Arkansas Blue Cross and Blue Shield

Providers' News

June 2007

Inside the June Issue:

Please Note:

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

We're on the Web!
www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com
and **www.fepblue.org**

The *Providers' News*

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

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Arkansas Blue Cross and Blue Shield: NPI Mandate - Updated May 2007

- **The mandated date for NPI per HIPAA has NOT changed.** What has changed is that CMS as the enforcement agency, will not apply penalties to parties that have made good faith efforts towards being compliant on May 23, 2007. No penalties will be applied until May 23, 2008.

- **NPI Contingency Plan for Arkansas Blue Cross and Blue Shield and its affiliate companies and subsidiaries:**
  As of May 23, 2007, providers may submit claims to Arkansas Blue Cross as follows:
  1. NPI alone (effective May 23, 2007) – PREFERRED METHOD
  2. NPI and Arkansas Blue Cross legacy number (was effective Oct 1, 2006)
  3. ABCBS legacy number alone - this is TEMPORARY

  Like Medicare, Arkansas Blue Cross will monitor claims submissions and the use of NPI past May 23, 2007 and will determine when to stop accepting Arkansas Blue Cross legacy numbers.

- **If you have your NPI, start using it.** Arkansas Blue Cross is seeing only a small percentage of claims with an NPI while our systems have over 70% of the needed NPIs registered. Providers have been able to submit claims with an NPI and Arkansas Blue Cross legacy number since Oct 2006. **Use your NPI now - if there are claims processing problems, find out now while you have flexibility. At some point, NPI alone will be your only option.**

- **Have you registered your NPI with Arkansas Blue Cross and Blue Shield?** Simply submitting a claim with an NPI is **NOT** enough. Providers must formally register their NPI with Arkansas Blue Cross to ensure it is populated throughout our claims processing systems. This may be entered via "NPI Administration" on AHIN or with a paper copy of the NPPES verification you receive and a change of data form.

  The national statistics show that there are over 4000 NPIs assigned to Arkansas providers over what Arkansas Blue Cross has in our databases. **Claims will be rejected for NPIs not matching provider information in our databases.**

- **If you do not have your NPI GET IT!** All healthcare providers submitting paper and electronic claims to Arkansas Blue Cross must get an NPI.

  Provider applications, change of data forms, billing authorizations forms, etc. will not be accepted without a provider's NPI.

Paper Claims:
Arkansas Blue Cross will follow the national schedules established by NUCC and NUBC.

UB-04: **New forms must be used as of May 23, 2007**

CMS 1500: **New forms mandated by July 1, 2007.**

Arkansas Blue Cross Blue Shield: NPI Position and Contingency Plan

Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas have met the requirements for the HIPAA National Provider Identifier (NPI) Rule prior to the compliance date of May 23, 2007. However, Arkansas Blue Cross and Blue Shield and its subsidiaries are still receiving many claims that do not contain NPIs.

Arkansas Blue Cross, Health Advantage, and BlueAdvantage are pleased that the Centers for Medicare and Medicaid Services (CMS) recently issued guidance permitting HIPAA-compliant payers the option to implement contingency plans to maintain the flow of claims payments for providers who are making a "good faith" effort to become compliant with the NPI rule. As such, Arkansas Blue Cross, Health Advantage, and BlueAdvantage will continue to accept HIPAA transactions that are compliant with pre-NPI requirements for a short period of time after the compliance date to allow trading partners additional time to complete the NPI implementation.

The end of the Arkansas Blue Cross and Blue Shield contingency plan will be published at a future date based on continual assessment of compliance but will be no later than May 23, 2008 as authorized in the CMS guidance.

If you have any questions regarding the HIPAA compliance please contact the Arkansas Blue Cross and Blue Shield HIPAA Project Office at (501) 378-3722 or (501) 378-3623.

Background

On January 23, 2004, the Secretary of Health and Human Services (HHS) published the final rule to establish a NPI and requirements for its use. In this rule, a compliance date of May 23, 2007 was established for all HIPAA covered entities except for small health plans who were given until May 23, 2008 for compliance. HIPAA covered entities are health plans, health care clearinghouses, and those health care providers who transmit any of the HIPAA standard transactions electronically.

As a health plan, Arkansas Blue Cross's requirement is to use the NPI as the provider identifier in all HIPAA standard transactions received on and after May 23, 2007. Arkansas Blue Cross began the transition to the NPI by allowing for its submission within electronic claim and claims' status transactions on October 1, 2006. The final component of the required NPI implementation was completed January 1, 2007 when Arkansas Blue Cross began including the NPI on the electronic remittance advice transactions.

Additionally, Arkansas Blue Cross has implemented system changes not mandated by HIPAA to allow providers to use their NPI on the newly revised paper claim forms. Arkansas Blue Cross began accepting the NPI on the revised physicians claim form on January 1, 2007 and on the newly redesigned inpatient facilities claim form on March 1, 2007. Arkansas Blue Cross also implemented other changes to utilize a provider's NPI in other forms of communication such as the interactive voice response (IVR) unit and on written correspondence.

Providers are charged with the responsibility of obtaining an NPI, sharing it with entities that need it, and using it within HIPAA standard transactions. The National Plan and Provider Enumeration System (NPPES) went online May 23, 2005 issuing the first NPIs.

CMS charges no fee for issuing an NPI and the provider has the option to apply online or via a paper form.

After obtaining an NPI, the provider is required to share their NPI with any entity that may need

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it for a legitimate business purpose. That obligation does include other providers who must identify that provider as an ordering or referring physician. Health plans must accumulate and validate NPIs prior to the provider using that NPI in their HIPAA standard transactions.

Arkansas Blue Cross is striving to assist our provider community in meeting their obligations for the NPI. Arkansas Blue Cross has included information on the requirements of the NPI in each provider meeting conducted since January of 2005.

As of this writing, Arkansas Blue Cross has included 19 articles regarding the NPI in our quarterly '*Providers News*' publication which is distributed to each contracted provider in the Arkansas Blue Cross networks.

Arkansas Blue Cross has constructed and deployed a facility on the Advanced Health Information Network (AHIN) web site allowing providers to electronically register their NPI with Arkansas Blue Cross. Arkansas Blue Cross has also established procedures allowing providers to register their NPI via mail if they so choose.

NPI and Paper Claims

Providers should not list their NPI on the old paper claim forms (UB92 and HCFA 1500). NPI numbers should only be reported on the new UB-04 and CMS 1500 forms. If providers list their NPI on the old paper claim forms, the claims will be rejected.

Timely Filing: Corrected Claim Filing and Adjustment Requests

All corrected claims and adjustment requests for previously processed claims must be received within 180 days of the initial process date. Requests received after the 180 day timeframe will not be processed and will be denied stating the request was received after the timely filing for corrected claim process. The member can not be held responsible for these charges, this is a provider write off.

Corrected Claims: Electronic and Paper

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

What is a "Corrected Claim"? A "Corrected Claim" is a claim that has been previously submitted for processing and has been finalized and reported on the Provider's Remittance Advice.

Paper Submission:
To submit on paper, the provider is asked to complete the Corrected Bill Submission Form for both the 1500 and the UB claim forms and attach the claim as it should have been filed originally. A corrected claim must be identified by the words "Corrected Bill for Claim" printed on the face of the claim form. This can be put in the top margin and should not overlap any text field on the claim form as this may cause problems in the scanning process. The claim will be returned to the provider unprocessed, or denied as a duplicate claim, unless the form is attached. The purpose of this change is to expedite processing time by assisting us in identifying the actual correction and the reason for the correction.

The ***Corrected Bill Submission Form*** can be accessed and printed from the Arkansas Blue Cross and Blue Shield web site at **www.ArkansasBlueCross.com.**

Electronic Submission:
To file corrected claims electronically for the 1500 claim form, the provider 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 will 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. 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 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. 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 the *Corrected Claims*, please contact customer service at:

Arkansas Blue Cross:
(501) 378-2307 or (800) 827-4814

Health Advantage:
(501) 221-3733 or (800) 843-1329

BlueAdvantage:
(501) 378-3600 or (888) 872-2531

AHIN Customer Support:
(501) 378-2336

Arkansas State and Public School Members Transferred from Qual-Choice to Health Advantage

Approximately 13,300 QualChoice members of the State and Public Groups were transferred to Health Advantage on May 1, 2007. Many of these members have been given a 90-day authorization to continue treatment with non-participating Health Advantage providers. This 90 day extension will allow members time to select participating providers within the Health Advantage network.

Effective September 1, 2007 the authorization for treatment by out-of-network providers will end. A member's request for an additional extension of time to complete a current episode of treatment for an acute condition must be prior approved by Health Advantage in order for the member to continue receive in-network benefits.

Advanced Practice Nurses (Advanced Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse Mid-wives) Coverage Expanded

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 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;
  - Advanced Practice Nurses are employed by the physician / physician group / hospital and have 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 ANP/CNS/CMN provider number with modifier AS in the first modifier position;
- Limited to procedures approved for assistant at surgery coverage.

