid. When the adjustment results in a reduction of the claim payment amount, Arkansas Blue Cross and Blue Shield sends the provider notice of any overpayments through a refund request letter as well as on the remittance advice (RA) in the section called "Adjustments." The notice contains patient and claim information including the patient account number for ease of tracking.

While Arkansas Blue Cross request refunds within 30 days from the date of the letter or RA, Arkansas Blue Cross prefers that providers allow recover of the overpayment from a future remittance if the provider agrees with the overpayment determination. This will take place after the 30-day period assuming the provider has claims payments to cover any, or all, of the overpaid amount. This requires less administrative work for the provider and Arkansas Blue Cross.

In order to close patient accounts more timely, providers may return the letter with a notation "Recoup Immediately," and Arkansas Blue Cross will initiate the recovery within approximately 10 days assuming the provider has claims payments to cover any, or all, of the overpaid amount. If the provider does not have claim payments sufficient to cover the overpayment during a 90-day period, Arkansas Blue Cross will send a follow-up requesting a check for the overpaid amount.

Please note that if Arkansas Blue Cross must offset to recoup duplicate or erroneous payments (overpayments) made to providers, providers are **not** allowed to pursue collection of such offset amounts from the members against whose claims such offsets are made.

Remittance Advice

A hardcopy Remittance Advice (R/A) will accompany the reimbursement check from Arkansas Blue Cross and Blue Shield for services rendered to our members. If a provider uses a billing service, please send copies of the Remittance Advice to the billing company.

Most of the column headings on the RA are self-explanatory. Those columns labeled “Service” code (type and place), “Remarks” code, and “Payment” code will contain a numerical character.

There are multiple ways to receive a remittance advice:

- Electronic Remittance Advice (ERA) - HIPAA ANSI 835 via Availity
- Viewing and printing a report via the Availity website (ANSI 835 type of report)
- Availity’s remit viewer
- Paper remittance advice

Examples of remittance advice:

- [Arkansas Blue Cross and Blue Shield](#)
- [Federal Employee Program \(FEP\)](#)

Reimbursement

Subject to Member Health Plan or Contract:

Provider reimbursement is subject to the terms of our member's applicable health plan or contract. This means that Arkansas Blue Cross and Blue Shield will pay for any services, supplies, drugs or equipment provided to our members only as provided in the member's health plan or contract.

If coverage is denied for any reason under the member health plan or contract, providers will not be entitled to reimbursement from Arkansas Blue Cross for any services to the member. For this reason, providers should be aware of the terms of the health plan or contract of Arkansas Blue Cross member.

Each member is issued a copy of their health plan or contract, so providers may request a member bring a copy to appointments. Providers may also request a copy of the member's health plan or contract from Arkansas Blue Cross. Providers may also obtain information regarding specific Arkansas Blue Cross Coverage Policies by accessing our web site at arkbluecross.com.



SECTION 6

Coding and Coding Edits

Billing Codes

Physician Responsibility in Selecting the Appropriate Billing Code for Medical Procedures

As additional medical techniques become available, it becomes more important for providers to ensure proper billing and coding of claims for such services.

Choose the Correct Code

When choosing new ways to bill a procedure or when incorporating medical innovations, providers are responsible for billing a procedure code whose name AND relative work under Resource Based Relative Value Scale matches the service performed. In addition, providers should not fragment services from global procedures (e.g., billing for closing the artery in addition to the cardiac catheterization), nor should physicians choose codes out of context from their CPT section. **It is the physician's responsibility to code correctly regardless of whether or how they utilize any manufacturer's or billing consultant's advice.**

Note: Arkansas Blue Cross relies on the proper coding to process provider claims and adjudicates the member's benefits. The codes providers select and enter on claims are representations to Arkansas Blue Cross that the member's treatment (and the provider's bill) was for the coded diagnosis, not others, and that the provider, in fact, performed the procedures as described in the American Medical Association Current Procedural Terminology (CPT) Manual or the Health Care Procedural Coding System Manual (HCPCS). Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider's network participation or other remedial action.

Coding strokes correctly

Stroke is an acute medical emergency that requires urgent attention and can only be accurately diagnosed by confirmation with a CT scan or MRI of the brain. Acute stroke codes (ICD-10 category I63.-) should only be used during the acute inpatient encounter and until discharge of that encounter. Therefore, a coder is unable to use the acute stroke codes (I63.-) in an office setting due to the nature of the event and the inability to accurately diagnosis in the office.¹

Once discharged from an acute-care facility, the patient now has a history of stroke (ICD-10 code Z86.73) and this code should be used after the initial stroke encounter. Z86.73 is a billable ICD-10 code used to specify a diagnosis of personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. (icd data). Any late effects should be documented and coded with ICD-10 category I69.-.

In the office setting, suspect conditions cannot be coded according to ICD-10 coding guidelines. As a result, an active stroke should not be coded in the office because it is still suspected and there has been no work-up on the patient to confirm the diagnosis.

Correct Complete Coding & Payer Policy Reminder

The need for correct and specific diagnosis and procedure coding has never been more important. It's not just a matter of ensuring claims contain a payable diagnosis, it now includes proving to our state and federal regulators that Arkansas needs additional funding to improve the state's health status.

¹ Yew, Kenneth and Cheng, Eric. Diagnosis of acute stroke. Am Fam Physician. 2015 Apr 15;91(8):528-536

Because Arkansas Blue Cross and Blue Shield and its family of companies are involved in state federal government programs, we must submit our claims data to regulators in order for them to gather health statistics. Coding your claims to the very most specific diagnosis codes is very important in this endeavor. Gone are the days of always using “unspecified” or “not otherwise specified coding.” In addition, the clinical documentation of these diagnoses within your medical records is also critical, as these regulators may choose your particular patient in an audit, thereby requiring our request and review of these medical records.

As a reminder, all of our provider network agreements indicate that facilities and providers agree “to accept and comply with the claims filing and coding policies or procedures established by the applicable payer for health plan claims.” Most of our policies have been placed in the online provider manual as well as this quarterly newsletter, Providers’ News.

Our agreements also state that facilities and providers agree “that all reimbursement is subject to all terms, conditions, limitations and exclusions of the member’s health plan, and to the application of a payer’s coverage policy and coding, billing and claims processing and appeals policies and procedures (Payer Policies and Procedures) as established by payers and as modified from time to time.” Our payer policies and procedures and claims filing and coding policies use various coding criteria and protocols including, but not limited to, the CPT Manual published by the American Medical Association, the National Correct Coding Initiative, Specialty Society guidelines and industry coding standards from the Centers for Medicare & Medicaid Services (CMS).

The agreements require that facilities and providers follow these noted industry coding standards.

Refer to the Current CPT Manual

The Current Procedural Terminology (CPT) manual is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The CPT Manual instructs providers to **“select the name of the procedure that most accurately identifies the service performed.”**

Refer to the Current HCPCS Manual

The Health Care Procedure Coding System (HCPCS) manual is designed to offer the basic information regarding coding and billing of medical services, supplies, and procedures using the HCPCS coding system. Do not submit claims using C, H, K, or T codes.

Note: The CPT and HCPCS manual are commonly used as standardized medical services classification and reporting systems. Arkansas Blue Cross relies on providers’ accurate use of these systems. However, neither these systems nor any associated manual or guidelines shall be interpreted to govern claims payment or require reimbursement for any code or related service. Coverage or non-coverage of all claims remains subject to the terms and conditions of each member’s health plan or policy.

Category III CPT Codes

Current Procedural Terminology (CPT), the official code book with rules and guidelines from the American Medical Association’s CPT editorial panel, includes a section of Category III CPT Codes. Category III codes are temporary codes created to identify emerging technology services and procedures.

Unlike unlisted or deleted codes, the Category III codes allow data collection for specific emerging technology services. If a Category III code is available, providers must use that code instead of an unlisted or deleted Category I code. The services or procedures represented by Category III codes may not have FDA approval, may

not be performed by many health care professionals across the country, and the service or procedure may not have proven clinical efficacy.

Claims filed for services using Category III codes will be denied unless the code is addressed as a covered service in an Arkansas Blue Cross Medical Coverage Policy.

CodeReview®

Arkansas Blue Cross and Blue Shield employs the latest in proven computer technology to process claims in a timely and efficient manner.

What is CodeReview®?

CodeReview® is a system that assists the claims processor in evaluating the accuracy of submitted CPT codes by using its clinical knowledge base to detect, correct and document coding inaccuracies on CPT- 4/HCPCS coded claims. It provides consistent and objective claim review by accurately applying coding criteria for the areas of: medicine, surgery, laboratory, pathology, radiology and anesthesiology.

CodeReview® is based upon the American Medical Association (AMA) CPT-4 guidelines. CodeReview® has achieved wide national acceptance among HMOs and other third-party payers. CodeReview® results in one of eight types of medically based recommendations to the claims processor:

1. Accept the code(s) as billed.
2. Consider changing the submitted code(s) to comply with generally accepted coding practices that are consistent with the CPT-4 Manual and the opinion of prominent physicians within the specialty. (Including addition of modifier 51 for multiple surgeries provided on the same date.)
3. To seek additional information from the physician's office because of inconsistent information in the claim.
4. Add a code(s).
5. Deny a code(s).
6. Revise a code(s) with a more correct code(s).
7. Exclude a code(s) from a claim.
8. Supersede a code(s) with a correct code(s).

CodeReview® assists the claims processor in evaluating the accuracy of the coding of the procedure(s), not the medical necessity of the procedure(s). Current coverage policies and contractual requirements will still apply. When a change is made to your submitted code(s), a medical explanation of the reason for the change will be provided. In a few instances where a change is made, it is usually because the CPT- 4 Manual indicates that one of the submitted codes should not be used separately when submitted with another code on the claim. This does not mean that the procedure/service was unnecessary; it means that according to generally accepted coding practice, the procedure/service is not coded separately under this circumstance.

Arkansas Blue Cross and Blue Shield believes CodeReview® will assist in processing claims more accurately and consistently. In addition, claims will be paid more quickly and efficiently.

Different Types of Edits and Logic CodeReview®:

There are several different types of edits and logic CodeReview® contains. Below are several examples. CodeReview® edits and logic includes:

Unbundling: When claims are submitted with a global procedure code along with multiple incidental procedures or codes that are an inherent part of performing the global procedure.

Fragmentation: Occurs when a claim includes all the incidental codes separately without listing the more global code. (Note: We do not pay separately for such fragmented charges when applicable CPT codes provide a global code that encompasses the “fragmented” charges.

Duplicate Procedures: CodeReview®’s knowledge base contains a list of valid procedures that are allowed more than once on the same date of service. Codes not contained on this list are excluded, or replacements are made.

Unlisted Procedure: CodeReview® always questions unlisted services (those codes generally ending in “99” because they are not specific enough to determine what service was actually performed. A description of the code will be requested from the provider through the Medical Review Request System.

Modifier Processing: Modifiers are added to the main procedure code to indicate that the services or procedures have been altered or are different in some way. CodeReview® processes all CPT-4 modifiers and a few HCPCS modifiers, as part of their modifiers edits. A modifier edit is a modifier check based on date of service and appropriateness. For the most part, the way you include modifiers will not change; it is consistent with both AMA and CMS guidelines. However, some may require submission in a different format. An example is modifier 50. CodeReview® is designed to accept bilateral procedures in the following format:

- Line 1 - CPT-4 code (primary or one site)
- Line 2 - CPT-4 code 50 (additional or a secondary site)

Age Edit: If a CPT-4 code is defined as age-specific, CodeReview® checks the date of birth or age (whichever is entered) to determine whether or not the appropriate codes are being used.

Gender Edit: CodeReview® checks gender for gender-specific CPT-4 codes to determine whether the code is appropriate.

Place of Service Edit: CodeReview® checks certain procedures to determine where they are performed.

Evaluation and Management Logic: These edits deal primarily with global procedures and E&M services performed as part of these global procedures. These edits follow the current Arkansas Blue Cross policies.

Clear Claim Connection™: [Clear Claim Connection™](#) is a disclosure tool that will enable providers to access the editing rules and clinical rationale existing in McKesson’s CodeReview® auditing product. Clear Claim Connection™ is designed to “mirror” how CodeReview® evaluates code combinations during claims processing. Through this capability the CodeReview® auditing rules, edit clarifications and associated clinical rationale are made available for Blue Cross, Health Advantage and BlueAdvantage Administrators claims.

Ancillary Code Editing – Claims Xten (CXT)

Arkansas Blue Cross and Blue Shield updated some of the editing with ClaimsXten in December 2018. As a part of this editing, an additional edit will be implemented for claims effective May 1, 2019.

The additional editing that will be implemented is for the ancillary services surrounding a non-covered service. Certain procedures are deemed to be non-covered based upon their medical and/or payment policies. When procedures related to those non-covered services are submitted, they should be denied as non-covered, as well.

This editing will look at the following five types of ancillary services: anesthesia, assistant surgeon, pre op testing, pathology or radiology. If no other payable major surgical service was performed on the same date of service, the ancillary services will also be denied.

Example: A provider submits procedure 15820 (Blepharoplasty), which is considered a non-covered procedure for Arkansas Blue Cross on 08/01/2019. The anesthesiologist bills procedure 00103 (Anesthesia for reconstructive procedures of eyelid ((i.e., blepharoplasty, ptosis surgery)). Due to the 15820 being a non-covered procedure, the 00103 procedure will also be denied.

- 15820 – Blephorplasty, lower eyelid;
- 00103 – Anesthesia for reconstructive procedures of eyelid (i.e., blepharoplasty, ptosis surgery)

Arkansas Blue Cross has always performed this type of review, and this edit will allow us to do so in a much more consistent and efficient way.

Medically Unlikely Edits (MUE's)

The National Correct Coding Initiative (NCCI) includes a set of edits known as Medically Unlikely Edits (MUE's). An MUE represents a maximum number of units-of-service that would be expected to be included in any specific CPT or HCPCS code, and therefore could be medically necessary.

The major purpose for the MUE's is to prevent incorrect payment resulting from erroneous unit entries on claims (for example, it is not rare to receive claims with the number 999 in the units field). The ClaimsXten (CXT) claims auditing software contains the MUE's, which do not require manually adding medically necessary units-of-service edits for each CPT/HCPCS code.

If more services are submitted than allowed for one date of service for a specific CPT or HCPCS code, the entire line item will be denied. For example, if a claim is for two appendectomies for the same member on the same day, that line item on the claim will be denied.

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.

National Drug Codes Required

Effective Oct. 1, 2020, Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage began requiring the National Drug Code (NDC) when billing for drugs. This requirement was already in place with the Blue Federal Employee program. We are seeing an increased amount of front-end rejections due to this requirement. Below are some ways to prevent common billing errors:

- Bill in the correct format (5-4-2 format per NDC guidelines).
- Don't add NDC to the line item on the claim for an office visit, administration code, lab or x-ray code.
- Bill for the appropriate HCPCS/NDC combination when available instead of a not otherwise specified (NOC) code.
- Don't bill with expired NDC/HCPCS combination, expired NDC code or expired HCPCS code.
- Make sure compounded drugs are covered by the member's plan. Most plans do not cover compounded drugs.

The edit will validate the correct NDC/procedure code/effective date combination and reject the claim if it is not a valid combination. If the line on the claim containing the NDC cannot be validated the entire claim will reject, and the provider must correct the error and resubmit the claim. See June 2020 Providers' News for more information.

Place of Service Codes

Place of Service (POS) codes are numeric codes on professional claims that identify where a service was rendered. A list of Place of Service codes is located in the Current Procedural Terminology (CPT) manual.

Place-of-service code for urgent care centers

This is a reminder that urgent care centers should use place-of-service code "20" for claims submission. Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage require all providers to use appropriate claims coding guidelines.

Transitional care management code amendment

The Transitional Care Management (TCM) codes (CPT codes 99495 and 99496) are intended to report management of a transition of a complex patient from one care setting to another, generally from an inpatient to outpatient status. The TCM codes are now reimbursable for any provider who meets the requirements as specified in the CPT manual, specifically including managing transition of the entire patient.

Please note, this service includes communication, medication management, reviewing the discharge records, interaction with other involved professionals, education, and assistance with scheduling follow-up with other providers and community services for all the patient's medical and psychosocial issues. This would generally fall in the purview of the patient's primary care provider.

The CPT code description states:

"The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact and continuous access."

The CPT code manual provides other important details regarding these codes, which includes both an office visit and contact with the patient outside of the office visit with time frames for the face-to-face visit and for initial contact after discharge. These codes are payable to only one provider per discharge and it are not payable to a surgeon during the global period following surgery. These TCM codes are subject to post-pay review.



SECTION 7

Provider Accessibility and Availability

Arkansas Blue Cross and Blue Shield is certified as a Qualified Health Plan (QHP), which is required to be a payer in the Affordable Care Act (ACA) metallic business (AR HOME and Exchange). As part of that QHP certification, we are accredited by URAC. Network adequacy of various specialties and provider types has always been a required measurement, but availability and accessibility are being added. It will be important for you to track how quickly patients are able to get in to see providers. We plan to capture measures in a new or recertifying provider/facility site visit or provider surveys that will ask about the maximum wait times for appointments with practitioners. Specifically, we will be required to report wait times for the following provider types:

- Primary care
- Specialty care
- Behavioral Health
- Hospitals
- Non-hospital inpatient facilities
- Outpatient facilities

Consolidated Appropriations Act (CAA) update

The Consolidated Appropriations Act (CAA) contains many requirements that have implications for health insurers, health plans, healthcare providers and consumers. We fully anticipate being able to meet our obligation to comply with any of the applicable effective dates of the law's provisions.

Arkansas Blue Cross is analyzing and relying on the legislation's text to guide our preliminary assessments, planning and compliance activities. We continue to closely monitor for additional regulations from the Department of Health & Human Services (HHS) related to the requirements put forth under the CAA so that we will be prepared to comply on the effective dates put out under the forthcoming rules' release(s).

Note: *While Arkansas Blue Cross and Blue Shield strives to be helpful, we do not provide legal or regulatory advice or services to third parties. If providers have questions about whether or how a law or regulation applies to them, they should consult with their own legal counsel. We can provide background information and offer our business perspective where we believe it would be helpful – but not legal, regulatory or compliance advice.*

We very much appreciate the quality care you provide to the people who count on us for their health coverage. As final rules and guidelines become available, we will be sharing more details about process changes that may affect you and that are required to implement the law's requirements.

As background, below are general explanations of some of the items included in the CAA that may impact healthcare providers in some way:

- **Price comparison tools** – This rule is similar to the 2020 Transparency Rule which applied to certain providers/facilities. The CAA requires group health plans and health insurance issuers to provide price comparison tools. It requires group health plans and health insurance issuers to maintain a "price comparison tool" available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider.

The Tool must be available for 500 covered items and services by **January 1, 2023**, and for all covered items and services by **January 1, 2024**.

To align the enforcement date of the CAA Price Comparison Tool with the enforcement date of the Transparency in Coverage Tool, enforcement of [the CAA price comparison tool] requirement was deferred until January 1, 2023.

Effective: January 1, 2023

- **Advance Explanation of Benefits (EOB)** – CAA requires group health plans and health insurance issuers to provide an advance explanation of benefits (EOB) for scheduled services. Requires individual and group health plans to provide a detailed estimate prior to services that are scheduled at least three days in advance. **Estimates will be based on mandated notice from providers** or members and must be created in three business days or less.
 - **Effective for providers and facilities:** Enforcement of the Advanced EOB requirement has been deferred, pending a rule-making process.
- **Surprise billing** – CAA establishes requirements to protect patients from surprise medical bills received from out-of-network hospitals, free-standing emergency facilities, out-of-network providers at in-network facilities, and out-of-network air ambulance carriers. Provides for patients to be responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain nonemergency situations in which patients do not have the ability to choose an in-network provider. This does not apply where the member chooses to receive services from an out-of-network provider.
 - **Out-of-network providers and facilities who have provided emergency services or out-of-network providers offering services in an in-network facility** where the member would not have the opportunity to know in advance that services would be provided by an out-of-network provider will have requirements to provide notice and receive consent to allow for balance billing.

Providers and facilities are encouraged to work with their legal representatives to ensure that they will be in compliance with this new law and its requirements.

Effective for plan years: beginning on or after January 1, 2022

- **Air ambulance** – As a part of the Surprise Billing protections, members who unknowingly receive services from out-of-network (OON) air ambulance providers are protected from out-of-network (OON) cost-sharing and balance billing.
 - Contains requirements for air ambulance providers and plans to both report and submit to the Tri-Agencies several metrics on air ambulance services within 90 days of the end of a plan year.

Effective for plan years: starting January 1, 2022

- **Provider directories** – CAA impacts:
 - **Requires providers to update directory information** and provide refunds to enrollees if OON costs are inappropriately applied (in certain circumstances).

- To ensure accurate provider directory information, the CAA requires group health plans and issuers offering group and individual health plans to establish a verification process to confirm directory information at least every 90 days.

Accordingly, it is very important that healthcare providers respond in a timely manner to inquiries about their provider information. This includes attesting to the information's accuracy to avoid possible network termination from our provider networks due to noncompliance with the requirements of the law.

Provider Data Management implementation –Per the Consolidated Appropriations Act (CAA), all providers **MUST** attest to their information every 90 days. CAA is very serious about the accuracy and timely updates of provider data. If providers do not attest to the accuracy of their data every 90 days, the CAA recommends that payers remove these providers from paper and on-line directories. If providers continue to be noncompliant, more severe action can be taken, such as termination from the provider networks.

Effective for plan years: starting January 1, 2022

- **Mental health parity** – CAA requires group health plans and health insurance issuers offering individual or group coverage to perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTL) when applicable to mental health/substance use disorder benefits.

Effective: February 10, 2021

- **Changes to ID Cards** – Requires group and individual health plans to identify on insurance cards the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum, and a phone number and website address for consumer assistance information.

Effective: Compliance enforcement deferred to January 1, 2023.

- **Continuity of care provisions** – The CAA contains provisions on continuity of care. For plan years **beginning January 1, 2022**, or thereafter, health plans are required to facilitate continuity of care for covered members who have qualifying conditions.

An individual is considered a continuing care patient if they are:

- Undergoing a course of treatment for a serious and complex condition that is life-threatening, potentially disabling or congenital and requires specialized medical treatment to avoid death or permanent harm.
- Undergoing a course of institutional or inpatient care.
- Scheduled to undergo nonelective surgery (including postoperative care).
- Pregnant and undergoing a course of treatment related to the pregnancy.
- Terminally ill and receiving treatment for that illness.

Health plans are required to:

- Notify members in writing of any significant changes in the availability or location of covered services, provider terminations, cessation of services or any other significant changes.
- Allow members to notify the health plan or issuer of their need for transitional care.
- Allow members to elect to continue to receive care from the originating provider (under the same terms and conditions that would have applied had the termination not occurred) for the previously covered services for up to 90 days.

Effective for plan years: starting January 1, 2022



SECTION 8

Coverage Policies & Procedures

Coverage Policy

(Specific to Discrete Procedures or Technologies)

The medical director of Arkansas Blue Cross and Blue Shield has established specific coverage policies addressing certain medical procedures or technologies.

The purpose of a Coverage Policy is to inform members and their physicians why certain medical procedures may or may not be covered under Arkansas Blue Cross and Blue Shield health plans. In addition to these specific Coverage Policies, all Arkansas Blue Cross and Blue Shield health plans or contracts also include more generally applicable coverage standards known as the Primary Coverage Criteria. The Primary Coverage Criteria apply to **ALL** benefits members may claim under their plan, no matter what types of health intervention may be involved or when or where members obtain the intervention. For more specifics on Primary Coverage Criteria, click on the Primary Coverage Criteria link below.

Search for a Policy

You can search by keyword, title, coverage policy number or procedure code at secure.arkansasbluecross.com/providers/coverage_policy.aspx.

What You Will See

When you select a policy, you will see its title, category and effective date at the top of the page. A description of the treatment and the actual policy, which explains what is covered, follows. At the bottom of the page, you will see related CPT codes and references.

Additional Information

What Is a Coverage Policy?

Coverage Policy means a statement developed by Arkansas Blue Cross and Blue Shield that sets forth the medical criteria for coverage under an Arkansas Blue Cross Evidence of Coverage. Some limitations of benefits related to coverage, drug, treatment, service equipment or supply are also outlined in the Coverage Policy.

The existence of an affirmative Coverage Policy does not certify coverage, nor does it override or replace specific coverage language listed in an individual policy or group health plan. While a procedure, technology or drug may be medically necessary, it still may be specifically excluded under the terms of a member's contract or benefit plan, or the use may be an investigational or experimental use of the service and therefore excluded under the experimental or investigational language of the member's benefit contract or plan.

The absence of a specific coverage policy does not indicate that a service is covered. For example, a new device or a new use of an old device may not have been proven safe and effective, but coverage may also have not been previously requested, thereby providing us an opportunity to study the information on the safety and effectiveness of the new use of the device.

A copy of a specific Coverage Policy is available from Arkansas Blue Cross and Blue Shield upon request at no cost, or a Coverage Policy can be reviewed on the Arkansas Blue Cross and Blue Shield website at arkansasbluecross.com.

How are Coverage Decisions Made?

The Arkansas Blue Cross and Blue Shield medical directors, including the regional medical directors, review each Coverage Policy before the policies are implemented. Input is requested from local physicians on each new Coverage Policy. Each existing coverage policy is reviewed for accuracy every two years if the policy restricts coverage of a service, procedure, device or drug.

The following sources of information are consulted for the development of Coverage Policies regarding new or emerging treatments, procedures, devices or drugs:

- Member's Benefit Certificate or Summary Plan Description: Is the service, procedure, device or drug specifically excluded?
- FDA Status: Does the service, device or drug require FDA approval?
- Assessment of the effectiveness and safety published by:
 - Agency for Healthcare Research and Quality
 - American Hospital Formulary Service and/or United States Pharmacopoeia Drug Information (USP DI®) Compendia: Has the drug been recommended for off-label use?
 - Blue Cross and Blue Shield Association Technology Evaluation Center
 - Cochrane Library of Systematic Reviews
 - Formal technology assessment committees of national medical societies
 - Hayes, Inc. Technology Assessment
 - National Institutes of Health (NIH)
- Results of Phase III clinical trials as published in peer-reviewed, mainstream medical journals
- Position papers of major medical organizations
- Consultation with national medical experts

A similar process is followed for additional new uses of established procedures, devices or drugs to establish Coverage Policies.

What is a CPT Code?

Current Procedural Terminology (CPT) is a five-digit code for reporting of treatment and diagnostic services performed by physicians. CPT is protected by copyright and trademark owned by the American Medical Association (AMA). Physicians use CPT codes in billing for their services.

What is primary coverage criteria?

The Primary Coverage Criteria apply to all benefits you may claim under your Plan, no matter what types of health intervention may be involved or when or where you obtain the intervention. Health Intervention or Intervention means an item or service delivered or undertaken primarily to:

- Diagnose, detect, treat, palliate or alleviate a medical condition; or
- Maintain or restore functional ability of the mind or body.

Purpose and Effect of Primary Coverage Criteria

The Primary Coverage Criteria are designed to allow Plan benefits for only those health interventions that are proven as safe and effective treatment. Members will receive an Explanation of Benefit (EOB), and Providers

will receive an Explanation of Payment (EOP) with claims processing remarks that indicate that a claim was not eligible for benefits since the Primary Coverage Criteria was not met.

Another goal of the Primary Coverage Criteria is to provide benefits only for the less invasive or less risky intervention when such intervention would safely and effectively treat the medical condition or to provide benefits for treatment in an outpatient, doctor's office or home-care setting when such treatment would be a safe and effective alternative to hospitalization. Examples of the types of health interventions that the Primary Coverage Criteria exclude from coverage include such things as the cost of a hospitalization for a minor cold or some other condition that could be treated outside the hospital or the cost of some investigational drug or treatment, such as herbal therapy or some forms of high-dose chemotherapy not shown to have any beneficial or curative effect on a particular cancerous condition.

Finally, the Primary Coverage Criteria require that if there are two or more effective alternative health interventions, the member's health plan or policy should limit its payment to the Allowable Charge for the most cost-effective intervention.

Regardless of anything else in a member's health plan or policy, and regardless of any other communications or materials received in connection with a member's health plan or policy, the member will not have coverage for any service, prescription drug, treatment, procedure, equipment, supplies or associated costs unless the Primary Coverage Criteria set forth are met. At the same time, just because the Primary Coverage Criteria are met does not necessarily mean the treatment or services will be covered under a member's health plan or policy. For example, a health intervention that meets the Primary Coverage Criteria will be excluded if the condition being treated is a Pre-Existing Condition excluded by the member's health plan or policy.

Elements of the Primary Coverage Criteria

To be covered, medical services, drugs, treatments, procedures, tests, equipment or supplies (interventions) must be recommended by the member's treating physician and meet all of the following requirements:

1. The intervention must be a health intervention intended to treat a medical condition. A health intervention is an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body. A medical condition means a disease, illness, injury, pregnancy or a biological or psychological condition.
2. The intervention must be proven to be effective (as defined below) in treating, diagnosing, detecting or palliating a medical condition.
3. The intervention must be the most appropriate supply or level of service, considering potential benefits and harms to the patient. The following three examples illustrate application of this standard (but are not intended to limit the scope of the standard):
 - a. An intervention is not appropriate, for purposes of the Primary Coverage Criteria, if it would expose the patient to more invasive procedures or greater risks when less invasive procedures or less risky interventions would be safe and effective to diagnose, detect, treat or palliate a medical condition;
 - b. An intervention is not appropriate, under the Primary Coverage Criteria, if it involves hospitalization or other intensive treatment settings when the intervention could be administered safely and effectively in an outpatient or other less intensive setting, such as the home; and
 - c. Maintenance Therapy is another example of this standard because under the Primary Coverage Criteria, chiropractor services or other physical therapy, speech or occupational therapy, are not considered

appropriate for purposes of coverage if the frequency or duration of therapy reaches a point of maintenance where the patient remains at the same functional level and further therapy would not improve functional capacity or ambulation.

4. The Primary Coverage Criteria allows the member's health plan or policy to limit its coverage to payment of the Allowable Charge for the most cost-effective intervention. Cost-effective means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention. For example, if the benefits and risks to the patient of two alternative interventions are comparably equal, a health intervention costing \$1,000 will be more cost-effective than a health intervention costing \$10,000. Cost-effective shall not necessarily mean the lowest price.

Primary Coverage Criteria Definitions

1. Effective defined.

- a. An existing intervention (one that is commonly recognized as accepted or standard treatment or which has gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed effective for purposes of the Primary Coverage Criteria if the intervention is found to achieve its intended purpose and to cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. This determination will be based on consideration of the following factors, in descending order of priority and weight:
 - i. Scientific evidence, as defined below (where available); or
 - ii. If scientific evidence is not available, expert opinion(s) (whether published or furnished by private letter or report) of an Independent Medical Reviewer(s) with education, training and experience in the relevant medical field or subject area; or
 - iii. If scientific evidence is not available, and if expert opinion is either unavailable for some reason or is substantially equally divided, professional standards, as defined and qualified below, may be consulted; or
 - iv. If neither scientific evidence, expert opinion nor professional standards show that an existing intervention will achieve its intended purpose to cure, alleviate or enable diagnosis or detection of a medical condition, then Arkansas Blue Cross and Blue Shield in its discretion may find that such existing intervention is not effective and on that basis fails to meet the Primary Coverage Criteria.
- b. A new intervention (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed effective for purposes of the Primary Coverage Criteria if there is scientific evidence (as defined below) showing that the intervention will achieve its intended purpose and will cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits.

Scientific evidence is deemed to exist to show that a new intervention is not effective if the procedure is the subject of an ongoing phase I, II or III trial or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with a standard means of treatment or diagnosis. If there is a lack of scientific evidence regarding a new intervention, or if the available scientific evidence is in conflict or the subject of continuing debate, the new intervention shall be deemed not effective, and therefore not covered in accordance with the Primary Coverage Criteria, with one

exception, if there is a new intervention for which clinical trials have not been conducted because the disease in issue is rare or new or affects only a remote population, then the intervention may be deemed effective if, but only if, it meets the definition of effective as defined above.

2. Scientific Evidence Defined. Scientific Evidence, for purposes of the Primary Coverage Criteria, shall mean only one or more of the following listed sources of relevant clinical information and evaluation:

a. Results of randomized controlled clinical trials as published in the authoritative medical and scientific literature that directly demonstrate a statistically significant positive effect of an intervention on a medical condition. For purposes of this Definition A, authoritative medical and scientific literature shall be such publications as are recognized by Arkansas Blue Cross and Blue Shield, listed in its Coverage Policy, or otherwise listed as authoritative medical and scientific literature on the Arkansas Blue Cross and Blue Shield website at arkbluecross.com.

or

b. Published reports of independent technology or pharmaceutical assessment organizations recognized as authoritative by Arkansas Blue Cross and Blue Shield. For purposes of this Definition B, an independent technology or pharmaceutical assessment organization shall be considered authoritative if it is recognized by Arkansas Blue Cross and Blue Shield, listed in its Coverage Policy, or otherwise listed as authoritative medical and scientific literature on the Arkansas Blue Cross and Blue Shield website at arkbluecross.com.

3. Professional Standards Defined. Professional standards, for purposes of applying the effectiveness standard of the Primary Coverage Criteria to an existing intervention, shall mean only the published clinical standards, published guidelines or published assessments of professional accreditation or certification organizations or of such accredited national professional associations as are recognized by the Arkansas Blue Cross and Blue Shield Medical Director as speaking authoritatively on behalf of the licensed medical professionals participating in or represented by the associations.

Arkansas Blue Cross and Blue Shield shall have full discretion whether to accept or reject the statements of any professional association or professional accreditation or certification organization as professional standards for purposes of this Primary Coverage Criteria. No such statements shall be regarded as eligible to be classified as professional standards under the Primary Coverage Criteria unless such statements specifically address effectiveness of the intervention and conclude with substantial supporting evidence that the intervention is safe, its benefits outweigh potential risks to the patient, and it is more likely than not to achieve its intended purpose and to cure, alleviate or enable diagnosis, or detection of a medical condition.

Application and Appeal of Primary Coverage Criteria

1. The following rules apply to any application of the Primary Coverage Criteria. Arkansas Blue Cross and Blue Shield shall have full discretion in applying the Primary Coverage Criteria, and in interpreting any of its terms or phrases, or the manner in which it shall apply to a given intervention. No intervention shall be deemed to meet the Primary Coverage Criteria unless the intervention qualifies under all of the following rules:

a. **Illegality:** An intervention does not meet the Primary Coverage Criteria if it is illegal to administer or receive it under federal laws or regulations or the law or regulations of the state where administered.

b. **FDA Position:** An intervention does not meet the Primary Coverage Criteria if it involves any device or drug that requires approval of the U.S. Food and Drug Administration (FDA), and FDA approval for

marketing of the drug or device for a particular medical condition has not been issued prior to the date of service. In addition, an intervention does not meet the Primary Coverage Criteria if the FDA or the U.S. Department of Health and Human Services or any agency or division thereof, through published reports or statements, or through official announcements or press releases issued by authorized spokespersons, have concluded that the intervention or a means or method of administering it is unsafe, unethical or contrary to federal laws or regulations. Neither FDA Pre-Market Approval nor FDA finding of substantial equivalency under 510(k) automatically guarantees coverage of a drug or device.

