Arkansas Blue Cross and Blue Shield

Providers' News

September 2007

Inside the September 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:

Karen Green, Editor
Arkansas Blue Cross and Blue Shield
P. O. Box 2181
Little Rock AR 72203-2181
Email: krgreen@arkbluecross.com

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Arkansas Blue Cross and Blue Shield: NPI Mandate - Updated September 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 a good percentage of claims with an NPI, but it does not match the large percentage of NPIs registered in our data bases. 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 and Blue Shield 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.

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

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

Arkansas Blue Cross Needs Your NPI!

(Reprint from September 2006 issue of *Providers' News*)

Providers who have already applied and received their National Provider Identifier (NPI), Arkansas Blue Cross and Blue Shield needs it to ensure our payment system is updated before the NPI deadline (May 23, 2007).

Please send a copy of the verification from the National Plan and Provider Enumeration System (NPPES) that indicates the provider and/or organization name and newly assigned NPI to the Provider Network Operations division of Arkansas Blue Cross and Blue Shield.

Providers may mail, fax, or email their NPI verification to:

Arkansas Blue Cross and Blue Shield
Provider Network Operations
P.O. Box 2181
Little Rock, Arkansas 72203-2181

Fax: 501-378-2465
E-mail: providernetwork@arkbluecross.com

Please attach the "Provider Change of Data" form (located under "Forms for Providers" on the "Provider" page of the Arkansas Blue Cross web site at www.arkbluecross.com) with the NPPES confirmation form. If the provider's demographics or payment information data has not changed, they should only complete the Provider #, Name, Email Address, NPI, Medical Records, Fax Number, and Practice Location Address information on the "Provider Change of Data" form.

Providers who have not already applied for their NPI, please do so ASAP. HIPAA requires that all covered entities completing electronic claims transactions (such as providers, health-care clearinghouses, and large health plans) must use only the NPI to identify covered healthcare providers in all standard trans-actions by May 23, 2007.

For additional information on NPI, visit the CMS website at ***http://new.cms.hhs.gov/***. On the CMS home page, select the "Regulations & Guidance" link located under "CMS Programs & Information" and then the "National Provider Identifier Standard" link located under the "HIPAA Administrative Simplification" section. Providers can also click on the NPPES link or go directly to their web site and apply online at ***http://nppes.cms.hhs.gov***.

For those providers with access to AHIN, the Advanced Health Information Network, a program has been created to notify Arkansas Blue Cross and Blue Shield about a provider's NPI assignment submitted through AHIN . All AHIN users can now select the "NPI Administration" button to submit their new NPI. Please check the AHIN bulletin board for instructions and additional information.

Total Hip Resurfacing

There is no specific CPT code that describes this procedure. It should be billed with 27299 – unlisted procedure, pelvis or hip joint. Coverage criteria for this procedure can be found in policy number 2006037 on our website.

Arkansas Blue Cross and Blue Shield: Evaluates NPI Adoption Rate & End of Contingency

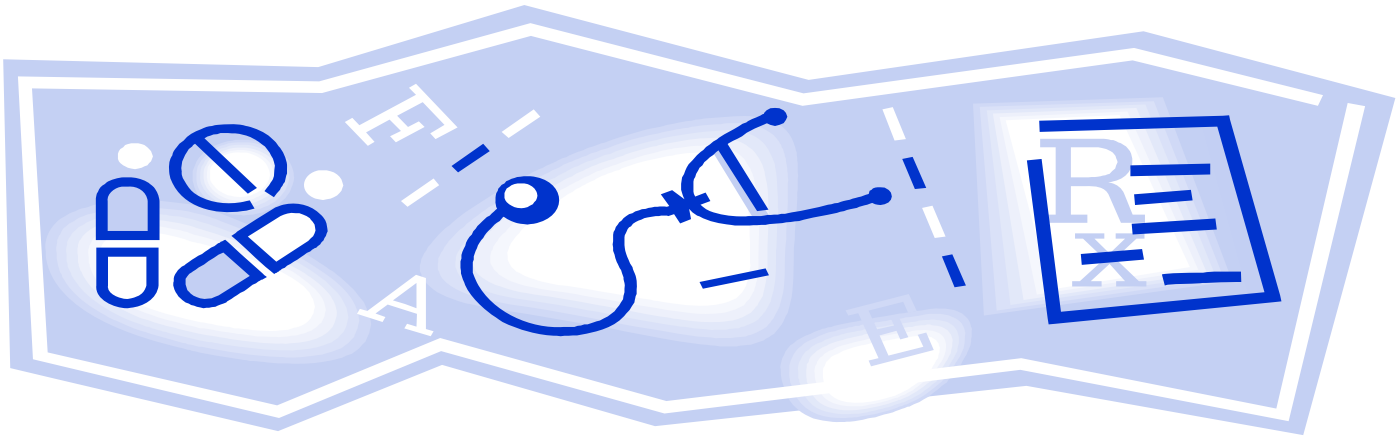
Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas met the requirements for the HIPAA National Provider Identifier (NPI) Rule prior to the compliance date of May 23, 2007. Under the guidance of CMS, we implemented an NPI contingency plan to assist providers that had not been able to obtain their NPI by the compliance date of May 23, 2007. By far, the majority of our local providers have acquired and are now using their NPIs on claims submitted to us. During August 2007, over 83% of our claims were submitted using the NPI.