Services Provided by Advanced Practice Nurses

Several inquiries have been received regarding Arkansas Blue Cross and Blue Shield's position on reimbursement of services provided by Advanced Practice Nurses. Following is the policy regarding Advanced Practice Nurses:

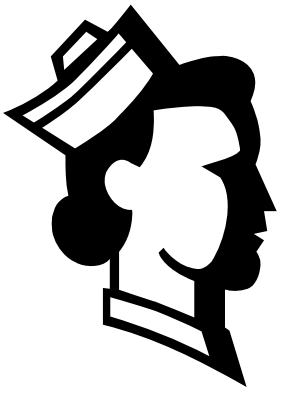
> Advanced Practice Nurses are registered nurses with the advanced education and clinical competency necessary for the delivery of primary health and medical care. Reimbursements for Advanced Practice Nurses (APN's) or Advanced Nurse Practitioners (ANP's) is limited to ANP's who are licensed in the state of Arkansas and have met the requirements for and possess a certificate of prescriptive authority. **The ANP 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.**

ANP's providing services for Arkansas Blue Cross members must comply with the following policy to qualify for reimbursement:

- The ANP must have a written and signed collaborative agreement 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 ANP 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.
- ANP services submitted by the supervising physician will be paid at the physician level to the physician.
- Services provided by ANP'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.
- ANP's 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 and 99213 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.
- ANP'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 ANP must be concordant with the specialty of the supervising physician.

Physicians wishing to bill for services provided by ANP's to Arkansas Blue Cross members should send copies of the ANP's collaborative agreement to:

Arkansas Blue Cross and Blue Shield
Division of Medical Management
P.O. Box 2181
Little Rock, Arkansas 72201



Physical Medicine and Rehabilitation Reimbursement Changes

Effective October 1, 2007, the conversion factor for physical medicine and rehabilitation services (CPT codes 97001-97799) will change from its current reimbursement of $48.89 to $40.00. The reimbursement allowance for the Arkansas Blue Cross and Blue Shield fee schedule will be calculated by using $40.00 times the applicable 2007 Medicare RVUs.

In addition, all discounts applied to these services will be **removed** for Arkansas Blue Cross and Blue Shield including reimbursement for provider networks operated by its affiliates and subsidiaries. Therefore, providers who participate in the Arkansas' FirstSource® PPO or True Blue networks or the Health Advantage HMO network will receive an Allowance of 100% of the Arkansas Blue Cross fee schedule for Covered Services represented by CPT Codes 97001 - 97799. In addition, Covered Services represented by HCPCS Codes G0237, G0238, G0283 and S9092 will be included in this revision.

As described in all providers' participation agreements as well as the Payer Policies and Procedures Conditions and Terms and Conditions for Arkansas' First Source® PPO, True Blue PPO and Health Advantage HMO, please consider this notice through ***Providers' News*** as an official notification of an amendment to our policies and all applicable provider Participation Agreements.

Physician Assistants

Effective with dates of service July 1, 2007 and after, assistant at surgery services provided by licensed Physician Assistants will be covered. The billing requirements are:

- The Physician Assistant (PA) must have an individual NPI number.
- Claims for assistant at surgery services by the Physician Assistant must be billed with the NPI for the Physician Assistant as the line item provider number.
- The Physician Assistant must agree to have payments for his services paid to a "clinic" NPI. The physician with whom the PA has his/her collaborative agreement must be a member of the same clinic.
- The clinic NPI must be submitted on the claim as the "Pay To" provider number. Note: If the current billing physician does not have a clinic NPI, one must be obtained.
- The assistant at surgery procedure must be billed with Modifier AS in the first modifier position on the claim.
- Arkansas Blue Cross and Blue Shield maintains a list of procedures that require an assistant surgeon. Only procedures on this list are allowed to an assistant at surgery, regardless of the specialty. This rule will apply to Physician Assistants.

New applicants should contact their regional Network Development Representatives. Physician Assistants must supply information regarding their supervising physician when making a network application.

Pharmacy Transition Changes in June 2007

In an effort to better serve our members as well as increase the efficiency of our processes, Arkansas Blue Cross and Blue Shield and its family of companies changed pharmacy benefit management services on June 1, 2007, from Argus Health Systems to Caremark Pharmacy Services.

This change will affect Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, and USAble Administrators members who utilize our pharmacy benefits.

There will not be any changes in benefits, formularies or networks; the medication tiers will not change for those members who have co-payments plans. Prior authorizations in place or in process will be transferred automatically.

However, members will receive new ID cards that will need to be shown to the pharmacy when filling prescriptions at the first visit following the change. Members will continue to use the same customer service numbers and access the web site in the same way.

More details will be forthcoming. New ID cards were issued prior to the June 1 conversion.

Nerve Conduction Studies

Effective July 1, 2007 there will be a new code to report nerve conduction studies performed with automated computerized devices. All studies performed with the NC-Stat system or other similar devices July 1, 2007 or after, should be billed using HCPCS code S3905 (Noninvasive electrodiagnostic testing with automated computerized hand-held device to stimulate and measure neuromuscular signals in diagnosing and evaluating systemic and entrapment neuropathies).

Beginning July 1, 2007, Arkansas Blue Cross and Blue Shield will require the use of HCPCS Code S3905 when billing for these services. HCPCS Code S3905 was introduced in HCPCS effective July 1, 2007 and S3905 is a HIPAA compliant code.

After July 1, 2007, claims filing for nerve conduction tests performed with automated hand held devices (e.g., Neuropath, Neurometrix) should not be reported to Arkansas Blue Cross and Blue Shield or its subsidiaries with CPT codes 95900, 95903, or 95904 as the work and practice expense relative value units associated with these codes were developed from significantly different nerve conduction testing instruments. CPT code 95999 should not be reported for these services as there is now a HCPCS code which is more specific.

Radiology Authorizations Available Online Through RadMD.com

In addition to the National Imaging Associates, Inc. Call Center, physicians may receive authorizations for high-tech imaging online through NIA's secure Web portal, RadMD. (NIA provides outpatient imaging management services for the Arkansas Blue Cross family of companies.)

To get started, simply follow the link, www.RadMD.com/SignUp *and set up a unique user name and password for each individual user in your office.* These unique user names and passwords should be kept confidential to further protect the personal health information involved.

Cases that are pended will be resolved as they are currently through our Clinical Review Departments, but the majority of cases should be completed online with ease.

Once user accounts are established, users will have online access to clinical algorithms, complete clinical guidelines for the prior authorization process, and other valuable information.

RadMD is available during the hours of 5 a.m. to 11 p.m. (CST), Monday through Friday, and 7 a.m. to Noon (CST) on Saturday.

Physicians still have the option to request exams telephonically.

For assistance or technical difficulties, contact webmaster@niainc.com or call 877-80-RadMD (877-807-2363).

Please note: online authorizations are not available for USAble Life Group Health or USAble Administrators members at this time.

HPV Testing with Additional Genetic Tests

Please be advised, the testing for HPV is covered in accordance with Coverage Policy 2001015 and the member benefit certificate for members insured by Arkansas Blue Cross and Blue Shield or Health Advantage.

However, additional genetic testing to determine the specific genotype is not covered due to the lack of medical literature that such identification will improve the health outcomes for the patient. Therefore, these additional tests do not meet the primary coverage criteria for benefit coverage; the member would not be responsible for these charges unless a specific waiver is signed.

Radiology Prior Authorization Updates

Since the Prior Authorization Program for outpatient diagnostic imaging procedures began in 2006, the Arkansas Blue Cross and Blue Shield family of companies have been working diligently to simplify and expedite the process for our physicians and their staffs to ensure timely and accurate service. The following are a few updates to note:

- Prior authorization is NOT necessary for **Medi-Pak Advantage** members.
- An **Interactive Voice Response (IVR) system** has been implemented that allows providers to access information regarding the status of their authorization requests using telephone voice response through the National Imaging Associates (NIA) Call Center, 24 hours a day (must have NIA tracking number).
- **Online authorizations** for high-tech imaging now are available through NIA's secure Web portal, RadMD. Simply follow the link, www.RadMD.com/SignUp *and set up a unique user name and password for each individual user in your office.*
- An ordering office CAN request an **expedited review (by telephone only)** to a nurse clinical reviewer (level 2) if the test requested is urgent and the appropriate clinicians are available to answer additional clinical questions. Please remember that the initial intake information is necessary to determine member eligibility and to process the request.
- A Prior Authorization can be requested after a procedure has been performed; however, the authorization must be obtained **within five (5) business days from the date of the procedure** and prior to the claim being submitted for processing. Prior Authorizations obtained after a claim has been denied for no prior approval are not valid. The claim will not be adjusted for payment in this situation.

As a reminder, always refer to the "Radiology Management Reference Guide" (dated February 2006) and the Clinical Guidelines (available at www.RadMD.com) for complete guidelines for the prior authorization process.