- c. **Proper License:** An intervention does not meet the Primary Coverage Criteria if the health-care professional or facility administering it does not hold the proper license, permit, accreditation or other regulatory approval required under applicable laws or regulations in order to administer the intervention.
 - d. **Plan Exclusions, Limitations or Eligibility Standards:** Even if an intervention otherwise meets the Primary Coverage Criteria, it is not covered under the member's health plan or policy if the intervention is subject to a Plan exclusion or limitation, or if a member fails to meet eligibility requirements.
 - e. **Position Statements of Professional Organizations:** Regardless of whether an intervention meets some of the other requirements of the Primary Coverage Criteria, the intervention shall not be covered if any national professional association, any accrediting or certification organization, any widely used medical compendium, or published guidelines of any national or international workgroup of scientific or medical experts have classified such intervention or its means or method of administration as experimental or investigational or as questionable or of unknown benefit. However, an intervention that fails to meet other requirements of the Primary Coverage Criteria shall not be covered, even if any of the foregoing organizations or groups classify the intervention as not experimental or not investigational, or conclude that it is beneficial or no longer subject to question. For purposes of this Definition E, national professional association or accrediting or certifying organization, or national or international workgroup of scientific or medical experts shall be such organizations or groups recognized by Arkansas Blue Cross and Blue Shield, listed in its Coverage Policy, or otherwise listed as authoritative medical and scientific literature on the Arkansas Blue Cross and Blue Shield website at arkbluecross.com.
 - f. **Coverage Policy:** With respect to certain drugs, treatments, services, tests, equipment or supplies, Arkansas Blue Cross and Blue Shield has developed specific Coverage Policies, which have been put into writing, and are published on the website at arkbluecross.com. If Arkansas Blue Cross and Blue Shield has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that a member received or seeks to have covered, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria.
2. Members may appeal a determination by Arkansas Blue Cross and Blue Shield that an intervention does not meet the Primary Coverage Criteria to the Appeals Coordinator using the procedures for appeals outlined in the member's policy or certificate.

Important Notice for Members: For any health intervention, there are six general coverage criteria must be met in order for that intervention to qualify for coverage under a member's health plan or policy:

1. The Primary Coverage Criteria must be met.
2. The health intervention must conform to specific limitations stated in the member's health plan or policy.

3. The health intervention must not be specifically excluded under the terms of the member's health plan or policy.
4. At the time of the intervention, the member must meet eligibility standards.
5. The member must comply with the applicable provider network and cost-sharing arrangements.
6. The member must follow the required procedures for filing claims.



SECTION 9

COVID-19

The federally declared public health emergency (PHE) related to the COVID-19 pandemic ended **May 11, 2023**. This resulted in changes in coverage and cost-sharing requirements for members of Arkansas Blue Cross and Blue Shield's and Health Advantage's fully insured health plans, as described below.

Please note: Coverage and cost-sharing changes for members of self-funded health plans administered by BlueAdvantage Administrators of Arkansas or Health Advantage are determined by the employers or plan sponsors who fund those self-funded plans. If you have questions about coverage for such plans, please call the number on the back of the health plan member ID card.

Member cost-sharing for COVID-19-related services

On **May 11, 2023**, federal mandates for coverage (without member cost-sharing) of certain healthcare services ended. Affected services rendered **May 12, 2023**, and thereafter will be subject to **member cost-sharing requirements of the member's plan** (copays/deductibles/coinsurance, etc.).

This resumption of member cost-sharing requirements for covered services **includes**:

- **Clinical encounters associated with COVID-19**, including:
 - Office visits.
 - Urgent care clinic visits.
 - Emergency department visits.
 - Telemedicine visits.
 - Lab evaluations performed in conjunction with any of the above-listed types of clinical encounters.
- **Diagnostic lab testing for COVID-19 performed in a medical setting** – including eligible specimen collection.
- **Pharmacy-based diagnostic lab testing for COVID-19 performed by pharmacists** – including eligible specimen collection.
- **All U.S. Food and Drug Administration-approved therapeutic agents used to treat COVID-19** – e.g., Veklury.

This resumption of member cost-sharing requirements **will not include** (meaning that members will not be subject to cost-sharing):

- **The cost of COVID-19 vaccines** that have been approved by the Centers for Disease Control & Prevention (CDC) Advisory Committee on Immunization Practices (ACIP).
- **Charges for administration of ACIP-approved COVID-19 vaccines** – which are covered as preventive services and therefore do not require cost-sharing for most members.

Coverage for at-home COVID-19 test kits

Coverage for such tests ended May 11, 2023.

Specimen collection codes

Healthcare Common Procedure Coding System (HCPCS) specimen collection codes **G2023** and **G2024** are no longer covered after May 11, 2023, and claims containing those codes will be denied.

Monoclonal antibodies

There currently are **no monoclonal antibody treatments approved** for COVID-19. Accordingly, any related services rendered May 12, 2023, and thereafter **will not be covered**.

High-throughput testing

The following HCPCS codes are no longer covered after May 11, 2023, for **any provider at any place of service**:

- U0003
- U0004
- U0005

Out-of-network COVID-19 testing

After May 11, 2023, there is **no coverage** for COVID-19 tests performed by entities that are not contracted participants in our health plans' provider networks. Fee schedule pricing will be applied to **covered** lab codes only.

Prior authorization/medical management

Laboratory services for which prior authorization requirements were suspended due to the public health emergency **are** subject to such prior authorization requirements beginning May 12, 2023.



SECTION 10

Health Insurance Marketplace Exchange

What is the Health Insurance Marketplace?

The [Health Insurance Marketplace](#) is a website designed to determine if a person is eligible for financial help to cover their health insurance costs. Some Americans will be eligible for a \$0 premium plan or a new kind of tax credit that lowers their monthly premiums. It also helps people shop for and purchase health insurance. People also may contact the Health Insurance Marketplace by telephone.

A Health Insurance Marketplace is set up in each state, either by the state itself, by the federal government, or in Arkansas' case, in partnership with the federal government. Each marketplace will be responsible for:

- Creating and maintaining a consumer shopping website.
- Providing access to all information necessary to determine if those applying are eligible for help paying for their premium or if they qualify for free coverage.
- Helping consumers shop for and purchase health plans.
- Making sure all health plans offered on the marketplace meet all the new regulations.

The Health Insurance Marketplace opens annually from November 1–January 15 for people to purchase coverage with an effective date of January 1 for the following year.

Many people are eligible to receive advance premium tax credits (subsidies) if they purchase a health plan through the marketplace. An advance premium tax credit is a new tax credit that can lower monthly premium costs beginning the effective date of the policy.

The amount of the advance premium tax credit that each household will receive is calculated by using their income, the size of their family and other factors. This new tax credit helps lower- and middle- income families. Some households, based on their income, will receive additional financial assistance when they receive medical care, known as cost-sharing reductions.

Affordable Care Act redefines out-of-pocket cost for health plan members

Health plan members—whether belonging to a PPO, HMO, or traditional comprehensive major medical plan—are familiar with cost sharing requirements in the form of copayments, coinsurance, and deductibles. Once a policyholder meets his/her deductible, a coinsurance amount is paid until an annual out-of-pocket maximum is reached.

Although no more financial obligation is required by the policyholder for major services, traditionally, cost sharing in the way of copayments still was expected for services rendered at a clinic or other health care facility, and pharmacy copayments for medications were required each time a prescription was filled. As of 2014, all new non-grandfathered individual and group health plans were required to have a single out-of-pocket maximum that applies to all in-network, covered medical services, including prescription drugs. This amount excludes premium cost. This is called the True Out-Of-Pocket (TrOOP) maximum.

The intent of this rule is that once the out-of-pocket maximum has been met, the member is not responsible for additional out-of-pocket cost sharing for in-network covered medical services for the remainder of the plan year.

Out-of-pocket maximums

The Affordable Care Act established a maximum annual out-of-pocket amount, which may be paid for in-network essential benefits covered under a plan with anticipated increases for inflation. Once a maximum is reached in a given plan year, any additional costs incurred for in-network essential benefits covered by the plan will be covered at 100% for the balance of the plan year. Remember that Availity maintains the current status of member's out-of-pocket expenses.

Enrollment update for Federal Health Insurance Marketplace and ARHOME

Please be advised that eligibility information for the federal Marketplace and state ARHOME membership processing, include mailing ID cards to the members at the address provided by either the ARHOME system or the federal exchange system and Availity, is kept current and up to date.

Due to the many challenges in the enrollment through the federal Health Insurance Marketplace, Arkansas Blue Cross and Blue Shield continues to receive enrollments that should have been transmitted earlier. Federal exchange member's coverage is not activated until their first premium payment is received and processed by Arkansas Blue Cross.

Arkansas Blue Cross expects high call volumes each year from October 1 through January 31 of the following year during open enrollment period of November 1–January 15. Additional staff is scheduled in our service support area; however, for eligibility inquiries, providers are strongly encouraged to use Availity or My BlueLine. Providers who are unable to locate a patient's information on Availity or My BlueLine should try the following:

ARHOME

If the member is not found on Availity or My BlueLine but has presented a letter of eligibility from Medicaid, please check the Medicaid eligibility system. If the patient is on the Medicaid eligibility system, their coverage has started with Medicaid and their coverage with Arkansas Blue Cross has not started and has not been sent to eligibility files from the ARHOME system for the patient. If the patient cannot be identified in the Medicaid eligibility system and the patient states they have enrolled with Medicaid, providers may want to contact their local Medicaid/DHS office for information.

If the patient's coverage with Arkansas Blue Cross has not yet started, they may be covered under traditional Medicaid. Providers should use the patient's Medicaid number for medical services and also advise the patient to use his or her Medicaid number for the pharmacy and the pharmacies will handle their prescriptions.

Note: The ARHOME system enrolls members by an auto assignment process if the member does not select a health plan. The member then has 30 days to decide to enroll in the health plan assigned or select another health plan. During these 30 days, Arkansas Blue Cross does not have information from the ARHOME. Arkansas Blue Cross does not receive the member's information until after the 30 days.

Federal exchange

If the patient cannot be located on Availity or My BlueLine and the patient indicates they enrolled in the federal exchange (healthcare.gov), please be advised that there is a delay of a day or two from the federal enrollment and the transmission to Arkansas Blue Cross.

Arkansas Blue Cross continues to receive changes from the federal exchange adjusting the original effective dates of the enrollments. These are transmitted to Arkansas Blue Cross in a separate transaction which requires a manual process and may take several days to complete.

If the patient cannot be located on Availity or My BlueLine and the patient indicates they enrolled in the federal exchange, please have the patient contact the federal exchange.

Essential health benefits at the core of new health plans on the Health Insurance Marketplace

Standardizing Health Plans

Consumers have long complained that choosing a health insurance plan is complicated. They have difficulty comparing what medical services are covered by each health plan under consideration. In addition, it is difficult for consumers to compare which plan offers the best financial value.

It is easy to compare monthly premiums from one plan to the next, but more difficult to figure out what total out-of-pocket costs might be when considering deductibles, copayments, and coinsurance maximums.

To make this process easier for employers and consumers, the Affordable Care Act specifies the medical services that must be covered by health plans.

Standardizing Covered Medical Services

Non-grandfathered health plans must cover a core set of benefits called “Essential Health Benefits.” This core set of benefits includes services in the following ten categories:

- Outpatient care
- Emergency services
- Hospitalization
- Mental health and substance abuse treatments
- Prescription drugs
- Rehabilitative and “habilitative” services and devices
- Laboratory services
- Preventive and wellness services
- Pediatric dental* and vision care
- Maternity and newborn care

These services are offered in every plan with no annual or lifetime dollar limits.

Preventive care and many women’s preventive services are offered with no member cost sharing as required by law. In other words, services like colonoscopy and contraceptives are provided at no charge.

These new health care rules became effective January 1, 2014, for all new fully insured individual and small group health plans sold, and for non-grandfathered plans at the first renewal date on or after January 1, 2019.

However, grandfathered, and self-insured health plans are exempt. Large group plans (groups with more than 50 employees) are required to meet the cost-sharing limits and the benefit levels but are not required to provide the full scope of benefits in the essential benefits package.

While the Affordable Care Act requires coverage for each of these categories, the law does not define the specific services that must be covered or the amount, duration, or scope of services. The Health & Human

Services secretary defines the specific benefits within each of these categories and updates the definition over time to address gaps or respond to changing medical practices in the future.

In defining the essential benefits package, the Health & Human Services secretary must decide not only which health services to include, but also how much discretion to leave to insurers in coverage decisions. For example, if the secretary determines that physical therapy to treat lower back pain is a covered benefit, she could determine the minimum number of physical therapy sessions that must be covered to treat the condition, or she could leave that to the discretion of the insurers.

*Pediatric Dental is not included in our Metallic Plan since there are stand-alone pediatric dental plans available.

Frequently Asked Questions

Are the Health Insurance Marketplace members' eligibility and benefits on Availity?

Yes, eligibility, benefit, and claims status information along with the status of applicable deductible and out-of-pocket accumulators are provided on Availity. Please note, to avoid delays when calling to check new members' eligibility, which could occur due to the high volume of new enrollments, we encourage that all providers use Availity for eligibility, benefits and claims status and limit calls to our provider lines for claims processing questions. If you have any questions regarding Availity, providers may contact Availity Client Services at **800-282-4548**.

Are members required to have a PCP and do members need a referral to see a specialist?

Exchange members are encouraged to select a PCP and referrals are not required to see a specialist. Members should use True Blue PPO providers for all services. If services are provided by an out-of-network provider, the result will be higher out-of-pocket costs to the member.

Do providers have to see ARHOME patients?

Providers who currently have restricted their practices to "current patients only" and are not accepting any new patients do not have to accept Health Insurance Marketplace members. If a practice is open, it's open to all patients. This would include all Health Insurance Marketplace and ARHOME members. Providers do have the option to "opt out" of the network.

Where do providers file claims for Blue Cross?

ALL claims should be filed to Arkansas Blue Cross as you do today for BlueCard claims. Please note that members with member ID card prefixes EXX, AXC, GXH, SXA do not have BlueCard benefits with providers outside the state of Arkansas, unless the provider is in a contiguous county and is directly contracted with ABCBS through the TB network. If a service is not available from a participating True Blue PPO provider in Arkansas or its contracted providers in contiguous counties, a network exception may be requested. An approved network exception will serve as a prior approval for services needed outside the coverage area. This does not apply if the service is an emergency.

If an eligible member has elected to receive an advanced premium tax credit (APTC) but fails to pay their portion of the total premium, will Arkansas Blue Cross request a refund on any claims paid during the special three- month grace period?

On the Health Insurance Marketplace, members who receive a federal subsidy (an advanced premium tax credit) that does not cover the full amount of the premium are allowed a three-month grace period beginning on the

premium statement due date missed. Note: The grace period is applicable after the member has paid their first premium payment and therefore effectuated their coverage. The three-month grace period is defined as a period of three consecutive months, not a rolling period.

Arkansas Blue Cross will pay claims for the first month in which the member is delinquent and will not request refunds on claims. If the member's portion of the premium is not paid for month two or three, the member will be considered uninsured. After the first month, the provider will be notified of the member's delinquent status via a message stating "Grace Period" on Availity. Providers should continue to file claims during this time.

Arkansas Blue Cross will suspend claims for months two and three pending the receipt of the member's payment. Providers will not receive a remittance advice for suspended claims but will be able to see on Availity suspended claim status code 766 "Services were performed during a Health Insurance Exchange (HIX) premium payment grace period."

Providers should collect payments from members per their usual office policy during the member's grace period. It is very important that providers verify coverage on Availity prior to providing services to these members.

Once the member pays the past due premium, the provider's claims will be released for payment and any portions that were collected up front from the member should be refunded to them, minus any applicable copayment, coinsurance or deductible.

If the member fails to pay their premium within the grace period, after the third month the suspended claims will be denied, and the member no longer will be considered covered by Arkansas Blue Cross. Please remember, Arkansas Blue Cross will not request a refund for claims paid to the provider during the first month of delinquency for non- payment of premium for the special three-month grace period. The grace period does not apply to ARHOME members, as there is no member portion of premium.

Can our clearinghouse tell us through auto eligibility if a member is in grace period?

Eligibility transactions (270) submitted via your clearinghouse or on the Availity portal will return a (271) response that the member is in their "grace period" when applicable. Providers will need to check with their clearinghouse to see how the information will be displayed.

Note: ARHOME members are not subject to the grace period provisions.

What are the services that need prior approval?

The following Metallic Plan benefits require a prior approval:

- Hospital services in connection with dental treatment
- Inpatient medical admissions including, but not limited to, medical and surgical admissions (scheduled and elective)
- Advanced diagnostic imaging services. (CT/PET scans, Nuclear Cardiology, MRI/MRA).
- Allowable charges for in vitro fertilization and infertility
- Autism spectrum disorder benefits
- Behavioral health admissions and services. (Partial hospitalization, intensive outpatient services, residential treatment and rTMS)

- Durable medical equipment with costs greater than \$500
- Implantable Osseo-integrated hearing aids / cochlear implants
- Prosthetic devices with costs greater than \$5,000
- Reduction mammoplasty
- Certain drugs (pharmacy)
- All transplants other than kidney and cornea
- Neurologic rehabilitation facility services
- Pediatric vision services, vision therapy, developmental testing. Only refers to eye prosthesis
- Enteral feedings
- Gastric pacemaker
- Medical disorder requiring specialized nutrients or formulas
- “Off label” use of medication
- Skilled nursing facility (SNF)
- Hospice/Home health
- Cognitive rehab
- Outpatient services – pain management only
- Hyperbaric therapy
- Wound vac
- Long term acute care (LTAC) excluding LTAC inpatient rehabilitation
- Inpatient mental health
- LVAD – heart mate
- Craniofacial anomaly
- Rehabilitation and habilitation services on occupational therapy, physical therapy, speech therapy, and chiropractic treatments
- Cardiac and pulmonary rehabilitation
- Non-emergency health interventions by out-of-area providers
- Reconstructive surgery/corrected surgery, and related health interventions
- Pain management
- Infertility testing, artificial insemination, and In Vitro fertilization
- Substance use disorder inpatient and outpatient services
- Pre-notification for maternity and obstetrical care including routine prenatal care and postnatal care

Can a provider pay a member’s premium?

According to a document dated November 4, 2013, from CMS regarding third party payments of premiums for qualified health plans in the marketplaces, the Department of Health and Human Services has broad authority to regulate the federal and state Marketplaces (e.g., section 1321(a) of the Affordable Care Act). It has been suggested that hospitals, other health care providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces.

Health and Human Services has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces. Health and Human Services discourages this practice and encourages issuers to reject such third-party payments. Health and Human Services intends to monitor this practice and to take appropriate action, if necessary.

In conjunction with the CMS statement, it is an Arkansas Blue Cross official policy to only accept premium payment from our members or groups.

To whom do providers direct patients to contact if they have questions about their plans?

Members may call Arkansas Blue Cross Customer Service at **800-800-4298** regarding their new plan. For general information regarding Health Insurance Marketplace products, members may call **855-625-0451**.

What do providers need to do to be in-network for the Metallic Plans?

Providers do not need to do anything if they are participating in the True Blue PPO network. Arkansas Blue Cross will be using the True Blue PPO network for the individual Metallic Plans sold both on and off the Health Insurance Marketplace. Participating providers, if appropriate, were mailed a contract amendment notifying them of a new fee schedule for these new Metallic Plans. Reimbursement for existing products that access the True Blue PPO network will not change.

What wellness benefits will the Metallic Plans use?

The Affordable Care Act (ACA) wellness benefits are covered at 100% in-network only. The ACA wellness benefits will be used in the plans sold both on and off the Health Insurance Marketplace. The ACA wellness benefits are posted in the Availity payer space under Resources, and coverage policies are on the Arkansas Blue Cross website (arkansasbluecross.com).

What is the difference in an ARHOME plan and a cost sharing reduction plan?

Plans with cost sharing reduction protect lower income people from high out-of-pocket costs when they receive medical services. Those plans have lower deductibles and copayments and are based upon income.

There are cost sharing reduction plans for both the ARHOME and for people who qualify for an advance premium tax credit (subsidy). People who qualify for the ARHOME will not owe any premium for their insurance plan.

ARHOME members who fall below 100% of the federal poverty level and are not eligible for traditional Medicaid will have no out-of-pocket cost. ARHOME members who fall between 100-138% of the federal poverty level will have lower out-of-pocket costs.

Consumers whose income falls between 139% and 250% of the federal poverty level may also enroll in a cost sharing reduction plan on the Health Insurance Marketplace, which also results in lower out-of-pocket expenses.

Are children covered under Arkansas' ARHOME plan?

The ARHOME is for adults ages 19-64 years old. Children, including newborns, may be eligible for Medicaid programs such as ARKids First.

Is pregnancy covered under the ARHOME?

Pregnant enrollees may be entitled to additional benefits under traditional Medicaid. Providers should encourage their patients to contact the Arkansas Medicaid offices in their county for information of the availability of these additional benefits. Additional benefits such as transportation services may be available for some enrollees.

Also, if a patient is enrolled in a ARHOME plan with member copayments, the member may be eligible for traditional Medicaid benefits without copayments. All ARHOME plans have free pregnancy-related services beginning in 2022. Cost sharing no longer applies to pregnancy deductibles.

What if a patient needs traditional Medicaid services?

State Medicaid is establishing a provider referral process and form by which individuals with exceptional and predictable need for services that are not covered under the health plan are identified. Providers should encourage these patients to contact the Arkansas Medicaid offices in their county for information of their eligibility for additional benefits covered by Medicaid but not covered by their health plan.

In keeping up with all the changes the exchange and ARHOME Metallic Plans will bring to providers, Availity becomes an increasingly important day-to-day tool. Providers need to remember not only to verify coverage and benefits, but also to check to make sure members who receive advance premium tax credits are not in the three-month grace period.

Additionally, the Metallic Plans comply with True Out-Of-Pocket (TROOP) requirements where all out-of-pocket expenses, including all deductibles, coinsurances, medical copayments, and prescription copayments are accumulated as a single out of pocket maximum. Once the TROOP max is met, copayments/coinsurance should no longer be collected. Availity is updated nightly in order to bring the most up-to-date information possible to providers.

To identify a Metallic plan, providers can look for the word Metallic on the member ID card. Below is a ARHOME member ID card example. To identify the ARHOME enrollees, providers should reference the Group numbers on the cards:

ABCBS Exchange ArHome Groups: MS00000009 - MS00000015

			
MEMBER NAME FIRST MI LAST		GROUP NO XXXXXXXXXXXX	
MEMBER ID XXXXXXXXXXXX		RXBIN XXXXXX RXPCN XXX RXGRP XXXXXX	
INN DED \$IND OON DED \$IND RX DED \$IND		COPAY \$XX RX COPAY \$XX INN MAX OOP \$IND OON MAX OOP \$IND	
SILVER			

HA Exchange ArHome Groups:
MSH0000003 - MSH0000009

 	
MEMBER NAME FIRST MI LAST	GROUP NO XXXXXXXXXXXX
MEMBER ID XXXXXXXXXXXX	RXBIN XXXXXX RXPCN XXX RXGRP XXXXXX
INN DED \$IND OON DED \$IND RX DED \$IND	COPAY \$XX RX COPAY \$XX INN MAX OOP \$IND OON MAX OOP \$IND
HA SILVER	

The member ID cards represent members with an alpha prefix of EXX, AXC (ABCBS) and GXH, SXA (Health Advantage). These members do not have out-of-area benefits for non-emergent care or without prior approval.

 	
MEMBER NAME FIRST MI LAST	GROUP NO XXXXXXXXXXXX
MEMBER ID XXXXXXXXXXXX	RXBIN XXXXXX RXPCN XXX RXGRP XXXXXX
INN DED \$IND OON DED \$IND RX DED \$IND	COPAY \$XX RX COPAY \$XX INN MAX OOP \$IND OON MAX OOP \$IND
SILVER	

 	
MEMBER NAME FIRST MI LAST	GROUP NO XXXXXXXXXXXX
MEMBER ID XXXXXXXXXXXX	RXBIN XXXXXX RXPCN XXX RXGRP XXXXXX
INN DED \$IND OON DED \$IND RX DED \$IND	COPAY \$XX RX COPAY \$XX INN MAX OOP \$IND OON MAX OOP \$IND
HA SILVER	

Frequently asked questions about the health care law

What is the health insurance marketplace?

The Affordable Care Act created these health insurance marketplaces (exchange) as a means for consumers to buy “qualified health plans” from private carriers. People who have not had access to health insurance in the past now have access to several options. The health insurance marketplace (exchange) is a state run, web-based service where Arkansas Blue Cross will offer qualified health plans that will access our True Blue PPO network. The health insurance marketplace also provides financial assistance to eligible insurance purchasers whose household incomes fall below 400 percent of the federal poverty level.

What is a qualified health plan?

A qualified health plan is an insurance plan that is certified by the federal government, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. They may be sold on and off the marketplace.

What are essential health benefits?

Qualified health plans are required to cover 10 essential health benefits at 100 percent; meaning the member pays nothing out of pocket for the medical service. These health benefits include:

- Ambulatory patient services, such as doctor’s visits and outpatient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral* and vision care

What does “on” and “off” the marketplace or exchange mean?

All health plans sold on the health insurance marketplace must be qualified health plans. People who purchase health plans on the marketplace may receive tax credits and, in some cases, additional financial assistance paying their medical costs. Insurance companies also may sell the qualified health plans off the marketplace to people who do not qualify for a tax credit. They also may sell HIPAA-Excepted Benefit (HEB) products, which include limited duration policies, new self-insurance products and defined contribution products.

What are Metallic Plans?

Qualified health plans must fall within two percent of four value levels, which have been given metallic names to represent their financial worth. Each level indicates a set percentage of medical costs a health plan would pay for the average person. For example, a bronze plan will cover 60 percent of the health care costs an average person might use in a year, while a platinum plan will cover 90 percent. The more the health plan pays, the higher the

premium will be, and the less out-of-pocket cost there will be when a policyholder receives medical care. (See the metallic coverage levels chart on the following page.)

Are Medicare health plans affected by the health care law?

No. Medicare patients will not have to make changes to their policies as a result of the health care law. They will not have to shop on the marketplace for their coverage and most of them will be able to keep their health plans. People eligible for Medicare, however, are not eligible for tax credits under the health care law.

**Pediatric Dental is not included in our Metallic Plan since there are stand-alone pediatric dental plans available.*

Opting out of individual metallic benefit plans*

Currently, the True Blue PPO network is utilized by several health benefit plans and participation in the True Blue PPO network has necessitated that providers be in-network for all of these plans. Effective July 1, 2015, providers who participate in the True Blue PPO provider network will be able to remove their participation (i.e., opt out) from being in-network for metallic plans in the individual health insurance Marketplace/Exchange yet remain in the True Blue PPO network for all other benefit plans.

To opt out of the metallic plans in the individual marketplace, providers must send a written request that indicates the provider wants to “opt out of the network for members who have the individual metallic benefit plans.” This written request must be placed on the provider’s official letterhead and must be signed by the provider making the request. Providers are not required to terminate their True Blue PPO participating agreement if they wish to opt out from the individual metallic plans. Please remember that if you are contracted through a physician hospital organization (PHO) or other group arrangement, that you must follow their respective contracting procedures requirements which may include obtaining their approval.

Requests to opt out of the individual metallic plan provider network should be mailed to:

PPO Arkansas
Attn: PNO - 3 North
P.O. Box 1489
Little Rock, AR 72203-1489

Please understand that opting out applies to all individual metallic plans and all of a provider’s locations. Once a provider has chosen to be removed from the metallic plans in the individual marketplace, the provider cannot be reinstated for these benefits plans for at least 12 months. To be reinstated, the provider will need to complete full application forms and must go through the initial credentialing process. Any provider who opts out will be designated as out of network for individual metallic plans and all services will be processed at the out of network benefit levels with any covered services paid to the member. Provider directories will include a notation that the provider is not participating as an in-network provider for individual metallic plans.

*** This notice is considered an amendment to the PPO Arkansas’ True Blue PPO participating provider agreement. True Blue agreements issued in the future will contain a separate exhibit addressing participation in the individual metallic plans’ network.**

Metallic Benefits Requiring Prior Approval

To view the prior approval requirements, click [Metallic Prior Approval Guide](#) for members with identification card alpha prefixes:

- ABCBS – XCB, EXX, AXC, XCO
- Health Advantage – HOG, GXH, EXA, SXA

Autism Spectrum Disorder Benefits

After prior approval, coverage is provided for members with autism spectrum disorder that is diagnosed by a licensed Doctor of Medicine or a licensed psychologist.

The following coverage is provided annually for applied behavior analysis, when ordered by a medical doctor or a psychologist for a member under the age of 18, and provided by a board-certified behavioral analyst:

Autism Spectrum Disorder Services	Frequency
Applied Behavioral Analysis Treatment Plan	Up to one every six months
Applied Behavioral Analysis Assessment	Up to three hours once every three months
Applied Behavioral Analysis BCBA services	Up to six hours per week for 50 weeks
Applied Behavioral Analysis Treatment by Behavioral Technician, a Board-Certified Associate Behavioral Analyst, or a Board-Certified Behavioral Analyst (direct or line)	Up to 40 hours per week for 50 weeks

Craniofacial Anomaly

Subject to prior approval from the Company, coverage for corrective surgery and related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly provided the Health Interventions meet Primary Coverage Criteria to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally accredited cleft-craniofacial team. A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall evaluate Covered Persons with craniofacial anomalies and coordinate a treatment plan for each Covered Person. Coverage includes corrective surgery, dental care, vision care and the use of at least one hearing aid.

Requests for prior approval of services other than those noted above must be in writing and faxed to Attn: Prior Approval 501-378-6647. To access the [prior approval form](#), click on the link or access at arkbluecross.com under the forms tab.

Please note: Prior approval does not guarantee payment or assure coverage, it means only that the information furnished to the company, at the time approval is requested, indicates that the services meet the primary coverage criteria requirements. All services must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the claims for the services are received by us, investigation shows that a benefit exclusion or limitation applies, that the covered person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the benefit certificate.

* If a prior approval is not received, the denied charges result in provider responsibility, **except** in the case of DME in which case a denied charge due to no prior approval results in member responsibility.

Habilitative care and modifier SZ

During January 2014, the Patient Protection and Affordable Care Act (PPACA) began requiring all health insurance issuers offering small group health insurance coverage (1-50 fulltime employees) and individual health insurance coverage to include essential health benefits in products offered on and off the Federal Health Insurance Marketplace. Federal law now requires that individual and small group products include the following 10 categories of essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Without a way to identify habilitative services and devices, Modifier SZ was created to help identify habilitative services. Modifier SZ has been deleted as of 12/31/2017. Modifier SZ has been replaced with Modifier 96, Habilitative Services

For dates of services on or after July 1, 2014 thru December 31, 2017, Modifier SZ should be used for Habilitative Care.

For dates of services on or after January 1, 2018, Modifier 96 should be used for Habilitative services. For dates of services on or after January 1, 2018, Modifier 97 should be used for Rehabilitative services.

What are habilitative services?

Arkansas' definition of habilitative services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

Coverage of habilitative services:

Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder.

Virtual prenatal and postpartum support programs

Maven, a virtual prenatal and postpartum care program, is now available at no additional cost to Arkansas Blue Cross and Blue Shield and Health Advantage ARHOME and ACA members.

Maven's program supports women in between their in-person clinic visits. Maven's trusted care advocates take a relationship-driven approach to offer coaching and education on topics ranging from mental health support and birth planning to nutrition and breastfeeding. Members can video chat or message with OB-GYNs, pediatricians, lactation consultants and infant sleep coaches.

Maven supports expecting parents during pregnancy and postpartum and includes the following across each track:

- **Care advocacy:** Navigation to resources on the Maven platform as well as to high-quality, in-person care for medical and social needs; risk detection and proactive outreach to personalize support, drive healthy behaviors and improve outcomes.
- **Telehealth consultations:** Telehealth capabilities with virtual providers and professionals, acting in a coaching and education capacity.
- **Educational materials:** A library of articles and video content to educate and guide participants in their health journeys.
- **Content and community:** Clinically-approached, engaging content and virtual classes; live community forums moderated by Maven providers to ensure responses are clinically grounded.
- **Diverse coverage:** Culturally diverse and conscious providers that speak multiple languages.

Members can sign up on the [Maven website](#).

We can also provide trifold or posters for your office. Please contact Kimberly Brown (kdbrown@arkbluecross.com) if you would like further information.



SECTION 11

Hospital and Inpatient Information

Policies and Procedures for Hospital Reimbursement

Introduction

The purpose of this portion of the provider manual is to provide information on the Hospital Reimbursement Program of Arkansas Blue Cross and Blue Shield with the specific objectives of explaining the policies and procedures of reimbursement as referred to in the contract with member hospitals. (The remainder of this provider manual continues to apply equally to hospitals, where applicable; this section is meant to address reimbursement issues specific to hospitals only.)

Diagnosis-Related Groups

These policies and procedures shall be applicable to reimbursement based on diagnosis-related groups (DRGs). This reimbursement system consists of established payment levels for groupings of claims according to medically meaningful characteristics. There are six major criteria utilized in assigning a particular claim to a specific DRG. These consist of:

- The principal diagnosis
- Procedures performed on the patient
- Patient's age
- Patient's sex
- Patient's discharge status
- Multiple diagnosis and complications

Note: Arkansas Blue Cross uses a variety of methods to establish its allowances, including DRG-based methods, and may change those methods or the formulas used at any time in its discretion.

Date of Admission versus Member Policy Effective Date

When the date of admission precedes the effective date of the member's policy, the claim will deny when billed electronically. The claim will be processed manually where payment will begin for the effective date of the policy. Admission dates prior to the date of coverage will be the responsibility of the member or the member's previous insurance carrier.

Definitions

ADJUSTED DRG AMOUNT - The DRG base rate plus any applicable daily allowance.

CONTRACTUAL ADJUSTMENT - The amount of reported charges in excess of the amount allowed under DRG reimbursement which may not be collected from Arkansas Blue Cross and Blue Shield or its policyholder.

DAILY ALLOWANCE (DA) - An allowance that is added to the DRG base amount for each day the length of stay exceeds the high trim point of the applicable DRG.

DIAGNOSIS-RELATED GROUPING (DRG) - A method of classifying hospital patients by similar diagnosis, procedure, age, sex, and discharge status.

DRG BASE AMOUNT - The amount as established by Arkansas Blue Cross that will apply to admissions for selected DRGs where the length of stay is less than the high trim point.

INCENTIVE RATE - A percentage from 0% to 100% which is used in incentive adjustments to those claims where the billed charges are greater than the adjusted DRG amount. Individual hospital rates are determined by a formula applied to claims submission history of the particular hospital.

INLIER - Claims that meet the criteria for being assigned a DRG and do not present any of the factors that would cause it to be considered an outlier.

MAP DETERMINED ALLOWANCE - The maximum amount that will be allowed for reimbursement of inpatient claims. This is determined by adding the DRG base amount, any applicable daily allowance and incentive adjustment.

MAXIMUM ALLOWABLE PAYMENT (MAP) - The amounts established by Arkansas Blue Cross as the maximum payment allowances for services provided to its members.

OUTLIER - Claims that have unique characteristics that are outside established parameters for each DRG. Claims with any of the following are outliers:

- Length of stay outside the trim points
- Death of patient
- Patients leaving against medical advice
- Patient transferred to another short-term general hospital

REPORTED CHARGES - The amount of charges billed for hospital services that the hospital is willing to accept as payment in full. If a hospital discounts a percentage of billed charges, these deductions should be reflected in the reported charges used to determine reimbursement.

TRIM POINTS - A range of days representing the expected length of a hospital stay for which the DRG base amount is applicable. A claim is considered an "outlier" if the length of stay is greater or less than the trim points.

Hospital Billing

Hospitals shall submit claims for hospital services provided to Arkansas Blue Cross and Blue Shield policyholders using the UB-04 paper claim form, magnetic tape or Electronic Media Claim System. All information necessary to adjudicate the claim shall be provided. Any incomplete claim will be returned for additional information or correction.

Inpatient Services

- Arkansas Blue Cross does not recognize distinct units of a hospital. Admissions involving transfer of a patient from one unit of the hospital to another should be billed as a continuous admission on a single claim form.
- All charges for hospital services provided to Arkansas Blue Cross members that are obtained from another hospital while an inpatient in the hospital submitting the claim shall be included on the same inpatient

billing. A patient cannot be considered an inpatient of one hospital and an outpatient of another hospital at the same time.