As we stated when implementing our NPI Contingency plan, Arkansas Blue Cross will end the contingency period at the earliest possible date when an adequate number of providers have met NPI compliance, but no later than May 23, 2008. Arkansas Blue Cross is closely monitoring the adoption rate of NPIs. When the contingency period has ended, claims submitted without using an NPI as the provider identifier will be rejected.

Arkansas Blue Cross and Blue Shield and its affiliates are still receiving some claims that do not contain NPIs. The NPI Rule and guidance issued by HHS and CMS states that providers have the responsibility of obtaining an NPI, sharing it with entities that need it, and using it within HIPAA standard transactions. No fees are charged for issuing an NPI and providers have the option to apply online for their NPI (***http://nppes.cms.hhs.gov***) or via a paper form.

After a provider has received their NPI, they must register it with Arkansas Blue Cross before using it on submitted claims. Arkansas Blue Cross has a facility on the Advanced Health Information Network (AHIN) web site allowing providers to register their NPI online. A provider may also use mail, fax or emails to register their NPI with Arkansas Blue Cross.

For assistance in obtaining an NPI or for registering an NPI with Arkansas Blue Cross, please refer to the article titled “Arkansas Blue Cross Needs Your NPI!” located on the previous page or contact your regional office.”



Correct Coding — Unlisted Procedures

Current Procedural Terminology (CPT™) is a systematic listing and coding of procedures and services performed by a physician. Prior to 2002, instructions for coding were to select the code that most accurately identifies the service performed.

In 2002, the instructions for the use of the CPT codes were changed and the following language remains in place:

> "Select the name of the procedure that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code."

Recent reviews of medical records have shown the inappropriate use of CPT codes that do not describe the service that was documented. An unlisted code from the appropriate section should be used if there is not a CPT code that accurately describes the service rendered.

Claim Forms No Longer Accepted - HCFA 1500 (12/90) and UB92

As of September 1, 2007, Arkansas Blue Cross and Blue Shield will no longer accept the **HFCA 1500 (12/90)** claim form. All providers must submit claims on the new **CMS 1500 (08/05)** claim form**.** (For instructions on filing the new CMS 1500 claim form see the June 2007 issue of the *Providers' News,* pages 16 – 19).

If a claim is submitted on the old HCFA 1500 (12/90) form on or after September 1, 2007, the claim will be returned with the following explanation:

> "***Your claim was filed on the old HFCA 1500 (12/90) form version. Claims received on or after September 1, 2007 must be filed using a new red CMS1500 (08/05) version. Please resubmit the claim on the new form".***

Arkansas Blue Cross and Blue Shield will also not be accepting the UB92 claim form received on or after November 1, 2007. All claims will be returned with the following explanation:

> *"**Your claim was filed on the old UB92 claim form. Claims received on or after November 1, 2007 must be filed using a new red UB04 version. Please resubmit the claim on the new form."***

All facility claims must be filed on the new UB04 red form. Guidance on submitting the new claim form can be obtained by visiting the NUBC website: http://www.nubc.org.

To file for secondary payment on the UB04 form for Arkansas Blue Cross and Blue Shield see the article in this newsletter referring to, "Filing Secondary Payment on UB04 Forms" located on page 6. ***To ensure no delay in claims processing please make sure claims are filed on the correct form.***

Filing Secondary Payment for UB04 Facility Claims

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 claim form, complete information about the payer from whom the provider is seeking payment should always be filed in the 50A with the Explanation of Benefits attached. All other payer information should be filed in line 50B and 50C. Line 50A should be either Arkansas Blue Cross and Blue Shield or one of its affiliates.

If the claim does not have complete and accurate information, the claim will be returned to the provider stating as follows:

> **"According to the June 2007 issue of the *Providers' News* (page 20), complete information about the payer from whom the provider is seeking payment should always be filed in line A of payer fields (boxes 50, 51, 57) and patient fields (boxes 58 through 62). Please resubmit a new red UB04 claim form**."