The Radiology Prior Authorization Call Center is available 7 a.m. to 7 p.m. (CST) at 1-877-642-0722 (toll free).

The outpatient High Tech Radiology procedure codes requiring prior authorization are located on pages 37—46 and are also available via AHIN.

Diagnosis Codes: Use of 4th & 5th Digits

In order to be HIPAA compliant, beginning July 1, 2007 Arkansas Blue Cross and Blue Shield and its affiliates will require the use of 4th and 5th digit diagnosis codes from providers when the ICD-9-CM coding manual indicates a fourth or fifth digit is required.

Providers who file claims through AHIN will be prompted to supply a 4th or 5th digit if they file an ICD-9 code using a 3rd or 4th digit when the code is designated as requiring a 4th or 5th digit. Claims with dates of service July 1, 2007 and after using a three or four digit diagnosis code when a more specific diagnosis code is available, will be rejected.

These changes also apply to the Arkansas State and Public School Employee health plan.

Coverage Policy Manual Updates

The following policies have been added to the Arkansas Blue Cross and Blue Shield Coverage Policy Manual or coverage has changed since March 2007. Other revised policies are not listed here because no change was made in coverage/non-coverage. Providers can access policies at www.arkbluecross.com to see the entire policy.

- Endovascular Stent Grafts for Thoracic Aortic Aneurysms or Dissections – FDA device approval criteria added to coverage field
- Rituximab, Off-label Use – coverage for CD20 positive CLL, non-coverage including but not limited to ITP, SLE or glomerulonephritis
- Cold Therapy – coverage field revised but non-coverage continued
- Current Perception Threshold Test – non-coverage extended to other devices
- Magnetic Resonance Imaging, Breast – coverage expanded
- Biomarker Genes for Detection of Lymph Node Metastases in Breast Cancer – new policy of non-coverage
- Nerve Graft for Patients Undergoing Radical Non-Nerve-Sparing Prostatectomy – non-coverage of any nerve graft, not just sural nerve
- Disc Biacuplasty – new policy of non-coverage
- Total Hip Resurfacing – coverage criteria added
- Identification of Microorganisms Using Nucleic Acid Probes – entire coverage field revised; additional limited coverage for several organisms

Health Advantage Laboratory Rates

As a reminder, Health Advantage laboratory reimbursement for individual providers (non-facility) located in the Central Region is based on the rates of Health Advantage contracted laboratories. The current reimbursement rate is 60% of the Arkansas Blue Cross and Blue Shield fee schedule.

Therefore, effective July 1, 2007, the Health Advantage laboratory reimbursement for individual providers in the following counties will be 60% of the Arkansas Blue Cross fee schedule: Cleburne, Conway, Faulkner, Grant, Lonoke, Perry, Pope, Prairie, Pulaski, Saline, Van Buren, White, and Yell. This also includes the self-funded HMO network.

Multiple Radiology Reduction

Effective July 1, 2007, a 25% reduction in the technical portion of multiple radiology procedures in the same family of procedures will also be implemented. The reduction will apply to the lesser valued procedure(s) when multiple procedures in the same diagnostic family (as defined by CMS) are performed during the same encounter.

This reduction was initially announced in December for an April 1, 2007 effective date, but was delayed until July 1, 2007.

Arkansas Blue Cross Updates Time Frame for CMS 1500 Form to Follow CMS Changes

The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional contractors (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. The CMS-1500 form is also used for billing of some Medicaid State Agencies.

The National Uniform Claim Committee (NUCC) is responsible for the maintenance of the CMS-1500 form. CMS does not provide the CMS-1500 form to providers for claim submission.

It has come to the attention of CMS that there are incorrectly formatted versions of the revised form. Given, the circumstances, CMS has decided to extend the acceptance period of the CMS-1500 Form (12/90) version beyond the original April 1, 2007 deadline to a new target deadline of July 1, 2007 while this situation is resolved. Contractors will be directed to continue to accept the CMS-1500 Form (12/90) until notified by CMS to cease.

The following link will help providers to properly identify which form is which. To read more about the implementation of the CMS-1500 go to the CMS web site:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

PDF download:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/1500%20problems.pdf

Arkansas Blue Cross and Blue Shield and its affiliates intend to follow the CMS schedule for the new CMS 1500 (08/05) claim form.

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 is 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.

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, not 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 12 Monospace font.

Time:

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

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of the CMS-1500 claim form. If no units are indicated on the claim, the claim will be denied.

UPPERCASE:
Use only UPPERCASE letters for alphabetical entries. Don't mix fonts or use italics, script, percent signs, question marks, or parentheses. By following these guidelines, providers will assist Arkansas Blue Cross and Blue Shield in meeting its goal of efficient, accurate claims processing.

CMS - 1500 Claims Guide: 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 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. **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: 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 the 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: Enter the Insured's address and telephone number.

Block 9(A-D) - Other insured's Name & Other Information (REQUIRED): **I**f the patient is

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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 and include all the following information in Blocks 9 (A) - (D).

- Other Insured's Policy or Group Number (Note: Do not use a hyphen or space within the policy or group number.);
- Other Insured's Date of Birth and Sex;
- Employer's Name or School Name; and
- Insurance Plan or Program Name.

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 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 11D - Is there another health benefit plan? Enter an "**X**" in the appropriate box. If marked "**Yes**", complete 9 and 9A-D.

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 populated with the accident date.
- Illness - Enter for acute medical emergency only and include onset date of condition;
- Pregnancy - Enter date of the last menstrual period (LMP) as the first date.

Block 17- Name of Referring Physician or Other Source: 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 17A - Other ID Number: If the name of the referring physician is provided in Block 17, it is **REQUIRED** that 17A reflect the proper two-digit qualifier (1B = Arkansas Blue Cross Provider number or 1G = Provider UPIN) along with the appropriate provider number for the referring physician.

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 for inpatient hospitalization related services.

Block 19 - 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(1-4) - Diagnosis and/or Nature of Illness or Injury (REQUIRED): Enter the appropriate ICD-9 diagnosis code (up to five digits) for the services performed. **Do NOT use any punctuation such as a decimal.**

Block 22 – Medicaid only.

Block 23 - Prior Authorization Number: Enter any of the following as assigned by the payer for the current service:

- Prior authorization number,
- Referral number, or
- Mammography pre-certification 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.

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 24I - ID Qualifier: If you are using the five-digit Arkansas Blue Cross legacy number, enter the 1B qualifier for the five-digit Arkansas Blue Cross provider number in the shaded area. **(1B = Arkansas Blue Cross Provider Number)**

Block 24J - Rendering Provider ID Number (REQUIRED): The individual provider rendering the service should be reported in

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Block 24J. **The original fields for Block 24J and 24K have combined and re-numbered as Block 24J.** Enter the five-digit Arkansas Blue Cross provider number in the shaded area of the field. **This number is required through May 23, 2007 or the claim will be rejected.** 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: 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 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.

Block 32A National Provider Identifier (NPI): 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 32B - Other ID Numbers: If you are using the five-digit Arkansas Blue Cross legacy number, enter the two-digit qualifier identifying the five digit Arkansas Blue Cross number followed by the ID number. Do not enter spaces, hyphens, or other separators between the qualifier and number. (1B = Arkansas Blue Cross Provider number)

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): 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.**

Block 33B - Other ID Numbers: If you are using the five-digit Arkansas Blue Cross legacy number, enter the two-digit qualifier **(1B = Arkansas Blue Cross)** identifying the five digit Arkansas Blue Cross number followed by the ID number. Do not enter spaces, hyphens, or other separators between the qualifier and the number.

New UB-04 Claim Form

Form locaters have been added and some are being relocated on the form. Please notify whoever files your claims that these changes are coming and be prepared.

UB-92 to UB-04 Core Changes

Additions to Form Locators:

Additions were made to better align the paper form with the electronic version:

1) Pay-to-name and address
2) Patient name – ID
3) Accident State
4) Page _ of _ Creation date
5) Identifiers
   - National Provider Identifier (NPI)
6) Diagnosis indicator field
   - To report if the diagnosis was present on admission
7) Patient Reason for Visit code
8) PPS code field

Form Locators Removed:

Deletions were made based on industry needs and input from users:

1) Patient marital status
2) Patient prior payments
3) Due from patient
4) Employment status code
5) Employer location
6) Provider representative signature
7) Date bill submitted
8) Various unlabeled fields

Modifications to Current Form Locators:

Modification of existing form locators were required to align the paper claim form to the electronic format and to prepare for future reporting. **If a claim is misaligned, the claim will be returned since it can not be scanned.**

1) Increase Type of Bill from 3 characters to 4
2) Increase field size for HCPCS/Rates/HIPPS Rate codes
   - Allows 2 additional modifiers
3) Added 3 Condition Code fields
4) Increased diagnosis code fields from 9 to 18
5) Expanded diagnosis code field to prepare for ICD-10-CM
6) Added additional Occurrence Span Code field
7) Usage matrix created for Type of Bill
8) Back of form modified to align language with current regulations and industry standards

Substitutions to Current Form Locators:

Various fields substituted or moved:

1) Covered Days – reported as Value Codes
2) Non-covered Days – reported as Value Codes
3) Coinsurance Days – reported as Value Codes
4) Lifetime Reserve Days – reported as Value Codes
5) Medical record number – moved
6) ICN/DCN – moved

Paper claims are designed to use the 10-pitch Pica type, 6 lines per inch. The new UB form is very unforgiving on space. Please make sure the correct type is used.