- In computing the number of hospital days provided to a member, the date of admission will be counted, but the day of discharge will not be counted.
- The hospital will not require payment from any Arkansas Blue Cross member prior to or following the rendering of a service for amounts more than any deductible, coinsurance, and non-covered amounts. The hospital will look only to Arkansas Blue Cross for payment of approved benefits with the exception of coinsurance, deductible and non-covered amounts.
- Separate claims for mothers and newborn shall be submitted.
- First interim bills may be submitted by Acute Care hospitals only when the admission extends beyond 60 days. Psychiatric hospitals, Rehabilitation hospitals, and Arkansas Children’s Hospital may submit first interim bills when the admission extends beyond fourteen (14) days.

Outpatient Services

- Reimbursement for outpatient services directly relating to an inpatient stay (e.g., preadmission X-ray or lab procedures) that were provided 24 hours prior to or 24 hours after the inpatient stay will be included in the DRG/per diem reimbursement for the same inpatient claim. The admission date and period covered should reflect only the inpatient dates of services. Outpatient services that are not related to the inpatient stay may be billed as outpatient even if provided within 24 hours of an inpatient stay.
- Claims submitted for services provided to an outpatient who was not admitted must be completed with all the required information necessary to adjudicate the charges, including the diagnosis and procedure codes.
- Separate outpatient claims should be submitted for each date of service.

Payment for selected outpatient services will be made on a global fee basis using the procedures and code number outlined in the Current Procedural Terminology (CPT4). This allowance will include all services associated with the procedure **except** physician services, certified registered nurse anesthetist (CRNA) services, ambulance services, and some implants and prosthetic devices.

Arkansas Blue Cross will notify the participating hospital 30 days in advance of adjustments to the outpatient maximum payment allowances.

Initial Hospital Visits Billed by Multiple Physicians

In March 2012, Arkansas Blue Cross and Blue shield sent notice to providers that only the admitting physician could bill the hospital admission CPT Codes 99221-99223. All other physicians seeing the patient, even if for the first time, were instructed to bill the subsequent hospital CPT Codes 99231-99233. However, most physicians continue to bill the hospital admission codes.

After data analysis and understanding that the consult CPT Codes are not available for providers to use, Arkansas Blue Cross agrees that the physicians providing ‘consults’ to the hospital patient may bill the first visit using the hospital admission CPT Codes 99221-99223 provided the service meets the requirements set forth by the Centers for Medicare & Medicaid Services (CMS) for this use.

The admitting physician should add Modifier A1 for reporting purposes only. Consulting physicians and subsequent attending physicians should not use the Modifier A1.

Observation Beds

Facility charges for observation beds are to be billed under revenue code 762. Coverage guidelines for observation beds are as follows:

- Observation bed charges will be recognized from general acute care and critical access hospitals only.
- Reimbursement for observation bed charges will be limited to one day's semiprivate room allowance.
- Hospital outpatient surgery fee schedule amount (global allowance) will encompass observation bed charges and related services.
- Observation bed services that occur within 24 hours of a hospital admission will be considered part of the inpatient hospital billing. The admission date will be the day that the patient is first considered an inpatient. For purposes of pre authorization (if applicable), the admission will be treated as an emergency so that the 48-hour prior notice requirement will not have to be met. The managed care company following the admission will post the actual admission date to their records.

Requirements for Outpatient Observation Care

In compliance with the Centers for Medicare and Medicaid Services Medicare Outpatient Observation Notice (MOON), Arkansas Blue Cross and Blue Shield requires all acute care and critical access hospitals to provide written notification and oral an explanation of the notification to patients receiving outpatient observation services for more than 24 hours. For Medi-Pak® Advantage members, observation stays require any pre-authorization or pre-notification requirements. The notice and accompanying instructions are available [here](#).

The notice should explain the following using contemporary language:

- The patient is classified as an outpatient
- Cost-sharing requirements
- Medication coverage
- Subsequent eligibility for coverage for services furnished by a skilled nursing facility
- Advise patients to contact his or her insurance plan with specific benefit questions

Registration of Hospital Room Rates

All room rates including private, semi-private and special-care units are to be registered with Arkansas Blue Cross and Blue Shield at least annually and when such rates change. These rates should be listed on the [Bed Complement Form](#). The form is used to calculate the average and most prevalent semi-private room allowances. The form is available by clicking on [Bed Complement Form](#).

In hospitals with only private rooms, the average semi-private room allowance will be equal to the average, routine Medical/Surgical Private Room Rate.

The rates and changes should be sent to:

Arkansas Blue Cross and Blue Shield
Hospital Reimbursement, & Pricing Division
Post Office Box 2181
Little Rock, Arkansas 72203-2181

Note: Hospitals are responsible for sending changes.

Hospital Reimbursement

The Maximum Allowable Payment (MAP) for:

- Inpatient claims - Based on the lesser of reported charges or a MAP-determined allowance.
- Outpatient claims - Based on the lesser of the reported charges or the maximum payment allowance.

The hospital's reported charge as submitted on the claim form will be considered the maximum allowable payment (MAP) when no DRG allowance has been established for a specific DRG or when no MAP has been established for an outpatient service.

Actual payment amounts will be based on benefits of the member's health plan or contract. Amounts related to the policyholder's deductible, coinsurance or non-covered services will be deducted from the MAP. These amounts will become the portion of charges delineated as "Patient Responsibility" on the Remittance Advice.

All payments shall be made on the basis of the rates and allowances in effect on date of admission for inpatient services and date of service for outpatient services. These dates will also be the determining date for changes in participation status of the hospital and application of member contract benefits.

On-site audits may be conducted to verify that the medical records contain sufficient information to support the data indicated on the claim that was used to determine reimbursement. Hospitals will be provided advance notification of the dates and procedures of the audits. The results of the audit will be provided to the hospital administrator and Arkansas Blue Cross and Blue Shield management to determine if adjustments are indicated.

Outliers

Outliers shall be reimbursed as follows:

1. **Length of Stay Below the Low Trim Point** — Charges will be recognized for medically necessary services up to the MAP-determined allowance for the specific DRG.
2. **Length of Stay Above the High Trim Point** — Charges will be recognized for medically necessary services up to the MAP-determined allowance.
3. **Outlier Due to Death** — Charges will be recognized for medically necessary services up to the Map-determined allowance.
4. **Transfers** — Charges will be recognized for medically necessary services up to the MAP-determined allowance.
5. **Patient Leaving Against Medical Advice** — Charges will be recognized for medically necessary services up to the MAP-determined allowance.

Claims for admissions involving more than one outlier will be paid using the MAP-determined allowance for the most significant outlier.

Outliers Hierarchy

Outlier Type	MAP
Death	Charges up to MAP determined allowance.
Days above high trim points	Charges up to MAP determined allowance.
Transfer	Charges up to MAP determined allowance.
Days below the low trim point	Charges up to MAP determined allowance.

Example: A claim with a stay above the high trim point when the patient was transferred to another short-term general hospital will be paid as shown in the second example above.

Daily Allowance

The daily allowance is a method of sharing the extra cost of an extraordinarily long length of stay by adding to the DRG base amount for each extra day the length of stay exceeds the high trim point.

This allowance is calculated by dividing the DRG base amount by the high trim point for the length of stay. The DRG base amount, daily allowance and trim points will be provided to the participating hospital.

Incentive Payment Rate

Participating hospitals will be allowed an incentive adjustment for cost-efficient management of inpatient cases. The incentive rate will be calculated using each hospital's historical charge data. The participating hospital will be notified in writing of the incentive rate no later than 30 days prior to the effective date.

The actual method of calculating the incentive payment rate is based on the total differences between reported charges on inliers and outliers compared to the adjusted DRG amounts. The incentive adjustment will only be applied to inpatient claim charges that are in excess of the adjusted DRG amount.

Any hospital with insufficient history to establish an incentive rate will have an initial rate of zero percent until sufficient charge history has been accumulated.

Incentive Rate Calculations

- A. For each hospital, divide all claims with a DRG base amount.
 1. Normal claims, or inliers, with reported charges over the adjusted DRG amount.
 2. Inliers with reported charges below the adjusted DRG amount.
 3. Outliers with reported charges over the adjusted DRG amount.
 4. Outliers with reported charges below the adjusted DRG amount.
- B. The rate will be calculated as a percentage using:
 1. Amount of reported charges over the adjusted DRG amount for inliers (A1, above).
 2. 50 percent of reported charges below the adjusted DRG amount for both inliers and outliers (A2 and A4, above).
 3. Amount of reported charges over the adjusted DRG amount for outliers (A3, above).

4. 25 percent of reported charges below the adjusted DRG amount for inliers (A2, above).
- C. Add the lower of B1 or B2 to the lower of B3 or B4. Divide this amount by the sum of B1 and B3 and multiply by 100 percent. This will be the rate.

Examples of Rate Calculation

INLIERS	EXAMPLE 1	EXAMPLE 2	EXAMPLE 3
A. Reported Charges over adjusted DRG amount	\$25,500	\$50,000	\$60,000
B. Reported Charges under adjusted DRG amount	\$40,000	\$26,000	\$16,000
OUTLIERS			
C. Reported Charges over adjusted DRG amount	\$15,000	\$5,000	\$5,000
D. Reported Charges under adjusted DRG amount	\$5,000	\$44,000	\$44,000
Lower of A or 50% (B + D)	\$22,500	\$35,000	\$44,000
Lower of C or 25%(B)	\$10,000	\$5,000	\$4,000
Sum of Lowerers =	\$32,500	\$40,000	\$34,000
(Divided by)			
Sum of A + C =	\$40,000	\$55,000	\$65,000
Rate =	81.25%	72.73%	52.31%

Contractual Adjustment:

- A. Information necessary to calculate contractual adjustment:
1. Total amount of reported room charges
 2. Total amount of reported ancillary charges
 3. Actual length of stay
 4. DRG number
 5. High trim point
 6. DRG base amount
 7. DRG daily allowance
 8. Average semi-private room allowance
- B. The amount of contractual adjustments will be calculated as follows:
1. Add room allowance (the lesser of actual room charges or the length of stay times the average semi-private room allowance) plus reported ancillary charges on the claim to determine the adjusted charges.
 2. Add DRG base amount plus any applicable daily allowance (days above high trim point times daily allowance) to determine the adjusted DRG amount.
 3. Subtract the adjusted DRG amount (#2 above) from the adjusted charges (#1 above) to determine the amount of any excess charges.

4. Multiply the excess charges (#3 above) by the hospital's incentive rate to determine the incentive adjustment.
5. Subtract the incentive adjustment (#4 above) from the excess charges (#3 above) to determine amount of contractual adjustment.

Contract benefits will be applied to reported charges on the claim less the amount of contractual adjustment to determine the Arkansas Blue Cross payment.

If the adjusted DRG amount is equal to or greater than the adjusted charges, there is no contractual adjustment; and contract benefits will be applied to reported charges on the claim.

Example of Contractual Adjustment Calculation:

Contractual Adjustment and Payment Calculation

Category	Example Information
HOSPITAL NAME	Arkansas Medical Center
PATIENT NAME	Jim Public
ADMISSION DATE	1/24/97
REPORTED CHARGES	\$8,192.92
ROOM	\$2,250.00
ANCILLARY	\$5,942.92
LENGTH OF STAY	9 DAYS
AVERAGE SEMI-PRIVATE ALLOWANCE	\$250.00
DRG	089
BASE AMOUNT	\$6,650
DAILY ALLOWANCE	\$475
HIGH TRIM	14 DAYS

Adjusted Charges		Adjusted DRG Rate	
Room Allowance – Lesser of actual room charges or (# days x ASP)		DRG Base Amount	\$6,650.00
\$2,295 Or \$(9 x \$250)	\$2,295.00	Extra Daily Allowance (# days x Daily Allow)	N/A
Reported Ancillary Charges	\$5,242.92	Total Adjusted DRG Rate	\$6,650.00
Total Adjusted Charges	\$8,192.92		
Contractual Adjustment		Payment Calculation	
Adjustment Charges	\$8,192.92	Total Reported Charges	\$8,192.92
Adjusted DRG Rate	\$6,650.00		
Excess Charges	\$1,542.92	Less Contractual Adjustment	\$300.87
Incentive Adjustment (80.5%)	\$1,242.05		
Contractual Adjustment	\$300.87	Contract Benefits Applied To	\$7,892.05

Hospital Discounts

If a hospital provides discounts below its usual charge for patient services, (i.e., deductibles, copayments, percentage of charges, etc.) the discount should be clearly indicated on the claim form. The discounted amount will be used as the reported charges in determining the maximum allowed payment (MAP).

When the Medicare deductible is discounted, no secondary payer should be listed in Locator 57 on the Medicare UB-04 claim form.

Hospital Appeals Issues

Administrative Decisions

Hospital appeals of administrative matters (e.g., peer group assignments, amounts for DRG incentive rates, etc.) should be submitted to Hospital Reimbursement and Pricing in writing, setting forth the specific issues of disagreement. Any appeal concerning matters affecting the calculation of incentive rates must be submitted within 30 days after hospital first receives the incentive rate notice and provider analysis report.

Any unresolved issues will be submitted to the Hospital Committee of the Arkansas Blue Cross and Blue Shield Board of Directors. The hospital will be informed of the decision within thirty (30) days of the appeal.

Determination of Non-Covered Services

The determination of a non-covered hospital service (e.g., diagnostic admission, pre-existing cosmetic, etc.) will be made by applying generally accepted medical standards based on documented facts of the case. When medical records are secured and reviewed, the case may be referred to the hospital's Utilization Review Committee for consideration and recommendations.

If the issue remains unresolved the claim will be referred to the ABCBS Medical Director who will either authorize benefits on the claim or refer it to a recognized medical review entity.

If the Medical Review Committee determines the services are non-covered, the hospital may appeal the decision by appearing before the review committee to present additional information.

If after the appeal, the review committee still determines the services to be non-covered, their decision will be binding.

DRG Assignment

Hospital appeals pertaining to the DRG assignment on a particular claim may be submitted as follows:

1. Discrepancies caused by incorrect information on the claim form can be corrected by submitting a corrected claim form with bill type 117 in form locator 4. Corrected claims may be reprocessed through the computer system to provide correct member utilization data (e.g., deductible, stop loss, etc.) resulting in the voiding of the original claims and payment of the corrected claim. This information will be reflected on the Remittance Advice.
2. Discrepancies caused by erroneous translation of information from the claim form into the computer system should be submitted to Arkansas Blue Cross and Blue Shield in writing within 60 days of the date of the Remittance Advice.

DRG Weights Calculation Policy

Each year a copy of the DRG weights is downloaded from the CMS website after the final rule is rendered in the Federal Register. This file is downloaded into an Excel format and is used to process inpatient hospital claims. Previously, the weights are carried to only four decimal places. For 2015, CMS has carried the decimal further than the four decimal places. However, the full calculation is only visible when clicking in the cell on the downloaded CMS spreadsheet. For purposes of consistency, the DRG weight will be rounded to the fourth decimal place in all Arkansas Blue and Blue Shield claims systems. For example, DRG 378 has a DRG weight of 1.002061 and will be rounded to 1.0021.

Inpatient Claims Financial Responsibility Policy

The Blue Cross Blue Shield Association has taken steps to ensure consistency among all Blues Plans regarding inpatient pre-service review (also known as pre-authorization or pre-certification). This change took effect January 1, 2014.

Inpatient facilities that fail to obtain pre-authorization or pre-certification when it is required will be financially responsible for any covered services not paid and the member will be held harmless. Not all health plans require inpatient pre-authorization or pre-certification, but where it is required, inpatient providers who fail to obtain it will be financially responsible for any covered services not paid and the member will be held harmless.

To implement this mandate from the Blue Cross Blue Shield Association, provider agreement language must be revised. Please consider this notification as an amendment to the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage HMO and PPO Arkansas' True Blue PPO and Arkansas' FirstSource® PPO provider network participation agreements.

The following sections in the Hospital and PHO provider network participation agreements will now contain the additional language:

Pre-Certification, Pre-Notification, & Eligibility Inquiries

Non-Emergency Admissions - Facility understands and agrees that for Health Plans that require pre-certification or pre-notification and Facility fails to obtain pre-authorization or pre-notification, that Facility will hold Member harmless of any amounts not paid for Covered Services.

Emergency Admissions - Facility understands and agrees that for Health Plans that require pre-certification or pre-notification within 24 hours after admission or by the end of the next working day, if on a weekend or holiday and Facility fails to obtain pre-authorization or pre-notification, that Facility will hold Member harmless of any amounts not paid for Covered Services.

Revenue Code Claims Filing Changes

Since March 1, 2011, outpatient institutional claims containing revenue codes 0905, 0906, 0912, 0913 and 0915 have required 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.

Also effective March 1, 2011, revenue code 0761 (specialty services – treatment room), have required 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.

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.

Revenue codes requiring CPT or HCPCS codes

Beginning July 1, 2015, outpatient institutional claims (UB04) containing revenue codes 0480, 0481, 0482, 0483 and 0489 will require CPT/HCPCS codes in conjunction with these revenue codes. The additional CPT/HCPCS codes will be required on both electronic and paper claims. Claims submitted without the appropriate CPT/HCPCS codes will be rejected and the member will not be held responsible. This revision applies to all outpatient UB04 claims submitted to Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage.

Injectable Drug Pricing for Hospital Outpatient Departments

An article was published in the September 2004 issue of Provider's News stating that administration fees for IV infusions, etc., would not be covered for facilities. The article specifically mentioned revenue codes 940 and 949.

It has come to the attention of Arkansas Blue Cross and Blue Shield that this denial has not been applied consistently. In an effort to control costs and to be fair to our providers, Arkansas Blue Cross will begin paying a nominal fee for these services.

Since the reimbursement for the facility practice expense is covered under other revenue codes when provided in the outpatient hospital setting, the reimbursement for the practice expense portion of these services has been removed from the fee schedule amount used for physicians.

Additionally, Arkansas Blue Cross will begin paying hospitals for injectable drugs (J0000-J9999, etc.) based on the Arkansas Blue Cross fee schedule which was developed to reimburse the cost of the medication. Some of the sources of the reimbursement amounts are Average Sales Price (ASP) plus 10% (with a 10% maximum of \$400), wholesale acquisition cost (WAC), 85% of average wholesale price (AWP), or invoice from the provider.

The fee schedule amounts will be the same as the amounts used to reimburse physicians and will be paid at 100% of the Arkansas Blue Cross fee schedule amount. Unlisted J codes will be listed as BR (By Report) and will be reimbursed using one of the sources noted for the drug and dosage provided.

Anytime a valid HCPCS or CPT code is available for the drug given, the HCPCS/CPT code is required to be billed with the appropriate revenue code.

Clinic Visits and Trauma Revenue Codes Billed by a Facility

Arkansas Blue Cross and Blue Shield, Health Advantage and PPO Arkansas do not recognize facility charges for clinic visits or trauma revenue codes. Facility charges for services performed in a clinic should be billed under revenue codes 0510-0519. Trauma revenue codes 0680-0689 will also be denied as non-covered. 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.

Implant Billing and Invoice Requirement Change

Effective for dates of service on or after January 01, 2018, there has been no allowance for implant revenue codes 275 or 278 when billing for Outpatient Hospital or Ambulatory Surgical Center (ASC) Surgery.

The provider may appeal this decision to Provider Compensation only if there is more than one device intensive procedure on the claim or the claim contains one of the limited numbers of pass-through codes. In these instances, an invoice will be required to price; there will no longer be threshold amounts.

Please note that in case of an appeal, we will still no longer accept a purchase order in place of a manufacturer's invoice.

Please contact your Network Development Representative with any questions or email the Provider Compensation team at providerreimbursement@arkbluecross.com.

UB-04 Claims

Arkansas Blue Cross relies on the proper coding to process provider claims and adjudicates the member's benefits. The codes providers select and enter on claims are representations to us that the member's treatment (and your bill) was for the coded diagnosis, not others, and that the provider, in fact, performed the procedures as described in the American Medical Association Current Procedural Terminology (CPT) Manual or the Health Care Procedural Coding System Manual (HCPCS). Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider network participation or other remedial action.

Claims Filing Information

Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their web site at nubc.org.

Scanning UB-04 Paper Claim Forms*

Arkansas Blue Cross is now scanning the UB 04 claim form (CMS-1450). From our experience with scanning, the following items commonly cause claims to be delayed or rejected on UB 04 claims.

- **All data must be contained within its defined area.**
- **All dollar fields should be blank or have real values.**
- **Do not include \$ or decimal points when reporting charges.**
- **Do not handwrite or put comments on claims.**

* Paper claim submission is not the preferred method. Paper claims may be delayed and result in delayed adjudication due to multiple factors. Paper claims have a higher rate of rejection due to increased errors. For information on submitting your claims electronically, please contact Availity at **800-282-4548** or 800-282-AVAILITY. Availity allows providers to submit claims using direct data entry (DDE) for free on the portal for all Arkansas Blue Cross and Blue Shield lines of business.

Most Common Errors

This process has also allowed us to process UB 04 claims through edits on the front end before they enter the claim system. The most common errors are:

- No Source of Admission Code in Form Locator 15
- No Patient Status Code in Form Locator 17
- No Provider Number in Form Locator 56 & 57

Form Instructions

The UB 04 manual is our guide for completing this form.

DATES – Box 6, 10, 12, 31-36, 45, 74-74E. All date fields except Box 10 should be filled out as “MMDDYY.” Do NOT use “/ -” or spaces to separate month, day or year. Always put a zero in front of single-digit days or months. Box 10 (birthday) should have a 4-digit year.

BOX 1 – Provider’s Name and Address: Do NOT type information above Box 1. Always place phone number as last line in this box. Format expected: Line 1 – provider’s name; Line 2 – provider’s street address; Line 3 – provider’s city, state, zip (5 or 9 positions); Line 4 – provider’s phone (7 or 10 positions).

BOX 3a – Patient Control Number: Should start on left side of box. Numbers next to bill type can become part of bill type.

BOX 8 a & b – Patient’s Name/ID: Enter in 8a the patient’s ID and in 8b the patient’s last, first and middle initial. No commas, periods or titles.

BOX 9 a-e – Patient’s Address: Enter the patient’s street address (9a), city (9b), state (9c), zip codes (5 or 9 digits) (9d), and country (9e). Do not use separators such as semi-colons, use spaces.

BOX 38 – Responsible Party’s Name and Address: Line 1 –Name (last name, first name) and initial. No periods, commas or titles. Line 2 –Address (street or apt, etc.) Line 3 - Can be a second street, box etc. Line 4 –City, state and zip (5 or 9). Do not enter phone numbers. Phone numbers distort OCR and there is no place to store them on the NSF records.

BOX 46 – Service Units: Enter whole numbers only up to seven numeric digits. Fractions and decimals are not allowed.

BOX 50 – Payer Name: Enter payer’s name, left-justified. If Medicare is the primary payer, enter “Medicare” on the line. (Line A – Primary Payer, Line B – Secondary Payer, and Line C – Tertiary Payer)

BOX 56 – National Provider Identifier (NPI): Please left-justify.

BOX 58 – Insured’s Name: Enter the last, first, middle initial of the insured. Do not use periods, commas or titles. (Line A – Insured’s Name Primary, Line B – Insured’s Name Secondary, and Line C – Insured’s Name Tertiary)

For complete [instructions on the UB-04 form](#), visit the CMS web site at cms.hhs.gov.

Paper claims submitted on black UB-04 (CMS-1450) claim forms will be returned to the provider. Paper facility claims should be submitted on the standard UB-04 claim form with red “drop out” ink. These may be obtained through various print vendors that comply with National Uniform Billing Committee (NUBC) specifications. Arkansas Blue Cross and Blue Shield recommends providers submit claims electronically and avoid using paper claim forms whenever possible.



SECTION 12

ICD-10

ICD-10 Claims Coding

Arkansas Blue Cross and Blue Shield and its family of companies requires the use of ICD-10 claims coding. Claims without ICD-10 codes will not be paid.

Availity claims acceptance criteria for ICD-10

Availity has the following criteria to comply with the federal regulation related to ICD-10. Claims not meeting this criterion will be rejected at the time of submission.

Criteria:

All claim types:

- If a claim is submitted with ICD-9 and ICD-10 codes on the same claim, the claim will be rejected.
- ICD codes must have the correct qualifier indicating whether the code is an ICD-9 code or ICD-10 code.
- The October 1, 2015 compliance date applies to both the ICD diagnosis and ICD procedure codes.

Inpatient claims:

- If the discharge date (statement to date) is prior to the compliance date, ICD-9 codes must be submitted for all service lines on claim.
- If the discharge date (statement to date) is on or after compliance date, ICD-10 codes must be submitted for all service lines on the claim.
- For interim bills, the same rules will apply.
- For inpatient claims with admission date prior to compliance date but a discharge date (statement to date) after compliance date, ICD-10 must be submitted on all service lines on the claim.

Professional and outpatient claims:

- If the statement to date or service date is prior to compliance date, ICD-9 codes must be submitted for all service lines on claim.
- If the statement to date or service date is on or after compliance date, ICD-10 codes must be submitted for all service lines on the claim.
- If a claim has service dates both prior to and on or after the compliance date, the claim must be split such that services prior to compliance date are billed on one claim with ICD-9 codes and services on or after compliance date are billed on second claim with ICD-10 codes.

ICD-10 guidelines for paper claim submissions

For detailed instructions on how to properly complete the CMS-1500 (02/12) claim form, Arkansas Blue Cross recommends following the National Uniform Claim Committee (NUCC) guidelines located on their website at nucc.org.



SECTION 13

Medical Records Review

Arkansas Blue Cross recently implemented electronic attachments via the Attachments Dashboard in Availity Essentials to reduce fax/mailed bar-code medical record requests. This electronic process will allow you to proactively submit 'unsolicited attachments' when you file the original claim. It will also enable you and your team to respond to 'solicited' medical record requests electronically.

The ability to upload documents (unsolicited and solicited attachments) can be accessed through a convenient dashboard on Availity Essentials portal: Access the dashboard from **Home | Claims & Payments | Attachments**.

Please note your user administrator must register your organization for this function.

Training videos are available in the Availity Learning Center. Providers can log in and select **Help & Training | Get Trained** to search the Availity Learning Center catalog:

- Attachments (Training demo)
- Attachments Dashboard Intro & Medical Attachments Setup (recorded webinar)
- Medical Attachments Setup (Training demo)
- Arkansas BCBS – Submit attachments with 837 and Direct-Data Entry (DDE) Claims (recorded webinar)

Terminology

Solicited Attachments – These are requests sent electronically from Arkansas Blue Cross to the provider for medical records related to a specific claim.

Unsolicited Attachments – Many providers know that the services they are billing require medical records. When they file the original claim, they can also attach the medical records. These are called Unsolicited Attachments

Medical Records Requests (MRR) is now referred to as Medical Attachments.

Some things to note about this change:

We will direct the medical record request to the clinic or facility whenever possible instead of the individual provider so the electronic request will be posted for the appropriate provider organization in Availity. There will be some instances where the request will be directed to a referring provider if Arkansas Blue Cross is unable to obtain clinic information.

Moving the request process from paper to electronic requires the use of standard coding known as Logical Observation Identifiers Names and Codes, or more commonly referred to as LOINC. *LOINC is the world's most widely used terminology standard for health measurements, observations, and documents. LOINC helps make health data more portable. To send providers electronic requests Arkansas Blue Cross must map the formerly faxed letters to a standard LOINC.* Some letters have not yet been mapped (i.e. Medical Questionnaires). Mapping of these requests is an on-going process we are working through. Due to this on-going process, only a portion of the medical request letters can be sent electronically at this time; the remaining requests continue to be sent via fax/mail. You may continue to receive a portion of record requests by fax/mail in addition to electronically until all request letters can be mapped.

The Patient Account number referenced on a Medical Record request may not match your records. Medical record requests we send to the referring provider will include the patient account number of the provider who submitted the claim (ie. Ancillary provider). Please use the patient's name to locate the member's records.

If a response is not received within 20 days of the original request (electronic or faxed), a follow-up request **letter** will be sent through USPS Mail.

Cancel Request

If you receive a request from Arkansas Blue Cross that, in your opinion, does not apply to you:

- The best practice is to respond to all requests.
- Select the request in question.
- Upload a note stating why you cannot respond with records. For example, the patient listed is not your patient, or unable to locate the date of service in question; in general, why should the request sent to this NPI be cancelled.
- Select **Submit**.

Troubleshooting

For primary support of the registration setup, you can:

- Create a support ticket in Availity through **Help & Training | Availity Support**, then **Contact Support**
- Call Availity Client Services at 1-800-AVAILITY (800-282-4548)
- Initiate a Live Chat with an Availity Client Services Representative through **Help & Training | Availity Support**, then **Contact Support**

For customer support regarding the request or claims status: Call the number on the back of the member ID card for specific questions related to the request. For example, was my request sent electronically or by fax. To inquire on the status of a claim pending for medical record review, please check claim status on Availity Essentials portal.



SECTION 14

Member / Patient Information

Case Management

The Case Management programs are provided through the continuum of care in a manner that allows the member to have optimal access to the Case Manager to meet the member's needs. CM services are provided predominately telephonically. The CM program design allows for utilizing other communication resources such as postal mail, email dialog, mobile messaging and may occur occasionally onsite through inter-disciplinary meetings or home visits.

The CM Program has adopted the definition of case management from the Case Management Society of America's Standards of Practice as follows: Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.

The CM Program goals/objectives are to:

- Promote quality, safe, and cost-effective care through clinical education with identified clinical needs to support post-discharge plans.
- Maximize efficiencies of available resources to achieve clinical and social determinants of health needs.
- Ensure appropriate access to care by working with primary care providers (PCP) and other clinical care providers.
- Work collaboratively with the member, family, and/or caregiver(s) as chosen by the member, the physician, providers of health care, and others to develop and implement a plan that meets the individual's clinical needs and goals, to achieve success.
- Support members' health care choices and promote self-care.
- Improved patient/caregiver, client, caregiver communication that clearly identifies the role of the case manager.
- Improvements in member satisfaction in case management
- Increased rates in depression screenings.

Arkansas Blue Cross case management nurses are licensed/certified clinical professionals who use their specialized skills to communicate effectively with members, caregivers, and treating providers. They do not, however, provide any medical services. All treatment decisions remain exclusively with the member/caregiver and their treating provider.

The Arkansas Blue Cross Case Management Team consists of a multidisciplinary team of clinical professionals. Case managers can be reached at 1-800-225-1891.

For more information regarding case management, please see the section on our website:

arkansasbluecross.com/members/individual-and-family/understanding-your-insurance/case-management-services.

Additional Programs under the umbrella of case manage include:

- Complex Chronic Condition Management for members who have Asthma, CAD, CHF, COPD, Diabetes, or renal disease.
- Catastrophic Case Management

- High Risk Maternity Program called Special Delivery
- Transition of Care program for members being discharged from an acute inpatient admission.
- Social Worker
- Behavior Health
- Specialty Case Management to assist with site of care steering for high cost infusions.

Member ID Cards

Members should present an identification card at the time of service. This card will include certain member information necessary for claim submission and should be transferred to the claim form exactly as presented on the ID card (unless you learn or have reason to know that such information is incorrect). Providers can view most member ID cards on Availity when verifying member eligibility.

Is the ID Card an Authorization for Service?

The ID card is neither an authorization for service nor a guarantee of payment. The ID card is provided for convenience only. All coverage or eligibility issues must still be decided by referring to the member's contract or health plan and must be evaluated and confirmed by Arkansas Blue Cross when a claim is received.

Misuse of the Member ID Card:

Arkansas Blue Cross and Blue Shield is not responsible for any individual member's misuse of an ID card, nor do we have any ability to recall ID cards previously issued when an individual ceases to be eligible for coverage. Members may also mistakenly use outdated ID cards with incorrect information.

Member Appeals

Members are entitled to appeal claims denials under procedures that are outlined in the member's applicable health plan or contract. All appeals are subject to timely filing and other standards as set forth in the member's health plan or contract.

Arkansas Blue Cross and Blue Shield welcomes a provider's input on member appeals in their role as patient advocate, and Arkansas Blue Cross does not intend this paragraph or any other statement or activity on our part as discouragement of any advocacy a provider believes is appropriate with respect to member appeals or access to benefits under their health plan or contract. At the same time, Arkansas Blue Cross does occasionally encounter situations in which it is clear that the member is being used by a particular provider to pursue the provider's own agenda, either to obtain payment for clearly non-covered services, or to simply wage a vendetta against Arkansas Blue Cross or other payers for perceived grievances or dissatisfaction of the provider.

Fortunately, Arkansas Blue Cross's relations with providers in general are excellent, so such instances are rare. However, Arkansas Blue Cross does ask that providers and their staff refrain from upsetting or inciting our members to file appeals in support of their own, separate agenda or when providers are aware that Arkansas Blue Cross has previously addressed the same coverage question and that the service in question is not covered under Arkansas Blue Cross health plans or contracts.

If Arkansas Blue Cross has previously addressed the same coverage issue, it would be appropriate for providers to offer any new or different information on that topic, but it would not be appropriate to simply encourage or participate in repeated member appeals presenting the same information or arguments previously addressed. This situation sometimes has occurred when a particular provider disputes Arkansas Blue Cross's determination that a treatment, drug or device is experimental/investigational and persists in encouraging and supporting multiple member appeals (involving many different members) regarding the precise same treatment, drug or device, even though Arkansas Blue Cross has fully reviewed the treatment, drug or device and has determined that it is experimental/investigational under Arkansas Blue Cross guidelines, as reflected in our member health plans or contracts.

Providers as Authorized Representative for Member Appeals

Arkansas Blue Cross and Blue Shield will recognize a provider as the authorized representative of a member, thereby permitting the provider to pursue an appeal on behalf of the member, in the following circumstances:

Urgent Care

If the treatment a provider is administering involves urgent care (where delay of immediate treatment would seriously jeopardize a member's life or health or the member's ability to regain maximum function) we will recognize the provider as an authorized representative to appeal any denial of pre authorization or prior approval that may be required for coverage under the member's health plan or insurance policy.

Written Designation by Member

In non-urgent care situations, we will recognize a provider as the authorized representative of the member to pursue an appeal of a claim denial on behalf of the member if the member has executed a written designation of the provider on a form that has been approved by us for this purpose. Approved designation forms may be obtained by contacting Provider Service or a Network Development Representative.

Re-Reviews

Anytime a provider disagrees with the denial of a code or the payment level of a code on a claim, the provider should submit a request for reconsideration by the re-review team in the Medical Audit and Review Services area. Please write Claim Re-review (MARS) on the letter. It is only after the re-review team upholds the denial or level of payment that it would be appropriate to appeal the denial or payment level to the Appeals Coordinator.

Member Eligibility Inquiries

A provider may contact the Arkansas Blue Cross and Blue Shield Customer Service Department during normal business hours to seek available information on whether a patient is eligible under any of the Arkansas Blue Cross benefit plans. This information can also be accessed through **My BlueLine** (24 hour Interactive Voice Response system) or on Availity. Availity is recommended as the preferred method of verifying eligibility and benefits. Availity is updated nightly.

Member Eligibility

When a customer service representative receives a call regarding eligibility, the customer service representative will ask for the Arkansas Blue Cross provider number and either the member's name, member identification number, or the member's Social Security number. When member eligibility is determined, the representative can provide the following information to providers:

- Benefits
- Coordination of Benefits information
- Effective date of coverage
- Effective date of termination
- Family members on policy

Special Note

Arkansas Blue Cross cannot give providers any kind of guarantee regarding eligibility. Arkansas Blue Cross can only give providers the data available to us and reflected on our computer system at the time a provider calls. Many factors beyond the knowledge or control of Arkansas Blue Cross may affect the eligibility status of a member. Therefore, a provider should not rely on the eligibility data Arkansas Blue Cross provides as assurance of coverage for the services or service date(s) in question. A provider's best source of the most up-to-date information on eligibility is the patient, who should know employment status and premium-payment history or intention on the date of service. Arkansas Blue Cross's participating provider agreements specifically address eligibility.

