Providers' News

To: All Providers

From: Provider Network Operations

Date: June 22, 2001

Please Note: This newsletter contains information pertaining to Arkansas Blue Cross Blue Shield, a mutual insurance company, it's wholly owned subsidiaries and affiliates (ABCBS). This newsletter does not pertain to Medicare. Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

What's Inside?

Arkansas State Employees 3
ABCBS Fee Schedule Change-MRIs/MRAs 3
Claims Payment Issues 1
Contrast Media in MRI and CT Scans 3
Dedicated MRI Information 3
Home Health Billing 3
New Look for Checks and Remittance Notices 5
Postoperative Global Period 3
Pre-Cert/Customer Service Information 4
Pre-Certification Information 5
Requests for Medical Information 3
Scanning UB92 Claim Forms 4
Sleep Study Coverage 3
Timely Filing Period for Medi-pak Claims 3

"Any five-digit Physician's Current Procedural Terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2000 American Medical Association. All Rights Reserved."

Claims Payment Issues

While one of our ongoing goals is to minimize the number of claims paid incorrectly, errors are occasionally made. Some of these errors can affect 1099 earnings and/or patients' 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. You must notify us promptly if your TIN or your name changes in order to ensure accurate reporting to the IRS. If the IRS sends us a B-Notice indicating that the Taxpayer Name and TIN we filed does not match their records, we will be required to withhold, and remit to the IRS, 31% of future amounts payable to you if corrected data is not received within the mandated time frame. Once withheld amounts are remitted to the IRS, they cannot be refunded to you, but will be reported on your 1099 as Federal Income Tax Withheld.

Notes to physicians:

For Paper Claims: As the provider of service, you should always enter your individual provider number in box # 24K of the HCFA1500 claim form. If you want a clinic to be the payee, you must enter the clinic's provider number in box # 33.

For Electronic Claims: As the provider of service, you should always enter your individual provider number beginning in position 93 of field 23 on the FA0 record.

- For non-Medicare claims, you must enter the "pay to" provider number beginning in position 105 of field 14 on the BA0 record. (Please note that if positions 213-227 of field 28 on the CA0 record are populated, that data will override the "pay to" provider number in fields 9 and 14 on the BA0 record.)
- For Medicare claims, the "pay to" provider number must be entered beginning in position 48 of field 9 on the BA0 record.
- Deductibles, benefit limits, out-of-pocket maximums, and lifetime maximums are accumulated by individual member. If erroneous claims are not adjusted appropriately and promptly, subsequent claims may be incorrectly adjudicated.

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

- Please verify that the payee is correct on all checks that you receive prior to negotiating them.

- If you receive payment for a claim for services that you did not provide:
  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. Your 1099 can only be corrected if the money is returned so that the claim can be re-processed to the appropriate party.

- If the patient was paid and payment should have been made directly to you:
  Please advise the patient to return the check, or refund the amount paid, along with a request to re-process the payment to the provider. If you accept payment from the patient, we could subsequently discover the error and send a request for refund to him/her since our records will reflect that he/she received the payment.

- If you were paid and payment should have been made to the patient:
  Please refund the payment to us (rather than to the patient) along with a request to re-process the payment to the patient. Your 1099 can only be corrected if the money is returned, so that the claim can be re-processed 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 us (rather than depositing it in the clinic's account) with a request to re-process the payment to the appropriate provider. Your 1099 can only be corrected if the money is returned, so that the claim can be re-processed 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 he/she is an employee of the clinic.

- We recommend that you endorse and deposit all checks as soon as possible after confirming that the payee is correct. Most of our checks have a pre-printed staledate 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 re-issued or, in some cases, the claim must be re-processed.

- As a deterrent to fraud and to enhance the quality of copies of cleared checks that might be requested in the future, we also recommend that endorsements be made in black ink and include the bank account number into which the deposit is being made.

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 your check.

- When sending us an *unrequested* refund:
  It is not necessary to return the original check and the entire remittance advice/ 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) provider number (pay to)
  (8) and TIN (pay to).
  A separate refund check for each claim is preferred, if you are not returning the original check.