Data Required on UB04 Facility Claims Submitted for Secondary Payment

Arkansas Blue Cross and Blue Shield and its affiliated companies will no longer be able to manually process facility claims submitted on paper with incorrect or incomplete information in the payer fields (boxes 50, 56, and 57) and the patient fields (boxes 58, 59, and 60).

Any time providers are filing for secondary payment on the UB04, complete information about the payer from whom the provider is seeking payment should always be filed in line 50A with the Explanation of Benefits attached. All others payer information should be filed in line 50B and 50C. Payment will always be made to the payer that is in line 50A. If the claim does not have complete and accurate information, the claim will be returned to the provider.

Arkansas Blue Cross is able to accept electronic submissions for secondary payment and would prefer that claims be sent in this medium. Providers are encouraged to submit claims electronically for all Arkansas Blue Cross lines of business.

With the implementation of the national coordination of benefits process for Medicare, it is unnecessary to submit claims to Arkansas Blue Cross for secondary payment for Medicare primary claims. Arkansas Blue Cross asks that providers not send paper claims for payment secondary to Medicare until at least 30 days after the primary payment was made by Medicare.

If after 30 days a secondary payment has not been received from Arkansas Blue Cross, providers can confirm that Arkansas Blue Cross has received the crossover in the AHIN system. If providers see the claim in AHIN, there is no need to file paper for secondary payment.

Revised Referral Forms

Due to the implementation of NPI, Health Advantage and BlueAdvantage Administrators of Arkansas have revised their referral forms to now include a space for providers to enter their NPI number in addition to their 5-digit Arkansas Blue Cross legacy number. Health Advantage and BlueAdvantage have also done away with the referral pads completely and have opted to use a single page form instead.

This form is available on the corresponding web sites under 'Forms for Providers' for provider's offices to download and print out whenever they need it.

Health Advantage web site:
http://www.healthadvantage-hmo.com

BlueAdvantage web site:
http://www.blueadvantagearkansas.com

Medi-Pak® and Medi-Pak® Advantage Members Have Access to SilverSneakers®

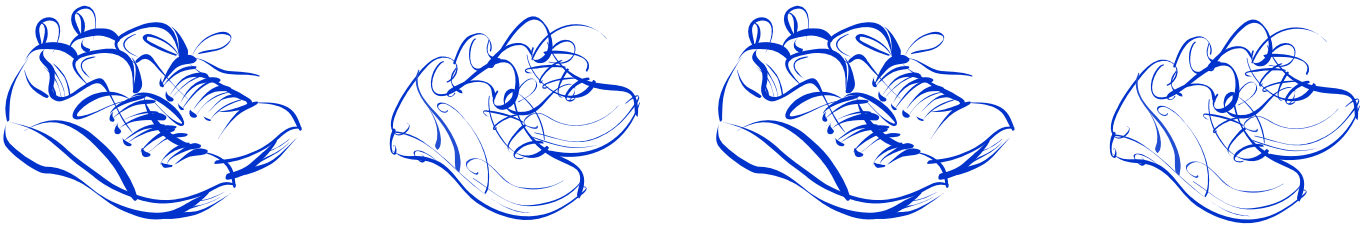
Both Medi-Pak® and Medi-Pak® Advantage are proud to announce our affiliation with the SilverSneakers® Fitness Program. The SilverSneakers® Fitness Program is a unique physical activity, lifestyle and social oriented program designed to encourage these members to increase their levels of physical activity and motivate them to continue to be active. The program reflects senior sensitivity, promotes social interaction and encourages participation in healthy lifestyle activities, showing that it's easy to get fit, have fun and make friends.

Physicians are encouraged to refer their Medi-Pak® or Medi-Pak® Advantage members to join SilverSneakers®. These members have received promotional information in the mail regarding the program and - with encouragement from their physician - Arkansas Blue Cross hopes members will join and begin a healthy lifestyle. The program is designed to prevent the onset of chronic disease, reduce and delay disabilities, and maintain members' physical and mental health.

Members receive a free membership at a participating fitness center. Members have access to all the services offered by the fitness center and SilverSneakers® Classes, which are designed to benefit members regardless of their fitness level. The group exercise class focuses on cardiovascular health, muscle strength, balance, coordination and conditioning. This improves seniors' daily living activities, some of which are putting on a seat-belt, lifting and pouring, turning and looking, opening jars, lifting and lowering items, stair/curb climbing, getting in and out of car, bath tub, chair and bed, and avoiding falls. SilverSneakers® Classes are safe, fun and taught by certified, trained instructors. Classes are available at each contracted fitness center. Senior Advisors are available at each fitness center to greet members, acquaint them with the program, and be of general assistance.

The SilverSneakers® Fitness Program also offers opportunities for fun social events such as fitness promotions and trips to local sporting events, as well as health seminars and workshops on topics such as cooking nutritiously, healthy aging and gardening. Members can make new friends while taking advantage of the benefits of exercise!

To help Medi-Pak® and Medi-Pak® Advantage patients find a fitness center near them, go to www.silversneakers.com. Just enter the patient's ZIP Code and you'll find all the nearby participating fitness centers. Centers are added frequently so please check the website for updates.



Colonoscopy Screening

Because of the state law, which became effective August 1, 2005, regarding screening colonoscopy and other procedures, **screening colonoscopy has been removed from the wellness benefit and has been added to the medical benefit for Arkansas Blue Cross and Blue Shield members.** The following are billing and payment requirements for Arkansas Blue Cross:

HCPCS Code G0104:

HCPCS Code G0104 (colorectal cancer screening; flexible sigmoidoscopy) is classified as RESTRICTED. HCPCS Code G0104 is a covered code but is restricted based on code definition, fragmentation, site-of-service, units-of-service, state mandate, and member benefit contract limitations.

It is restricted to patients who are 50 years of age or older and are not at high risk for colon cancer (high risk as defined by the American Cancer Society, 2005: personal history of colon cancer, a strong family history of colon cancer or polyps in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer), or polyps in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0104 is a fragmentation of CPT Codes 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45387, 45391, and 45392 and HCPCS Codes G0105 and G0121. All of these codes represent colonoscopy procedures and would include examination of the sigmoid colon.

Code G0104 is considered a component of CPT 45303, 45305, 45308, 45309, 45315, 45317, 45320, 45321, 45327, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, and 45345 as each of these codes represent "surgical sigmoidoscopy" and diagnostic endoscopy is included in surgical endoscopy, based on CPT coding instructions. HCPCS Code G0104 is limited to one unit-of-service and is subject to site-of-service payment differential. HCPCS Code G0104 is restricted to once every 5 years based on the Arkansas Act 2236.

The appropriate ICD-9 code for screening purposes is ICD-9 V76.51 (Special screening for malignant neoplasm; colon).

For screening sigmoidoscopy for members who are asymptomatic for colon disease, HCPCS Code G0104 should be reported. If "screening" sigmoidoscopy is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT Code 45330 and the appropriate diagnostic ICD-9 code should be reported if no disease is found on colonoscopy or if disease is found but no surgical endoscopy procedure is performed. If disease is found and an endoscopic surgical procedure performed (e.g., biopsy, snare, ablation), the code that represents the appropriate surgical sigmoidoscopy code should be reported.

HCPCS Code G0105:

HCPCS Code G0105 (colorectal cancer screening, colonoscopy on an individual at high risk) is classified as RESTRICTED. This is a covered code but is restricted based on code definition, fragmentation, site-of-service, units-

of-service, state mandate, and member benefit contract limitations.

HCPCS Code G0105 is restricted to patients who are asymptomatic for colon disease, and are at high risk for colon cancer (high risk as defined by the American Cancer Society, 2005: personal history of colon cancer or adenomatous polyp, a strong family history of colon cancer or polyps, colon cancer in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0105 is a fragmentation of CPT Codes 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45387, 45391, and 45392. These codes represent "surgical" endoscopy codes, and surgical endoscopy codes include diagnostic endoscopy based on CPT coding instructions.

HCPCS Code G0105 is mutually exclusive with G0121 based on code descriptors. HCPCS Code G0105 is mutually exclusive with CPT Code 45378, as 45378 can also represent a screening colonoscopy. If HCPCS Code G0105 billed with CPT Code 45378, 45378 is denied as a fragmentation.