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 and Blue Shield 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.

This does no apply to the Federal Employee Program (FEP).

DME Fee Schedule Updated

The Arkansas Blue Cross and Blue Shield fee schedule for durable medical equipment (DME) will be updated October 1, 2007. This update will include fees for durable medical equipment, medical supplies, and orthotics/prosthetics. The DME fee schedule can be found by using the Advanced Health Information Network (AHIN).

If you have any questions about this notice, please contact the Network Development Representative (NDR) in your region. A list of NDRs is located on the Arkansas Blue Cross web site at www.arkansasbluecross.com/providers/replisting.aspx.

Orthotic/Prosthetic Reimbursement

On September 1, 2007, the reimbursement for Orthotic and Prosthetic providers changed for Arkansas' FirstSource PPO, True Blue PPO and Health Advantage HMO. Previously, the contractual reimbursement allowance was 80% of the Arkansas Blue Cross and Blue Shield fee schedule. Effective September 1, 2007, the allowance increased to 90% of the fee schedule.

In addition, the fee schedule for durable medical equipment, medical supplies, orthotics and prosthetics will be updated October 1, 2007 (please note the following article). A copy of this updated schedule is now available on our Advanced Health Information Network (AHIN).

For questions regarding the amendment, please contact your Network Development Representative. A complete list of Network Development Representatives is located under the "Provider" tab on the Arkansas Blue Cross web site at www.arkansasbluecross.com.

Physical Medicine and Rehabilitation Reimbursement Changes

(reprinted from June 2007 issue of the *Providers' News*)

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. This change applies to outpatient facilities as well as individual practitioners.

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.

Osteoarthritis Injection Medications No Longer Need Prior Authorization

On October 1, 2007, the following medications will undergo a ***pre-payment post-service*** review -- the same review as other medications administered in physicians' offices -- and will not need prior authorization (PA).

- Euflexxa
- Hyalgan
- Orthovisc
- Supartz
- Synvisc

Benefits are available for coverage of these medications under certain clinical conditions. Conditions for coverage can be found under "viscosupplementation" or under coverage policy number 1998119 located at the following website:

http://www.arkbluecross.com/members/coverage_policy_disclaimer.aspx?header_image=providers.

Please consult the coverage criteria prior to administering the medication**.**

In the past, physicians were directed to obtain these medications through a single preferred specialty pharmacy vendor when using the PA process. This is no longer the case. **Beginning October 1, 2007, there will be no requirement for physicians to obtain these medications from a specialty designated pharmacy vendor.**

For providers who have questions or need more information, please call the Pharmacy Department with Arkansas Blue Cross and Blue Shield at (501) 378-3392.

RSV Season: Pre-Payment Post-Service Review for Synagis

Respiratory Syncytial Virus (RSV) season will be here shortly. Starting this season, Synagis, the respiratory syncytial virus antibody, **will not be required to go through prior authorization (PA).** Instead, Synagis will undergo a **pre-payment post-service** review, the same review as other medications administered in physicians' offices.

Benefits are available for coverage of Synagis (palivizumab) under certain clinical conditions. Conditions for coverage can be found under "Synagis," or under coverage policy number 1998155 located at the following website:

http://www.arkbluecross.com/members/coverage_policy_disclaimer.aspx?header_image=providers.

Please consult the coverage criteria for Synagis prior to administering the medication.

In the past, physicians were directed to obtain Synagis through a single preferred specialty pharmacy vendor when using the PA process. **Beginning this season, however, physicians will not be required to obtain Synagis from a specialty pharmacy.**

For providers who have questions or need more information, please call the Pharmacy Department with Arkansas Blue Cross and Blue Shield at (501) 378-3392.

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.