- **Your 1099 earnings can only be corrected if we have your specific provider name, number, and TIN. If you use the services of a third party for these financial transactions, please instruct them to provide this information on each refund.**

- Please do not combine refunds for Arkansas Blue Cross Blue Shield, Health Advantage, USAble Administrators, First Pyramid Life (FPL), and Medicare. The following are the correct addresses to use for claims refund:

  Arkansas Blue Cross Blue Shield
  P.O. Box 2099
  Little Rock, AR 72203

  Health Advantage
  P.O. Box 8069
  Little Rock, AR 72203

USAble Administrators
P.O. Box 1460
Little Rock, AR 72203

First Pyramid Life
P.O. Box 1151
Little Rock, AR 72203

Medicare *(part A or B)*
P.O. Box 8075
Little Rock, AR 72203

- Please do not issue refund checks made payable to Arkansas First Source. Refund checks pertaining to a FirstSource member should be made payable to the appropriate company: Arkansas Blue Cross and Blue Shield, First Pyramid Life, USAble Administrators, Health Advantage or another outside carrier that accesses our FirstSource PPO Network. If that carrier information is not available then please issue check to the employer of the subscriber.

Postoperative Global Period

Effective October 1, 2001, ABCBS and Health Advantage will begin using 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 reimbursement of the surgical/ invasive procedure. Only those related postoperative services that are considered significant and separately identifiable should be billed.

ABCBS Fee Schedule Change-MRIs and MRAs

Beginning October 1, 2001, the ABCBS fee schedule for MRIs and MRAs will change. The practice expense of the technical component will be computed using the year 2001 national Medicare conversion factor of $38.61.

Dedicated MRI Information

A reminder: Dedicated MRIs (those with low level magnets, designed specifically for extremity use) do not have a specific CPT number. Dedicated MRIs will continue to be paid at a reduced fee schedule amount to reflect the difference in cost for the dedicated unit. The fee schedule for dedicated MRIs is $193.49, total component; $101.41, technical component; and $92.08, professional component.

Contrast Media in MRI and CT Scans

ABCBS, HA and USAble pay for MRI and CT (computerized tomography) studies that include the use of contrast materials based on the HCFA/Medicare relative value units. The practice expense relative value units for the technical component and the full component of MRI and CT procedures include payment for paramagnetic contrast media. Billing additionally for the paramagnetic contrast media, whether with HCPCS codes or revenue codes, and whether to the member or ABCBS, HA or USAble will be denied as unbundling of the procedure.

Arkansas State Employees

Effective January 1, 2001, the Arkansas State Employees Group changed from a self-insured group to a fully insured group. ABCBS and Health Advantage had previously asked that all claims with dates of service prior to January 1, 2001, be filed by May 31, 2001. This deadline has been extended to June 30, 2001. If you do not file calendar year 2000 claims by this date ABCBS and HA will not process the claims. These claims will need to be forwarded to: Employee Benefits Division, PO Box 15610, Little Rock, AR 72231.

Home Health Billing

An intermittent care visit is defined as a visit of two hours or less. When billing a visit, please line item bill these for each day visit separately. If there are multiple intermittent visits on the same day, this should be indicated in the units field. If billing for continuous care services, this is defined as hourly. Again, please bill each day's continuous care services for each day separately. If there are multiple services on the same day, this should be indicated in the units field.

Requests for Medical Information

Effective July 1, 2001, USAble Administrators will require that requested medical information be submitted with a copy of the request. This includes letters, faxes, and Explanations of Payment requesting medical information. Medical information that is not properly identified will be returned to your office. Please continue to submit medical records with claim submissions, when appropriate.

This change will enable us to process claims in a more timely manner. We appreciate your cooperation.

Timely Filing Period for Medi-Pak Claims

Medi-Pak claims may be paid up to six months following the date Medicare paid.

Sleep Study Coverage

Effective January 1, 2001 for Health Advantage and April 1, 2001 for ABCBS and USAble, sleep studies will only be covered when performed in a hospital setting.

ABCBS -- FEP -- USABLE -- HEALTH ADVANTAGE

ATTN: OFFICE MANAGERS/INSURANCE COORDINATORS

Please use the pre-cert number on the back of the patient's Insurance ID card for admission pre-certification calls ONLY!

For Patient insurance information, call the Customer Service number on the back of the ID card or utilize the AHIN System for your best source of information.

For Example, Call Customer Service or use AHIN to:

- ✓ Check to see if the Plan requires pre-cert for outpatient services
- ✓ Check to see if insurance is primary
- ✓ Check to see if specialty referral is required
- ✓ Check member benefits
- ✓ Service coverage
- ✓ Network status of providers

CUSTOMER SERVICE TELEPHONE NUMBERS:

Arkansas Blue Cross Blue Shield	1-800-827-4814
Health Advantage (HA)	1-800-843-1329
USAble Administrators	1-888-USABLE1
Federal Employee Program (FEP)	1-800-482-6655

Regional Customer Service Numbers:

Central Region (Little Rock) HA only	1-800-843-1329
West Central Region (Fort Smith)	1-800-299-4060
Southwest Region (Texarkana)	1-800-470-9621
Southeast Region (Pine Bluff)	1-800-236-0369
South Central Region (Hot Springs)	1-800-588-5733
Northeast Region (Jonesboro)	1-800-299-4124
Northwest Region (Fayetteville)	1-800-817-7726

Scanning UB 92 Claims Forms

We have been scanning the UB 92 claim forms (HCFA 1450) for approximately 2 months. We have been scanning the HCFA 1500 for one year now and many of the same TIPS will help your claims be processed successfully. From our experience with scanning, the following items commonly caused claims to be delayed or rejected on UB 92 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 hand write or put comments on claims.