Effects of Pre authorization or Pre-notification Responses

Provider understands and agrees that pre authorization for inpatient treatment, pre-notification and any "verification of benefits" or other eligibility inquiries made prior to, at or after admission or provision of any services to members are not a guarantee of payment.

Pre-notification means only that Arkansas Blue Cross (or the applicable payer) has been notified of the hospital admission. Pre-notification is required for all out-of-state inpatient hospital admissions and in-state admission to hospitals not in the Arkansas Blue Cross network.

While Arkansas Blue Cross (or the applicable payer) or its designated representative will endeavor in good faith to report member eligibility information available to Arkansas Blue Cross within its records or computer systems at the time of admission or provision of services, providers acknowledge and agree that it is not possible to guarantee accuracy of such records or computer entities.

Providers understand and agree that the eligibility of all members and coverage for any services shall be governed by the terms, conditions and limitations of the member's health plan. The member's health plan shall take precedence over any inconsistent or contrary, oral or written representations.

No reimbursement shall be due from Arkansas Blue Cross (or the applicable payer) for services if, following any inpatient treatment or other services, it is discovered or determined that:

- Premiums had not been paid for a member's coverage,
- A former member was no longer employed and eligible for participation in the health plan at the time of the admission, or
- Coverage had lapsed or terminated for any reason.

Member Financial Obligations

In most situations, Arkansas Blue Cross and Blue Shield members will be responsible for part of a provider's bill for services; and, as the Arkansas Blue Cross provider agreement outlines; providers will not waive the member's financial responsibilities (e.g., the member copayment, coinsurance and deductible) as specified in the member's health plan or contract.

Non-Covered Services

Members will generally be exclusively responsible for any non-covered services provided, except that, as specified in Arkansas Blue Cross provider agreement, providers may not bill members for services that do not meet Primary Coverage Criteria or which are experimental/investigational, unless a member waiver is first obtained. Select the [Patient Waiver Form](#) (PDF) link for the physician notice and member agreement information.

Note: Except for applicable copayment, coinsurance or deductible, providers are not permitted to request or require payment in advance by any of Arkansas Blue Cross members or from anyone else as a condition of providing services to members.

Billing

Providers are not permitted to "balance bill" a member for amounts more than the Arkansas Blue Cross and Blue Shield allowance (member copayment, coinsurance and deductible are deemed part of the allowance for this purpose and should be billed to the member). Providers are also responsible for any billing or collection service activities that they may engage, or to whom a provider may assign any accounts receivable or other claims against Arkansas Blue Cross members.

If Arkansas Blue Cross finds that any billing service, collection agency or other agent engaged by a provider has improperly attempted to bill any member or collect any amounts from members in violation of the Arkansas Blue Cross provider agreement or the guidelines in this Provider Manual, providers are obligated to promptly take all necessary steps to halt any such activity, to ensure that it is not repeated, and to reimburse Arkansas Blue Cross and the member for any expenses or losses incurred in responding to or defending against the claims or collection actions of any such billing service, collection agency or other agent.

My BlueLine for Eligibility and Benefits

My BlueLine provides Eligibility and Benefits Information as outlined below:

Eligibility

	Arkansas Blue Cross Blue Shield	FEP Federal Employees Program	Medipak®	Health Advantage	BlueAdvantage Administrators of Arkansas
Active or Termed	X	X	X	X	X
Effective Date	X	X	X	X	X
Termination Date	X	X	X	X	X
Whether Pre-Existing Applies & been met	X	X	X	X	X

Benefits

Arkansas Blue Cross and Blue Shield

- Deductibles
- Deductibles amount satisfied
- Copays
- Coinsurance
- Stop-loss
- Lifetime maximums
- Pre authorization requirements
- Wellness
- Maternity
- Accident
- Chiropractor
- Durable Medical Equipment
- Ambulance
- Mental health
- Outpatient physical and occupational therapy
- Outpatient speech therapy

BlueAdvantage Administrators of Arkansas

Benefit Information is not available.

Federal Employees Program (FEP)

- Deductibles
- Copays



- Coinsurance
- Pre authorization requirements
- Outpatient medical services
- Inpatient hospital
- Catastrophic benefits
- Diagnostic X-rays and lab
- Adult preventive care
- Maternity
- Allergy Care
- Physical, occupational, speech and cognitive therapy
- Chiropractor
- Accident

Health Advantage:

- PCP copay
- Specialty copay
- In- and out-of-network deductibles
- Outpatient therapy visits, copay and coinsurance
- DME maximum amounts, copay and coinsurance
- Outpatient coinsurance
- Out-of-network coinsurance

Medi-Pak®:

- Medi-Pak IIan
- Deductibles
- Coinsurance
- Copays
- Drug Coverage

My BlueLine provides the following claim status information:

	Arkansas Blue Cross Blue Shield	FEP Federal Employees Program	Medipak®	Health Advantage	BlueAdvantage Administrators of Arkansas
Allowance	X	X		X	X
Check Number	X	X	X	X	X
Check Status	X	X	X	X	X
Check Total	X	X	X	X	X

	Arkansas Blue Cross Blue Shield	FEP Federal Employees Program	Medipak®	Health Advantage	BlueAdvantage Administrators of Arkansas
Coinsurance	X	X		X	X
Copayment	X	X		X	X
Deductible	X	X		X	X
Denial Reason	X	X	X	X	X
Paid Amount	X	X	X	X	X
Pended Reason	X	X	X	X	X
RA Date	X	X	X	X	X
Risk Amount				X	

Waiver of Health Plan Liability

Waivers of Health Plan Liability are used to educate members on services that may not meet the Primary Coverage Criteria of the member's policy. This applies to all policies under Arkansas Blue Cross and Blue Shield's various products. Using waivers allows providers to collect for services that may not be deemed as meeting the Primary Coverage Criteria particularly for services designated as experimental/ investigational or which are not for the treatment of a medical condition.

It is the provider's responsibility to inform the member before a service is provided when the service(s) may be considered as not meeting coverage criteria (e.g., which may be experimental or investigational). This process was designed to prevent Arkansas Blue Cross members from unwittingly having and/or paying for services that do not meet coverage criteria, (e.g., are considered as experimental/investigational under the coverage policy) or cosmetic services/procedures.

Providers may collect billed charges from members for services that are deemed as not meeting the Primary Coverage Criteria of the member's health plan only if the provider obtains a written statement from the member before any services are provided. Please follow the guidelines below when obtaining a waiver.

A Valid Waiver Must Include

1. The CPT code and/or description of service that may be denied
2. Reason for likelihood of denial: "this procedure does not meet coverage criteria" or "this procedure is considered experimental and/or investigational"
3. Dollar amount of charges for the service
4. Patient's signature
5. Signature date

General Guidelines

1. Waivers are only required for services considered not meeting coverage criteria or those considered experimental/investigational.
2. The patient must sign the waiver before the service is performed.
3. "Blanket" waivers are not acceptable. Providers must not require a waiver routinely or obtain waivers for all services as a precaution. Waivers should only be used for specific services the provider knows or has reason to believe Arkansas Blue Cross may deny for failure to meet the Primary Coverage Criteria (e.g., due to the experimental/investigational nature of the service).
4. Patients should not routinely sign a waiver.
5. Providers should not add information to a waiver after it has been signed by the patient.
6. Members should not be asked to sign a **blank** waiver of liability.
7. Each date of service will require a separate waiver.
8. The member must understand their responsibility when signing a waiver, and why a waiver is necessary for the service.

Note: Providers who abuse the waiver procedure or these rules shall be subject to exclusion from the network.

When a Patient Won't Sign Waiver

It is the provider's responsibility to inform Arkansas Blue Cross patients when a service(s) may be considered not meeting the Primary Coverage Criteria, (e.g., experimental/investigational under Arkansas

Blue Cross coverage policy). This pre-notification process was designed to prevent Arkansas Blue Cross members from unwittingly having and/or paying for services that do not meet Primary Coverage Criteria (e.g., are experimental/investigational under Arkansas Blue Cross coverage policy). Providers have access to coverage policies through the Arkansas Blue Cross website. Coverage policies may be searched by description, CPT Code, or title. A drop-down box is also provided listing all coverage policies alphabetically.

When the patient is advised of the likelihood of denial, they have two options:

1. Do not have the service rendered.
2. Sign the waiver and be financially liable for payment of the denied service.

If a patient refuses to sign the waiver, you have two options:

1. Render the service. If it is denied, write off the charge.
2. Do not render the service.

It is important to note that the patient must understand what he or she is signing and why he or she is signing it. Waivers are only required for services considered as not meeting the Primary Coverage Criteria (e.g., experimental/investigational services) or those services that are not provided to treat an actual medical condition (e.g., cosmetic services/procedures).

Sample Waiver

Click [here](#) (PDF) to download a sample waiver form.



SECTION 15

Mental Health Services

Please refer to the Coverage Policy for APRNs and PAs who are providing mental health services. There are edits in place that capture specific services that require the provider to have certain credentials to bill for, and seek reimbursement of, these services.

Lucet (formerly New Directions)

The Mental Health Parity (MHP) Act requires that mental health benefits be equal to physical health benefits. Member ID cards will include the telephone number of Lucet (formerly New Directions) a company assisting with mental health services on behalf of Arkansas Blue Cross and Blue Shield, PPO Arkansas, and Health Advantage.

Behavioral Health Management

Arkansas Blue Cross, Health Advantage, and Blue Advantage have contracted with Lucet Behavioral Health to perform behavioral health utilization management services. Lucet is a full-service behavioral health organization and is accredited as an MBHO by NCQA and has URAC accreditation for utilization management and case management.

Inpatient, Partial Hospital and Intensive Outpatient Services

- Contact Lucet for pre-notification of all inpatient, partial hospital and IOP services.
- Lucet will conduct concurrent stay reviews and will work with your staff to provide discharge planning.

For pre-authorization or pre-notification of behavioral health services for Arkansas Blue Cross, Health Advantage and Blue Advantage members, contact Lucet at (877) 801-1159. For Walmart associates, call (877) 709-6822

Lucet WebPass

Lucet now offers a Provider WebPass, allowing providers and office staff to:

- Submit pre-authorization requests
- Submit pre-notification of hospital services
- Submit pre-notification

Click [here](#) to access the Provider WebPass, select "Provider Section," then select "Provider WebPass."

Before using the Lucet WebPass System, providers must obtain a username and password from Lucet Behavioral Health at: webpass.ndbh.com/Contact.aspx

The registration should be completed by Lucet Behavioral Health within two business days and new login information will be e-mailed at that time.

Claims

Continue to submit mental health claims via Availity or through a clearinghouse. Individual policyholders applying for, or already with Arkansas Blue Cross, also may select MHP benefits.

Autism: Applied Behavior Analysis Coverage

On October 1, 2011, and upon renewal of group insurance policies and HMO contracts for 2012, Arkansas Blue Cross and Blue Shield and Health Advantage began covering and administering benefits for Applied Behavioral Analysis (ABA) in accordance with Act 196 of 2011, codified at ACA. §23-99-418, enacted by the General Assembly of the State of Arkansas which mandates coverage of Early Intensive Behavioral Intervention (EIBI), with the following conditions:

1. Applied Behavioral Analysis (ABA) must be ordered for a specific individual diagnosed with autism spectrum disorder (ASD) by a licensed physician or psychologist.
2. ABA must be provided or supervised by a therapist certified by the nationally accredited Behavior Analyst Certification Board.
3. The individual with ASD must be less than eighteen years of age.
4. ABA shall have an annual limitation of \$50,000.

The following HCPCS codes should be submitted for ABA services:

- **H2012:** Day treatment per hour – supervision by board certified behavior analyst (BCBA) limited to six hours per week; H2019 plus H2012.
- **H0031:** Mental health assessment by non-physician – ABA testing (initial or reassessment) limited to no more often than every three months; record of test must be submitted with the claim.
- **H0032:** Mental health service plan development by non-physician – development of individual treatment plan (ITP); limited to no more often than every six months; record of ITP must be submitted with claim.
- **H2019:** Therapeutic behavioral services (fifteen minutes) –supervision by BCBA; limited to six hours per week; H2019 plus H2012.
- **H2020:** Therapeutic behavioral services (per diem).
- **H0046:** Mental health services, not otherwise specified – direct service provider for ABA per hour. These services may be provided by the BCBA or by an associate trained in direct services for autism. Whether provided by the BCBA or the associate, these services should be billed with the BCBA's provider number. Services are limited to forty hours per week.

Residential Treatment Centers

Residential Treatment Centers are licensed by the state health department as Residential Substance Abuse Centers. Arkansas Blue Cross and Blue Shield offers PPP, True Blue, Arkansas First Source and Health Advantage participating agreements for these providers.

Inpatient claims are billed with bill type 86X and room revenue codes 1001 and 1002. Allowances are based on global, all-inclusive per diems that are approved by Facility Reimbursement and Pricing. There is no additional allowance for physician services.

Outpatient Claims will now be allowed from these facilities. Outpatient claims should be billed with bill type 13X and must contain revenue codes 0905, 0906, 0912, 0913 and 0915 which require CPT/HCPCS codes in conjunction with the revenue code(s).

HCPCS codes S0201 (Partial hospitalization services, less than 24 hours, per diem) and S9480 (Intensive outpatient psychiatric services, per diem) are allowed on a global basis and all other services billed with these codes will be rolled up for pricing. S0201 can only be billed with revenue codes 0912 and/or 0913. S9480 can only be billed with revenue codes 0905 and/or 0906.

Benefits for residential treatment center are dependent upon any payable member benefits.



SECTION 16

Modifiers

Modifiers

A modifier allows the reporting physician to indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. For Arkansas Blue Cross and Blue Shield claims filing, modifiers, when applicable, should be indicated by placing the appropriate two-digit number in the indicated space in Block 24D after the usual procedure code.

The applicable modifiers are listed by code and defined in each CPT section. Some common modifiers that always should be considered when filing claims include the following:

Modifier	Definition
21	Prolonged evaluation and management services.
22	Unusual procedural services.
23	Unusual anesthesia.
24	Unrelated evaluation and management service by the same physician during a postoperative period.
25	Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure or other service.
26	Professional component.
27	Multiple outpatient hospital E/M encounters on the same date.
32	Mandated services.
47	Anesthesia by surgeon.
50	Bilateral procedure.
51	Multiple procedures.
52	Reduced Services.
53	Discontinued procedure.
54	Not recognized. Surgical care only.
55	Not recognized. Postoperative management only.
56	Not recognized. Preoperative management only.
57	Decision for surgery
58	Staged or related procedure or service by the same physician during the postoperative period.
59	Distinct procedural service.
62	Two surgeons.
63	Procedure performed on infants.
66	Surgical team.
73	Discontinued out-patient procedure prior to anesthesia administration.

Modifier	Definition
74	Discontinued out-patient procedure after anesthesia administration.
76	Repeat procedure by same physician.
77	Repeat procedure by another physician,
78	Return to the operating room for a related procedure during postoperative period.
79	Unrelated procedure or service by the same physician during the postoperative period.
80	Assistant surgeon.
81	Minimum assistant surgeon.
82	Assistant surgeon (when qualified resident surgeon not available).
90	Reference (outside) laboratory.
91	Repeat clinical diagnostic laboratory test.
92	Alternative laboratory platform testing.
*96	Habilitative services.
*97	Rehabilitative services.
99	Multiple modifiers.
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

* Modifier SZ has been discontinued as of December 31, 2017. Please use the following modifiers when billing habilitative services. Please use the following modifiers for habilitative services for dates of services on or after January 1, 2018:

- Modifier 96 for habilitative services.
- Modifier 97 for rehabilitative services.

Modifiers Impacting Pricing

Some modifiers impact pricing. Listed below are modifiers and their applicable pricing adjustments in the Arkansas Blue Cross and Blue Shield fee schedule, subject to medical necessity.

- Modifiers TC and UE point to the technical component fee schedule amounts.
- Modifiers 26 and RR point to the professional component fee schedule amounts.
- Modifier NU points to the total component fee schedule amount.
- Modifier 22: Increased Services 25% of allowable charges based on documentation that the surgical service provided is greater than that usually required for the procedure.
- Modifier 50: Bilateral Surgery - 50% of allowable charges and services must be billed on two lines.
- Modifier 51: Multiple Surgery - 50% of allowable charges.
- Modifier 52: Reduced Services 67% of allowable charges based on documentation.

- Modifier 53: Discontinued Procedure - 25% of allowable charges.
- Modifier 62: Co-Surgery - 62.5% of allowable charge.
- Modifier 63: Infant Procedure - 120% of allowable charge.
- Modifier 73: Discontinued Procedure - 50% of allowable charge (limited to facility billings).
- Modifier 78: OR Return - 70% of allowable charge.
- Modifier 80: Assistant Surgeon - 20% of allowable charge.
- Modifier 81: 20% of allowable charge.
- Modifier 82: 20% of allowable charge.
- Modifier AS: 20% of allowable charge (limited to specialties 50 and 89; in combination with specialty discount of 75%, results in payment of 15% of allowable).

Arkansas Blue Cross and its family of companies do not recognize modifiers 54, 55, or 56. Providers should bill E&M codes for these services rather than billing the surgery code with these modifiers.

Modifier Usage

When used appropriately, modifiers provide additional information that aids in the adjudication claims. When used inappropriately, modifiers will slow the process of a claim, require manual handling, and usually additional information from a provider's office.

Modifier 25 - Significant, Separately Identifiable Evaluation & Management Service:

Modifier 25 should only be used with Evaluation and Management procedure codes (99201 – 99499), and only when a provider has performed an E&M service that is separate and identifiable from the other procedure(s) provided on the same day.

Modifier 50 – Bilateral Procedure:

Charges must be submitted on two lines. The first line should include a descriptive modifier, i.e., LT (left side) or RT (Right side). Modifier 50 should be in the first modifier position on the second line, with the descriptive modifier in the second position.

If a provider bills a bilateral surgery on one line with Modifier 50, the payment will reflect one half of one side. A corrected claim must be submitted to obtain correct payment. Modifier 50 is for use with surgical procedures.

Modifier 51: Multiple Surgical Procedures

The Arkansas Blue Cross claims systems will automatically assign Modifier 51 to the secondary surgical procedure(s) based on the relative value units assigned to the procedures. Arkansas Blue Cross will not apply multiple surgery guidelines to procedures exempt from Modifier 51 based on CPT or to add-on codes. Modifier 51 does not apply to these groups of procedures by definition. Addition of Modifier 59 to these procedures will result in manual adjudication of the claim with no change in payment.

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.

Modifier GT: Via interactive audio and video telecommunication

Modifier GT should be used when billing for telemedicine services except for interpretation of radiology procedures or interpretation of rhythm strips. Since July of 2004, telemedicine has not been covered based on member benefit contract exclusions for Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage and USABLE Administrators.

Modifier PT versus modifier 33

Modifier PT is used for a colorectal screening test converted to a diagnostic test or other procedure. Modifier PT provides information that the procedure was scheduled to be a screening but was converted to a diagnostic procedure.

Modifier PT should only be used with the codes for the colonoscopy, flexible sigmoidoscopy or barium enema when initiated as a screening procedure. In these cases, the diagnostic procedure would be billed with Modifier PT. For contracts with Patient Protection and Preventive Care Act (PPACA) coverage, these procedures would be paid without deductible or coinsurance. The Modifier PT should never be used with the anesthesia procedure 00810.

Modifier 33 is used for preventive services. When the primary purpose of the service is delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending Modifier 33 to the procedure.

Modifier 33 is the appropriate modifier to use with anesthesia CPT code 00810 for a screening colonoscopy whether it is completed as a screening or is converted to a diagnostic procedure. Please see the preventive services newsletter item for a complete list of services that may be billed with Modifier 33.

Modifier FX: X-ray taken using film

Effective January 1, 2017, CMS Change Request (CR) 9727 was implemented. HCPCS Modifier FX reduces the technical component (TC) (including the TC portion of a global service) of X-ray imaging services provided using film.

The FX modifier must be included for X-ray services using film. A payment reduction of 20% applies to the technical component for X-ray services furnished using film for which payment is made.

Modifier 59

Modifier 59: Distinct Procedural Service

Modifier 59 continues to be the most misused modifier. Use of modifier 59 should be rare, should only be used when no other modifier is applicable, and should never be used if there is only one service on a claim. Inappropriate use of modifier 59 will delay processing of a claim.

An appropriate use of Modifier 59:

- Two procedures are provided. When entered in Clear Claim Connection via AHIN, one of the procedures denies as inclusive in the other procedure billed.
- The two procedures represent distinct services that will be supported by the medical records.

Inappropriate uses of Modifier 59:

- Evaluation and Management services
- Multiple or bilateral surgery where Modifier 50 or 51 is appropriate
- Single line claims

Modifier 59 Billing Instructions

Under certain circumstances, a physician may need to indicate that a procedure was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/

excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

However, when another already established modifier is appropriate, it should be used rather than Modifier 59. Only if no other, more descriptive modifier is available, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used.

Arkansas Blue Cross has received a number of claims in which Modifier 59 has been inappropriately used, (e.g., in instances where only one procedure code is billed for a given date of service). Because Modifier 59 is intended to be used where there is a second or separate procedure performed on the same day, Modifier 59 should never be used when only one procedure code is billed for same date of service,

Modifier 59 is never appropriate for Evaluation and Management (E&M) codes. Modifier 25 is the appropriate modifier to bill when reported with an E&M service on the same day as a procedure code with a 0, 10, or 90-day global to identify a separate and distinct E&M service.

E&M services represent “daily services” and the relative value units for E&M services include some RVUs for the case in which the physician must see the patient more than once in a 24-hour day. In this case, the E&M code that best describes ALL the evaluation and management services provided on that day should be reported.

As a rule for surgical procedures, if a surgery would be reimbursed based on multiple surgery guidelines without Modifier 59, no additional reimbursement would be warranted with Modifier 59 appended. The inappropriate appending of Modifier 59 will result in additional claim processing time and potential requests for clinical information.

Most billings of Modifier 59 will require the submission of medical records. The medical records should clearly support the distinct and independent status of the procedure to which Modifier 59 has been appended.

Review of Modifier 59:

- Modifier 59 is used to report distinct and separate procedures performed on the same day.
- Modifier 59 should be used with caution since this modifier affects the processing and reimbursement. Modifier 59 is not designed to provide reimbursement for separate procedures that are performed as an integral part of another procedure. Use of Modifier 59 will normally require submission of medical records.
- When a procedure is described in the CPT code descriptor as a “separate procedure” but is carried out independently or is unrelated to other services performed at the same session, the CPT code may be reported with Modifier 59.
- Modifier 59 should not be used when another, more descriptive modifier is available.
- Documentation needs to be specific to the distinct procedure or service clearly identified in the medical record.

There are modifiers available that describe the body location. (i.e., LT and RT, for left and right side. There are others to describe specific Modifier 59 digits, eyelids, etc.) If a modifier is available that specifically describes the body location, that modifier should be used INSTEAD of Modifier 59.

Clear Claim Connection (CCC):

The September 2004 issue of the Providers' News provided information on Clear Claim Connection (CCC), a new tool available to Arkansas Blue Cross providers via Advanced Health Information Network (AHIN). This tool should be used to determine the appropriate use of Modifier 59.

The code combination being billed should be entered into CCC, without Modifier 59. If Modifier 51 applies to the secondary procedure, the reimbursement for covered services will be based on 50% of the allowance for the secondary procedure(s). In cases such as this (where CCC indicates that Modifier 59 should be used), Arkansas Blue Cross will not ordinarily request medical records. While providers may append Modifier 59 to any claim when warranted, they should be aware that doing so will ordinarily trigger a request for medical records, and thus may delay the processing of the claim.

If the secondary procedure would be denied based on CCC and it meets the conditions for billing Modifier 59, Modifier 59 should be appended AND Arkansas Blue Cross will require submission of medical records in MOST cases. When medical records are needed, they will be requested via the automated Medical Records Request system.

If CCC combines two procedures into one procedure that includes both of the services provided, providers should bill using the one procedure that includes both procedures. An example is CPT Codes 93501 & 93510 which are more accurately reported using CPT Code 93526. Arkansas Blue Cross receives in excess of 7,500 line items per month with Modifier 59 appended. Arkansas Blue Cross has reviewed numerous claims submitted with Modifier 59. Listed below are examples of inappropriate billing of Modifier 59.

Modifier 59 is NEVER appropriate with:

- E&M codes (CPT Codes 99200-99499);
- Anesthesia Procedures (CPT Codes 00100 - 01999 [except 01967] and 99100 - 99140);
- Single procedure on the date of service;
- Administration codes corresponding to injection, immunization or vaccine (the administration is paid separately from the code for the drug without addition of Modifier 59);
- Injection codes with multiple units (Providers are expected to bill for the appropriate dosage. If the injection code is for 50 mg and 100 mg is given, providers should bill with 2 units of service. Modifier 59 is not necessary.); EVERY administration code on a claim;
- E&M, influenza vaccine, and administration (this combination is acceptable without a Modifier 25 on the E&M and/or without Modifier 59 on the administration code);
- Code Combination in CCC accessed via AHIN, allows all services;
- Code Combination in CCC accessed via AHIN appends Modifier 51 to the secondary procedure(s) (Modifier 59 may be included in situations where it is necessary to identify a different lesion, session, etc., not defined by a more specific modifier. Colonoscopy procedures discussed separately in this newsletter is an example.);
- Code Combination in CCC accessed via AHIN replaces the two codes with one code that describes both services (i.e., CPT Code 93501 + 93510 = 93526);
- One upper and one lower GI Endoscopy procedure (The two procedures address different areas of the body based on definition.);

- E&M plus radiology plus one surgical procedure (In this scenario, Modifier 59 is not appropriate on the surgical procedure. If the E&M code meets the conditions described by Modifier 25, then the appropriate coding is to add Modifier 25 to the E&M procedure.)
- ALL clinical laboratory services billed on one day;
- Line items billed separately with RT and LT modifiers (These modifiers distinguish the different sites without using Modifier 59.);
- E&M and surgery on the same day (If the E&M service meets the conditions of Modifier 25, Modifier 25 should be appended to the E&M service. It is never appropriate to also bill Modifier 59 with the surgical procedure.); and
- Outpatient facility claims where only one surgical procedure was performed. (All ancillary, lab and radiology services will be combined with the surgical procedure and reimbursed.)

Modifiers to replace modifier 59

On January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) added four new modifiers to further define Modifier 59. These four new modifiers can be used instead of Modifier 59 (assuming the requirements for Modifier 59 are met.) The new modifiers and their descriptions are noted below. These new modifiers are set up in ClaimsXten to work in the same manner as Modifier 59, but are not included in C3 (Clear Claim Connection). Providers utilizing C3 will need to continue using Modifier 59.

Modifier		Description
XE	Separate encounter	Service that is distinct because it occurred during a separate encounter.
XP	Separate practitioner	Service that is distinct because it was performed by a different practitioner.
XS	Separate structure	Service that is distinct because it was performed on a different organ/structure.
XU	Unusual non-overlapping service	The use of a service that is distinct because it does not overlap usual components or the main service.

Modifier billings with ClaimsXten

ClaimsXten has some very strict edits on procedure versus modifier. If the modifier is not valid for the procedure, the claim line will be denied. Some examples/guidelines are:

- Modifier 50, bilateral, is not valid on a procedure with bilateral in the description or with PT/OT codes.
- RT or LT is not valid on a procedure with bilateral in the description (i.e. radiology)
- Modifier 26 is not valid with surgical procedures
- Site specific modifiers are not appropriate with Evaluation and Management codes.
- Be sure the modifier is valid by using the CPT and/or HCPCS book.
- Repeat clinical diagnostic lab procedures should be billed with Modifier 91 and NOT with Modifier 76.
- Specific finger modifiers (F1-F9 and FA) are not valid with procedures specific to the hand.
- Specific toe modifiers (T1-T9 and TA) are not valid with procedures specific to the foot.
- Modifier AT is only valid with CPT codes 98940-98943
- Modifiers 24 and 25 are only valid with Evaluation and Management codes.

Modifier 25

Modifier 25: Significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service. It is important to bill Modifier 25 with Evaluation and Management code IF a provider is performing an unrelated separate procedure. For example, when providing a minor surgery service, the visit on that day is included in the payment for the procedure.

However, when performing an E&M service unrelated to the minor surgical procedure, providers should append modifier 25 to the E&M code. If it is appended to the surgery code, the surgery line will be denied for incorrect coding. The same criterion applies when providing other procedures, including chemotherapy administration, allergy injections, chiropractic manipulation, etc. The visit is included in the other procedure codes unless it is a separate and identifiable E&M procedure.

Some criteria for the appropriate use of modifier 25:

- Are there signs, symptoms, and/or conditions that the physician must address before deciding to perform a procedure or service?
- Was the evaluation and management of the problem significant and beyond the normal preoperative and postoperative work?
- Is there more than one diagnosis present that is being addressed and/or affecting the treatment or outcome?

Modifier 59

- **Modifier 59:** Distinct procedural service. A more detailed article regarding modifier 59 was printed in the September 2010 issue of Providers' News. Please refer to that article for complete billing instructions.
- Modifier 59 only applies to non-E&M services. If submitted with an E&M service, the E&M service will be denied as incorrect coding.
- Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

- No other established modifier is appropriate, i.e., multiple or bilateral surgery.
- Modifier 59 should be used with caution.

When a procedure is described in the CPT code descriptor as a “separate procedure” but is carried out independently or is unrelated to other services performed at the same session, the CPT code may be reported with modifier 59.



SECTION 17

Network Terms and Conditions

Network Terms and Conditions and Credentialing Standards

All companies of Arkansas Blue Cross and Blue Shield operate networks that require full, formal credentialing and also have adopted specific Credentialing Standards and Network Terms and Conditions. These separate companies and networks include Arkansas Blue Cross and Blue Shield's Preferred Payment Plan "PPP", Health Advantage's HMO Network, and two PPO networks organized by Preferred Provider Networks of Arkansas "PPN of Arkansas", known as True Blue PPO and Arkansas' FirstSource® PPO.

The admission of any practitioner to the PPP, HMO, or PPO networks is a matter within the discretion of the affiliate company; accordingly, practitioners should look to the Arkansas Blue Cross and Blue Shield, Health Advantage and PPN of Arkansas, for complete details and any decisions regarding network participation. Nevertheless, because the affiliation of Arkansas Blue Cross and Blue Shield with Health Advantage and PPN of Arkansas is well-known, we provide on this Arkansas Blue Cross and Blue Shield provider website, for the convenience of providers who commonly participate in the HMO and PPO networks as well as PPP, some basic information regarding the separate networks and related network standards of Health Advantage and PPO Arkansas.

Network Participation Guidelines

Practitioners requesting participation in the Arkansas Blue Cross and Blue Shield PPP network, PPN of Arkansas' True Blue PPO network, Arkansas' FirstSource® PPO network and the Health Advantage HMO network must agree to follow the network Policies and Procedures and Terms and Conditions and meet the network Credentialing Standards.

Providers who have questions about participation should contact their region's [network development representative](#).

Provider Network Operations provides administrative support for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, PPN of Arkansas' True Blue PPO and Arkansas' FirstSource® PPO and the Health Advantage HMO network.

Provider Network Operations
P.O. Box 2181
Little Rock, Arkansas 72203-2181

Telephone: **501-210-7050**

Fax: **501-378-2465**

E-mail: providernetwork@arkbluecross.com

[Health Advantage Network Participation Guidelines](#)

[True Blue PPO Network Participation Guidelines](#)

[Arkansas's FirstSource PPO Network Participation Guidelines](#)

Accreditation Accepted for Network Durable Medical Equipment Providers

Any durable medical equipment /home medical supply provider with “bricks and mortar” in Arkansas that has ABC durable medical equipment accreditation and would like to join the PPP, HMO or PPO provider networks, should contact their respective regional Network Development Representative. A list of representatives may be found at arkbluecross.com.

Accreditation

- Accreditation organizations recognized by the Networks are: The Joint Commission (TJC) DME
- American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) O&P
- Accreditation Commission for Health Care, Inc (ACHC) DME
- Community Health Accreditation Program (CHAP) DME
- Healthcare Quality Association on Accreditation (HQAA) DME

Revision to Payer Policies and Procedures and Terms and Conditions

In this rapidly changing health care environment, health insurers and network sponsors are faced with the challenge of meeting market demand for more information about health care providers.

Consumers now expect to find reliable, standardized comparative performance data for health care providers, procedures, and policies as well as data reflecting the performance of providers, including cost and quality ranking where available. Arkansas Blue Cross and Blue Shield, as a sponsor of a health maintenance organization and preferred provider organization networks, (respectively, Health Advantage and PPO of Arkansas) is not alone in dealing with market pressure for increased transparency around the cost and quality of medical services our members receive.

To address the needs of our customers in this regard, effective February 1, 2012, the published “terms and conditions” for participation in Health Advantage’s HMO network and for PPO Arkansas’ True Blue PPO and Arkansas’ FirstSource® networks will be changed to remove from “Section VII. Publication of Utilization, Quality and Other Practice Data” any references to a provider “opting out” of or otherwise avoiding publication of the provider’s utilization, cost, quality, or other practice data. This means that as of February 1, 2012, any provider who participates in the Health Advantage HMO network or in either of the two PPO networks of PPO Arkansas will be subject to publication of any and all utilization, cost, quality, or other practice data that Health Advantage or PPO Arkansas may deem meaningful or helpful to publish to their members.

This means that as of February 1, 2012, any provider who participates in the Health Advantage HMO network or in either of the two PPP networks of PPO Arkansas will be subject to publication of any and all utilization, cost, quality or other practice data that Health Advantage or PPO Arkansas may deem meaningful or helpful to publish to their members.

Please note that except for deleting the option of a participating provider to “opt out” of, veto or avoid data publication, all other provisions of Section VII. “Publication of Utilization, Quality and Other Practice Data” shall remain in effect as written, until further notice of any additional modifications.

While “opting out” of data publication is no longer an option for participating providers, physicians will still receive an advance copy of any utilization, cost, quality, or other practice data that Health Advantage or PPO Arkansas intend to publish to their membership. Health Advantage and PPO Arkansas will endeavor to provide their information for review 45 days in advance of publication.

Providers who have questions about their data may contact their respective regional Network Development Representative. Currently the available cost and quality data of Arkansas Blue Cross, Health Advantage and PPO Arkansas is only published on Blueprint Portal, which is a password protected member portal.

The quality information published in Blueprint Portal currently is summarized to the overall statewide specialty level, not at the individual physician level. The cost information is reported per physician but is rolled up to one overall level, not per procedure.

Effective February 1, 2012, this may switch to individual physician-level reporting, and the cost and quality ratings reflected there may be published in other formats or places accessible to members, employers or other stakeholders of Arkansas Blue, Health Advantage or PPO Arkansas.

Imaging Centers Purchased by Hospitals

Per the terms of participation for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage HMO network, and PPN of Arkansas' True Blue PPO and Arkansas' FirstSource® networks, advanced imaging centers must be accredited by one of the agencies that meets approval per these networks' required accreditation program. This includes advanced imaging centers purchased by another organization, including hospitals.

In most situations, a currently accredited imaging center can simply notify the accrediting agency (e.g., American College of Radiology or Intersocietal Accreditation Commission) and ask for a certificate with the new organization's name applied to it. Arkansas Blue Cross, Health Advantage, and PPN of Arkansas will need a copy of the new certificate.

Please understand that if the imaging center's new owner is a hospital, the hospital's Joint Commission accreditation does not automatically apply. For this to apply, the hospital must be performing both inpatient and outpatient imaging services and the imaging center must have been part of the on-site review performed by the Joint Commission when the accreditation was given.

Imaging centers have 180 days from the date of the new owner's date of purchase to submit the proof of accreditation required to remain in network. Please submit proof of accreditation to:

Provider Network Operations
P. O. Box 2181
Little Rock, AR 72203

If you have questions, or need additional information, please contact you network development representative.