Policy #	Policy Title and Information
1997113	Immune Globulin, Intravenous. Revisions to policy and rationale fields, references added; Q4087-Q4092 added.
1997126	Low Level Laser Therapy. Extensive revisions in all fields but non-coverage unchanged.
1997190	Stem Cell Growth Factors, Epoetin. Coverage added for treatment of anemia associated with HCV antiviral therapy. References added.
1997210	Stereotactic Radiosurgery (Gamma Knife Surgery, Linear Accelerator, Proton Beam). Formal statement of noncoverage for extracranial SRS. Spine added to coverage statement. References added.
1998001	Brachytherapy of the Prostate. HDR codes removed. For HDR refer to 2006109.
1998017	Transplant, Heart. Policy field revised, rationale added, references added.
1998158	Trastuzumab. Additional indications added.
1998161	Infliximab (Remicade). Review for coverage for sarcoid. References added; no change in coverage
1999017	Identification of Microorganisms Using Nucleic Acid Probes. Many changes to all fields of the policy.
2002007	Varicose Veins: Endoluminal Radiofrequency or Laser Ablation. Revisions of description, coverage, and rationale fields. References added.
2002009	Xenon Chloride Excimer Laser Therapy for Treatment of Psoriasis. Noncoverage for scalp removed. References added.
2004026	MR Guided Ultrasound Ablation - Uterine Fibroids. Title changed.
2004027	Stem Cell Growth Factor, Darbepoetin. Statement of noncoverage for the treatment of anemia associated with antiviral therapy for hepatitis C. References added.
2004029	Genetic Testing, Breast Cancer, Risk Recurrence to Determine Need for Adjuvant Therapy (Oncotype). Limited coverage now available.
2006019	Brachytherapy, Prostate, High-Dose Rate Temporary. Literature review, no change in policy of non-coverage. References added.
2007006	Radiology Subtraction Ictal Single Photon Emission Computed Tomography (SPECT) [SISCOM]). Policy finalized.
2007008	Genetic Testing, Breast Cancer, Detection of Lymph Node Metatases (GeneSearch). Removed from another policy, remains non-covered.
2007009	Gastric Neurostimulation for Obesity. New policy – non-covered.
2007010	Intravitreal Implant, Fluocinolone Acetonide. New policy.
2007012	Genetic Testing, Breast Cancer, Assessment of Risk of Distant Metastasis (MammaPrint). New policy.

Federal Employee Program (FEP): Skilled Nursing Facilities Benefits

The purpose of this article is to provide guidance on submitting Skilled Nursing Facility claims for members covered under the Federal Employee Program (FEP).

FEP members have identification numbers starting with R followed by 8 digits. (Example R12345678). The identification card will also have an enrollment code.

The enrollment code for the Basic Option:
111 (individual) or
112 (family).

The enrollment code for Standard Option:
104 (individual) or
105 (family).

The Basic Option does not have benefits for Inpatient Skilled Nursing services. For outpatient services covered when billed by a Skilled Nursing Facility, there are limited benefits for physical, occupational, and speech therapy. The Standard Option has limited benefits for Skilled Nursing facilities as described below.

For Standard Option Skilled Nursing Facilities benefits are limited:

When Medicare A is the primary payer and has made a payment: Inpatient Skilled Nursing Facility claims, for each confinement period, FEP will pick up the Medicare daily copay from the 21st through the 30th day. The member is responsible for the Medicare daily copay after the 30th day through the 100th day per each confinement period.

When the patient does not have Medicare Part A or the Skilled Nursing Facility benefits for Medicare Part A are exhausted (beyond the 100th day):

Standard Option and Basic Option follow these guidelines:

A. When the patient has Medicare Part B coverage that is primary, file a Medicare Part B claim for ancillary services.
   1. The Standard Option provides benefits for only physical, occupational, or speech therapy or a combination of all three limited to 75 visits per person per calendar year.
   2. The Basic Option provides benefits for only physical, occupational, or speech therapy or a combination of all three limited to 50 visits per person per calendar year. The provider must be preferred for benefits to be eligible. When the provider is not preferred, the member is responsible for all charges.
   3. When Medicare B is primary for both the Standard and Basic Option, attach the Medicare Summary Notice to the claim. FEP will review the claim for medical necessity. FEP will pick up Medicare's deductible and coinsurance for covered physical, occupational, and speech therapy charges.

B. When the patient does not have Medicare Part B coverage and FEP is primary, file an outpatient Skilled Nursing facility claim to FEP at Arkansas Blue Cross and Blue Shield.
   1. The Standard Option provides benefits for only physical, occupational, or speech therapy or a combination of all three limited to 75 visits per person per calendar year. Benefits are provided based on the contracting status of the facility.
   2. The Basic Option provides benefits for only physical, occupational, or speech therapy or a combination of all three limited to 50 visits per person per

calendar year. The provider must be preferred for benefits to be eligible. When the provider is not preferred, the member is responsible for all charges.

3. For both the Standard and Basic Option when FEP is primary, FEP will review the claim for medical necessity. FEP will process the claim based on the contracting status of the facility for covered physical, occupational and speech therapy charges.*****

C. Prescriptions drugs when billed by a Skilled Nursing Facility for both Standard and Basic Option:

1. When the pharmacy is not a part of the nursing home, prescription drug claims should be submitted to the Retail Pharmacy program. Contact the Retail Pharmacy program at 1-800-624-5060 for further information on how to file prescription drug claims.*****

2. When the pharmacy is part of the nursing home, prescription drug claims should be submitted to

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

   Please submit the claim and attach an itemization of the prescription drugs with the dates of service, National Drug Code (NDC#), name of the drug, dosage and amount charged.*****

*****This benefit applies to the Basic Option members when the provider is a preferred provider. When the provider is not a preferred provider, the member is responsible for all charges.