HCPCS Code G0105 is limited to one unit-of-service and is subject to site-of-service payment differential. The appropriate ICD-9 code for screening purposes is ICD-9 V76.51 (Special screening for malignant neoplasm; colon).

For screening colonoscopy for members who are asymptomatic for colon disease, HCPCS Code G0121 should be reported. For colonoscopy for patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT Code 45378 and the appropriate diagnostic ICD-9 code should be reported if no disease is found on colonoscopy. If disease is found and an endoscopic surgical procedure performed, the code that represents the appropriate surgical endoscopy code should be reported.

Screening for patients who are at high risk, as defined above, is covered once every 3 – 5 years for the individual with previous adenomatous polyp or previous personal colon cancer.

HCPCS Code G0106:

HCPCS code G0106 (Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema) is classified as NONCOVERED. HCPCS Code G0106 is for a screening barium enema for an asymptomatic individual as an alternative to sigmoidoscopy; the barium enema component of the code is identical to G0122.

HCPCS Code G0106 is covered under G0122, and must meet the following criteria established for G0122:

1) For screening barium enema for members who are asymptomatic for colon disease, HCPCS G0122 should be reported. If "screening" barium enema is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT 74280 and the appropriate diagnostic ICD-9 code should be reported.
2) The appropriate ICD-9 code for screening purposes is V76.51 (Special screening for malignant neoplasm; colon).

HCPCS Code G0120:

HCPCS Code G0120 (Colorectal cancer screening; alternative to HCPCS Code G0105, screening colonoscopy, barium enema) is classified as NONCOVERED. HCPCS Code G0120 is for a screening barium enema for an asymptomatic individual as an alternative to sigmoidoscopy; the barium enema component of the code is identical to G0122.

HCPCS Code G0120 is covered under Code G0122, and must meet the following criteria

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established for G0122:

1) For screening barium enema for members who are asymptomatic for colon disease, HCPCS Code G0122 should be reported. If "screening" barium enema is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT Code 74280 and the appropriate diagnostic ICD-9 code should be reported.
2) The appropriate ICD-9 code for screening purposes is ICD-9 Code V76.51 (Special screening for malignant neoplasm; colon).

HCPCS Code G0121:

HCPCS Code G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) is **RESTRICTED**. HCPCS Code G0121 is a covered code but is restricted based on code definition, fragmentation, site-of-service, units-of-service, state mandate, and member benefit contract limitations.

HCPCS Code G0121 is restricted to patients who are 50 years of age or older, and are not at high risk for colon cancer (high risk as defined by the American Cancer Society, 2005: personal history of colon cancer or polyp, a strong family history of colon cancer or polyps in a first degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0121 is a fragmentation of CPT Codes 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45387, 45391, and 45392, as all of these codes represent "surgical" endoscopy codes, and surgical endoscopy codes include diagnostic endoscopy based on CPT coding instructions. HCPCS Code G0121 is mutually exclusive with Code G0105 based on code descriptors.

HCPCS Code G0121 is mutually exclusive with CPT Code 45378, as 45378 could also represent a screening colonoscopy. HCPCS Code G0121 is limited to one unit-of-service and is subject to site-of-service payment differential. Code G0121 is covered for screening for colon cancer for members whose age is 50 or greater who are asymptomatic for colon disease (once every 10 years if the colonoscopy is normal). The appropriate ICD-9 code for screening purposes is V76.51 (Special screening for malignant neoplasm; colon).

For screening colonoscopy for members who are asymptomatic for colon disease, less than 50 but at high risk for colon cancer (as defined above) G0105 should be reported. For "screening" colonoscopy for patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool) CPT 45378 and the appropriate diagnostic ICD-9 code should be reported if no disease is found on colonoscopy. If disease is found and a endoscopic surgical procedure performed, the code that represents the appropriate surgical endoscopy code should be reported.

HCPCS Code G0122:

HCPCS Code G0122 (Colorectal cancer screening; barium enema) is classified as RESTRICTED. HCPCS Code G0122 is restricted based on Coverage Policy #2002020 which considers virtual colonoscopy or CT colonography to be investigational.

HCPCS Code G0122 is allowed based on member benefit contract specific inclusion of coverage for colon cancer screening. Screening barium enema for colon cancer is included in Arkansas Act 2236 effective August 1, 2005. G0122 is restricted to:

1) Patients who are 50 years of age or older, and are not at high risk for colon cancer; and
2) Patients of any age at high risk for colon cancer (high risk as defined by the American Cancer Society, 2005: personal history of colon cancer, a strong family history of colon cancer or polyps in a first

degree relative under the age of 60 or in 2 first degree relatives of any age [first degree relative is defined as parent, sibling or child], personal history of chronic inflammatory bowel disease, or family history of a hereditary colorectal cancer syndrome [familial adenomatous polyposis] or hereditary non-polyposis colon cancer).

HCPCS Code G0122 has a total, professional and technical component. The total component is allowed only from site-of-service non-facility. Code G0122 is limited to one unit-of-service. The appropriate ICD-9 code for screening purposes is ICD-9 V76.51 (Special screening for malignant neoplasm; colon).

For screening barium enema for members who are asymptomatic for colon disease, HCPCS Code G0122 should be reported. If "screening" barium enema is performed on patients with colon symptoms (e.g., change in stool habit or caliber, persistent diarrhea, blood in stool), CPT code 74280 and the appropriate diagnostic ICD-9 code should be reported.

When screening colonoscopies became mandated coverage under state law, they became part of the routine medical benefit and all deductibles and co-insurance still applies. Screening colonoscopies and other procedures described in this article are NOT part of the separate, optional Wellness benefit.

Federal Employee Program Benefits and Guidelines: Colonoscopy & Sigmoidoscopy

The Federal Employee Program (FEP) covers colonoscopies at 100% of the FEP allowance when billed with a preventive diagnosis and performed by a Preferred provider.

When a patient is seen in the provider's office and the patient complains of a problem (i.e. bleeding) during the visit with the physician, a screening diagnosis is not appropriate. Providers should code these claims with a medical diagnosis.

When medical necessity guidelines are met, covered Colonscopy and Simoidoscopy procedure codes with a covered medical diagnosis are eligible for medical benefits except for HCPCS Codes G0105 or G0121*.

Preventive Colonoscopy Screening: G0105*, G0121*, 45355, 45378-45387, 45391, 45392. Preventive Sigmoidoscopy: G0104, G0106, 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, anesthesia (00902) 45341, 45342, 45345	Standard Option: All Performing Provider Network Status. Basic Option: Preferred providers only	Covered Preventive Diagnosis: V10.00, V10.03, V10.04, V10.05, V10.06, V10.07, V12.72, V16.0, V19.8, V76.41, V76.50, V76.51, or V84.09

*****Under the Standard Option and Basic Option, HCPCS codes G0105 and G0121 performed by a Preferred provider are covered as Cancer Screenings for all covered diagnosis.

For example:

Under the Standard Option: HCPCS Code G0105 or G0121 performed by a Preferred Provider with a medical diagnosis, Arkansas Blue Cross will pay at 100% of our allowance not subject to the Calendar Year deductible.

Under the Basic Option: HCPCS Code G0105 or G0121 performed by a Preferred physician with a medical diagnosis, Arkansas Blue Cross will pay at 100% of our allowance after $20.00 Primary Care Provider copayment or a $30.00 Specialist Copayment.

Access Only PPO Customers of USAble Corporation

Group Name	Network
Aalf's Manufacturing Inc / Midland's Choice	Arkansas' FirstSource PPO
Anchor Packaging / Hermann Co.	True Blue PPO—Effective 1/1/06
Ark Sheet Metal Workers -Local #36-L	Arkansas' FirstSource PPO
Arkansas Pipe Trades Health & Welfare	True Blue PPO— Effective 01/01/07
Arkansas State University Athletes	Arkansas' FirstSource PPO
Arvest Bank	True Blue PPO—Effective 1/1/06
Ashley County Medical Center	Arkansas' FirstSource PPO
BEKAERT - Rogers, AR Location	Arkansas' FirstSource PPO
BEKAERT - Van Buren, AR Location	Arkansas' FirstSource PPO
Boar's Head Provisions Co	Arkansas' FirstSource PPO
Brentwood Industries, Inc	Arkansas' FirstSource PPO
Bridgestone - Firestone	Arkansas' FirstSource PPO
Bryce Corporation	True Blue PPO—Effective 11/01/06
Columbia Forest Products	True Blue PPO—Effective 01/01/06
Defiance Metals	Arkansas' FirstSource PPO
Diocese Of Little Rock / Christian Brothers	Arkansas' FirstSource PPO
Franklin Electric	Arkansas' FirstSource PPO
Harps Food Stores	True Blue PPO Effective 06/01/06
Iberia Bank	True Blue PPO—Effective 02/01/07
KLA Benefits/Klipsch LLC	Arkansas' FirstSource PPO
LA Darling	True Blue PPO—Effective 01/01/06
Levi Hospital	Arkansas' FirstSource PPO
Magnolia Hospital	Arkansas' FirstSource PPO