SECTION 18

Patient Protection and Affordable Care Act (PPACA)

Preventive services covered under the Affordable Care Act

Subject to change as regulations and further clarifications are received

For non-grandfathered plans

The Preventive Care Services coverage policy with coding for ICD-10 and CPT or HCPC's codes is listed in the coverage policy coding instructions for the Preventive Care Services Coverage Policy which can be found in the "Providers" section of the Arkansas Blue Cross and Blue Shield web site, arkansasbluecross.com/providers.

Coding for Preventive Services

- Correctly coding preventive care services is key to receiving accurate payment for those services.
- Preventive care services must be submitted with an ICD-9 code that describes encounters with health services that are not for the treatment of illness or injury. Please avoid using general coding such as V70.0.
- These diagnosis codes must be identified as the primary diagnosis code on the claim form.
- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and the patient claims will be paid using their normal medical benefits rather than enhanced preventive care coverage.
- Use CPT coding designated as "Preventive Medicine Evaluation and Management Services" to differentiate preventive services from problem-oriented Evaluation and Management office visits (CPT codes 99381-99397, 99461, 99401-99404, S0610, and S0612). Non-preventive care services incorrectly coded as "Preventive Medicine Evaluation and Management Services" will not be covered as preventive care.

Modifier 33 - Preventive Service

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be billed with the modifier 33.

The correct coding for ICD-10 and CPT or HCPC code is also required as listed in the coverage policy coding instructions of the Preventive Care Services coverage policy.

Preventive Care Services Update

Non-Grandfathered/PPACA Wellness Summary

March 2013, Version 2, 2013-03-01

Over the last several months we have had calls and questions on the differences between the wellness benefits for health coverage established before the Patient Protection and Affordability Act (PPACA) and the PPACA wellness benefits for non-grandfathered health plans. Arkansas Blue Cross and Blue Shield hopes that the following Preventive Care Services Summary in this Providers' News will help providers have a clearer understanding of the preventive services covered (these, of course, are subject to change).

The preventive services component of the law requires all "non-grandfathered" health insurance plans cover those preventive medicine services given an "A" or "B" recommendation by the U.S. Preventive Services Task Force (USPSTF). Arkansas Blue Cross has studied these recommendations and has developed a coverage policy on each of these preventive medicine services; please refer to arkbluecross.com or healthadvantage-hmo.com. Arkansas Blue Cross has added a link to the latest PPACA grid in the Availity payer space under Resources.

In order to comply with PPACA, Women's Preventive Services was added to many health plans. The change was made to certain employer-sponsored health insurance plans in 2012. The change took place on January 1, 2013 for certain individual health plans.

Arkansas Blue Cross encourages physicians and other providers of preventive services to become familiar with the USPSTF, Bright Futures, and Women's Health Initiative recommendations as well as Arkansas Blue Cross coverage policies. Most of the inquiries we have received are on lab (urinalysis) and other services such as chest x-rays, electrocardiograms, breathing capacity tests, catheter for hystero-graphy, vitamins, B-12 injections, cardiovascular stress tests, CT for bone density, CT for head/brain, removing ear wax, consultations, etc., that are not included in the USPSTF, Bright Futures, or Women's Health Initiative recommendations for screening.

These are not part of the Arkansas Blue Cross coverage policy for non-grandfathered/PPACA Preventive Services. Claims for these services, if billed for screening, would be provider write-offs since they do not meet the Primary Coverage Criteria or are not medically necessary. These claims will not be a member liability if billed with a preventive diagnosis unless the ordering provider has obtained a signed waiver from the member specifically stating why the requested service would not be covered.

Summary of Arkansas Blue Cross Blue Shield and Health Advantage Coverage Policies

The Federal Patient Protection and Preventive Care Act (PPACA) was passed by Congress and signed into law in March 2010. The preventive services component of the law became effective September 23, 2010. A component of the law requires that all "non-grandfathered" health insurance plans are required to cover those preventive medicine services given an "A" or "B" recommendation by U.S. Preventive Services Task Force (USPSTF).

Plans are not required to provide coverage for the preventive services if they are delivered by out-of-network providers. Task Force recommendations are graded on a five-point scale (A-E), reflecting the strength of evidence in support of the intervention.

- **Grade A:** There is good evidence to support the recommendation that the condition be specifically considered in a periodic health examination.

- **Grade B:** There is fair evidence to support the recommendation that the condition be specifically considered in a periodic health examination.
- **Grade C:** There is insufficient evidence to recommend for or against the inclusion of the condition in a periodic health examination, but recommendations may be made on other grounds.
- **Grade D:** There is fair evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.
- **Grade E:** There is good evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.

Those preventive services listed as Grade A and B recommendations are covered without cost sharing (i.e., deductible, coinsurance, or co-pay) by Health Plans for appropriate preventive care services provided by an in-network provider. If the primary purpose for the office visit is for other than Grade A or B USPSTF preventive care services, deductible, coinsurance, or copayment may be applied.

The appropriate office visit code should be used for services typically included as part of a normal wellness visit. Evaluation and Management codes for preventive services CPT Codes 99381-99397 will always be considered preventive. CPT Codes 99401-99404, when used to designate a preventive service, must have the applicable wellness/preventive diagnosis code as the primary reason for visit.

Note: CPT Codes 99401-99404 are considered components of CPT Codes 99386-99387 if billed on the same date-of-service.

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be billed with Modifier 33. The correct coding as listed for both ICD-9 and CPT or HCPCS codes in this summary is also required along with Modifier 33. CPT Codes Copyright © 2012 American Medical Association.

Summary of Women's Preventive Services

Effective August 1, 2012, for certain employer-sponsored health insurance plans. The change will take place on January 1, 2013 for certain individual health plans.

- **Well-woman visits:** Annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their doctors determine they are necessary.
- **Gestational diabetes screening:** For women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
- **HPV DNA testing:** Women who are 30 years of age or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of pap smear results.
- **STI counseling, and HIV screening and counseling:** Sexually active women will have access to annual counseling on HIV and sexually transmitted infections (STI's).
- **Contraception and contraception counseling:** Coverage of prescription contraceptives on the drug list (brand contraceptives may have a copayment if a generic is available without a copayment), sterilization procedures and patient education and counseling. Plan B (morning-after pill) when prescribed for members under 18 will be covered. Any drugs used to cause abortion (e.g. RU 486) are not covered. Over-the-counter birth control methods, even if prescribed by a doctor, are not covered.

- **Breast feeding support, supplies and counseling:** Pregnant and postpartum women will have coverage for lactation counseling from applicable health care providers. Manual breast pumps are covered; electric breast pumps and supplies are not covered. NOTE: Pregnancy services including prenatal, delivery and postnatal care subject to member copayments, deductibles and coinsurance.
- **Domestic violence screening:** Screening and counseling for interpersonal and domestic violence will be covered for all women.

Subject to change as regulations and further clarifications are received, please refer to additional clarifications at the end of this article.

For Self-funded plans with SPD language

Certain self-funded plans may have a different list of preventive care benefits. Please refer to the enrollee's plan specific SPD for coverage. Group specific policy will supersede this policy when applicable. This policy does not apply to the Walmart Associates Group Health Plan participants.

Note: Please encourage your patients to update their personal Health Record with information gathered during a preventive visit.

Note: The cost of drugs, medications, equipment, vitamins, or supplements that are recommended but not prescribed for preventive measures are generally not covered as a preventive care benefit.

Examples include, but are not limited to:

- Aspirin, OTC
- Supplements, including but not limited to, oral fluoride supplementation, and folic acid supplementation
- Tobacco cessation products or medications
- Condoms, diaphragms, sponges, spermicides, etc.
- Electric breast pumps

Aspirin, prescribed by a health care provider with prescribing authority, for prevention of coronary artery disease is covered (DOL/HHS ruling; effective on date of renewal of policy, following 2013-02-20).

FDA approved cervical diaphragms for contraception, prescribed by a health care provider with prescribing authority, for prevention pregnancy, are covered (DOL/HHS ruling; effective on date of renewal of policy, following 2013-02-20).

Habilitative care and modifier 96 and modifier 97

In January 2014, the Patient Protection and Affordable Care Act (PPACA) began requiring all health insurance issuers offering small group health insurance coverage (1-50 fulltime employees) and individual health insurance coverage to include essential health benefits in products offered on and off the Federal Health Insurance Marketplace. Federal law now requires that individual and small group products include the following 10 categories of essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Without a way to identify habilitative services and devices, Modifier SZ was created to help identify habilitative services. Modifier SZ has been deleted as of 12/31/2017. Modifier SZ has been replaced with Modifier 96, habilitative services.

- For dates of services on or after July 1, 2014 thru December 31, 2017, Modifier SZ should be used for habilitative care.
- For dates of services on or after January 1, 2018, Modifier 96 should be used for habilitative services.
- For dates of services on or after January 1, 2018, Modifier 97 should be used for rehabilitative services.

What are habilitative services?

Arkansas' definition of habilitative services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

Coverage of habilitative services

Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder.



SECTION 19

Pharmacy

Pharmacy

Pharmacy Program Advantages

Member's pharmacy benefits are administered through the Arkansas Blue Cross and Blue Shield Pharmacy Program, which eliminates paper claim forms and employs the latest technology for electronic pharmacy claims processing. When a member fills a prescription at a participating pharmacy, the Pharmacy Program computer network instantly alerts the pharmacist to the following:

- Any potential harmful interaction of the medication about to be dispensed with any other medication that the patient may already be taking.
- Whether this medication may duplicate another medication the patient is taking.
- Whether the prescribed dosage or strength is appropriate for the age of the patient.

These features help members save money and promote good health and safety.

Common Prescription Benefit Structures

[2023 Metallic Formulary | List of Covered Drugs](#) (PDF)

The Metallic Drug List corresponds to our Gold, Silver, and Bronze products that are qualified health plans (QHP). The specific dollar amount of copayment for each medication will vary depending upon the member's policy benefits, but the tier assignment for the medication will be the same for all members.

- **First tier:** Preventive medications defined by Health Care Reform that member can obtain for \$0 cost to the member
- **Second tier:** Almost all generic medications
- **Third tier:** Preferred brand-name medications and other lower-cost, brand-name medications
- **Fourth tier:** High-cost medications or medications classified as non-preferred
- **Fifth tier:** Specialty drugs that may require either special handling and/or storage and may be only purchased through a select specialty pharmacy
- **Sixth tier:** Non-preferred specialty drugs that may require either special handling and/or storage and may be only purchased through a select specialty pharmacy

[2023 Step Therapy and Tier 4 Specialty Formulary](#) (PDF)

The Standard Step Therapy promotes cost savings through using more generic medications and over the counter products rather than branded prescription drugs. The specific dollar amount of copayment for each medication will vary depending upon the member's policy benefits, but the tier assignment for the medication will be the same for all members.

- **First tier:** Almost all generic medications
- **Second tier:** Preferred brand-name medications and other lower-cost, brand-name medications
- **Third tier:** High-cost medications or medications classified as non-preferred
- **Fourth tier:** Highest plan member copayment. Specialty products are at Tier 4.

How Are Medications Added to the Formulary? (Covered Drug List)

The services of an independent National Pharmacy and Therapeutics Committee (P&T Committee) are used to approve safe and clinically effective drug therapies. The P&T Committee is an external advisory body of experts from across the United States. The P&T Committee's voting members include physicians, pharmacists, a pharmacoeconomist and a medical ethicist, all of whom have a broad background of clinical and academic expertise regarding prescription drugs.

Prior Approval and Exception Request Form

Some drugs require providers to request prior approval to dispense, review quantity limits. For those requests and step therapy and non-formulary exceptions, please complete the [Prior Approval and Exception Request form](#) (PDF).

Prior Approvals and Exceptions — Caremark

- Drugs requiring prior approval
- Birth control exceptions
- Dosages in excess of the plan's quantity limits
- Step therapy

Providers may contact CVS/Caremark directly by calling **877-433-2973** or faxing the Prior Approval and Exception Request form to **888-836-0730**.

Hours are Monday - Friday from 8:00 a.m. - 6:00 p.m. CST

Exceptions — Arkansas Blue Cross and Blue Shield Pharmacy Department

- Prescription drug fertility treatments
- Non-covered drugs

Providers may contact the Arkansas Blue Cross Pharmacy Department at **501-378-3392** or by fax at **501-378-6980**. Hours are Monday - Friday from 8:00 a.m. - 5:00 p.m. CST

Pharmacy Directory

Providers may search for a network pharmacy by using the [Network Pharmacy Search](#).

For More Information

For more information about a member's prescription drug coverage, call **800-863-5561**.

Specialty Drugs

The Specialty Drug Program addresses treatment for many complex diseases, including:

- Acromegaly
- Anemia
- Atopic dermatitis
- Cryopyrin-Associated Periodic Syndrome (CAPS)
- Cushing's syndrome
- Cystic fibrosis
- Electrolyte disorders
- Hemophilia
- Hepatitis
- Hereditary angioedema
- Hormonal disorders
- Idiopathic pulmonary fibrosis
- Idiopathic thrombocytopenic purpura
- Immunologic disorders
- Infectious diseases
- Inflammatory bowel disorder
- Iron overload
- Lipid disorders
- Movement disorders
- Multiple sclerosis
- Neutropenia
- Oncology
- Osteoporosis
- PKU
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Seizure disorders
- Systemic lupus erythematosus
- Urea cycle disorders

The program provides an efficient, cost-effective way for members to receive coverage of injectable and select oral medications.

For more information, visit Caremark Specialty RX. [Caremark Specialty RX](#) is the Specialty Drug Program administrator for Arkansas Blue Cross and Blue Shield.

Medications and Supplies Not Covered

The following medications and supplies are not covered under most Arkansas Blue Cross and Blue Shield contracts or health plans. However, some contracts or health plans may cover an item on this list. The final authority on exclusions is the member's specific benefit certificate or health plan. This list is for illustrative purposes only and is not an exhaustive list.

The following medications and supplies are not covered:

1. Medications purchased from a nonparticipating pharmacy, except in an emergency situation.
2. Medications used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction, which is not covered by Arkansas Blue Cross, or for which benefits have been exhausted.
3. Medications for use or intended use which would be illegal, abusive, or are not needed to treat an actual medical condition.
4. Experimental or prescription medications labeled, "Caution: Limited by Federal Law to Investigational Use."
5. Medications for which, normally (in professional practice), there is no charge.
6. Medications dispensed for use by a covered person while such person is in a hospital, extended- care facility, nursing home, convalescent or psychiatric facility or any institution or any medication consumed or administered at the place where it is dispensed.
7. Non-legend over-the-counter medications (except insulin) which do not, by law, require a prescription order from a physician.
8. Medications dispensed for use by a covered person while such person is in a hospital, extended- care facility, nursing home, convalescent or psychiatric facility or any institution or any medication consumed or administered at the place where it is dispensed.
9. Vitamins or food/nutrient supplements unless used to treat a select group of approved conditions.
10. Rogaine, minoxidil or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth or replace lost hair.
11. Medications obtained by unauthorized, fraudulent, or abusive use of the identification card.
12. Legend medications that are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given.
13. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion.
14. Medications prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.
15. Medical supplies such as colostomy supplies, bandages, and similar items.

Prescription Safety and Monitoring Solution Program

Arkansas Blue Cross and Blue Shield encourages physicians to use the Prescription Monitoring Program. The program focuses on:

- the number of opioid prescriptions,
- emergency department visits related to opioid drug misuse or abuse,
- drug overdose deaths involving opioid pain relievers.

Arkansas Blue Cross has a Prescription Safety and Monitoring Solution Program identifying members who are potentially abusing or misusing controlled substances. The main focus is to ensure quality patient care and safety. High-risk members are identified through an algorithm based on pharmacy claims history and are flagged when:

- there are prescriptions for several controlled substances,
- prescriptions filled at several pharmacies, and
- prescriptions written by several physicians.

When a high-risk member is identified, a letter is sent to each physician who prescribed a controlled medication in the last nine months to verify and evaluation the patient's drug therapy.

As a provider, you can assist by verifying patients' drug therapy and patterns using the Arkansas Prescription Monitoring Program (AR PMP). All prescriptions for controlled substances, whether paid for by any insurance or cash, will show up on your patients' profile. Physicians can delegate a staff member to access the database on their behalf. Registration and access for the database can be found [here](#).

Exclusions

Arkansas State Employees (ASE) and Public School Employees (PSE)

Pharmacy benefits for ASE and PSE are administered by MedImpact, which is not affiliated with Health Advantage; however, all calls go to EBRx for benefits and claims.

- EBRx phone number: **855-757-9526**
- EBRx alternate number: **501-526-0384**
- EBRx prior approval calls: **866-564-8258**

Federal Employee Program (FEP)

Arkansas Blue Cross and Blue Shield's Federal Employee Program (FEP) has implemented a change in the way certain specialty drugs are managed that fall under the FEP medical benefit.

This new program is administered by Magellan Rx Management (Magellan Rx).

Providers should contact Magellan Rx to obtain prior authorizations for applicable drugs for FEP members for dates of service on or after March 1, 2022.

Providers will be able to complete the prior authorization process via the internet or by phone. Prior authorization will be required for the medical specialty drugs when they are administered in the following settings:

- Physician office (CMS Place of Service code 11)
- Patient homes (CMS Place of Service code 12)
- Outpatient facilities (CMS Place of Service codes 19 & 22)

Reference materials such as a **Frequently Asked Question (FAQ)** document and the list of affected drugs may be found on the [Arkansas Blue Cross and Blue Shield website](#).

If you have questions, please contact the provider service line at **800-482-6655**.

Medical Pharmacy Prior Approval Program

On April 1, 2018, Arkansas Blue Cross and Blue Shield and its family of companies enacted prior approval for payment of specialty medications used in treating rare, complex conditions that may go through the medical benefit. Since then, medications have been added to the initial list as products come to market. **A list of medications that require prior approval through medical benefit can be accessed in the most current issue of *Providers' News, Availity, and individual medication coverage policies.***

ASE/PSE, FEP, and Medicare are not included in this prior approval (PA) program but have their own PA program.

For more information on how to submit a request for prior approval of one of these medications, please call the appropriate Customer Service phone number on the back of the member ID card. Customer Service will direct callers to the prior approval form specific to the member's group.

Blue Advantage members can find the form at the following link:

blueadvantagearkansas.com/providers/forms.aspx.

For all other members, the appropriate prior approval form can be found at the following link:

arkansasbluecross.com/providers/resource-center/prior-approval-for-requested-services.

These forms and any additional documentation will be faxed to **501-378-7051** for Blue Advantage members. For all other members, the appropriate fax number is **501-378-6647**.



SECTION 20

Products

A Word about Our Affiliated Companies

This Provider Manual is created and published by Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company, headquartered in Little Rock, Arkansas at 601 Gaines Street. The Provider Manual is intended to be a guide for providers participating in the Arkansas Blue Cross and Blue Shield Preferred Payment Plan (“PPP”) Network.

At the same time, however, this Provider Manual contains numerous references to networks, products or services of other companies that are affiliated with but separate and distinct from Arkansas Blue Cross and Blue Shield. Most participating providers are already familiar with these affiliated companies and their networks, products and services; nevertheless, in order to be sure that all providers understand the references in this Manual to affiliated companies and their networks, products and services, Arkansas Blue Cross provides below a brief summary of the affiliated companies and their relationship to Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross wants providers to understand that while these companies are affiliated with us, they are separate organizations with their own Boards of Directors, officers, and operations, as well as policies and procedures. Providers who wish to participate in any network of these separate, but affiliated companies, must meet the terms and conditions, and execute the participation agreements required by these separate, affiliated companies.

Preferred Provider Networks of Arkansas

Preferred Provider Networks of Arkansas (PPN of Arkansas), formerly PPO Arkansas, is a subsidiary of Arkansas Blue Cross and Blue Shield. PPN of Arkansas does business in several names because it has organized several different statewide provider networks, and because it offers several distinct types of third party administration services (claims administration or “TPA” services) for self-funded employee health benefit plans. Participating providers are generally familiar with these business names rather than the formal corporate name of the legal entity, PPN of Arkansas. These business names include **BlueAdvantage Administrators of Arkansas**, for TPA services inside the state of Arkansas, and **USable Administrators**, for TPA services outside the state of Arkansas.

Two other business names are associated with the operations and activities of PPN of Arkansas —**Arkansas’ FirstSource® PPO** and **True Blue PPO**. These two business names signify the two statewide provider networks that have been organized and contracted by PPN of Arkansas. Arkansas’ FirstSource® PPO network serves only self-funded employee health benefit plans and employer-sponsors of such plans; True Blue PPO network serves any customer, self-funded or otherwise, who seeks access to a statewide PPO network open to all providers who meet True Blue PPO network credentialing standards, terms and conditions.

It is important to note that PPN of Arkansas (whether operating in the name of BlueAdvantage Administrators of Arkansas, USable Administrators, Arkansas’ FirstSource® PPO or True Blue PPO) **is not an insurer, nor is it a funding source or payer** of any health insurance or health benefit plan claims. PPN of Arkansas’ role is strictly limited to either:

1. Organizing and providing access to a provider network, or
2. Serving as the TPA to process claims for a self-funded health benefit plan, using money provided by the self-funded health benefit plan or its employer-sponsor.

Responsibility for funding all claims remains exclusively with the employer-sponsor or self-funded health benefit plan as PPN of Arkansas assumes no role in underwriting, funding or paying any insurance or health benefit plan claims.

HMO Partners, Inc. or “Health Advantage”

Arkansas Blue Cross and Blue Shield has an HMO affiliate company known formally as “HMO Partners, Inc.,” but known to participating providers by its business name, Health Advantage. While Health Advantage is affiliated with Arkansas Blue Cross and Blue Shield, its ownership is shared among Arkansas Blue Cross and Blue Shield’s subsidiary, Preferred Provider Networks of Arkansas, Baptist Health hospital system, and a group of Central Arkansas physician investors. Preferred Provider Networks of Arkansas (PPN of Arkansas) owns 50% of Health Advantage, Baptist Health (through one of its subsidiaries) owns 25%, and the remaining 25% is divided among individual physician investors.

Health Advantage organizes a separate, statewide HMO Network to provide access and services to Health Advantage’s HMO members. Health Advantage, as an HMO, usually underwrites or funds the claims payments Health Advantage makes for its HMO plan customers. Thus, Health Advantage, unlike PPN of Arkansas, is ordinarily the final authority with responsibility for payment (and funding of payment) or denial of provider claims on Health Advantage members.

At the same time, Health Advantage also provides some HMO-plan TPA services to certain group customers who choose to self-fund their health benefit plans but wish to structure their plans around HMO concepts or approaches. In those instances where Health Advantage is serving only as the TPA for a self-funded group customer with an HMO-style plan, Health Advantage is like PPN of Arkansas in terms of its payment obligations, i.e., Health Advantage as TPA may render payment on a claim on behalf of its self-funded plan customer, but Health Advantage as a TPA is not an underwriting or funding source or payer of such self-funded health benefit plan claims. It is important for providers to understand that Health Advantage does not always serve as the underwriter or funding source for group business administered through Health Advantage.

Arkansas' FirstSource® PPO

Cutting Costs

Arkansas' FirstSource® is a preferred provider organization (PPO) network organized by Preferred Provider Networks of Arkansas, formerly PPO Arkansas. FirstSource® is offered to self-funded employers and therefore is exempt from the provider network requirements of the 1995 Arkansas Patient Protection Act also known as the Any Willing Provider law.

Responsible Payers for FirstSource® PPO Members

Please note that different FirstSource® PPO members may have different payers because Preferred Provider Networks of Arkansas (PPN of Arkansas) is not a payer and does not underwrite any health plan benefits of any kind. Instead, PPN of Arkansas' function is to organize a network of providers who agree to serve the covered employees and dependents of various FirstSource® PPO customers who have contracted with PPN of Arkansas for access to the FirstSource® PPO network.

In effect, PPN of Arkansas' only role is to serve to link its PPO customers up with providers who have agreed to provide services at discounted PPO rates, to be paid by the customers. As a provider, you will always look to the employer-sponsor of the employee health benefit plan or the insurance carrier who insures that employer-sponsor's plan for payment of claims, not PPN of Arkansas. Arkansas Blue Cross and Blue Shield is an insurance carrier that has contracted with PPN of Arkansas to provide FirstSource® PPO network access to Arkansas Blue Cross and Blue Shield PPO members, so in the case of Arkansas Blue Cross and Blue Shield PPO members, Arkansas Blue Cross and Blue Shield is the responsible payer, not PPN of Arkansas.

PPN of Arkansas also contracts for FirstSource® PPO access with numerous employer-sponsors who self-fund their own employee benefit plans. In the case of each of these self-funded employee benefit plans, the various employer-sponsors of those plans are the payers for all claims of such FirstSource® PPO members, not PPN of Arkansas. As a provider, you agree to look to the responsible payer, not PPN of Arkansas, for payment or other responsibility with respect to your claims for services to FirstSource® PPO members.

Relationship of USABLE Administrators

Some employer-sponsors of self-funded employee benefit plans administer their own benefit plan claims, and simply contract for access to the FirstSource® PPO network (these are called "Access-Only" groups). Other employer-sponsors of self-funded employee benefit plans contract with USABLE Administrators for what is called "third party administration" or "TPA" services. This TPA agreement with USABLE Administrators gives the employer-sponsor's benefit plan members access to the FirstSource® PPO network, and it means that USABLE Administrators provides the day-to-day claims processing functions for the self-funded benefit plan. It is important for you to understand that USABLE Administrators is not a payer for any of these self-funded benefit plans. The sole responsibility for funding any claims payment on self-funded benefit plan members remains with the employer-sponsor of that benefit plan.

USABLE Administrators' only role is to conduct an initial review of claims filed under the employee benefit plan, and issue an initial claim determination, including, where appropriate, payment in accordance with the terms of the employee benefit plan. USABLE Administrators does not fund such payments and can only pay your claims if and when the funding for those claims is provided by the employer-sponsor. You should also understand that

that final authority on claims payment or denial issues for self-funded employee benefit plans always rests with the designated “Plan Administrator” for that benefit plan.

USABLE Administrators is not the same thing as the “Plan Administrator” – in the case of most self-funded benefit plans for which USABLE Administrators serves as TPA, the “Plan Administrator” is the employer who sponsors and funds that benefit plan. In effect, USABLE Administrators merely works for the employer- sponsor, in accordance with its directions, to perform certain very limited functions. Any dispute over whether the self-funded benefit plan covers or does not cover any claim, treatment, drug or procedure is the ultimate responsibility of the employer-sponsor as Plan Administrator (unless that particular employer- sponsor has designated another specific person or company (not USABLE Administrators) to serve as Plan Administrator).

While USABLE Administrators will serve to communicate routine claims payments and initial decisions in accordance with the terms of the benefit plan document, you understand and agree that USABLE Administrators is simply the TPA and is not obligated in any instance to make or guarantee any payments for services you provide to self-funded benefit plan members, nor will USABLE Administrators be liable to you or any other party for payment or denial of self-funded benefit plan claims.

Comprehensive Major Medical

Traditional Fee-for-Service Plan

Major Medical coverage is traditional indemnity (“fee-for-service”) health insurance. Major medical coverage offers the greatest choice of medical providers of any Arkansas Blue Cross and Blue Shield plan. Major Medical coverage places no restrictions on Arkansas Blue Cross members regarding their choice of physicians, hospitals or other providers. Arkansas Blue Cross and Blue Shield pays a percentage of allowable charges for health-care services after a deductible is met.

Preferred Payment Plan (PPP)

Members may choose any provider they wish but can save money by choosing from health-care providers who participate in the Preferred Payment Plan (PPP) and hospitals that participate in the Hospital Reimbursement Program (HRP). These providers, listed in our directory represent 95 percent of the doctors and 100 percent of the hospitals in the state. (Go to arkbluecross.com and select the “MEMBERS” tab to search a complete list of PPP providers.) Participating health-care providers agree to accept allowances established by Arkansas Blue Cross as payment in full and collect from the member-only deductibles, coinsurance and non-covered services.

Hospital Reimbursement Program (HRP)

Closely related to the Preferred Payment Plan is the Hospital Reimbursement Program. Under this program, hospitals agree to a reimbursement system based on maximum allowable payments. For inpatient care, the allowable payments are based on diagnosis-related groups (DRGs). Hospitals agree to accept as payment-in-full the lesser of their billed charges or the maximum allowance set by Arkansas Blue Cross and to charge the member for nothing other than deductibles, coinsurance and non-covered services.

For More Information

Call: **501-378-3070** or **800-421-1112**

E-mail: compmjrmed@arkbluecross.com

Dental

Arkansas Blue Cross and Blue Shield offers several dental products to groups and individuals. All insured dental products offered utilize the participating dental providers located on the [Arkansas Blue Cross and Blue Shield](#) website. Participating providers are listed in the provider directory available on the Arkansas Blue Cross website and in a published dental directory.

Dental Participation Advantages

Dental providers that participate in the Arkansas Blue Cross and Blue Shield Preferred Payment Plan (PPP) network receive direct reimbursement for services. Non-participating providers do not receive direct payment, rather the member receives reimbursement. Employers and members are encouraged to use participating providers.

Fee Schedule (Reimbursement Allowances)

The Arkansas Blue Cross and Blue Shield schedule of allowances (fee schedule) utilized for dental provider reimbursement is based on a review of average amounts billed by Arkansas dental providers, as well as, the allowances utilized by other Arkansas dental insurers. An attempt is made to revise the Arkansas Blue Cross fee schedule allowance once a year and also update it with the latest American Dental Association CDT procedure codes.

Claims Status Inquiry

Using simple and common PC software, providers have instant access to: patient benefits, patient eligibility, and claims status.

Limitations and Exclusions

National industry standards along with American Dental Association recommendations are applied to policy limitations and exclusions.

Claims Submission and Payment

Submission of dental claims, pre-determinations and inquiries should be sent to:

Dental Claims Administrator
P. O. Box 69436
Harrisburg, PA 17106-9436

Claims status information: **888-224-5213**

Federal Employee Program (FEP)

The numerous independent Blue Cross and Blue Shield companies across the United States, through their participation in the Federal Employee Program (FEP), insure 4 million federal government employees, dependents and retirees. FEP is the largest privately underwritten health-insurance contract in the world. Sixty-five percent of all federal employees and retirees who receive their health care through the government's Federal Employee Health Benefits program (FEHBP) are members of an independent Blue Cross and Blue Shield company. Arkansas Blue Cross and Blue Shield participates in the FEP program for federal employees located in Arkansas.

The website at fepblue.org is devoted exclusively to the FEP program. This site explains the benefits of the Blue Cross and Blue Shield FEP Service Benefit Plan. Because the Office of Personnel Management negotiates the benefits and premiums of this plan annually on a nationwide basis, the benefit information is updated each year. A printable PDF file may be downloaded from the Web site for future reference.

Up-to-date information on providers, pharmacy programs and resources, such as Blue Health Connection, a 24-hour nurse telephone service, also is available on this site. Newsletters provide health and benefit information for federal employees, including those who are overseas. Links to health-information sites also are listed.

For More Information

Call FEP Customer Service: **800-482-6655** or **501-378-2531**

Federal Employee Program - Dental

Effective January 1, 2006, the FEP Dental Maximum allowances were updated. When dental claims for FEP members are rendered in the state of Arkansas, claims should be sent to Arkansas Blue Cross and Blue Shield for processing. Please submit FEP dental claims to:

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

Arkansas Blue Cross discourages the use of a paper claim form; instead, providers are encouraged to submit all claims electronically through one of the following methods:

- Secure File Upload to Availity
- Electronically through a third-party clearinghouse
- Direct data entry on the Availity portal. For questions related to registering on Availity, providers should contact Availity Client Services at **800-282-4548** or **800-282-AVAILITY**.
- **To ensure proper payment of claims:** Obtain the ID number from the member's identification card. The FEP identification number beginning with an "R" followed by 8 digits. (Example R12345678).

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

Medi-Pak®

For Medicare beneficiaries (who have Part A and Part B coverage) residing in Arkansas

Medi-Pak® is a Medicare supplement for Medicare-eligible Arkansans. To be eligible to purchase this product, members must:

- Have Medicare Part A and Part B coverage
- Be a resident of Arkansas

Depending on the particular plan members choose, Medi-Pak® pays many of the deductibles, copayments and coinsurance not covered by the federal Medicare program.

Arkansas Blue Cross and Blue Shield has seven different Medi-Pak® plans. Members can choose the one that fits their needs and budget.

Go to the federal Medicare website at [medicare.gov](https://www.medicare.gov) for more information on these plans.

For a table that compares the benefits and monthly premiums for the seven Medi-Pak® options offered by Arkansas Blue Cross and Blue Shield, link on the link below.

arkansasbluecross.com/lookingforinsurance/medicareplans

Medi-Pak: Remittance advice changes

Effective June 1, 2015, changes were made to the Medi-Pak Remittance Advice (RA). The column header named “Explanation” was changed to “Remarks Codes.” The remark code(s) now displays under the new column header on the far right side of the RA.

The explanation for each remark code displays on the last page of the RA above the place of service and type of service codes. This change allows for current and future expansion in the remarks code explanations.

Providers with questions regarding the RA changes should contact the Medicare Customer Service division at **800-238-8379**.

Medicare Advantage PFFS Information

Arkansas Blue Cross and Blue Shield offers two Medicare Advantage private fee-for-service plans: Medicare Advantage MA and Medicare Advantage MA-PD. A Medicare Advantage Private Fee-For-Service plan works differently than a Medicare supplement plan. The doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services, except for emergencies. If the doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services, except in emergencies.

[Provider Manual - Medicare Advantage](#): Policies and procedures to assist providers in filing claims, referral requests and other services.

New Medicare Advantage Networks

Arkansas Blue Cross and Blue Shield will be launching various new and enhanced Medicare Advantage plans effective January 1, 2021. These new plans have led to the creation of new Medicare Advantage provider networks that will focus on providing our Medicare Advantage members with optimal and coordinated healthcare, as well as focus on clinical improvement and accuracy programs such as HEDIS and risk and care management efforts.

The table below provides a crosswalk demonstrating the flow from the old networks to the new plans and their networks:

Old Networks	New Plan	Provider Network
Medi-Pak Advantage PFFS	BlueMedicare Value/Preferred	Medicare Advantage PFFS
Medi-Pak Advantage HMO	Health Advantage Blue Classic	Medicare Advantage Health Advantage HMO
Medi-Pak Advantage LPPO	BlueMedicare Choice	Medicare Advantage PPO (NEW USABLE)
	BlueMedicare Premier	Medicare Advantage HMO (NEW USABLE)

The creation of these new networks will be focused in Central, Northwest, Northeast, and South Central Arkansas and will be centered around the large and clinically integrated health systems, including individual primary care and specialty clinics located in these various regions.

Please note that the new Medicare Advantage HMO network is different from the existing Medicare Advantage Health Advantage HMO network. It will be important to ensure referral patterns stay within the HMO network in which the member participates. There are no out-of-network benefits.

True Blue PPO

In 2005, the Eighth U.S. Circuit Court of Appeals made a ruling that implemented the 1995 Arkansas Patient Protection Act, commonly known as the Any Willing Provider (AWP) law. PPO Arkansas created the True Blue PPO network to provide an AWP-compliant network option for PPO Arkansas' current and future customers who are not self-funded employer groups. Although exempt from AWP, self-funded employers may also choose to use True Blue provider network.

True Blue PPO is a preferred provider organization (PPO) now under the entity of Preferred Provider Networks of Arkansas. Product lines using the True Blue Network include Arkansas Blue Cross and Blue Shield fully insured PPO, Federal Employee Program (FEP), BlueCard, the Arkansas Comprehensive Health Insurance Pool (CHIP), and Workers' Compensation.

Freedom of Choice

True Blue members may choose any health care provider from within the statewide network and receive the benefit of the negotiated fee discounts.