This process has also allowed us to process UB 92 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 20
- No Patient Status Code in Form Locator 22
- No Provider Number in Form Locator 51

The UB 92 manual (available from the Arkansas Hospital Association) is our guide for completing this form.

DATES - box 6, 14, 17, 32-36, 45, 80, 81. All date fields except box 14 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 14 (birthday) should have 4 -digit year.

BOX 1 - Provider name and address. Do not type information above box 1. Always place phone number as last line in this box. Format expected is line 1 provider name, line 2 provider street, line 3 provider city, state, zip (5 or 9 positions). Line 4 provider phone (7 or 10 positions).

BOX 3 - patient control number. Should start on left side of box. Number next to bill type can become part of bill type.

BOX 12 - Patient name - enter last, first and initial. No commas, periods, or titles.

BOX 13 - Patient address - Enter street, city, state, zip (5 or 9 digits). Do not us separators like; use spaces.

BOX 38 - Insured name and address. First line is for name, last first and initial. No periods commas or titles. Line 2 - address one contains street or apt, etc. Line 3 can be a second street, box etc. Line 4 is city, state, and zip (5 or 9). Do not enter phone numbers as they distort OCR and there is no place to store them on the NSF records.

BOX 46 - Enter whole numbers only. Fractions and decimals are not allowed.

BOX 50 - Enter payer left justified try to stay away from box 51.

BOX 51 - Provider number, please left justify.

BOX 58 - Insured name - enter last, first, middle initial. Do not use periods, commas or titles.
BOX 66- Employer location- Format is street, city, state, zip.

BOX 67 - 80 . Codes and dates must be in their allocated space. Space is tight and can easily flow to the next box.

BOX 82 - Attending Physician ID should be entered on the first line only, do not put on second line. Phys name should be entered on the second line as last, first, initial. No periods commas or titles.

BOX 83 - A and B - Allows for two entries of other physicians. Use the same rules as box 82. Enter ID on line one only and name on line two. Name format is last, first, initial. No commas, periods, or titles.

Adhering to these rules will greatly improve the quality of the data the scanning process attempts to interpret.

New Look for Checks and Remittance Notices

Arkansas Blue Cross Blue Shield is changing the look of its provider checks. What is different?

1. The background color of the checks is changing to blue. Each individual check will be on an 8 1/2 by 11 sheet with the check portion located on the bottom one third of the sheet.
2. In the past, information such as check date, check amount, etc, has been located in various positions on the different check types. We have developed a standard format for all check types; therefore, you may notice such information is located in a different position than in the past.

The look of the remittance notices is also changing. Remittance details will be printed on both sides of the paper. Please be sure to check the back of each page to ensure that you view all the information necessary to balance your accounts. If reason code narratives/ explanations were previously located on the back of each page of your remittance notices, they will now be located on the last page only.
If you have any questions regarding your checks or remittance notices, please call your customer service line.

Pre-Certification Information

Access Health is experiencing an increase in calls from providers regarding benefit issues. Please do not call Access Health for these questions. Attached is a matrix to help guide you in making decisions regarding pre-certification.

Pre-Certification Requirements

Product Line	Inpatient Pre-Cert/Pre-Note	Continued Stay Review	Outpatient Pre-Cert
Arkansas Blue Cross Blue Shield (Indemnity, PPO, Blue Card, Access Only)	**Yes***	**Yes***	**No**
FEP	**Yes***	**Yes***	**No**
Health Advantage**	**Yes** (SW, SC, NE, SE Regions) **No** (CN, WC, NW Regions)	**Yes** (SW, SC, NE, SE Regions) **No** (CN, WC, NW Regions)	**No**
USAble	**Yes***	**Yes***	**Yes** Some Groups do require Outpt. Precert. Call 800USABLE-1 to verify.
*Call the 800 # on the back of the Member's ID Card	**All out of network services must be prior approved by your local Regional Blue Cross Office.	All information on this chart is correct as of June 1, 2001	

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