Group Name	Network
Marshalltown Company	Arkansas' FirstSource PPO
Maverick Tube Corp	True Blue PPO Effective 08/01/06
Motor Appliance Corporation	Arkansas' FirstSource PPO
Nestle USA	True Blue PPO—Effective 08/01/06
Odom's Tennessee Pride Sausage	True Blue PPO—Effective 01/01/07
Peterson Manufacturing / Mission Plastics	Arkansas' FirstSource PPO
Rea Magnet Wire Co	Arkansas' FirstSource PPO
Siplast Inc	Arkansas' FirstSource PPO
Southern Painters Welfare	Arkansas' FirstSource PPO
Stephens Media Group	True Blue PPO—Effective 01/01/06
St. Michael Healthcare - Cobra	Arkansas' FirstSource PPO
St. Michael Healthcare-Hosp	Arkansas' FirstSource PPO
St. Michael Healthcare-Rehab	Arkansas' FirstSource PPO
St. Michael CH Wilkerson - Texarkana	Arkansas' FirstSource PPO
Town & Country Grocers / Price Chopper	Arkansas' FirstSource PPO
Townsend Foods	True Blue PPO—Effective 01/01/06
UFCW (Kroger & Consumer Market)	True Blue PPO—Effective 10/01/05
Wabash National / Cloud Corp	Arkansas' FirstSource PPO

Groups Terminated Since January 1, 2006	Termination Date
Arkansas Carpenters Health & Welfare Fund	Term Effective 05/31/07
FedEx Freight East, Inc (Formerly American Freightways)	Term Effective 12/31/06
Genmar - Ranger Boats	Term Effective 12/31/06
Harding University	Term Effective 12/31/06 Changed to BlueAdvantage
Southern Painters Welfare	Term Effective 05/31/06
Wallace & Owens	Moved to BlueCard 08/01/06

Dental Fee Schedule

The following dental fee schedule for general dentists will be effective on July 1, 2007.

Procedure Code	Description	Allowance
D0120	Periodic Oral Examination	$26.00
D0140	Limited Oral Evaluation - Problem Focused	$35.00
D0145	Oral Evaluation-Patient Under 3	$26.00
D0150	Comprehensive Oral Examination	$36.00
D0160	Detailed And Extensive Oral Evaluation (Problem Focused)	$50.00
D0210	Intraoral - Complete Series (Including Bitewings)	$85.00
D0220	Intraoral- Periapical-First Film	$18.00
D0230	Intraoral-Periapical-Each Additional Film	$15.00
D0240	Intraoral-Occlusal Film	$25.00
D0250	Extraoral-First Film	$30.00
D0260	Extraoral - Each Additional Film	$20.00
D0270	Bitewing-Single Film	$18.00
D0272	Bitewings - Two Films	$26.00
D0274	Bitewings - Four Films	$35.00
D0277	Vertical Bitewings - 7 To 8 Films	$60.00
D0330	Panoramic Film	$65.00
D0340	Cephalometric Film	$70.00
D0460	Pulp Vitality Tests	$25.00
D0470	Diagnostic Casts	$40.00
D1110	Prophylaxis - Adult	$47.00
D1120	Prophylaxis - Child	$32.00
D1203	Topical Application Fluoride - Child	$18.00
D1351	Sealant - Per Tooth	$28.00
D1510	Space Maintainer - Fixed Unilateral	$180.00
D1515	Space Maintainer - Fixed- Bilateral	$250.00
D1550	Recementation Of Space Maintainer	$40.00
D2140	Amalgam - One Surface, Primary Or Permanent	$65.00
D2150	Amalgam - Two Surfaces, Primary Or Permanent	$80.00
D2160	Amalgam - Three Surfaces, Primary Or Permanent	$94.00
D2161	Amalgam - Four Surfaces, Primary Or Permanent	$115.00
D2330	Resin - One Surface, Anterior	$82.00
D2331	Resin - Two Surfaces, Anterior	$100.00
D2332	Resin - Three Surfaces, Anterior	$125.00
D2335	Resin - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	$160.00

Procedure Code	Description	Allowance
D2390	Resin-Based Composite Crown, Anterior	$160.00
D2391	Resin- Based Composite - One Surface, Posterior	$90.00
D2392	Resin-Based Composite - Two Surfaces Posterior	$120.00
D2393	Resin-Based Composite - Three Surfaces, Posterior	$150.00
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	$165.00
D2510	Inlay - Metallic - One Surface	$380.00
D2520	Inlay - Metallic - Two Surfaces	$480.00
D2530	Inlay - Metallic - Three Surfaces	$520.00
D2542	Onlay - Metallic - Two Surfaces	$480.00
D2543	Onlay-Metallic - Three Surfaces	$540.00
D2544	Onlay-Metallic - Four Or More Surfaces	$600.00
D2610	Inlay - Porcelain/Ceramic - One Surface	$450.00
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	$500.00
D2630	Inlay - Porcelain/Ceramic - Three Surfaces	$600.00
D2642	Onlay- Porcelain/Ceramic - Two Surfaces	$625.00
D2643	Onlay-Porcelain/Ceramic - Three Surfaces	$650.00
D2644	Onlay-Porcelain/Ceramic - Four Or More Surfaces	$675.00
D2650	Inlay - Composite/Resin - One Surface	$425.00
D2651	Inlay - Composite/Resin - Two Surface	$450.00
D2652	Inlay - Composite/Resin - Three Or More Surfaces	$500.00
D2662	Onlay - Composite/Resin - Two Surfaces	$560.00
D2663	Onlay - Composite/Resin - Three Surfaces	$610.00
D2664	Onlay - Composite/Resin - Four Or More Surfaces	$625.00
D2740	Crown - Porcelain/Ceramic Substrate	$710.00
D2750	Crown - Porcelain Fused To High Noble Metal	$675.00
D2751	Crown - Porcelain Fused To Predominantly Base Metal	$580.00
D2752	Crown - Porcelain Fused To Noble Metal	$630.00
D2780	Crown - 3/4 Cast High Noble Metal	$625.00
D2781	Crown - 3/4 Cast Predominately Base Metal	$570.00
D2782	Crown - 3/4 Cast Noble Metal	$600.00
D2783	Crown - 3/4 Porcelain/Ceramic (Not Veneers)	$680.00
D2790	Crown - Full Cast High Noble Metal	$635.00
D2791	Crown - Full Cast Predominantly Base Metal	$560.00
D2792	Crown - Full Cast Noble Metal	$600.00
D2910	Recement Inlay	$50.00
D2920	Recement Crown	$50.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$135.00

Procedure Code	Description	Allowance
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$135.00
D2932	Prefabriated Resin Crown	$150.00
D2933	Prefabricated Stainless Steel Crown With Resin Window	$180.00
D2934	Prefab Esthetic Stainless Steel Crown - Primary	$180.00
D2950	Core Buildup, Including Any Pins	$128.00
D2951	Pin Retention - Per Tooth, In Addition To Restoration	$45.00
D2952	Cast Post & Core In Addition To Crown	$225.00
D2954	Prefabricated Post & Core In Addition To Crown	$180.00
D2962	Labial Veneer (Porcelain Laminate) - Lab	$690.00
D2980	Crown Repair, By Report	$125.00
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$95.00
D3310	Root Canal Therapy - Anterior (Excluding Final Restoration)	$405.00
D3320	Root Canal Therapy - Bicuspid (Excluding Final Restoration)	$460.00
D3330	Root Canal Therapy - Molar (Excluding Final Restoration)	$600.00
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	$500.00
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	$550.00
D3348	Retreatment Of Previous Root Canal Therapy - Molar	$700.00
D3351	Apexification/Recalcification - Initial Visit	$155.00
D3352	Apexification/Recalcification - Interim Medication Replacement	$100.00
D3353	Apexification/Recalcification - Final Visit	$300.00
D3410	Apicoectomy/Periradicular Surgery - Anterior	$400.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$495.00
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	$600.00
D3426	Apicoectomy/Periadicular Surgery- Each Addt'l Root	$180.00
D3430	Retrograde Filling - Per Root	$120.00
D3450	Root Amputation - Per Root	$200.00
D3920	Hemisection (Including Any Root Removal)	$260.00
D3950	Canal Preparation & Fitting Of Preformed Dowel Or Post	$120.00
D4210	Gingivectomy/Gingivoplasty - One To Three Teeth, Per Quadrant	$250.00
D4211	Gingivectomy/Gingivoplasty-Per Tooth	$100.00
D4240	Gingival Flap, Including Root Planing - Per Quadrant	$300.00
D4241	Gingival Flap, Including Root Planing - 1 To 3 Teeth, Per Quadrant	$160.00
D4249	Crown Lengthening - Hard/Soft Tissue, By Report	$350.00
D4260	Osseous Surg (Incl. Flap Entry & Closure- 4 Or More Teeth Per Quad)	$600.00
D4261	Osseous Surg (Incl. Flap Entry & Closure - 1 To 3 Teeth, Per Quad)	$345.00
D4263	Bone Replacement Graft - Single Site	$350.00
D4264	Bone Replacement Graft - Each Additional Site In Quadrant	$200.00
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	$425.00