Members who choose a provider outside the network are responsible for a greater percentage (also pre-determined) of the allowed amount. For example, if a member usually pays 20 percent of the allowed amount for in-network services, he or she might be required to pay 40 percent of the allowed amount for out-of-network services. Also, if out-of-network is chosen, the member may be responsible for balance billing by the provider.

Arkansas' FirstSource® PPO

The Arkansas' FirstSource® PPO will continue to exist and Preferred Provider Networks of Arkansas will continue to administer the FirstSource network. However, Arkansas' FirstSource® PPO will be used exclusively for self-funded groups exempt from AWP. Reimbursement for the True Blue PPO is generally the same as the current Arkansas' FirstSource® PPO reimbursement.

If you have any questions, please contact your region's Network Development Representative.

Workers' Compensation

Health Plan Coverage Issues

All health benefit plans insured by Arkansas Blue Cross and Blue Shield contain an exclusion for coverage of any treatment, drugs or services if the member in question has filed a workers' compensation claim, or recovers, or could have recovered any benefits under workers' compensation laws, either by settlement with the self-funded employer or the workers' compensation carrier, or otherwise.

The reason for this exclusion is to prevent shifting costs for workers' compensation injuries from the workers' compensation carrier (or self-funded workers' compensation plan) to Arkansas Blue Cross. Arkansas Blue Cross will pick up the costs of covered services for injured employees if it is finally determined by the Arkansas Workers' Compensation Commission (and not overturned on appeal) that the workers' compensation claim is not "compensable" under workers' compensation laws.

Right to Payment

A provider's right to payment for any services rendered to an injured employee is always subject to all terms and conditions of the member's health-benefit plan, including the workers' compensation exclusion in Arkansas Blue Cross-insured health benefit plans.

It is very important that to provide Arkansas Blue Cross all information with each claim that would identify whether the claim is work-related and whether the member has filed or intends to file a workers' compensation claim with respect to the injury in question. Included on the claim form is a specific field [10-a] for designating whether the injury is work-related.

As with all information stated by a provider, by a provider's staff or by a provider's billing agent on any claim forms filed with Arkansas Blue Cross, relies on the completeness and accuracy of that information in processing your claims.

If the workers' compensation data field is not supplied, or supplied incorrectly, a provider may be responsible for any incorrect claims adjudication and become liable to refund all such incorrect payments to us.

A provider agrees to refund promptly any payments made to them if it is later determined by Arkansas Blue Cross that the member's treatment was for a work-related injury that was a compensable injury under workers' compensation laws, as referenced in the member's health-benefit plan.

Workers' Compensation Insurance and USABLE MCO

As noted above, Arkansas Blue Cross-insured health benefit plans do not cover work-related injuries that would otherwise qualify for coverage under workers' compensation laws; in fact, all health benefit plans insured by Arkansas Blue Cross exclude coverage of work-related injuries that are "compensable" injuries under worker's compensation, as defined in the member's health benefit plan. However, a subsidiary company of Arkansas Blue Cross is involved in some activities on the workers' compensation insurance side of the equation — not as an insurer or payer of any workers' compensation benefits, but as a network organizer, much like the PPO network organizing conducted by Preferred Provider Networks of Arkansas for the True Blue and First Source PPOs. This workers' compensation network is known as "USABLE MCO," also organized by Preferred Provider Networks of Arkansas.

The USable MCO includes all providers who are members of True Blue PPO, as well as the chiropractors, podiatrists, dentists and optometrists who are members of the Arkansas Blue Cross and Blue Shield Preferred Payment Plan.

Note: USable MCO is not a payer of any workers' compensation or other claim or benefit plan obligations. See discussion of "Responsible Payers for True Blue® PPO Members," for an explanation of different payers' roles, which applies equally where workers' compensation networks and Arkansas PPO/USable MCO are concerned.

Originally enacted in September of 1996, Rule 33 of the Arkansas Workers' Compensation Commission (AWCC) was revised in January of 1997. As modified, Rule 33 allows insurance carriers and self-insured employers to voluntarily join a Workers' Compensation Managed Care Organization (MCO) in order to manage health care costs for injured employees.

It is Important to Remember

- Rule 33 [Managed Care] states that once a self-insured employer or insurer has selected an MCO and employee notice has been posted, all treatment for work-related injuries, with the exception of emergency treatment, will be provided by MCO network providers.
- Rule 33 [Section III, Part 1] states that all referrals by initial health care providers shall be to providers who participate in the MCO that the employer/insurer has selected.
- Rule 33 [Section III, Part 2, a, (1)(c)] requires that a change of physician to a participating or nonparticipating provider must be approved by the employer, insurer, MCO or AWCC prior to delivery of services. (Note: Nonparticipating providers that have been approved to provide services must agree to all MCO terms including the AWCC and/or MCO reimbursement rates.)
- Rule 33 [Section III, Part 2, a, (1)(b)] states that participating or nonparticipating providers must refer the employee to MCO-participating providers for any treatment the employee requires that cannot be provided by the referring provider.
- Rule 33 [Section IV, Paragraph 4] states that any treatment or services furnished or prescribed by any physician other than the ones selected according to the above guidelines, except emergency care, shall be at the claimant's expense.
- Rule 33 [Section XIII, Part 1] requires that the maximum allowances for services be determined by the AWCC. If the allowance for services under the USable MCO is less than the allowance under AWCC, the lesser amount is applied. In no case will an allowance be greater than the AWCC allowance.

To see AWCC Rule 33 in its entirety go to awcc.state.ar.us/rules/rule099_33.pdf (PDF).

Commonly Asked Questions and Answers

Question: How does the employer's selection of the USable MCO network change the way I treat injured workers?

Answer: Providers who currently obtain hospital preauthorization, meet the reporting requirements of Rule 30 (Medical Cost Containment Program), implement appropriate treatment plans that focus on a return to work, and who work effectively with MCO case managers should not experience significant changes. Providers continue to bill the same payers as at present. USable is not involved in payment of workers' compensation medical charges.

Question: I understand that care is to be provided only by providers who participate with the MCO. How can I tell which MCO covers a particular injured worker and whether I am a part of that MCO network?

Answer: Providers should contact the employer or insurer to determine MCO network status under Arkansas Workers' Compensation law.

Question: As a physician, how can I be assured that I will receive reimbursement for my services and that the physicians I refer to and facilities where procedures/services are performed will be paid?

Answer: The provider is responsible to ensure that referrals to other physicians and facilities are in-network. The AWCC (Rule 33) does not require employers or insurers to reimburse for services performed by nonparticipating providers or for services provided by participating physicians at nonparticipating facilities, unless these services are for emergency medical care or are authorized by the employer, insurer, MCO or the AWCC prior to being rendered. If a provider is not reimbursed for services not authorized prior to treatment, it will not be an acceptable defense for that provider to claim that he or she was not told that there would be no reimbursement. When providers contact employers and insurers to ask for information on employment and coverage, the provider or his or her representative should ask whether the employer falls under an Arkansas Workers' Compensation Managed Care Plan that has been certified by the AWCC. (Note: USABLE MCO is not a payer of any claims or benefit plan obligations. See discussion of "Responsible Payer for TrueBlue® PPO Member.")

Question: How is a physician selected to provide the initial care for an injured worker?

Answer: Under Rule 33 (Section II), the employer has the right to choose a provider from the list of participating providers in its designated MCO. The AWCC has stated that employers choosing not to participate in managed care as defined under Rule 33 do not have the legal right to select the initial treating physician for their injured workers.

Question: Which employers/insurers have selected the USABLE MCO network for their injured workers?

Answer: Currently, more than 15,000 employers, representing more than 600,000 employees have selected the USABLE MCO network for their Workers' Compensation medical services. This represents approximately 75 percent of eligible Arkansas employees. A list of these carriers/employers may be obtained by contacting the USABLE MCO at **501-396-4097**, or P.O. Box 2181, Little Rock, Arkansas 72203-2181.

Additional Resources

Systemedic is a Managed Care Organization and longtime business associate of USABLE MCO. Systemedic is the expert in Arkansas Workers' Compensation and offers multiple services. These services include medical bill review, utilization review, medical case management, hospital admission preauthorization services, comprehensive vocational rehabilitation, and return-to-work services as well as other managed care services as required by the Arkansas Workers' Compensation Commission's Rule 33 [Managed Care].

To contact Systemedic or for additional information, please visit their website at systemedic.com.



SECTION 21

Provider Information

Billing

Billing for services to provider family members prohibited

Arkansas Blue Cross and Blue Shield wishes to remind all providers of a long-standing policy against providers billing for services they perform for their immediate family members. Arkansas Blue Cross, Health Advantage and Preferred Provider Networks of Arkansas (formerly USAble Corporation) have published claims-filing policies and procedures that prohibit a participating provider from billing for services* provided to any immediate family member. The immediate family, for this purpose, includes a spouse, parent, child, brother, sister, grandparent or grandchild, whether the relationship is by blood or exists in law (e.g., legal guardianship).

In addition, all underwritten health plans or policies issued by Arkansas Blue Cross and Health Advantage expressly exclude coverage of services providers perform for immediate relatives. Any claim intentionally or mistakenly filed and that is subsequently paid for such services, requires the billing provider to immediately refund all such payments upon notification.

Violation of these policies and procedures and/or failure to make prompt refunds for erroneous payments will subject the offending provider to termination from the networks sponsored by Arkansas Blue Cross, Health Advantage and Preferred Provider Networks of Arkansas. Moreover, a provider's filing of claims for services rendered to immediate relatives (and receiving payment for such claims), is an abusive claims-filing practice that also may constitute fraud and could lead to permanent exclusion from the networks.

*** Services to immediate family members include not only those personally performed by the provider, but also any services, equipment, drugs, or supplies ordered by the provider and supplied/ performed by another party—including any pharmacy charges resulting from prescriptions written by the provider.**

Fraud and Abuse

Fraud: Healthcare fraud occurs when a person, or persons, who intentionally deceives the health care system to receive benefits or payments.

Waste: The incorrect submission of claims due to factors such as uneducated staff, coding illiteracy, or keying errors. Wasteful billing can typically be resolved after the provider and their staff are educated on the proper billing requirements and/or claim submission rules.

Abuse: Practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Why is Healthcare fraud a problem?

The healthcare industry loses billions of dollars each year to fraud. Fraud may result in increased premiums, potential tax increases, and unnecessary medical procedures. Unnecessary medical procedures could result in physical and/or mental harm to the member.

Common Types of Fraud, Waste, and Abuse

Here are some examples of fraudulent and abusive billing:

- **Non-rendered Services:** billing for services that never happened; example can be seen in providers billing the insurance company for services when a patient has cancelled or did not show for their appointment.
- **Upcoding:** billing for a higher level of services, such as a complex office visit when a lower level of services was provided; or knowingly ordering unnecessary services for members.
- **Misrepresentation of Services:** falsifying medical records to support medical necessity or services never rendered.
- **Kickbacks:** offering, soliciting, paying, or receiving remuneration (in kind or in cash) or in return for a referral of patients.
- **Unbundling:** submitting claims in a fragmented fashion to maximize the reimbursement of various tests or procedures that are required to be billed together under one code.
- **Free Services:** offering “free services” that are not really free, because the insurance company is billed for the service.

There are many other examples, but these are the most common.

What can you do to prevent fraud, waste, and abuse?

Arkansas Blue Cross and Blue Shield relies on the accuracy and completeness of claims submitted for payment. Here is what you can do to help:

- Document every aspect of the member’s encounter thoroughly according to documentation standards set by Arkansas Blue Cross and Blue Shield, the appropriate licensing board, state and/or federal agencies, or CMS guidelines.
- Understand and refer to your provider contract. The provider contract includes any correspondence through the Provider Manual and/or Provider News. These resources can be found [here](#).

Reporting fraud is easy. Use one of the following if you suspect fraud is happening by a provider, a member, or any other entity.

- **Fraud Hotline: 800-FRAUD-21 or 800-372-8321**
- **Email: specialinvestigation@arkbluecross.com**
- Speak to your Network Development Representative.

Together we can work towards eradicating healthcare fraud, waste, and abuse in Arkansas.

Changes/Updates of Information

Please notify the Provider Network Operations (PNO) division of Arkansas Blue Cross and Blue Shield with ANY changes to provider information. Receipt of updated information will assist Arkansas Blue Cross in providing current information to referring physicians and its members. Click [here](#) for online access to the **Provider Change of Data Form**. Members are given false information regarding providers if information is not accurate. The Centers for Medicare and Medicaid Services requires 100% accuracy for online and print directories. Changes can be mailed or faxed to the address below, emailed to providersnews@arkbluecross.com, or contact the [Regional Office](#) in your area.

Arkansas Blue Cross and Blue Shield
Attn: PNO Division
601 Gaines Street
P.O. Box 2181
Little Rock, AR 72203-2181

501-210-7050

501-378-2465 (fax)

Forms for Providers

The forms listed on the menu below are in portable document format (PDF) and allow you to complete the form online, print, sign and return to the appropriate address with supporting documents. Contact your [Network Development Representative](#) at the [Regional Office](#) nearest you for assistance. Additional forms can be accessed [here](#).

For medical providers

- [Authorization Form for Clinic/Group Billing](#) (PDF)
Use for notification that a practitioner is joining a clinic or group.
- [Claim Reconsideration Request Form](#) (PDF)
- [Designation of Authorized Appeal Representative](#) (PDF)
- [Expedited Appeal Request Form](#) (PDF)
- [Network Exception Form](#) (PDF)
- [Notice of Payer Policies and Procedures and Terms and Conditions](#) (PDF)
- [Other Insurance/Coordination of Benefits \(COB\)](#) (PDF)
- [Patient Waiver Form](#) (PDF)
Use to educate members on services that may not meet the Primary Coverage Criteria of the member's policy. Waivers allows providers to collect for services that may not be deemed as meeting the Primary Coverage Criteria particularly for services designated as experimental/investigational or which are not for the treatment of a medical condition.
- [Physician/Supplier Corrected Bill Submission Form](#) (PDF)
Use when submitting previously finalized (corrected) bills.
- [Prior Approval and Exception Request](#) (PDF)
- [Provider Change of Data Form](#) (PDF)
Use to report a change of address or other data. Completion of this form DOES NOT create any network participation.
- [Provider Refund Form](#) (PDF)
Use this form to submit a claim refund.
- [Termination Form for Clinic/Group Billing](#) (PDF)
Use for notification that a practitioner is leaving a clinic.

For dental providers

- [Authorization Form for Clinic/Group Billing](#) (PDF)
Use for notification that a practitioner is joining a clinic or group.
- [Provider Change of Data Form](#) (PDF)
Use to report a change of address or other data. Completion of this form DOES NOT create any network participation.
- [Member Dental Claim Form](#) (PDF)
- [Accident Form for Dental Injury](#) (PDF)
Use this form to file a claim with your medical plan. Accidents are not covered under your dental policy.

Providers' News

Communication is an important factor in delivering quality services to members and educating providers.

The [*Providers' News*](#) is a quarterly publication designed to update providers and their office staff regarding changes or improvements in Arkansas Blue Cross policies and procedures, provider workshops, plus other interesting topics. The newsletter is sent to all providers who participate with Arkansas Blue Cross.

The newsletters cover a wide variety of health care topics including:

- Current events relative to Arkansas providers
- Helpful hints for understanding health benefit plans and other coverage options
- Pertinent changes in Arkansas Blue Cross policies and procedures
- Educational meeting schedules and updates
- General topics of interest

It is essential these publications are read by providers and their staff. A provider's network participation status could be affected by failure to keep abreast of all notices published in the *Providers' News*. This is one way of assisting providers in accessing available health plan benefits for Arkansas Blue Cross members. To subscribe to *Providers' News* please submit email request to providersnews@arkbluecross.com.

For ideas, comments, or suggestions of topics to be addressed in the *Providers' News*, please call Customer Service at **501-221-3733** or **800-843-1329** or the local Arkansas Blue Cross.



SECTION 22

Ambulance Providers

Ambulance Providers

Arkansas Blue Cross and Blue Shield and Health Advantage are creating their own ambulance network. It is highly likely that self-insured groups of Blue Advantage Administrators will choose to use this network, but that will be up to each employer.

Arkansas Blue Cross has decided to terminate its relationship with Alacura Transportation Benefit Manager effective July 31, 2023. The 2023 Arkansas Legislative Session resulted with new laws passed making the Alacura model very difficult to operate.

Arkansas Blue Cross is targeting July 1, 2023 to be the effective date for ambulance provider agreements.

Ambulance Medical Records

The Arkansas Blue Cross provider agreements indicate that medical records, sometimes referred to as run sheets, must accompany every claim submitted to Arkansas Blue Cross.

Claims that are submitted with modifier combinations RE, RG, RH, RI, RJ, RN, RS, RX, SH, SI, SP, SR, and SX, will not require the run sheet/ health record.

For further clarification, there will be a diagnosis code system edit on ambulance claims that could result in the request of records even if these modifier combinations have been submitted.

Credentialing

The contracting packets include standards that must be met. These standards will be placed on the Arkansas Blue Cross website.

One of the requirements is that ambulance providers must be CMS certified. For most providers, CMS issues a tie-in notice indicating official addition to the Medicare program. If the ambulance provider does not have an official tie in notice, please submit documentation from CMS that will prove your company's Medicare approval. Documentation will be reviewed for approval.

Arkansas Blue Cross still prefers the \$1 million/ \$3 million amounts stated in the provider agreements; however, we understand that this may not be the community standard and will revisit the coverage amount requirements. For now, if your city or county requires lower amounts through an ordinance or other legal documents, please submit those documents for review.

Claims Filing – Availity

Ambulance providers or their clearinghouses must enroll with Availity for claims filing.

Contract Questions

Arkansas Blue Cross has received questions about the section in our provider agreements that does not allow balance billing when a claim does not meet our primary coverage policies. Some might refer to these as medical policies. An option is for a provider to obtain a waiver stating that the member understands the service may not be covered and the member will be financially liable. A similar waiver is called an advanced beneficiary notice (ABN) in the CMS world.

Arkansas Blue Cross does understand that sounds complicated on the surface. The new laws effective July 30, 2023 have changed those policies substantially. The services not meeting the coverage policies requirements should be few. Arkansas Blue Cross asks that the EMS community review them again and we believe you will agree that obtaining the waiver is plausible.

Arkansas Blue Cross has 180-day timely filing requirements for all claims and all providers. If we are in the secondary position in coordination of benefits, we will use the date the primary carrier paid as the beginning of the 180-day timely filing calculation.

Electronic Funds Transfer (EFT)

EFT is required. If you are signing new agreements but already have an active EFT contract with Arkansas Blue Cross, you do not have to complete new agreements.

Hospital Based Ambulance

Hospital provider agreements were never intended to include hospital-based ambulance. Because of the unique benefits Arkansas Blue Cross had for many years, we needed the ambulance companies to be created separately from the hospital. That said, we understand that over the years, ambulance claims may have been paid on the hospital's NPI. We need to correct this. As we develop the contracted ambulance network in 2023, Arkansas Blue Cross needs hospital-based ambulance organizations to obtain their own NPI and ensure claims are billed separately from the hospital on an 837P claim form.

National Provider Identifier (NPI)

On your enrollment form the key number we need is your NPI, but we would prefer to also have any Medicare provider number different than your NPI.



SECTION 23

Special Billing and Coding Issues

Anesthesia Billing

How to Bill for Anesthesia Time When Filing A Paper Form of CMS-1500

Recently Arkansas Blue Cross and Blue Shield began scanning and imaging paper claims to improve the processing of claims. If a provider files paper claims for anesthesia services, these guidelines will help the claims get processed correctly.

Arkansas Blue Cross would prefer providers file electronically; but if a provider must file on paper, please follow these guidelines.

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in block 24g of the CMS-1500. If no time units are indicated on the claim, the claim will be denied.

Base Units

Base unit values have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual preoperative and postoperative care and evaluation. Arkansas Blue Cross uses the anesthesia base units recommended by the American Society of Anesthesiologists.

Do not report base units in the units field (block 24g) on your claim submissions, report the actual total minutes that anesthesia was administered. The Arkansas Blue Cross claims processing system automatically determines the base units based on the reported procedure code and modifiers. If a provider's software automatically prints a comment line below the service line with the base units, it will not interrupt the processing of the claim as long as no data prints in the date of service or charge fields.

Time Units

Anesthesia time involves the continuous actual presence of the anesthesiologist or CRNA and begins when the physician or anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Anesthesia time ends when the anesthesiologist/CRNA is no longer in personal attendance, i.e., when the patient may be safely placed under post-operative supervision. The anesthesiologist/CRNA's should report the total anesthesia time on the CMS-1500 claim form as the sum of the continuous anesthesia block times. The medical record should be documented so that a medical record auditor can see the continuous and discontinuous periods and that the reported total anesthesia time sums to the blocks of continuous time.

Time units are determined on the basis of total minutes. Providers should report the total anesthesia time in minutes on the claims. For example, if the total time is 1 hour and 35 minutes, report "95" in the units file (block 24g) of the CMS-1500.

Physical Status Modifiers

The following physical status modifiers are used to give Arkansas Blue Cross additional information about the level of complexity of the anesthesia service provided. The points are additional units added to the total time. Providers should bill for only one (1) physical status modifier per procedure.

	POINTS
P1: A normal healthy patient	0
P2: A patient with mild systemic disease	0
P3: A patient with severe systemic disease	1
P4: A patient with severe systemic disease that is constant threat to life	2
P5: A moribund patient who is not expected to survive for 24 hours with or without the operation	3
P6: A declared brain-dead patient whose organs are being removed for donor purposes	0

Anesthesia Reimbursement

Anesthesia services are paid based on the Anesthesia Relative Value Units. The customary values for reimbursement of anesthesia services are based on the sum of the following components:

- Base units for the primary procedure
- Total time
- Physical status

The following formula is used to determine reimbursement:

$$\text{(Anesthesia base Unit)} + \text{Physical modifying} + \text{Total time (units)} \times \text{Conversion factor} = \text{Anesthesia fee allowance} \times \text{Contractual allowance units}$$

For example, 00865P3 performed in total time of 1 hour and 25 minutes:

(Anesthesia base Unit)	+	Physical modifying	+	Total time (units)	x	Conversion factor	=	Anesthesia fee allowance	x	Contractual allowance units	=	
7 units	+	1 unit	+	6 units*	x		=	14 units	x	\$50	=	\$700

Reimbursement would be \$700 X Contract Benefit. In other words, if a provider has agreed to accept 90% of the Arkansas Blue Cross and Blue Shield allowance, their reimbursement would be \$700 X 90% = \$630.00.

* Partial units are rounded to the next whole unit; 1 unit = 15 minutes. So, 85 minutes/ 15 minutes = 13.67 units, which = 14 units.

Documentation Requirements

Arkansas Blue Cross does not require the anesthesia record with each claim submission. Do not submit anesthesia records unless it is requested; then follow the instructions in the letter of request. The following are the most common situations in which Arkansas Blue Cross requests anesthesia notes:

1. Procedures in the Monitored Anesthesia Care policy may require a letter documenting why monitored anesthesia was necessary for the particular patient.
2. Submission of any miscellaneous procedure codes. Most miscellaneous codes end in "999" (i.e., "01999"). The record is required to identify the actual procedure performed, because the code does not provide sufficient information.
3. Anesthesia administered for dental procedures. Since the member's dental-related coverage may be limited, the anesthesia record permits us to make a coverage determination on the particular case.
4. If two different anesthesia services are billed on the same claim, the anesthesia record is needed to document that two different operative sessions occurred on the same day.
5. If a procedure is billed that is not site specific, i.e., removal of a foreign body, Arkansas Blue Cross may request the anesthesia record to determine the site to ensure coverage should be allowed.
6. If two or more procedures are provided at the same operative session, the anesthesiologist/CRNA should bill using the related anesthesia procedure with the highest base units.

Anesthesia Billing Reminder

As stated in the Arkansas Blue Cross and Blue Shield provider manual for anesthesia billing:

1. If two different anesthesia services are billed on the same claim, the anesthesia record is needed to document that two different operative sessions occurred on the same day.
2. If two or more procedures are provided at the same operative session, the anesthesiologist/CRNA should bill using the related anesthesia procedure with the highest base units

When these situations are identified, a medical records request (MRR) form will be sent to providers to document different operative sessions on the same day when two anesthesia services are billed for the same patient on the same day. Arkansas Blue Cross will pay either the anesthesiologist or the CRNA who delivers the anesthesia service, but not both.

Arkansas Blue Cross does not pay for supervision. Claims for supervision, documented appropriately with Modifier QK, will be denied. In these situations, Arkansas Blue Cross will only pay the CRNA who provided the anesthesia service.

Nerve Block

Billing Information for Nerve Block

If a nerve block is used in the pre or post-operative period as pain management following the procedure, the appropriate block code should be billed with Modifier - 59 to indicate the pain block was not part of the anesthesia for the procedure, and Modifier - 51 as multiple procedure rules.

If the nerve block is used as the anesthesia for the procedure, and given along with conscious sedation, the nerve block would be considered the anesthesia and would be allowed. If the nerve block is given prior to or during the procedure, along with deep sedation (for which a general anesthesia code is billed), the nerve block would not be allowed as it would be considered part of the anesthesia for the procedure.

If the nerve block is given in the preoperative setting and only conscious sedation is given during the procedure (i.e., no general anesthesia code is reported), the nerve block is covered as the anesthesia for the procedure.

Billing for Diabetes Self-Management Training (DSMT)

Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas self-funded employer groups have covered Diabetes Self-Management Training (DSMT) for quite some time. Per Arkansas Law ACA 23-79-601, the coverage is for one DSMT program. Additional programs may be covered if a member's symptoms or conditions change significantly.

When billing for a DSMT program, providers should bill using HCPCS codes G0108 or G0109. All outpatient hospital UB04 claims for DSMT should be submitted with revenue code 942 but also must include HCPCS codes G0108 or G0109. Revenue code 942 always require an HCPCS/CPT code on an outpatient claim; otherwise, the claim will be rejected. DSMT services from professional providers should be billed on a CMS 1500 claim form but must also include HCPCS code G0108 or G0109.

Eligible programs for Diabetes Self-Management training must meet the following standards listed below. These guidelines follow the requirements of Arkansas Law ACA 23-79-601 (also known as Rule 70).

- **Compliance:** The program must be in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association. These standards may be found at care.diabetesjournals.org/content/diacare/early/2017/07/26/dci17-0025.full.pdf (PDF).
- **Required elements:** Elements required to meet minimum standards are:
 - a) Needs assessment
 - b) Education plan
 - c) Education intervention
 - d) Evaluation of learner outcomes
 - e) Plan for follow-up for continuing learning needs
 - f) Documentation
- **Certification:** To qualify for benefits, the provider must provide certification that the insured individual has successfully completed the diabetes self-management training.

Discograms

Correct Billing of Discograms (CPT Codes 72285 and 72295)

There has been some confusion regarding the billing of Discograms. From the CPT Assistant, April 2003, page 27,

“Question: Which CPT codes should be reported for a lumbar discography at L2-3, L3-4, L4-5 and L5-S1 levels? Would the appropriate code be reported more than once since the procedure is performed at four different levels? Is the radiological interpretation an inclusive component to the primary procedure, or is it separately reported?”

AMA Comment:

“The discography procedure performed at the L2-3, L3-4, L4-5 and L5-S1 levels may be reported with CPT code 62290, Injection procedure for discography, each level; lumbar. This code should be reported four times since four levels were imaged. Also, CPT code 72295, discography, lumbar, radiological supervision and interpretation, may be reported four times for the radiological supervision and interpretation as this code can be reported for each lumbar level. If the physician performed only the professional component of the discography, then Modifier 26, Professional component, should be appended to CPT code 72295 to indicate this circumstance. There must be documentation of suspected disease at levels in order to receive payment for numerous provocations.”

If CPT code 72285, discography, cervical or thoracic, radiological supervision and interpretation, is performed on more than one level, it should be billed in the same manner described above.

The provider who is completing the injection should be billing for CPT code 62290 (Injection procedure for discography, each level; lumbar). If a radiologist is then sent an X-ray of the position of the needle to provide a written report for the record, the radiologist should bill code 72295 with Modifier 26 present, not the provider completing the injection. The provider completing the injection should not bill code 72295.

HCPCS: K Codes

Effective January 1, 2014 Arkansas Blue Cross and Blue Shield will start accepting some high dollar HCPCS K codes. The following K codes will be accepted.

HCPCS Code	Description
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom motorized/power wheelchair base
K0014	Other motorized/power wheelchair base
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0607	Replacement battery for automated external defibrillator, garment type only, each
K0608	Replacement garment for use with automated external defibrillator, each
K0609	Replacement electrodes for use with automated external defibrillator, garment type only, each
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds
K0802	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle, not otherwise classified
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds

HCPCS Code	Description
K0824	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0826	Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838	Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840	Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0843	Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0850	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds

HCPCS Code	Description
K0851	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0852	Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0854	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0858	Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859	Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862	Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863	Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864	Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0870	Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871	Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds

HCPCS Code	Description
K0879	Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880	Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0886	Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0898	Power wheelchair, not otherwise classified
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria

Immunoassay for Analytes

Proper Billing of Immunoassay for Analytes

There has been some confusion regarding how providers should be billing CPT code 83516. Therefore, this is a review of the proper billing of immunoassays for analytes. CPT code 83516 is an immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method. CPT code 83516 is a nonspecific code for immunoassay procedures which use highly specific antigen to antibody binding to identify specific chemical substances (analytes) by immunoassay techniques for immunoassay procedures that are not specifically identified in CPT. More specific methods reported with these codes include enzyme immunoassay (EIA), and fluoroimmunoassay (FIA). CPT code 83516 is limited to one unit-of-service unless performed for a separate analyte.

CPT code 83516 is a nonspecific code and may be reported for anti-mullerian antibody determination. This test measures a chemical produced in the body called anti-mullerian hormone, or AMH, which has been shown to provide an accurate snapshot of a woman's egg count. Cost for this procedure will accrue to the total benefit allowance for in vitro fertilization, which is a specific member benefit allowance. Arkansas Blue Cross and Blue Shield's Coverage Policy #1998041 excludes coverage of blood/serum testing (cytotoxic food allergy testing). CPT code 83516 is mutually exclusive with CPT Code 83518. If CPT code 83516 is reported with CPT code 83518, CPT code 83516 is denied as a fragmentation.

If the codes listed below are billed with CPT code 83516, 83516 will be denied as a fragmentation. If CPT code 83516 is performed for an analyte separate from the codes listed below, CPT code 83516 should be reported with Modifier 59.

- **80101** - (Drug screen, single drug class method [e.g., immunoassay, enzyme assay], each drug class) as each code represents qualitative immunoassay for an analyte other than infectious agent antibody or infectious agent antigen
- **86200** - (Cyclic citrullinated peptide [CCP], antibody), a semi-quantitative/qualitative enzyme- linked immunosorbent assay
- **86602** - CPT 86793, as all of the latter procedures represent qualitative immunoassays for detection of antibodies for specific infectious agents
- **86021** - (Antibody identification; leukocyte antibodies), a semi-quantitative/qualitative antibody test
- **86022** - (Antibody identification; platelet antibodies), a semi-quantitative/qualitative antibody test
- **86023** - (Antibody identification; platelet associated immunoglobulin assay), a semi- quantitative/qualitative antibody test
- **86255** - (Fluorescent noninfectious agent antibody; screen, each antibody), a semi- quantitative/qualitative antibody test
- **86294** - (Immunoassay for tumor antigen, qualitative or semi-quantitative), a semi- quantitative/qualitative antibody test
- **86318** - (Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method [e.g., reagent strip]), a semi-quantitative/qualitative antibody test
- **86376** - (Microsomal antibodies [e.g., thyroid or liver-kidney], each), a semi- quantitative/qualitative antibody test
- **86430** - (Rheumatoid factor; qualitative), a qualitative antibody test

- **86800** - (Thyroglobulin antibody), a qualitative antibody test
- **86850** - (Antibody screen, RBC, each serum technique) a semi-quantitative/qualitative antibody test
- **86870** - (Antibody identification, RBC antibodies, each panel for each serum technique), a semi- quantitative/ qualitative antibody test

Molecular Diagnostics and Cytogenetic Testing

Proper Billing

Arkansas Blue Cross and Blue Shield recently has noticed a significant increase in the number of molecular diagnostic and cytogenetic testing claims received. Many of the claims being filed for these services are filed incorrectly. Effective immediately, Arkansas Blue Cross and its affiliates no longer will review the denied claims for these services if the claim is billed with any of the molecular diagnostic or cytogenetic testing codes (83890-83914 and 88230-88299) when the claims are submitted without a specific genetic modifier, found in Appendix I of the 2010 Current Procedural Terminology (CPT®) Manual, and the number of probes performed with each code. The following information is what any facility or lab must include on a claim for molecular diagnostic or cytogenetic testing:

1. Claims must have the name of the genetic test that was performed along with the reason the test was ordered.
2. All of the molecular diagnostic codes (codes contained in the series from 83890-83914) and/or cytogenetic codes (codes contained in the series from 88230-88299) must be included on the claim for that genetic test ordered. In addition, the exact number of probes performed for each molecular diagnostic or cytogenetic code must be appended to the claim.
3. The correct genetic modifier, found in Appendix I of the 2010 CPT Manual for the genetic test ordered must be appended to the claim.

If a review of a denied claim is received and the claim was not submitted correctly, a letter will be sent to the provider stating the following:

“Please be advised, the claims will not be paid when submitted unless the proper genetic modifier, which is found in Appendix I of the 2010 CPT Manual, is properly appended to the claim with the molecular diagnostic/cytogenetic testing codes with each code having the number of probes that was performed with each code.”

The claim denial also will be changed to the appropriate code per line of business, indicating the claim was incorrectly coded and the member cannot be held financially responsible.

Pathology Consultation

Billing of Pathology Consultation Codes (CPT Codes 88331 and 88332)

Due to some confusion as to the appropriate manner which CPT code 88331 should be billed, the following is a guideline for the appropriate billing of this code.

CPT code 88331 is the pathology consultation during surgery; first tissue block, with frozen section(s), single specimen. The CPT Assistant July 2000, Page 4 states, "During the course of a surgical procedure, a pathology consultation may be required. Pathology consultations during surgery that involve frozen sections are reported with CPT codes 88331 and 88332." The phrase, "with frozen section(s), single specimen," has caused some confusion over the intent of the code, prompting some to believe that CPT code 88331 can only be used once per surgery, rather than once per specimen. In fact, multiple separately submitted specimens may be received during surgery for frozen section examination for diagnosis or immediate evaluation, resulting in the use of multiple units of 88331.

In order to properly use these codes, the terms "block" and "section" must be defined. A block is a portion of tissue from a specimen that is frozen or encased in a support medium such as paraffin or plastic, from which sections are prepared. A section is a thin slice of tissue from a block prepared for examination. The examination is usually by light microscopy.

When a section from the first block of tissue from a specimen is examined, CPT code 88331 would be used. When sections from subsequent blocks of the same specimen are examined, the appropriate coding is one unit of service of CPT code 88332 for each section examined. If more than one specimen is submitted for consultation, the services for each specimen would be coded as explained above.

Any routine stains (e.g., rapid H&E, Wright) applied to the frozen section are included in CPT codes 88331 and 88332. If other techniques (e.g., fine needle aspiration, touch preparation, examination of a cell sample) are used in the course of a pathology consultation during surgery, they should be reported using appropriate cytology codes. When the definitive permanent section examination is performed, subsequent to the frozen section during surgery, the appropriate surgical pathology code should be reported.

CPT Changes

CPT Changes 2001 Rationale CPT code 88331 was revised to allay confusion regarding the intent of the code. The descriptor of CPT code 88331, "with frozen section(s), single specimen," has caused confusion over the intent of the code prompting some to believe that CPT code 88331 can only be used once per surgery rather than once per specimen. The addition of "first tissue block" to the code descriptor was necessary to prevent misinterpretation.

Therefore, CPT code 88331 is restricted to one unit per specimen. If a frozen section is performed on a second block of tissue, CPT code 88331 should be reported with Modifier 59 or the LT or RT Modifiers.

Postoperative Global Period

Arkansas Blue Cross and Blue Shield uses the postoperative global periods used by Medicare. Each surgical and/or invasive procedure will have a global period of either zero, ten or ninety days. This means that all usual postoperative services occurring within those respective time frames are included in the Arkansas Blue Cross allowance and reimbursement of the surgical/invasive procedure. Providers will not receive additional payments. Only those related postoperative services that are considered significant and separately identifiable should be billed.

Transitional care management services

Arkansas Blue Cross and Blue Shield and Health Advantage cover the new Transitional Care Management Services (TOC) codes to reimburse for services provided during the critical period of discharge from a facility. These services are billed using CPT code 99495 and 99496.

These CPT codes are billable when an established patient requires moderate or highly complex medical decision-making during a transition of care from an inpatient setting (including acute hospital, rehab hospital, long term acute care, partial hospital, observation status, or skilled nursing/nursing facility).

Reimbursement for these CPT codes requires an attempt to contact the patient within two business days of discharge, culminating in a successful contact (for example by phone) separate from a face-to-face visit. In addition, reimbursement requires that a face-to-face visit occur within seven days of discharge (CPT code 99496) or within 14 days of discharge (CPT code 99495).

This face-to-face visit is part of the TOC service and is not billable separately from the TOC code. The TOC service is payable only once per 30 days. In the event of overlapping hospitalizations within a 30-day period, only one discharge is eligible for TOC reimbursement.

The TOC codes are payable only to primary care providers, including general practice/family medicine, internal medicine, pediatrics, or gerontology. The date of service can be billed either as the date of the face-to-face visit or the date 30 days after discharge (the latter being the Medicare policy).

Treatment of Temporomandibular Joint Disease

Treatment of Temporomandibular Joint Disease is only covered if the member's certificate has a TMJ rider for coverage. The only exception is for an individual contract issued prior to January 1, 2002. Providers should contact customer service for information on whether these benefits are in place and what dollar amount of coverage is available.



SECTION 24

Utilization Review

Introduction

Utilization management (UM) has long been used by healthcare purchasers to encourage appropriate use of services and high-value care. Through UM, health plans, hospitals, physicians and pharmacists share information to ensure the highest quality of care is provided to members in the most appropriate settings and from the most appropriate providers. UM programs are designed to identify areas of risk, reduce waste, improve patient safety and keep healthcare affordable by lowering costs. Health plans pursue UM programs to avoid over-utilization and under-utilization of healthcare services by making coverage determinations based on evidence-based guidelines.

Consistent with our five-year plan to improve value, Arkansas Blue Cross and Blue Shield has created a framework and is implementing several initiatives to enhance sustainability and improve efficiencies. The Utilization Management Program is coordinating efforts with the provider quality improvement department to enhance pay-for-performance and quality programs to help support our high-performing providers.

Arkansas Blue Cross encourages the use of preventive and wellness services to improve health and reduce costs, as such our UM staff will not require prior approval for certain services such as:

- Emergency room services
- Ambulances
- Urgent care
- Primary care
- Specialist visits
- Other practitioner office visits
- Preventive care
- Screenings
- Immunizations
- Diagnostic tests

The goal of the Arkansas UM team is to ensure high-quality, cost-efficient care for our members. There is no incentive to deny prior approvals through utilization review.

Basis for Determining Medical Necessity (vs. using primary coverage criteria in benefit)

Arkansas Blue Cross reviews are based upon evidence-based guidelines to assess medical necessity, including Milliman Care Guidelines and the Arkansas Blue Cross Medical Coverage Policy developed with input from physicians within our networks and external specialty physicians, in accordance with standards used by national accreditation organizations and regulatory agencies. These guidelines are reviewed annually and updated to include new treatments or technologies adopted as generally accepted professional medical practice. Arkansas Blue Cross strives to ensure that medical necessity guidelines are applied in a way that considers the individual health needs of each member.

Arkansas Blue Cross may have to change medical necessity guidelines to reflect new findings on effectiveness for new or existing treatments. Providers are notified 30 days in advance of changes to these guidelines.

Definitions

The general term “prior approval” is used universally at Arkansas Blue Cross to define a process that is used when medical tests, procedures or services require review by the enterprise before the medical test, procedure or service meets primary coverage criteria and will be covered by the member’s benefit plan. There are more specific terms that may be utilized in UM programs. Some of these include:

1. **Primary coverage criteria:** Criteria established by Arkansas Blue Cross that must be met before benefits are available for a service. Elements of the primary coverage criteria include:
 - a. The intervention must be a health intervention intended to treat a medical condition.
 - b. The intervention must be proven to be effective.
 - c. The intervention must be the most appropriate supply or level of service considering potential benefits and harms to the patient.
 - d. The intervention must be the most cost-effective intervention.
2. **Pre-certification:** Reviewing inpatient admissions to determine whether hospitalization is medically necessary, or whether needed services could be provided in an outpatient or other alternative setting.
3. **Pre-authorization:** Determining (by Arkansas Blue Cross) in advance if a medical service, medication, supply, test or equipment meets primary coverage criteria for a covered person.
4. **Pre-notification:** Contacting the health plan prior to admission or other medical service to **alert** us of the admission or service.

If you have questions about prior approval and utilization management, you can email your questions to:

abcbspriorauth@arkbluecross.com

For questions regarding prior approval for members on the exchange, email expriorapproval@arkbluecross.com



Arkansas Blue Cross and Blue Shield

Product Line	Admission Prior Approval	Outpatient Prior Approval
Arkansas Blue Cross and Blue Shield	Required (<i>see below</i>)	Required for select services (<i>see below</i>)
FEP	Required (Please note all ID cards have the Arkansas Blue Cross logo and the ID # begins with an "R")	Not Required

Health Advantage

Product Line	Admission Prior Approval	Outpatient Prior Approval
Health Advantage	Not Required Pre-notification required for out of state or out of network.	Not Required

BlueAdvantage Administrators of Arkansas

Product Line	Admission Prior Approval	Outpatient Prior Approval
BlueAdvantage Administrators of Arkansas	Required	Required for Certain Groups Call the following phone number to inquire 800-872-2531

Arkansas Blue Cross Exchange Population Prior Approval Requirements

Inpatient Medical Admissions

Coverage of all medical inpatient admissions require prior approval. While emergency care does not need approval, medical* inpatient admissions as a result of emergent situations do require approval. Medical inpatient admissions include, but are not limited to:

- Medical and surgical admissions (scheduled and elective)
- Inpatient hospice care
- Skilled nursing facilities
- Rehabilitation facility admissions

* In emergent situations, providers **should not** delay admission while waiting on approval.

When submitting a prior approval request, you should submit relevant clinical information. If you must call in a request, it should be followed with written documentation. Calls should be made to **800-558-3865**, 8 a.m. to 4:30 p.m., Central time, Monday – Friday, except on major holidays. Information also may be submitted through the Provider Portal in AHIN. Requests submitted after hours and on weekends through the Provider Portal will be processed the following business day.

Prior approval information should include:

- Member name, date of birth and Arkansas Blue Cross member ID
- Provider's NPI #
- Facility name
- Admitting or primary diagnosis/procedure codes
- Relevant clinical information to support admission and level of service
- Admission type (SNF, inpatient medical, rehab)

Prior approval decisions for medical inpatient admissions are made by our local team in a time appropriate for the medical exigencies, but no later than one business day of receiving all relevant clinical documentation. That information is also made available for future, prospective and concurrent review.

Utilization management decisions are determined by the Arkansas Blue Cross Medical Coverage Policy and Milliman Care Guidelines (MCG). These policies and guidelines are evidence-based and systematically reviewed and updated by the Arkansas Blue Cross Medical Policy Committee. These guidelines are available on AHIN.

Concurrent review will also be utilized to assure the appropriateness of care, the setting and the progress of discharge plans and to link Arkansas Blue Cross members to care management as needed to improve health outcomes. The ongoing review is directed at facilitating the right care, at the right time, in the right setting (or level) appropriate for the patient.

For members not on Exchange policies, out-of-state and out-of-network hospital admissions require pre-notification by calling the 800 number located on the member's ID card. In-network and in-state hospital admissions do not require pre-notification. Please be aware when calling to pre-notify an out-of-state or

out-of-network admission that the phone menu has changed. Providers must listen to the entire menu to assure calls are being transferred to the appropriate location.

For more information, please call your local Arkansas Blue Cross and Blue Shield office.

Admission Pre-notification/Pre-certification Requirements for Out-Of-State or Out-Of-Network 2011	
Arkansas Blue Cross Blue Shield	Pre-notification requirements for out-of-network and out-of-state only. Effective Jan. 1, 2011, pre-notification calls are taken by Arkansas Blue Cross Customer Service. Call the phone number on the member's ID card, listen to the menu of options, and choose the Arkansas Blue Cross option after the tone. Excluding Exchange members on metallic plans.
BlueAdvantage Administrators of Arkansas	Precertification and Continued Stay Review are required for many groups. Review, carefully, the member's ID card for pre-certification or pre-notification instructions and the appropriate 800 number to call.
FEP	There have been no changes in this process. Pre-certification is requirement for hospital admissions. Pre-certification services are provided by Health Integrated. Call the phone number on the member's ID card, listen to the menu of options, and choose the FEP option after the tone.
Health Advantage	<p>Pre-notification requirement for out-of-network and out-of-state only. Calls are taken by Health Advantage Customer Service by calling the phone number on the member ID card, listen to the menu of options, and choose the Health Advantage option after the tone.</p> <p>For Arkansas State and Public School members (ID prefix PXG), Health Advantage administers prior authorization/pre authorization service requests. Health Advantage is partnering with Lucet Health Behavioral Health and Carelon.</p> <p>For Behavioral Health/Substance Abuse, pre authorization will need to be obtained by Lucet Health at 877-982-8295.</p> <p>High Tech Radiology services will need to be precertified by Carelon at 877-642-0722.</p> <p>All other medical services that require prior authorization/pre authorization will need to be obtained by calling Health Advantage at 800-482-8416 (internal transfer extension 50158). Outpatient service requests can also be submitted by fax or mail using the form available on the Health Advantage website:</p> <p>Prior approval for requested services - Health Advantage</p> <p>Prior Authorizations for Specialty Medications will continue to go through EBRx, and a separate list will be updated as changes occur.</p> <p>Acute medical conditions do not require pre-certification.</p>
USABLE Administrators	Precertification and Continued Stay Review are required for many groups. Review, carefully, the member's ID card for pre-certification or pre-notification instructions and the appropriate 800 number to call.

Admission Pre-notification/Pre-certification Requirements for Out-Of-State or Out-Of-Network 2011

USable Life Group Health

Pre-notification requirement for out-of-network and out-of-state only. Calls are taken by the regional Customer Service not Health Integrated. Providers should dial the Customer Service phone number located on the back of the member's ID card which directs callers to the appropriate regional Customer Service area. Callers should listen to the menu of options, and choose the USable Life Group Health option after the tone.

Additional Services Requiring Prior Approval

The following services will require prior approval (PA) as of April 1, 2022.

Arkansas Blue Cross and Blue Shield Fully Insured

- Home health visits and hospice subject ***except metallic***.
- Mental health inpatient ***except metallic***.
- Inpatient acute, LTAC, rehab: group business only ***except metallic***.
- Prosthodontics services.
- Additional services require PA as part of the Craniofacial Anomaly reconstructive surgery: Sclera contact lenses, including coatings, ocular impressions of each eye; every two years, two hearing aid molds and a choice of two wearable bone conductions, two surgically implantable bone-anchored hearing aids or two cochlear implants including metallics and the US65 individual plans.

Arkansas Blue Cross and Blue Shield Exchange

- Additional services require PA as part of the Craniofacial Anomaly reconstructive surgery: Sclera contact lenses, including coatings, ocular impressions of each eye; every two years, two hearing aid molds and a choice of two wearable bone conductions, two surgically implantable bone-anchored hearing aids or two cochlear implants including metallics and the US65 individual plans.
- Prosthodontics services.

Special Note

Arkansas Blue Cross and Blue Shield cannot give providers any kind of guarantee regarding eligibility – Arkansas Blue Cross can only give the data available and reflected on our computer system at the time a provider calls. Many factors beyond the knowledge or control of Arkansas Blue Cross may affect the eligibility status of a given member; therefore, providers should not rely on the eligibility data provided as assurance of coverage for the services or service date(s) in question. A provider's best source for the most up-to-date information on eligibility is the patient, who should know employment status and premium payment history or intention on the date of service.

The Arkansas Blue Cross participating provider agreements specifically address eligibility, providing the following: Effect of Eligibility and Pre-certification or Pre-Notification Responses – Provider understands and agrees that pre-certification for inpatient treatment, pre-notification or any "verification of benefits" or other eligibility inquiries made prior to, at or after admission or provision of any services to members are not a guarantee of payment.

Pre-certification means only that, based on information provided to Arkansas Blue Cross (or the applicable payer) or its designated representative at the time of admission, coverage for the admission (and for the initial number of inpatient days authorized for reimbursement) will not be denied solely on the basis of lack of medical necessity (as defined by the member's health plan) for inpatient treatment. Pre-notification means only that Arkansas Blue Cross (or the applicable payer) has been notified of the admission.

While Arkansas Blue Cross (or the applicable payer) or its designated representative will endeavor in good faith to report member eligibility information available to Arkansas Blue Cross within its records or computer systems at the time of admission or provision of services, provider acknowledges and agrees that it is not possible to guarantee accuracy of such records or computer entries. A provider understands and agrees that the eligibility of all members and coverage for any services shall be governed by the terms, conditions and limitations of the member's health plan, which shall take precedence over any inconsistent or contrary oral or written representations.

If, following any inpatient treatment or other services, it is discovered or determined that premiums had not been paid for a member's coverage, that a former member was no longer employed and eligible for participation in the health plan at the time of the admission, or that coverage had lapsed or terminated for any reason specified in the member's health plan, no reimbursement shall be due from Arkansas Blue Cross (or the applicable payer) for such services.

For More Information

For more information regarding pre-certification requirements, see the section on the Arkansas Blue Cross Web site: <https://secure.arkansasbluecross.com/providers/mprecertrouter.aspx>

Fax number for hospital pre-certification services

Arkansas Blue Cross and Blue Shield's hospital admission pre authorization fax number is **501-378-2050**. Please make sure all clinics and facilities are using the fax number when sending pre authorization clinical information for members of BlueAdvantage Administrators of Arkansas, FEP, and USABLE Administrators.

Providers who have questions regarding this change should contact their network development representative.

Behavioral Health Admissions and Services

To better address behavioral healthcare needs in our state, Arkansas Blue Cross will be implementing high intensity community-based case management and utilization management that will be coordinated with the patient's mental health provider and primary care physician. Accordingly, prior approval of coverage for select behavioral health services will be required. These services include inpatient behavioral health admissions, intensive outpatient treatment, residential treatment programs, applied behavioral analysis (ABA) and repetitive transcranial magnetic stimulation treatment (rTMS).

- To obtain prior approval contact Lucet Health directly at **877-801-1159**.
- Prior approval may also be requested through Lucet Health's secure web access portal, WebPass. For information about WebPass and how to access it, contact Lucet Health at **888-611-6285**.
- Requests must include key clinical information such as the patient's diagnoses, mental status, precipitating event or events leading to treatment, prior treatment history, current outpatient providers, medications, proposed treatment plans, risk and safety concerns, family and support systems, tentative discharge plans and estimated length of treatment.

Outpatient Services

Utilization management for outpatient services includes prior approval for the following services:

- Durable medical equipment: over \$500
- Prosthetics: over \$5,000
- Vacuum assisted closure (wound vac)
- Infertility services health plans
- Rehabilitation services (Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic Services) do not require prior approval, but have a maximum combined services visit limit of 30 per calendar year. Additional visits require prior approval.
- Habilitation services
- Home health
- Reconstructive surgery
- Outpatient services: certain outpatient hospital services and ambulatory surgical center procedures are subject to prior approval. Call customer service for more information.

Pregnancy-related services will be automatically approved but will require prior notification to ensure high- risk pregnancies may be adequately identified and monitored for optimal health outcomes for mother and child.

- Complete the [prior approval form](#) (PDF).
- For efficient service, you should submit prior approval requests via the Provider Portal on AHIN. Requests submitted after hours and on weekends through the Provider Portal will be processed the following business day.
- You also may fax your request to **501-378-6647**. Be sure to include medical records along with the prior approval form.
- If for some reason you cannot access AHIN, contact AHIN Customer Support at **501-378-2336** or by email at customersupport@ahin.net.

Pharmacy

To ensure the appropriate use of prescription drugs, in terms of both cost-effectiveness and safety, certain drugs on the formulary for the individual marketplace will require prior approval, quantity limits, or step therapy. To see which drugs require these measures, visit arkansasbluecross.com/members/individual-and-family/pharmacy-information and reference the Metallic formulary.

The pharmacy help desk is available at **800-364-6331** if assistance is needed.

High Tech Radiology Prior Approval

Ionizing radiation from medical imaging exposes patients to increased risk of radiation induced malignancies over time. There is also increased utilization of imaging procedures. The cumulative risk of patients undergoing frequent or repeated studies is now recognized as a growing public health concern and an area of ongoing research. Coverage of all enhanced high-tech imaging will require prior approval with submission of relevant medical record documentation. Clinical validation will be required for the following:

- Abdominal and pelvic CT
- Chest/thorax CT
- Head CT
- Sinus CT

As part of the approval process, providers will need to fax or upload on providerportal.com to Carelon certain pieces of a patient's medical records and/ or additional clinical information as part of the clinical review for determination.

- To initiate a request for an approval please contact Carelon via toll-free number **877-642-0722** or providerportal.com
- To check the status of an approval please contact Carelon via toll-free number **877-642-0722** or providerportal.com
- Provider will be able to upload requested records on the Carelon website providerportal.com or at **877-642-0722**.

If an urgent clinical situation exists outside of a hospital emergency room, please contact Carelon at **877-642-0722** immediately with the appropriate clinical information for an expedited review.

Out of State/Out of Area

Arkansas Blue Cross and Blue Shield recognizes the value of ensuring our exchange members see True Blue PPO providers. As of January 1, 2018, coverage for out-of-area/out-of-state services on some exchange policies will only be provided with prior approval for services not available from a True-Blue provider or in emergency situations. There are border state providers participating in the True Blue PPO. If the medical service is best offered by an out-of-state provider (e.g., certain types of transplants), those services will be permitted upon review of a prior approval request.

Continuity of care will be considered for complex conditions that have been maintained for a significant length of time by an out-of-state doctor following a prior approval request. You can identify policies with no out-of-area/out-of-state coverage by no suitcase symbol on the member ID card and by verifying eligibility on Availity.

- For consideration, submit a continuation of care election form, found at arkansasbluecross.com/providers/resource-center/provider-forms

Transplants

Prior approval is required for transplant evaluation and treatment. Prior approval is not required for kidney and cornea transplants.

Fax a letter of request for transplant evaluations and services along with medical records to **501-399- 3967**, attention: Carolyn Webb/Lisa Todd.

Carelon (formerly AIM Specialty Health)

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

A prior approval program for outpatient diagnostic imaging procedures began February 1, 2006. The prior approval program applies to all Arkansas Blue Cross members, including those who access the True Blue PPO network, as well as all Health Advantage members.

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

In August 2018, Arkansas Blue Cross and Blue Shield made the decision to transition the administration of advanced diagnostic imaging from National Imaging Associates (NIA) to Carelon for its members.

Why the change?

Carelon administers services nationwide, which will allow us to serve members outside the Arkansas service area through a single vendor. Carelon serves about 50 health plans and related organizations, representing more than 42 million people. The Carelon staff of 1,000 associates includes 600 healthcare professionals (licensed in all 50 states, with board certification in more than 20 specialties and subspecialties).

What changes will customers notice?

This transition will be seamless for the vast majority of our fully insured customers. Here are some important notes on the transition:

- **Effective date** – The move from NIA to Carelon is effective January 1, 2019.
- **Phone number** – Arkansas Blue Cross purchased the telephone number listed on the back of some member ID cards and will redirect it to Carelon. Members or providers calling for diagnostic imaging pre-authorization will follow the same process as before the vendor change. For questions or inquiries:
 - Call Carelon Specialty Health toll-free at **877-642-0722**
 - Hours: Monday – Friday [7:00 am to 7:00 pm CST]
- For member inquiries to their network plan, please call the customer service number listed on the member's ID card.
- **ID cards** – No member will receive a new ID card solely because of the move to Carelon.
- **Websites** – All of the networks websites are now redirected to link provider to Carelon's website.
- Get fast, convenient online service via the Carelon **ProviderPortal**SM (registration required). ProviderPortal is available twenty-four hours a day, seven days a week. Go to providerportal.com to begin.

The following information is needed to submit a request to Carelon:

- Member's identification number, name, date of birth, and health plan
- Ordering provider information
- Imaging provider information
- Imaging exam(s) being requested (body part, right, left or bilateral)
- Patient diagnosis (suspected or confirmed)

BlueAdvantage Administrators of Arkansas

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

Federal Employee Program

Arkansas Blue Cross and Blue Shield's Federal Employee Program (FEP) has engaged Carelon, to operate a new Radiology Utilization Management Program for that health plan's members, effective April 1, 2022.

As of that date, Carelon will handle medical necessity review of diagnostic imaging services for FEP members.

Carelon works with leading insurers and providers, through evidence-based practice initiatives, to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe and affordable.

For services that are scheduled to begin on or after April 1, 2022, all providers must contact Carelon to obtain pre-service review for the following nonemergency modalities:

- Nuclear imaging (including myocardial perfusion imaging), cardiac blood pool imaging, infarct imaging and positron emission tomography (PET) myocardial imaging.
- Computed tomography (CT), including CT angiography, structural CT and quantitative evaluation of coronary calcification.
- Magnetic resonance imaging (MRI).Magnetic resonance angiography (MRA).
- Magnetic resonance spectroscopy (MRS).
- Functional MRI (fMRI).

How to submit a request for review:

Starting March 14, 2022, providers may begin submitting requests for review or verify order numbers, using one of the following methods:

Online

The fully interactive Carelon ProviderPortalSM is available 24/7 and processes requests in real-time, using clinical criteria. Register at the [Carelon Specialty Health provider portal](#).

By phone

Call Carelon Specialty Health toll-free at **866-688-1449** (7 a.m. - 7 p.m. Central, Monday - Friday).

For more information:

Online

Providers may access [Radiology Utilization Management Program resources](#) on the Carelon website. The [Carelon website](#) also has more information about the program and provides access to useful information and tools such as order entry checklists and clinical guidelines.

By phone

Providers who have questions or observations may contact their designated Arkansas Blue Cross network development representative.

Arkansas Blue Cross and Blue Shield's Federal Employee Program greatly values the trusted healthcare providers that serve the members who depend on us for their health coverage, and we look forward to working with you and Carelon to maintain a high standard of care.

Note: *Aim Specialty Health is an independent company that operates separately from Arkansas Blue Cross and Blue Shield and administers radiology utilization management services for the benefit of Arkansas Blue Cross Federal Employee Program members. Arkansas Blue Cross and Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.*

Advanced imaging program for Tyson and Walmart

BlueAdvantage Administrators of Arkansas will continue working with Carelon for outpatient diagnostic imaging procedures for Walmart associates and Tyson team members and their covered dependents throughout the United States. Walmart associates and Tyson team members residing in Arkansas will be included in this national care management program.

This is the same advanced imaging review program currently utilized by Arkansas Blue Cross and Blue Shield, Health Advantage and select employer groups administered by Blue Advantage through Carelon. The imaging program for Tyson and Walmart, administered by Carelon, includes clinical appropriateness review of advanced imaging services and assists members in finding a "best value" site for MRI and CT exams using the Blue Cross and Blue Shield Association's National Consumer Cost Tool (NCCT) data set.

There are three primary components included in the imaging management program as described below:

- 1. Clinical appropriateness review:** Carelon will provide prospective clinical review for elective, outpatient CT, MRI, Nuclear Cardiology, PET and Echocardiography exams.
- 2. Provider transparency:** During the clinical review process, Carelon will share NCCT cost information with the ordering physician's office.
- 3. Member transparency:** Carelon will make phone calls to members if there is an opportunity for the member to maximize their benefits by selecting a different facility for their MRI or CT exam. These conversations will be supported by the NCCT cost information as well.

Clinical appropriateness review

Physicians ordering elective, outpatient diagnostic imaging exams for the members listed above will be asked to obtain an order number from Carelon before scheduling the procedure. These services include:

- Computed Tomography (CT/CTA)

- Magnetic Resonance Imaging (MRI/MRA)
- Nuclear Cardiology
- Positron Emission Tomography (PET)
- Stress Echocardiography (SE)
- Resting Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and free standing surgery centers), urgent care centers, or 23-hour observations are excluded from this requirement.

Physicians in your service area will find discover information about the program when checking benefits and eligibility through BlueAdvantage. Messaging will instruct the physicians to contact Carelon to request or verify an order number one of two ways:

- Online through Carelon’s ProviderPortalSM at aimspecialtyhealth.com/goweb or
- Via the toll-free telephone number displayed on the back of the member’s ID card, or direct to Carelon at **866-688-1449**. The member also may call Carelon to initiate the process.

Provider transparency

To support national transparency efforts and through partnership with its Blue clients, we are leveraging the NCCT cost values for Blue imaging providers. During the clinical review process, we will be sharing MRI and CT costs with ordering providers in an effort to promote transparency and increase awareness.

Member engagement

Using the clinical appropriateness approval as the trigger, we also will be engaging members in their site of service selection through the Specialty Care ShopperSM program. When a CT or MRI/MRA exam is scheduled, a customer service specialist will proactively reach out to members to inform them of the imaging facility options available to them. During this outreach, members will have an opportunity to maximize their health care benefits by selecting an alternative imaging facility. Members will not be denied access to benefits if they decide to stay with their existing facility. Our goal is simply to provide members with information to make informed choices about their health care.

Submitting online request to Carelon

To submit a request for outpatient diagnostic imaging procedures online to Carelon, providers will first need to create and register a username and password with ProviderPortalSM. To register, visit aimspecialtyhealth.com/goweb and select “BCBS National Accounts” from the drop down menu under the heading “To Register, simply select your health plan.” ProviderPortal is available twenty-four hours a day, seven days a week. Go to providerportal.com to begin.

At the “Member Login” page, select “Register Now” from the right-hand side of the screen under the caption “New User?” to complete the registration. The registration wizard will walk users through the process step by step. For further assistance, providers can contact Carelon at **800-252-2021**.



Radiology Management Reference Guide

Prior Approval Fact Sheet

A prior approval program for outpatient diagnostic imaging procedures was implemented on February 1, 2006. This correspondence serves as notice of change to the Utilization Review Programs under the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage, PPO Arkansas' True Blue and Arkansas' FirstSource provider agreements.

The following outpatient services require the new prior approval*:

- CT Scan
- Nuclear Cardiology
- MRI/MRA
- PET Scan

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

- Emergency room, observation department of a hospital, and inpatient imaging procedures do not require prior approval.
- These services will apply to all Arkansas Blue Cross and Blue Shield members, including those who access the Arkansas' FirstSource and True Blue PPO network, as well as Health Advantage members.
- Customers of BlueAdvantage Administrators of Arkansas can elect to add this program on a group- by-group basis, which would be indicated on the member's ID card.
- These radiology services do not apply to members of the Federal Employee Program (FEP) at this time.
- The ordering physician is responsible for obtaining the prior approval number for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call.
- Call center hours of operation are Monday through Friday, 7 a.m. to 7 p.m. ·Providers may obtain prior approval by calling Carelon at **877-642-0722**. (Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact Carelon within five business days of the date of service and before the claim is submitted to obtain proper approval for the studies, which will still be subject to review.)
- Average calls are completed within five minutes. Peak call volume occurs between the hours of 1 p.m. to 6 p.m.
- Approvals may be obtained on-line after the user is registered at: providerportal.com.
- Carelon's guidelines are located on their website at: providerportal.com. The guidelines are available in a PDF format that may be printed for future reference.
- Prior approval is not a guarantee of coverage. The radiology services are subject to the member's eligibility and benefit plan provisions.

Please note: Just because prior approval is obtained it does not mean coverage is guaranteed or even available for the particular member or service involved. Coverage is always subject to the specific terms and conditions of the member's health plan or policy, which must be met when the claim is received and reviewed. Such terms and conditions may include but are not limited to lifetime maximums, specific benefit limits or caps in some

cases, out-of-network limitations, eligibility requirements such as the timely payment of premiums, and specific health plan or policy exclusions. See the “Pre-Certification” section of your participating provider agreement.

The Prior Approval Implementation Recommendations for Ordering Physicians and Participating Facilities

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

Ordering Physician

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

Emergency room, observation department of a hospital and inpatient imaging procedures do not require prior approval. To expedite the approval process, please have the following information ready before calling the Carelon Utilization Management staff (***Information is required**):

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

If requested, please be prepared to fax the following information: Clinical notes; X-ray reports; Previous CT/MRI reports; Specialist reports/evaluation; and Ultrasound reports;

Participating Imaging Facilities

It is the responsibility of the ordering physician to ensure that prior approval is obtained. The rendering facility should not schedule procedures without prior approval. For urgent tests, the rendering facility can begin the process, and Carelon will follow up with the ordering physician to complete the process. Procedures performed that have not been properly approved will not be reimbursed, and the member cannot be balance billed. A separate authorization number is required for each procedure ordered.

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

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

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

Radiology Management Reference Guide

Frequently Asked Questions

The following are the most common questions with answers regarding the prior approval changes from Carelon.

Q.1. Is prior approval from Carelon required for all radiological procedures?

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

Q.2. Who is responsible for obtaining prior approval from Carelon?

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

Q.3. Are there situations that do not require prior approval from Carelon?

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

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

Q.4. Is prior approval required for an emergency situations?

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

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

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

Q.6. What information does the ordering physician need to expedite a prior approval call to Carelon?

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

- Name and office telephone number of ordering physician*;
- Member name and ID number*;
- Requested examination*;
- Name of provider office or facility where the service will be performed*;
- Anticipated date of service (if known);
- Details justifying examination:*
 - Symptoms and their duration;
 - Physical exam findings;
 - Conservative treatment patient already has completed (for example: physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications);

- Preliminary procedures already completed (for example: X-rays, CT's, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation);
- Reason the study is being requested (for example: further evaluation, rule out a disorder).

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

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

Also, providers can perform authorization requests on line at providerportal.com.

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

A.8. Yes.

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

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

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

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

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

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

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

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

Q.13. How long is an approval number valid?

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

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

A.14. It is important to notify office staff and educate them about this new policy. This policy is effective January 1, 2019. Claims for CT, MRI/MRA, PET and Nuclear Cardiology procedures that are not prior authorized will not be paid, and the members must be held harmless if the service is provided by a participating provider.

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

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

Q.16. Who will receive the prior approval number from Carelon?

A.16. On completion of the prior approval process, Carelon will notify the ordering physician of the authorization status. If the ordering physician is able to provide sufficient clinical and demographic information at the time of the initial call, a verbal authorization number will be issued. If the authorization request requires additional review, Carelon will provide an authorization tracking number that will serve as a means of tracking the status of the process. Once a final determination has been reached, Carelon will notify the ordering physician of the decision verbally or in writing (fax or letter). If the ordering physician does not complete the prior approval process, the status will be "transaction denied for prior approval noncompliance, no member liability."

Q.17. How can the Carelon approval number be identified?

A.17. The Carelon approval number consists of 11 alphanumeric characters (Example: NYMMDD####).

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

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

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

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

Q.20. Is an Carelon prior approval number needed for a CT-guided biopsy?

A.20. No.

Q.21. Which PET scans require a prior approval?

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

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

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

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

A.23. No.

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

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

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

A.25. Yes.

Q.26. How are procedures that do not require an Carelon prior approval handled?

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

Q.27. Can I speak directly with a clinical reviewer or physician (peer-to-peer) level reviewer?

A.27. Once the initial intake process is complete, you may request to be transferred to the clinical level of review. Initial intake information is necessary to determine member eligibility and to process the request.

Q.28. What steps will the ordering provider take when the approval is not given during the initial intake process (level 1)?

A.28. The case will be forwarded to Carelon's clinical departments who will review the clinical information submitted. If needed, the clinical staff will request via fax, additional clinical information. This information can be faxed to Carelon's dedicated clinical fax line. An ordering office might request a hot transfer to a nurse clinical review (level 2) during the initial request, however, this should only be requested if the office has a clinician who can speak with the Carelon nurses and who have additional clinical information that would support the requested study.

Q.29. If Carelon denies the prior approval of an imaging study, does a provider have the option to appeal the decision?

A.29. Yes, through normal appeal procedures as directed in the denial letter. If Carelon makes the decision to deny the request at the end of the telephone call, and the physician does not agree with the decision made by Carelon, the physician should request an appeal of the decision from Carelon.

Q.30. Is there a way to bypass the Carelon recorded announcement?

A.30. When dialing into the toll-free number, callers will hear a seven-second system greeting that identifies the Carelon Imaging Approval Service. The short announcement will instruct callers to press option one to initiate a new request for authorization on an imaging exam or option two for the status of a case that was previously called in for approval. The announcement also will provide information that emergency procedures do not require a prior approval. The entire greeting may be bypassed by immediately pressing the desired option whenever the announcement starts.

Q.31. If Carelon approves prior approval of an imaging study, does this guarantee payment of the claim?

A.31. No. A prior approval does not guarantee payment or ensure coverage; it means only that the information furnished to Carelon at the time indicates that the imaging study that is the subject of the prior approval meets the Primary Coverage Criteria. A claim receiving prior approval must still meet all other coverage terms, conditions, and limitations. Coverage for any such prior authorized claim may still be limited or denied if, when the claimed imaging study is completed and Arkansas Blue Cross, BlueAdvantage, and

Health Advantage receives the post service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date imaging study services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the patient's health plan applies to limit or exclude payment of the claim.

Q.32. What is the toll-free telephone number and hours of operation for the Carelon Call Center?

A.32. Providers can reach the Carelon Call Center by calling the toll-free number **877-642-0722**, Monday through Friday, from 7 a.m. to 7 p.m.

Utilization Determination Timeframes

Type	Time Frame	
	In Patient	Out Patient
Prospective/Urgent	24 hours	24 hours
Prospective/NonUrgent	24 hours	2 business days /10 days ACT 815
Concurrent Review	48 hours	

Peer to Peer and Appeals

A written or verbal request for appeal may be requested by a physician, facility, provider or patient contesting an organizational determination of an adverse benefit determination and requesting a review for correctness.

Claims Received Without Prior Approval

Failure to submit a pre-service claim for Prior Approval will result in a denial of coverage.

Note: Prior Approval does not guarantee payment or assure coverage. It means only that the information furnished to the Company at the time indicates that the services meets the Primary Coverage Criteria requirements and is not subject to a Specific Plan Exclusion. All services receiving Prior Approval must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the claims for the services are received, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Interventions described in the pre- service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of- network limitations apply, or any other basis specified in the members policy.

Contact the [network development representative](#) for questions or call customer service at the number on the back of the member's ID card.

Enhancement for Prior Approval Submissions

Effective August 24, 2020, prior approval requests initiated through the provider portal located on the AHIN site now provides for the submission of clinical documentation. This applies to Arkansas Blue Cross and Blue Shield, Blue Advantage and Health Advantage. It does not apply to the Federal Employees Plan (FEP).

This enhancement feature allows uploading of the supporting clinical documentation for the prior approval request. Accepted document types include Word, PDF, JPEG and PNG files. The allowed file size is 10 MB or less.

Files over the file limit must be faxed to Arkansas Blue Cross and Blue Shield or the applicable company. These files should include the episode number associated with the request and full member's name on the included cover sheet. For medical inpatient PA requests, please fax to **501-210-7032**. For outpatient service requests, please fax to **501-378-6647**.