Procedure Code	Description	Allowance
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site	$200.00
D4270	Pedicle Soft Tissue Graft Procedure	$300.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site)	$475.00
D4273	Subepithelial Connective Tissue Graft Procedure	$450.00
D4275	Soft Tissue Allograft	$475.00
D4276	Combined Connective Tissue And Double Pedicle Graft	$550.00
D4341	Periodontal Scaling And Root Planing - Per Quadrant	$155.00
D4342	Periodontal Scaling And Root Planing - 1 To 3 Teeth, Per Quadrant	$90.00
D4910	Periodontal Maintenance (Following Active Therapy)	$70.00
D5110	Complete Denture - Upper	$850.00
D5120	Complete Denture - Lower	$850.00
D5130	Immediate Denture - Upper	$900.00
D5140	Immediate Denture - Lower	$900.00
D5211	Upper Partial - Resin Base (With Conventional Clasps,Rests & Teeth	$600.00
D5212	Lower Partial - Resin Base (With Conventional Clasps,Rests & Teeth	$600.00
D5213	Upper Partial - Cast Metal Base With Resin Saddles	$950.00
D5214	Lower Partial - Cast Metal Base With Resin Saddles	$950.00
D5281	Removable Unilateral Partial Denture -1 Piece Cast Metal	$550.00
D5410	Adjust Complete Denture - Upper	$40.00
D5411	Adjust Complete Denture - Lower	$40.00
D5421	Adjust Partial Denture - Upper	$40.00
D5422	Adjust Partial Denture - Lower	$40.00
D5510	Repair Broken Complete Denture Base	$100.00
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	$100.00
D5610	Repair Resin Saddle Or Base	$100.00
D5620	Repair Cast Framework	$150.00
D5630	Repair Or Replace Broken Clasp	$125.00
D5640	Replace Broken Teeth - Per Tooth	$85.00
D5650	Add Tooth To Existing Partial Denture	$110.00
D5660	Add Clasp To Existing Partial Denture	$135.00
D5670	Replace All Teeth And Acrylic On Cast Metal Frame Work (Maxillary)	$550.00
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	$550.00
D5710	Rebase Complete Upper Denture	$300.00
D5711	Rebase Complete Lower Denture	$300.00
D5720	Rebase Upper Partial Denture	$300.00
D5721	Rebase Lower Partial Denture	$300.00
D5730	Reline Complete Upper Denture (Chairside)	$175.00

Procedure Code	Description	Allowance
D5731	Reline Complete Lower Denture (Chairside)	$175.00
D5740	Reline Upper Partial Denture (Chairside)	$175.00
D5741	Reline Lower Partial Denture (Chairside)	$175.00
D5750	Reline Complete Upper Denture (Lab)	$275.00
D5751	Reline Complete Lower Denture (Lab)	$275.00
D5760	Reline Upper Partial Denture (Lab)	$240.00
D5761	Reline Lower Partial Denture (Lab)	$240.00
D6210	Pontic - Cast High Noble Metal	$625.00
D6211	Pontic - Cast Predominantly Base Metal	$560.00
D6212	Pontic - Cast Noble Metal	$660.00
D6240	Pontic - Porcelain Fused To High Noble Metal	$660.00
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	$575.00
D6242	Pontic - Porcelain Fused To Noble Metal	$635.00
D6245	Pontic - Porcelain / Ceramic	$680.00
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	$300.00
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	$260.00
D6600	Inlay - Porcelain/Ceramic , Two Surfaces	$500.00
D6601	Inlay - Porcelain/Ceramic, Three Or More Surfaces	$550.00
D6602	Inlay - Cast High Noble Metal, Two Surfaces	$475.00
D6603	Inlay - Cast Noble Metal, Three Or More Surfaces	$525.00
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	$495.00
D6605	Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	$525.00
D6606	Inlay - Cast Noble Metal, Two Surfaces	$450.00
D6607	Inlay - Cast Noble Metal, Three Or More Surfaces	$495.00
D6608	Onlay - Porcelain/Ceramic , Two Surfaces	$500.00
D6609	Onlay - Porcelain/Ceramic , Three Or More Surfaces	$525.00
D6610	Onlay - Cast High Noble, Two Surfaces	$600.00
D6611	Onlay - Cast High Noble Metal, Three Or More Surfaces	$610.00
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	$500.00
D6613	Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	$510.00
D6614	Onlay - Cast Noble Metal, Two Surfaces	$525.00
D6615	Onlay - Cast Noble Metal, Three Or More Surfaces	$530.00
D6740	Crown - Porcelain / Ceramic	$715.00

Procedure Code	Description	Allowance
D6750	Crown - Porcelain Fused To High Noble Metal	$675.00
D6751	Crown - Porcelain Fused To Predominantly Base Metal	$580.00
D6752	Crown - Porcelain Fused To Noble Metal	$630.00
D6780	Crown - 3/4 Cast High Noble	$585.00
D6781	Crown 3/4 Cast Predominately Based Metal	$550.00
D6782	Crown 3/4 Noble Metal	$560.00
D6783	Crown 3/4 Porcelain / Ceramic	$620.00
D6790	Crown - Full Cast High Noble Metal	$635.00
D6791	Crown - Full Cast Predominantly Base Metal	$550.00
D6792	Crown - Full Cast Noble Metal	$575.00
D6930	Recement Bridge	$65.00
D6970	Cast Post & Core In Addition To Bridge Retainer	$225.00
D6971	Cast Post As Part Of Bridge Retainer	$175.00
D6972	Prefabricated Post And Core In Addition To Bridge Retainer	$160.00
D6973	Core Build-Up Or Retainer, Including Any Pins	$150.00
D6980	Bridge Repair - By Report	$150.00
D7111	Coronal Remnants - Deciduous Tooth	$45.00
D7140	Extraction, Erupted Tooth Or Exposed Root	$75.00
D7210	Surgical Removal Of Erupted Tooth	$140.00
D7220	Removal Of Impacted Tooth - Soft Tissue	$175.00
D7230	Removal Of Impacted Tooth - Partially Bony	$210.00
D7240	Removal Of Impacted Tooth - Completely Bony	$240.00
D7241	Removal Of Impacted Tooth - Completely Bony With Complications	$325.00
D7250	Surgical Removal Of Residual Tooth Roots - Cutting Procedures	$160.00
D7260	Oral Antral Fistula Closure	$250.00
D7261	Primary Closure Of A Sinus Perforation	$300.00
D7280	Surgical Exposure Of Impacted Or Unerupted Tooth - Ortho	$200.00
D7281	Surgical Exposure Of Impacted Or Unerupted Tooth To Aid Eruption	$200.00
D7310	Alveoplasty In Conjunction With Extractions - Per Quadrant	$150.00
D7311	Alveoplasty In Conjunction With Extractions - 1 To 3, Per Quad	$110.00
D7320	Alveoplasty Not In Conjunction With Extractions - Per Quadrant	$160.00

Procedure Code	Description	Allowance
D7321	Alveoplasty Not In Conjunction With Extractions - 1 To 3, Per Quad	$110.00
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	$290.00
D7350	Vestibuloplasty - Ridge Extension (Including Soft Tissue Grafts, Etc.)	BR
D7471	Removal Of Exostosis - Maxilla Or Mandible	$260.00
D7472	Removal Of Torus Palatinus	$260.00
D7473	Removal Of Torus Mandibularis	$260.00
D7485	Surgical Reduction Of Osseous Tuberosity	$260.00
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	$90.00
D7530	Removal Of Foreign Body, Skin, Or Subcutaneous Alveolar Tissue	$130.00
D7560	Maxillary Sinusotomy For Removal Of Tooth Frag Or Foreign Body	$280.00
D7960	Frenulectomy - Separate Procedure	$200.00
D7970	Excision Of Hyperplastic Tissue-Per Arch	$235.00
D7971	Excision Of Pericoronal Gingiva	$100.00
D8010	Limited Orthodontic Treatment Of Primary Dentition	$1,000.00
D8020	Limited Orthodontic Treatment Of Transitional Dentition	$1,000.00
D8030	Limited Orthodontic Treatment Of Adolescent Dentition	$1,000.00
D8040	Limited Orthodontic Treatment Of Adult Dentition	$1,200.00
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	$2,000.00
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	$2,000.00
D8070	Comprehensive Ortho Treatment Of The Transitional Dentition	$5,000.00
D8080	Comprehensive Ortho Treatment Of The Adolescent Dentition	$6,000.00
D8090	Comprehensive Ortho Treatment Of The Adult Dentition	$7,000.00
D8210	Removable Appliance Therapy	$1,000.00
D8220	Fixed Appliance Therapy	$1,200.00
D8680	Orthodontic Retention	$500.00
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedures	$45.00
D9220	Deep Sedation (Unconscious)/General Anesthesia - First 30 Minutes	$250.00
D9221	Deep Sedation (Unconscious) / General Anesthesia - Each Additional 15 Minutes	$65.00
D9940	Occlusal Guards By Report	$300.00