You will continue to receive a Request for Information letter upon your submission. This is a bar coded letter to be used should you prefer to continue faxing in your clinical documentation supporting your request. This bar coded letter can also be used for those files over the file limit.



SECTION 25

Miscellaneous

Advanced Practice Registered Nurses - Certified Nurse Midwives, Clinical Nurse Specialists and Certified Nurse Practitioners

Effective October 1, 2005, Arkansas Blue Cross expanded its covered services for Advanced Practice Registered Nurses. Advanced Practice Registered Nurses (APRNs) are registered nurses with the advanced education and clinical competency necessary for the delivery of primary health and medical care.

Reimbursement for Advanced Practice Registered Nurses (APRN's), which includes Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS) and Certified Nurse Midwives (CNMs), is limited to APRN's who are licensed in the state of Arkansas and have met the requirements for and possess a certificate of prescriptive authority. The APRN must work in collaboration with the physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision.

APRN's providing services for Arkansas Blue Cross members must comply with the following policy to qualify for reimbursement:

- The APRN must have a written and signed collaborative agreement and quality assurance plan with a supervising medical doctor (MD) or doctor of osteopathy (DO). A copy of the agreement must be provided to Arkansas Blue Cross and Blue Shield.
- The APRN must have licensure and be in good standing with Arkansas State Board of Nursing, as well as with all Arkansas Blue Cross and Blue Shield and any networks of its affiliates.
- The APRN must have prescriptive authority.
- The APRN adheres to the collaborative responsibilities by participating as a team member in the provision of medical and health care, interacting with physicians to provide comprehensive care according to established and documented protocols.
- Physicians may continue to bill for appropriate APRN services as "incident to" but cannot bill for services already submitted under the APRN's NPI. "Incident to" requires direct supervision of the physician.
- APRN services submitted by the supervising physician will be paid at the physician level to the physician.
- Services provided by APRN's are limited to those patients presenting problems of low to moderate severity and the medical decision making involved does not exceed that same level. Patients with more severe problems must be referred to physicians.
- The APRN can bill for services in a collaborative practice with a physician but are limited to the use of E & M CPT codes 99201, 99202 and 99203 for new patients and CPT codes 99211, 99212, 99213, and 99214 for established patients. Current published guidelines for assigning CPT codes to services and documentation to support the "medical necessity" of all services must be met.
- Services performed in an inpatient/acute facility will not be paid.
- The APRN may order diagnostic laboratory and x-ray studies that are medically indicated for the level of service as indicated above in accordance with established and documented protocols.
- The service provided by the APRN must be concordant with the specialty of the supervising physician.
- Physicians may continue to bill for appropriate APRN services as "incident to" but cannot bill for services already submitted under APRN's provider number. "Incident to" requires direct supervision of the physician.
- The APRN must present him/herself so the public and other payers are fully aware of the practitioner's business operations. This includes items such as signage, letterhead and other marketing elements.

Practitioner cannot be a network participant if services being provided are eligible to be billed by a facility, institution or other medical entity.

- The APRN must have professional liability coverage as required per network participation agreement (\$1 million/ \$3 million).
- The APRN must meet all other contractual requirements.

Physicians wishing to bill for services provided by an APRN to Arkansas Blue Cross members should send copies of the APRN's collaborative agreement and quality assurance plan to:

Arkansas Blue Cross and Blue Shield Division of Medical Management
P.O. Box 2181
Little Rock, Arkansas 72201

Emergency Room Evaluation and Management and Assistant Surgery Services

The coverage of lower level Emergency Room Evaluation and Management Services and Assistant at Surgery Services have been added to the list of payable services provided by Advanced Practice Registered Nurses effective for dates of service July 1, 2007 or after.

Low level Emergency Room Evaluation and Management codes:

- The normal scenario will be:
 - A physician or physician group is employed by the hospital to staff the emergency room;
 - The Advanced Practice Registered Nurse is employed by the physician / physician group / hospital and has a collaborative agreement with the emergency room physicians.
- Payable services are limited to less complex encounters normally provided by a physician;
- Triage services are not covered as triage services are included in the facility payment;
- If the patient is transferred to an emergency room physician, only the emergency room physician may bill for the ER visit;

Assistant at surgery services:

- Must be billed under the APN/CNS/CMN provider number with modifier AS in the first modifier position.
- Limited to procedures approved for assistant at surgery coverage.

Copayment changes for Advanced Practice Registered Nurses

Arkansas Blue Cross and Blue Shield will begin applying primary care copayments during claims adjudication for certain Advance Practice Registered Nurses (APRN). APRNs must work in collaboration with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision. APRNs must also have a written collaborative practice agreement and quality assurance plan with a physician.

The distinction between primary care benefits versus specialist benefits will be based on the specialty of the collaborating physician. For example, if the written collaborative practice agreement that has been supplied to Arkansas Blue Cross by the APRN during the network enrollment process is signed by a primary care physician, then that APRN will be considered a primary care APRN for benefit application/claims adjudication purposes.

In most cases, Family Medicine, General Practice, Internal Medicine, and Pediatric Medicine will be considered primary care.

The copayment change was effective on April 1, 2008 for Arkansas Blue Cross.

Keep in mind that not all benefit plans make the distinction between primary care services and specialist services and that self-funded employer health plans have the option to implement or reject this benefit.

Allergy Injections

Provided all the terms and conditions of coverage are met (including, but not limited to, the Primary Coverage Criteria), Allergy injections/services are covered in physician's office, as well as, in an allergist's office. The serum for the injection is covered under all Arkansas Blue Cross and Blue Shield plans. Please contact Customer Service for more specific coverage and reimbursement information.

Please note that Arkansas Blue Cross does not give oral assurance of coverage prior to claims being filed and received. All coverage is always subject to final claim investigation upon receipt of the claim and all related information needed to evaluate the claim for whether it meets coverage criteria under the applicable member health plan or contract.

Coverage for RAST testing requires a documentation and prior approval of coverage by Arkansas Blue Cross.

Up to ten screening RAST tests are covered only for the evaluation of rhinitis, extrinsic asthma, extrinsic allergic alveolitis, pulmonary eosinophilia, atopic dermatitis, urticaria, anaphylactic shock due to adverse food reactions, venom or serum. Even then, they are covered only when certain conditions prevent the performance, or adversely affect the interpretation, of skin tests. Those conditions are:

- Erratic wheezing;
- Hyperreactive skin;
- Urticaria;
- Dermatographism;
- Severe eczema;
- Food anaphylaxis;
- Allergy to latex;
- Patient refuses skin testing;
- Patient taking pharmacological drugs that interfere with the interpretation of skin tests and the drugs cannot be discontinued (ie, antihistamines, tricyclic antidepressants or beta blockers).

Medical record documentation must state which of the above conditions precludes skin testing.

If the above conditions are present, up to 10 screening RAST tests will be covered. If one or more of these is unequivocally positive, up to 30 more RAST tests may be covered. A copy of the positive screening RAST test is normally the only documentation needed with the claim for coverage of the additional 30 RAST tests.

Allergen immunotherapy - provision of antigens

Arkansas Blue Cross and Blue Shield uses the Centers for Medicare & Medicaid Services (CMS) Relative Value Units (RVU) to calculate physician fee schedule amounts. The physician fee schedule allowance for CPT code 95165 is \$16.06. CMS regulations indicate that:

“...a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multi-dose vial would significantly overpay the practice expense component attributable to this service.”

Arkansas Blue Cross is adopting this CMS rule. Providers should limit billing of CPT code 95165 to 10 units per multi-dose vial, even if providers actually obtain 30 units from the vial.

CPT code 95165 will be subject to medical review. In the event CPT code 95165 is used, medical records will be ordered. Providers' office records should document the number of doses per vial and the number of vials prepared for each member.

Durable Medical Equipment, Prosthesis and Orthotic Appliances and Medical Supplies

Coverage for Durable Medical Equipment (DME), Prosthesis, Orthotics and medical supplies will vary for Arkansas Blue Cross and Blue Shield members, depending upon the benefit plan, and is subject to Medicare coverage guidelines. All covered services must meet the Primary Coverage Criteria and be obtained through a participating Provider listed in the current Arkansas Blue Cross and Blue Shield Provider Directory or web site, unless the member has out of network benefits. Each member's plan may have different items that require prior approval of coverage and may also have an annual limitation. Always contact customer service to access this information.

Any Provider may obtain information about Member benefit coverage by calling the Customer Service Department. Please note that Arkansas Blue Cross does not give oral assurance of coverage prior to claims being filed and received. All coverage is always subject to final claim investigation upon receipt of the claim and all related information needed to evaluate the claim for whether it meets coverage criteria under the applicable member health plan or contract.

When it is more cost effective, Arkansas Blue Cross (at its discretion) will purchase rather than lease equipment for Members. Please Note: Arkansas Blue Cross and Blue Shield will not, in any case, be responsible to pay any lease or rental payments in excess of the purchase price of the applicable equipment.

Coverage for DME and prosthetic devices is limited to initial acquisition and replacement or repair when Primary Coverage Criteria is met. Most Arkansas Blue Cross plans have a \$5,000 calendar year limit on all DME. Check with customer service to see if the member receiving equipment has such a plan. It is the DME or Prosthetic provider's responsibility to assist in the coordination of the overall provision of health care services to Arkansas Blue Cross and Blue Shield members. This responsibility will involve the need to communicate with the member's attending physician, as well as, other providers of care, such as home health agencies, home infusion providers, or hospitals.

Reimbursement will be according to the current Participating Provider contract. Any supplies considered by Arkansas Blue Cross and Blue Shield to be part of the medical service being provided will not be reimbursed separately.

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.

Excluded from coverage are:

- Personal comfort items,
- Hygiene items,

- All over the counter items,
- Disposable items, or
- Any equipment, devices, and supplies that are not primarily intended for medical use, are not covered.

Oxygen and Supplies

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers that oxygen reimbursement is a bundled payment. All options, supplies, and accessories are considered included in the monthly rental payment for oxygen equipment. Separately billed options, accessories or supply items will be denied as unbundling.

Oxygen accessories, including but not limited to trans-tracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the physician. Accessories used with beneficiary-owned oxygen equipment will be denied as non-covered.

Oxygen billing codes:

E1390 and E1392 includes the oxygen concentrator, an integrated battery or beneficiary- replaceable batteries that are capable of providing at least two hours of remote portability at a minimum of 2 LPM equivalency, a battery charger, an AC power adapter, a DC power adapter, and a carrying bag and/or cart. (Rental reimbursement for concentrators will be paid for up to 36 months with a maintenance period the following 24months)

When code K0738 is billed, code E0431 (portable gaseous oxygen system, rental) must not be used. When code E0433 is billed, code E0434 (portable liquid oxygen system, rental) must not be used.

E1352 is an all-inclusive code consisting of a control unit, flow regulator, connecting hose, and nasal interface (pillows). For questions or more information, please email providerreimbursement@arkbluecross.com.

Ventilators and Supplies

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers that ventilator reimbursement is a bundled payment. All options, supplies, and accessories are considered included in the monthly rental payment for ventilation equipment. Separately billed options, accessories or supply items will be denied as unbundling.

Reimbursement for ventilators is based on patients meeting the necessary clinical criteria.

Ventilator billing codes:

E0465 - Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)

E0466 - Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

For questions or more information, please email providerreimbursement@arkbluecross.com.

Hearing Aid Billing

Providers always should bill the monaural code (one ear) that applies to the type of hearing aid they are supplying and bill each ear separately. Providers should use Modifiers LT and/or RT on each line, whatever is applicable. One unit of service should be used per claim line. Providers should not submit a claim for a hearing aid until the aid has been placed in the member's ear — not when the order for the hearing aid is placed.

Imaging centers

CT dual auto injector equipment

In the September 2014 issue of Providers' News, Arkansas Blue Cross and Blue Shield and its affiliates, PPO Arkansas and Health Advantage published updated assessment criteria which applies to all participating imaging centers that was effective January 1, 2015. Included in the update was a specific requirement for imaging centers performing CT, CTA and CCTA which outlines the required utilization of dual auto injector equipment for contrast enhanced studies.

The rationale for requiring dual-syringe power injectors for CTs is to minimize the pooling of contrast in the injected extremity. This pooling reduces the effective contrast dose to the target organ being imaged while at the same time exposing the patient to as much as 30 percent unnecessary or non-imaged contrast dose.

As a reminder, Arkansas Blue Cross and its affiliates require all participating imaging centers to have dual-auto injector equipment in place and operational when performing any CT modality which includes CT, CTA and/or CCTA.

Laboratory Services

Physicians need to ensure that contracted reference laboratories are used if specimens are sent outside of a clinic. Arkansas Blue Cross and Blue Shield and all other affiliated companies are receiving claims from labs that are not contracted. It is a contractual obligation that all contracted providers use other contracted providers when making referrals or using outside services.

In addition, Arkansas Blue Cross is receiving claims from out-of-state laboratories that are not contracted. The Blue Cross and Blue Shield Association claims-filing rules require that specimens collected within a Blue Plan's service area be filed directly to that local Blue Plan. Therefore, all specimens collected in Arkansas for all Blue Cross and affiliated companies' members, must be filed directly to Arkansas Blue Cross or its affiliates and subsidiaries. Claims for specimens collected in Arkansas should not be filed directly to another Blue Plan.

Ameritox, Berkeley, Genzyme, Myriad and Prometheus Labs are not contracted with Arkansas Blue Cross nor its local affiliates and subsidiaries.

If a provider needs a higher-level lab service, one that the provider does not believe can be processed within Arkansas, please first consult with some of the national labs with whom we have provider agreements. Some of them own other companies that likely may accommodate your service and are contracted with Arkansas Blue Cross and its family of companies. Please also check our Web sites to ensure that the service being ordered is covered by meeting our primary coverage criteria.

Payment for claims from out-of-network lab providers, both in state and out of state, may be denied, or at a minimum, the member will pay a higher portion.

Effective April 1, 2018, Arkansas Blue Cross and its family of companies require the referring provider on all professional service claims. Any outpatient claim submitted with a laboratory service must contain the referring provider name and NPI. The referring provider will need to be a provider registered/enrolled in the provider database of Arkansas Blue Cross or its family of companies. Listing a referring provider who is not registered with Arkansas Blue Cross will result in claim rejection or denial.

Do not use out-of-network laboratories

Arkansas Blue Cross and Blue Shield and its affiliates have recently noticed an increase in the utilization of non-participating laboratory vendors and the performance of novel “cardiovascular risk” panels at an out-of-network laboratory. These panels include assays which are not covered benefits under the terms of the members’ health plans or policies.

Many of the claims for novel “cardiovascular risk” panel at an out-of-network laboratory are being submitted to one out-of-network vendor, Health Diagnostic Laboratory (HDL). As a reminder, using HDL or other out-of-network laboratory service providers could result in termination of your network participation agreements with Arkansas Blue Cross and its affiliates, PPO Arkansas (True Blue and Arkansas’ FirstSource® PPO networks) and Health Advantage (Health Advantage HMO network).

Referral to out-of-network providers—including labs—constitutes a breach of the network participation agreement except where referral is unavoidable due to an emergency or if a covered service is not available in-network. Referral to out-of-network providers is not just a business or contract concern of Arkansas Blue Cross and its affiliates but these violations have adverse financial consequences for members as well if members are subjected to “balance billing” in excess of the in-network allowance.

Please be aware that if a provider’s network participation agreements are terminated due to breach, including a breach due to out-of-network lab referrals, then the provider will not be eligible or considered for re-admission to the networks for three years.

Most out-of-state labs are **NOT** in the Arkansas Blue Cross or its affiliate’s networks. Claims for specimens collected in Arkansas cannot be submitted through other Blues Plans via the BlueCard system. The claim must be filed with a participating Arkansas Blue Cross provider. Other labs that are not in network for Arkansas Blue Cross or its affiliates include Ameritox, Aegis Sciences Corp, Ambry Genetics, Clariant Diagnostics, Genomics Health, GenPath, Health Diagnostics Lab, Medical Diagnostic Lab (MDL), PerkinElmer Labs, Sequenom, Veracyte and Verinata.

For a list of current in network laboratory service providers, visit the Arkansas Blue Cross website at arkbluecross.com.

Outpatient Hospital and Ambulatory Surgery Center (ASC) Surgery Payments

Primary Surgical Procedure

- Reimbursed at 100% of the Arkansas Blue Cross and Blue Shield Outpatient or ASC Surgery Fee Schedule allowance (correlates to highest APC weight and reflected by the Fee Schedule as the highest allowance amount)

Additional Surgical Procedure

- Reimbursed at 50% of the Arkansas Blue Cross and Blue Shield Outpatient or ASC Surgery Fee Schedule allowance

These amounts are reduced by any contractual agreements.

“Never Events” Policy Reminders

“Never Events” are adverse events or errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. Identifying and addressing adverse medical events and “Never Events” has gained more attention throughout the healthcare industry. Industry drivers include the following:

- The National Quality Forum (NQF) has identified a list of 28 “Never Events” that is gaining interest from various constituencies focused on health-care quality, including health plan organizations, employers and state hospital organizations.
- Since October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) no longer pays the extra cost of treating the 12 Hospital Acquired Conditions (HACs) that occur while the patient is in the hospital.
- CMS requires that most hospitals use a Present on Admission (POA) indicator on claims to indicate if the patient’s specific condition was present when the patient was admitted to the hospital or if it was acquired during the inpatient stay (e.g., infection or ulcers). In addition, CMS requires all Medicare Advantage plans to report “Never Events” and claims with the POA indicator.
- The National Business Group on Health, which represents 300 large employers, supports the reporting of medical errors and continues to apply pressure to all payers for solutions.

As of October 1, 2008, Medicare defined HACs are considered “Never Events” as they relate to this policy. HACs include:

- Pressure ulcers, Stages III and IV,
- Catheter-associated urinary tract infections,
- Vascular catheter-associated infection,
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG),
- Air embolism,
- Blood incompatibility,
- Foreign object retained after surgery,
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock),
- Surgical-site infections following certain orthopedic procedures,
- Surgical-site infections following bariatric surgery for obesity,
- Manifestations of poor glycemic control, and
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

In addition, “Never Events” include:

- Surgery performed on a wrong body part,
- Surgery performed on a wrong patient, and
- Wrong surgical procedure performed.

The Arkansas Blue Cross “Never Event” policy, effective since January 1, 2010, states:

- All acute care hospitals participating in the Arkansas Blue Cross, USAble Corporation and Health Advantage provider networks must populate the POA indicator on all acute care inpatient hospital claims for all “Never Events,” as applicable. Valid POA values include:
 - Y = Yes

- N = No
- U = Unknown/No information in the record
- W = Clinically undetermined
- 1 = exempt from reporting on 837 claim
- Blank = exempt from reporting on paper claim
- This policy applies to all acute care hospitals including critical access hospitals and specialty hospitals.
- All participating acute care inpatient hospitals will not receive or retain reimbursement for inpatient services related to “Never Events.”
- All participating acute care inpatient hospitals will not bill members (hold harmless) for any inpatient services related to “Never Events.”

All HACs should be billed normally using the correct diagnosis codes and will be accommodated through POA indicators. All appropriate E codes should be billed for “Never Events.” All inpatient hospital claims will be passed through the Arkansas Blue Cross internal DRG grouper. Hospitals will NOT receive a higher reimbursement rate due to “Never Events” and members will not be responsible for higher deductible, copayments or coinsurance amounts resulting from “Never Events.”

Arkansas Blue Cross, Health Advantage and PPO Arkansas will not reimburse hospitals, ambulatory surgery centers or other outpatient settings for surgery performed on a wrong body part, surgery performed on a wrong patient or the wrong surgical procedure performed. This includes all services related to these “Never Events.”

- All services provided in the operating room or applicable surgical setting when the error occurs are considered related. These services will not be reimbursed nor will members be liable for their charges.
- All providers in the operating room or applicable surgical setting when the error occurs, who could bill individually for their services, are not eligible for payment nor will members be liable for their charges.
- All related services provided during the same hospitalization or outpatient setting in which the error occurred will not be reimbursed nor will members be liable for their charges.
- Providers should note that related services do not include performance of the correct procedure.

“Never Events” discovered through any and all avenues such as post pay audits and customer service calls are subject to this policy.

Physical Therapy, Occupational Therapy, and Speech Therapy

As a reminder, Arkansas Blue Cross and Blue Shield evaluates all physical and occupational therapy, whether provided by an independent therapist or by a therapist employed in a physician's office, to determine where such services meet Primary Coverage Criteria.

The treatment must significantly improve the condition of the member being treated in a reasonable period of time, pursuant to nationally established guidelines, not to exceed 60 days of progress without prior approval of coverage, and periodic assessment reports approved by Arkansas Blue Cross. All services must be furnished in accordance with a written treatment plan established and certified by the treating physician. Services that exceed those guidelines are not covered. Any service that exceeds the established guidelines will be reviewed on an individual basis.

Most Arkansas Blue Cross benefit certificates limit speech therapy to \$500 of eligible charges and/or 45 visits per calendar year.

Coverage of physical or occupational therapy is provided under the member's certificate up to 45 visits per year when Primary Coverage limitations are met. The therapy visits are counted in an aggregate fashion. Maintenance therapy is an exclusion under the member's certificate. Speech therapy, for all members, is limited to \$500 per calendar year and/or 45 visits.

For Terms and Conditions required to obtain a provider agreement, select the following link:

[Network Terms and Conditions.](#)

Payment reduction for multiple therapy services performed on the same day

The Centers for Medicare & Medicaid Services (CMS) completed an in-depth analysis of the practice expense of providing physical therapy, occupational therapy, and speech therapy services. Their analysis found that the practice expense of providing two or more modalities on the same day is less than the practice expense cost as reflected by the practice expense RVUs. Arkansas Blue Cross and Blue Shield uses Medicare/CMS RVUs in calculating payment for physical therapy, occupational therapy, and speech therapy services.

As a reminder, on October 13, 2013, Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, and Health Advantage began following the Medicare policy of reducing payment for the second and subsequent therapy services when multiple therapy procedures are performed on the same day. On April 1, 2013, Medicare reduced the payment by 50% of the practice expense payment for the second and subsequent modalities.

Arkansas Blue Cross, BlueAdvantage, and Health Advantage will reduce the second and subsequent therapy procedures by 20% of the practice expense portion of the procedure, whether provided in a facility setting or a non-facility setting. When these services are provided on multiple days, each line item on the claim for the modality must be for one day only. Date spans for these procedures will not be accepted. For the most up to date file of multiple procedure payment reductions, please refer to [cms.gov](https://www.cms.gov) to view the list available under the Physician Fee Schedule information.

Physical therapy assistants & physical therapy aides

Physical therapy assistants and physical therapy aides are not recognized as providers under the Arkansas Blue Cross and Blue Shield member benefit contract. Physical therapy codes describing one-on-one contact or constant attendance are covered only when performed by a registered physical therapist or physician. Reimbursement for physical therapy codes that do not require one-on-one contact or constant attendance may be made when services are provided by an assistant working under the supervision of a registered physical therapist or physician. Physical therapy aides are not a covered provider, even when working under the supervision of a physical therapist.

Arkansas Blue Cross and Blue Shield and Health Advantage member benefit certificates do not recognize physical therapy assistants as “providers” as defined in their certificates. However, Arkansas Blue Cross and Health Advantage have determined that for members covered under certificates insured or underwritten by Arkansas Blue Cross or Health Advantage, the services of physical therapy assistants may be covered if all the following conditions are met:

- Services provided by physical therapy assistants must fall within the scope and definition of covered services under the written terms of the member’s benefit certificate;
- Services provided by physical therapy assistants must not fall within the scope or definition of any exclusion in the member’s benefit certificate (other than the definition of “provider”);
- All services provided by physical therapy assistants must be supervised by a licensed physical therapist;
- Physical therapy assistants must hold an active and unrestricted license to perform physical therapy assistant services, in full compliance with applicable state laws and regulations;
- The supervising licensed physical therapist (or hospital employing the supervising licensed physical therapist) must bill for services provided by physical therapy assistants. Physical therapy assistants may not bill separately or directly for any physical therapy assistant services;

- Services provided by physical therapy assistants will not be covered or paid by Arkansas Blue Cross or Health Advantage for their insured or underwritten members if services include any evaluation or assessment services¹ or if services include the physical therapy assistants making clinical judgments or decisions regarding the member's care or treatment;
- Services provided by physical therapy assistants will not be covered or paid by Arkansas Blue Cross or Health Advantage for their insured or underwritten members if the services include the development, management or furnishing of any skilled maintenance program services¹ or if the services include the physical therapy assistants taking or asserting overall responsibility for services;
- Services provided by physical therapy assistants will not be covered or paid by Arkansas Blue Cross or Health Advantage for their insured or underwritten members if the services are not supervised at the level appropriate to the particular setting involved, meaning that (a) at least general supervision² by a licensed physical therapist is always required and (b) direct supervision³ by a licensed physical therapist is required for any physical therapy assistants services administered outside of a hospital inpatient or hospital outpatient setting.

Special note with respect to self-funded health plans: The preceding standards may or may not apply where self-funded health benefit plan members served by Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, or Health Advantage are concerned. While some self-funded health benefit plans may choose to adopt the same approach as outlined above, others may choose to continue excluding coverage for physical therapy assistants altogether. As with all services to self-funded plan members, providers (and members) must check the terms of the specific, applicable self-funded health benefit plan's Summary Plan Description in order to determine the specific coverage criteria of the self-funded plan with respect to physical therapy assistants or their services.

Physician Assistants

Physician Assistants (PAs) are licensed practitioners with the advanced education and clinical competency necessary for the delivery of primary health and medical care. Physician Assistants (PAs) must possess a certificate of prescriptive authority. The PA must work in collaboration with the physician to deliver health care services with medical direction and appropriate supervision.

PA's providing services to Arkansas Blue Cross and Blue Shield members must comply with the following policy to qualify for reimbursement:

- The PA must have a written and signed collaborative agreement with a supervising medical doctor (MD) or doctor of osteopathy (DO). The collaborative agreement must be with a physician whose specialty mirrors the practice of the PA (e.g., if the PA is practicing primary care medicine, the collaborative agreement must be with a Family Medicine physician or General Internist). A copy of the agreement must be provided to Arkansas Blue Cross upon request.
- The PA adheres to collaborative responsibilities by participating as a team member in the provision of medical and health care, interacting with physicians to provide comprehensive care according to established and documented protocols.
- Services provided by PA's are limited to those patients presenting problems of low to moderate severity and the medical decision making involved does not exceed that same level. Patients with more severe problems must be referred to physicians.
- Current published guidelines for assigning CPT codes to services and documentation to support the "medical necessity" of all services must be met.
- Services, performed in an inpatient/acute facility, are not covered, with the exception of assistant at surgery services provided when the collaborative physician is present.
- PA's may order diagnostic laboratory and x-ray studies that are medically indicated for the level of service as indicated above in accordance with established and documented protocols.
- The service provided by the PA must be concordant with the specialty of the supervising physician.
- The PA must present him/herself so the public and other payers are fully aware of the practitioner's business operations. This includes items such as signage, letterhead and other marketing elements.

The following billing instructions apply to PAs licensed in Arkansas:

- No payments may be made directly to the PA based on the Arkansas State Medical Board Arkansas Medical Practices Acts & Regulations.
- The line item or rendering provider is listed in Block 24J on paper claims and in Loop 2310B, segment NM108 (NPI qualifier) and segment NM109 (NPI number) on electronic claims.
- The billing/pay to provider is listed in Block 33A on paper claims and in Loop 2010AA (Billing) and in loop 2010AB (Pay To) for electronic claims.
- Services provided in the provider's office and the collaborative physician is present in the office suite:
 - Services provided may be billed by the PA or by the collaborative physician (similar to Medicare's "incident to" guidelines).
 - The collaborative physician's NPI should be used as the line item provider number on CMS 1500 and 837P.
- Services provided in the provider's office and the collaborative physician is NOT present in the office suite:

- Services should be billed by the provider of service.
- The PA NPI should be used as the line item provider number on CMS 1500 and 837P.
- Services provided in the Emergency Room department:
 - Lower level ER visits may be billed by the provider of service.
 - This excludes triage and services for patients transferred to an ER physician.
 - The PA NPI should be used as the line item provider number on CMS 1500 and 837P.
- Services provided to patients designated as “inpatients” in a facility and the collaborative physician is NOT present or does not see the patient at another time during that day:
 - Inpatient services are not covered. All services will be denied.
 - The PA NPI used as line item provider on CMS 1500 and 837P.
- Services provided to patients designated as “inpatients” in a facility and the collaborative physician sees the patient with the PA or at another time of day
 - Only one E&M service is covered during a 24-hour day. The collaborative physician must have a brief note on the chart indicating the patient was seen; this visit should be reported under the collaborating physician’s NPI.
- Services provided when acting as assistant at surgery in an inpatient or outpatient hospital or ambulatory surgery center:
 - Assistant at surgery is covered only for those CPT surgical codes for which Arkansas Blue Cross Blue Shield allows coverage for Assistant Surgeon.
 - Modifier ‘AS’ should be used on all line items.
 - The PA NPI should be used as the line item provider number on CMS 1500 and 837P.
- Services provided to a patient in a home setting, when the PA is NOT employed by or contracted to a Home Health agency.
 - Lower level home visits may be billed by the provider of service.
 - The PA NPI should be used as the line item provider number on CMS 1500 and 837P.

Reimbursement to PAs when the PA NPI is submitted as the line item provider is based on 75% of the corresponding physician reimbursement.

Sleep Study Centers

Freestanding Sleep Study Centers are eligible for payment of the technical component of sleep medicine services effective January 1, 2007. If the Freestanding Sleep Study Centers meet the credentialing standards, they will be considered participating. If the Freestanding Sleep Study Centers do not meet the credentialing standards, they will be considered out of network.

Freestanding Sleep study centers must bill the technical component of sleep medicine procedures for reimbursement. The physician who interprets the study must bill for the professional component. The total components of sleep medicine procedures will be denied as incorrect coding.

Effective January 1, 2009, all facility based sleep study centers must meet the same credentialing standards or be terminated from Network participation.

Home Sleep Studies

Home sleep studies must be billed with the appropriate HCPCS code to distinguish the level of study provided. The appropriate HCPCS codes are:

Code	Description
G039 8	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
G039 9	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
G040 0	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

HCPCS Code G0398 is the only level of sleep study covered in the home setting. Home sleep studies billed using CPT code 95806 will be denied as incorrect coding.

Telemedicine coverage update

Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries had a pilot telemedicine policy in place since April 2014. Effective January 1, 2016, a new policy became effective. With few exceptions, services covered in a face-to-face setting will be covered when performed via telemedicine. Telemedicine reimbursement requires that the provider have a professional relationship with the member, and that the member be physically present in a credentialed facility or office. The Arkansas Blue Cross and Blue Shield coverage policy for telemedicine covers all telemedicine services provided within the allowable scope-of- practice for the provider type performing the service. Specific requirements are noted in the Arkansas Blue Cross coverage policy 2015034, which is available on the Arkansas Blue Cross website. Please refer to coverage policy 2015034 for details.

The professional service allowable for telemedicine is equivalent to the allowable to the same service when done face-to-face, and this service should be billed with a –GT modifier in the first modifier position. The originating site (where the patient is located) should bill Q3014 for the same date of service. Q3014 (originating site fee) is allowed in most clinical locations (as specified in the coverage policy); Q3014 is not be allowed for other locations (e.g. home, school, pharmacy) where a patient might be located during an encounter. Providers must use site-of-service 02 on professional claims; on Q3014 claims use the site-of- service where the member is physically located during the encounter. The telemedicine clinician is responsible for ensuring that a HIPAA-compliant audio-visual connection is used, and that an appropriate relationship is in place with the communication service. Email, text (including photographs), or voice-only interactions are not covered.

Telemedicine is allowed only when the service is one which can be performed remotely to the same standard of care that can be provided in a face-to-face visit. See coverage policy 2015034 for a list of codes which are covered when done by telemedicine.

Telemedicine is covered when ALL of the following conditions are met:

1. The service is one which is allowed for the specific provider type when done in a face-to-face setting and can be safely and effectively performed via telemedicine to the same standard of care as with a face-to-face visit.
2. If the originating site is a clinical setting, a Presenter is available at the Originating Site to orient the patient, operate the equipment, problem solve, and gather clinical data.
3. The encounter is by real-time audio visual communication. (Store-and-forward, asynchronous, audio-only, email, fax, and telemonitoring services are not reimbursable.)
4. A clinical record of the encounter which contains at least the same elements as are included in a face-to-face encounter record is maintained; the location of the Originating Site and Distant Site, along with the date and time of the connection must be recorded in the note.
5. For visits which include a physical exam, the equipment allows for remote examination by the provider (e.g., stethoscope, otoscope, etc. giving a diagnostic-quality signal to the provider) OR a qualified, licensed person capable of performing the exam supplements the examination and relays the findings to the provider.
6. Data transmission must be accomplished using a HIPAA-compliant network, with sufficient bandwidth and screen resolution to permit adequate interaction with the patient and assessment of behavioral and physical features. The network must maintain a log of connections, with time, date, and duration. An example of a compliant network is Arkansas e-Link. (To connect to the Arkansas e-Link network, providers may call the Center for Distance Health at **501-686-6998** or enroll online at arkansaselink.com.)
7. The Distant Site provider must be licensed as required by the appropriate state's Medical Board, and the service provided must be within the scope of practice for that provider.

Please contact your Network Development Representative with questions or concerns.



Transplant Facilities and Procedures

Arkansas Blue Cross and Blue Shield member health plans and contracts require specific coverage approval procedures (“Prior Approval”) for all transplants except kidney and cornea transplants. Before any transplant services, including transplant evaluation, are provided, a request for Prior Approval of coverage should be sent to Arkansas Blue Cross and Blue Shield.

In order to be covered, transplants must meet all terms, conditions and limitations of the member’s health plan or contract, including but not limited to the Primary Coverage Criteria. In addition, to be covered, a transplant must be the subject of a specific Arkansas Blue Cross and Blue Shield Coverage Policy and the member must meet all of the required criteria necessary for coverage, as set forth in the Coverage Policy and the member’s health plan or contract. Providers may access such specific Coverage Policies on the Arkansas Blue Cross and Blue Shield website, click on the link under the “Coverage Policy” section of the on-line version of this Manual.

Reimbursement for covered transplants will be affected by whether an in-network or out-of-network facility is used for the transplant, and member health plans and contracts specify clear limitations on reimbursement. Arkansas Blue Cross arranges access for its members to the Blue Cross and Blue Shield Association’s Blue Distinction Centers for Transplant, a nationwide network of participating transplant facilities. Members receive the maximum health plan or contract benefit by utilizing a participating facility. When an out-of-network facility is used, members may be liable for charges by the facility in excess of the Arkansas Blue Cross and Blue Shield Allowance.

Reimbursement includes payment based on a Transplant Global Period and a global payment for all transplant-related services rendered during the Transplant Global Period. No payment will be made for separately-billed services related to the transplant because the global payment is deemed to include payment for all related necessary services (other than non-covered services).

Several other specific coverage rules and criteria apply to transplants, including but not limited to specific standards for limited coverage of certain donor or harvesting services, autologous transplants, allogeneic transplants and nonmyeloablative allogeneic stem cell transplantation. For a complete description of those rules and criteria, please review the transplant provisions of the applicable member health plan or contract, because coverage and any payments to providers are always subject to the health plan or contract terms.

A Note on “Prior Approval”: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the transplant meets the Primary Coverage Criteria requirements set out in the member’s health plan or contract. All services, including any transplant receiving Prior Approval, must still meet all other coverage terms, conditions and limitations, and coverage for any transplant receiving Prior Approval may still be limited or denied, if, when the claims for transplant are received by us, investigation shows that a benefit exclusion or limitation applies, that the member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the member’s health plan or contract. Contact for Obtaining Prior Approval: For assistance regarding transplants for our members, and related Prior Approvals, contact Carolyn Webb, RN at **501-378-2386**.