Fee Schedule Updates

The following CPT and HCPCS Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
19295	$152.94	$0.00	$0.00	$0.00	$0.00	$0.00
56442	$150.57	$0.00	$0.00	$75.29	$0.00	$0.00
57410	$0.00	$0.00	$0.00	$167.76	$0.00	$0.00
58356	$1,402.83	$0.00	$0.00	$524.83	$0.00	$0.00
78708	$411.40	$97.81	$313.59	$0.00	$97.81	$0.00
90378	$669.90	$0.00	$0.00	$0.00	$0.00	$0.00
90669	$73.75	$0.00	$0.00	$0.00	$0.00	$0.00
90680	$66.94	$0.00	$0.00	$0.00	$0.00	$0.00
90710	$124.37	$0.00	$0.00	$0.00	$0.00	$0.00
90734	$88.68	$0.00	$0.00	$0.00	$0.00	$0.00
93581	$0.00	$0.00	$0.00	$2,163.72	$2,163.72	$0.00
93650	$0.00	$0.00	$0.00	$952.04	$952.04	$0.00
93651	$0.00	$0.00	$0.00	$1,441.69	$1,441.69	$0.00
93652	$0.00	$0.00	$0.00	$1,568.55	$1,568.55	$0.00
94002	$0.00	$0.00	$0.00	$136.90	$0.00	$0.00
95060	$27.27	$0.00	$0.00	$0.00	$0.00	$0.00
E0481	BR	BR	BR	$0.00	$0.00	$0.00
E0730	$0.00	$0.00	$272.93	$0.00	$0.00	$0.00
J3240	$804.88	$0.00	$0.00	$0.00	$0.00	$0.00
Q4084	$201.24	$0.00	$0.00	$0.00	$0.00	$0.00
S2078	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule Updates

The following HCPCS Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule effective March 13, 2007.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
A9527	BR	BR	$0.00	$0.00	$0.00	$0.00
A9542	$2,260.00	$2,260.00	$0.00	$0.00	$0.00	$0.00
Q9945	$0.29	$0.29	$0.00	$0.00	$0.00	$0.00
Q9946	$1.97	$1.97	$0.00	$0.00	$0.00	$0.00
Q9947	$1.39	$1.39	$0.00	$0.00	$0.00	$0.00
Q9949	$0.39	$0.39	$0.00	$0.00	$0.00	$0.00
Q9950	$0.23	$0.23	$0.00	$0.00	$0.00	$0.00
Q9952	$2.92	$2.92	$0.00	$0.00	$0.00	$0.00
Q9954	$9.29	$9.29	$0.00	$0.00	$0.00	$0.00
Q9956	$51.59	$51.59	$0.00	$0.00	$0.00	$0.00
Q9957	$64.05	$64.05	$0.00	$0.00	$0.00	$0.00
Q9958	$0.08	$0.08	$0.00	$0.00	$0.00	$0.00
Q9960	$0.10	$0.10	$0.00	$0.00	$0.00	$0.00
Q9961	$0.20	$0.20	$0.00	$0.00	$0.00	$0.00
Q9962	$0.13	$0.13	$0.00	$0.00	$0.00	$0.00
Q9963	$0.41	$0.41	$0.00	$0.00	$0.00	$0.00
Q9964	$0.20	$0.20	$0.00	$0.00	$0.00	$0.00

High Tech Radiology Procedures

The outpatient High Tech Radiology procedure codes requiring prior authorization are listed below and are also available via AHIN.

Proc Code	Description
Head and Neck:	
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)
70450	Computed tomography, head or brain; without contrast material
70460	Computed tomography, head or brain; with contrast material(s)
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
70482	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections
70486	Computed tomography, maxillofacial area; without contrast material
70487	Computed tomography, maxillofacial area; with contrast material(s)
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections
70490	Computed tomography, soft tissue neck; without contrast material
70491	Computed tomography, soft tissue neck; with contrast material(s)
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
70496	Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
70498	Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)
70542	Magnetic resonance(eg, proton) imaging, orbit, face &/or neck; w/contrast material(s)

Proc Code	Description
Head and Neck (continued):	
70543	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences
70544	Magnetic resonance angiography, head; without contrast material(s)
70545	Magnetic resonance angiography, head; with contrast material(s)
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences
70547	Magnetic resonance angiography, neck; without contrast material(s)
70548	Magnetic resonance angiography, neck; with contrast material(s)
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time
Chest	
71250	Computed tomography, thorax; without contrast material
71260	Computed tomography, thorax; with contrast material(s)
71270	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections
71275	Computed tomographic angiography, chest(noncoronary), without contrast material(s), followed by contrast material(s) and further sections, including image postprocessing
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)

Proc Code	Description
Chest (continued)	
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)
71551	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)
71552	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
Spine and Pelvis	
72125	Computed tomography, cervical spine; without contrast material
72126	Computed tomography, cervical spine; with contrast material
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72128	Computed tomography, thoracic spine; without contrast material
72129	Computed tomography, thoracic spine; with contrast material
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
72131	Computed tomography, lumbar spine; without contrast material
72132	Computed tomography, lumbar spine; with contrast material
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)

Proc Code	Description
Spine and Pelvis (continued)	
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72191	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
72192	Computed tomography, pelvis; without contrast material
72193	Computed tomography, pelvis; with contrast material(s)
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)
Upper Extremities	
73200	Computed tomography, upper extremity; without contrast material
73201	Computed tomography, upper extremity; with contrast material(s)
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections
73206	Computed tomographic angiography, upper extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)

Proc Code	Description
Upper Extremities (continued)	
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)
73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
73223	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)
Lower Extremities	
73700	Computed tomography, lower extremity; without contrast material
73701	Computed tomography, lower extremity; with contrast material(s)
73702	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections
73706	Computed tomographic angiography, lower extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)
73720	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)
73723	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)

Proc Code	Description
Abdomen	
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
74175	Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)
0066T	Computed tomographic (CT) colonography (ie, virtual colonoscopy); screening
0067T	Computed tomographic (CT) colonography (ie, virtual colonoscopy); diagnostic
S8037	Magnetic resonance cholangiopancreatography (MRCP)
Heart	
75552	Cardiac magnetic resonance imaging for morphology; without contrast material
75553	Cardiac magnetic resonance imaging for morphology; with contrast material
75554	Cardiac magnetic resonance imaging for function, with or without morphology; complete study
75555	Cardiac magnetic resonance imaging for function, with or without morphology; limited study
75556	Cardiac magnetic resonance imaging for velocity flow mapping
0144T	Computed tomography, heart, without contrast material, including image postprocessing and quantitative evaluation of coronary calcium
0145T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology

Proc Code	Description
Heart (continued)	
0146T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium
0147T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium
0148T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium
0149T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium
0150T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology in congenital heart disease
0151T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing, function evaluation (left and right ventricular function, ejection-fraction and segmental wall motion) (List separately in addition to code for primary procedure)
Vascular Procedures	
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

Proc Code	Description
Other Procedures	
76093	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral **(Valid for dates of service prior to 12/31/2006 only)**
76094	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral **(Valid for dates of service prior to 12/31/2006 only)**
76380	Computed tomography, limited or localized follow-up study
76390	Magnetic resonance spectroscopy
76400	Magnetic resonance (eg, proton) imaging, bone marrow blood supply **(Valid for dates of service prior to 12/31/2006 only)**
S8042	Magnetic resonance imaging (MRI), low-field
Breast, Mammography	
77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral **(Valid for dates of service on or after 1/01/2007 only)**
77059	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral **(Valid for dates of service on or after 01/01/2007 only)**
Bone/Joint Studies	
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply **(Valid for dates of service on or after 01/01/2007 only)**
Nuclear Medicine-Cardiovascular System	
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78460	Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification
78461	Myocardial perfusion imaging; multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification
78464	Myocardial perfusion imaging; tomographic (SPECT), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification
78465	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique

Proc Code	Description
Nuclear Medicine-Cardiovascular System (continued)	
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing
78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification
78478	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)
78480	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)
78481	Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78483	Cardiac blood pool imaging, (planar), first pass technique; multiple studies, at rest and with stress (exercise and/ or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
Nuclear Medicine-Nervous System (PET)	
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation

Proc Code	Description
Nuclear Medicine-Other Procedures (PET)	
78811	Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/ neck)
78812	Tumor imaging, positron emission tomography (PET); skull base to mid-thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body
G0235	PET imaging, any site, not otherwise specified

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