Federal Employee Program (FEP): Eligibility Claim Status & Benefit Information Available Through AHIN and My BlueLine

Arkansas providers, who provide services to Arkansas members covered under the Blue Cross and Blue Shield Service Benefit Plan (FEP), can obtain eligibility, claim status, and benefit information by calling ***My Blue Line*** at 1-800-827-4814 or 501-378-2307. ***My Blue Line*** is available to participating providers 24 hours a day, 7 days a week.

During the call, if at any point providers need to speak with a Customer Service Representative during regular working hours, simply say "Customer Service." At that time, callers will be given an option of visiting with a Customer Service Representative with Arkansas Blue Cross Blue Shield Federal Employee Program.

FEP truly hopes this self-service option is utilized as much as possible for information concerning routine questions and claim status updates to keep the FEP Customer Service Representatives available for any questions that cannot be answered through ***My BlueLine***.

Providers can also find the same information with additional detail for eligibility, claim status, and benefit information through AHIN. To access benefit information for FEP members, select "Out of State BCBS" on **Organization Name** on the "Verify Eligibility" page. Then proceed to enter the member's first and last name, ID number, and date of birth. Once the eligibility and benefit page populates, please select the "Show Detail" link on the "Product/ Plan" line. This will give the member's benefits and show the member's effective date of their policy.

Federal Employee Program (FEP): Guidelines in Filing Claims When Medicare is Primary

When an FEP member has Medicare primary, lives in the state of Arkansas, and the services are rendered in the state of Arkansas, please allow 30 days after Medicare has processed the claim before submitting a paper claim directly to the Arkansas Blue Cross and Blue Shield Federal Employee Program.

Normally, for services filed with Medicare, FEP will receive an electronic claim from Medicare indicating their payment. By waiting 30 days before submitting a claim, this will enable us time to process the claim from Medicare.

When it has been 30 days since Medicare has paid and a payment has not been received, please submit a paper claim to:

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

The paper claim should include the appropriate claim form with the FEP member's Federal Employee 8-digit ID# and attach the Medicare Summary Notice.

Note: At this time, electronic claims submitted by providers with Medicare payment information cannot be processed by FEP.

Federal Employee Program (FEP): Guidelines in Filing Claims When Other Insurance is Primary

When an FEP member has Other insurance that is primary, lives in the state of Arkansas, and the services are rendered in the state of Arkansas, please submit a paper claim to:

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

The paper claim should include the appropriate claim form with the FEP member's Federal Employee 8-digit ID# and attach the Other Insurance Explanation of Benefits.

Note: At this time, electronic claims submitted by providers with Other insurance payment information, cannot be processed by FEP.

Modifiers 54, 55, and 56

Surgeons should bill the appropriate CPT codes when billing for surgical procedures. If a physician other than the operating ophthalmologist is performing the pre-operative or post-operative care of the patient associated with eye surgery, the physician providing these services should use the 92012 or 92014 visit codes.

Claims submitted with modifiers 54, 55 or 56 will be denied as incorrect coding.

54 - Surgical Care Only
55 - Postoperative Management Only
56 - Preoperative Management Only

Password Requirements for NetX Gateway Users

On July 15, 2007, all gateway users that had not changed their password in the past 30 days became inactivated.

A notification was placed on the gateway main menu login screen on May 10, 2007 alerting submitters of this new process; but it has come to our attention that not everyone has the ability to read this screen for whatever reason(s) (i.e., submitters are on a software script, or ftp users, etc.); therefore, many submitters were not prepared for this change.

Future changes of such magnitude will be placed on our login screens, included in our Provider Newsletters, as well as sent out via our listserv.

Recommendations:
If you use a software vendor or clearinghouse, **urge** them to capture messages from our main menu login screen. This is the easiest way for us to post important messages. Your vendor or clearinghouse can then pass these along to you.

What does this mean to me?
When your submitter number becomes inactivated, before you can have it reactivated, you must first be listed as a contact for the submitter number. If so, call our service line at 866-582-3247 during normal business hours and ask to have your password reset.
It is STRONGLY RECOMMENDED that providers perform manual password changes PRIOR TO EVERY 30 days to avoid their submitter number from becoming inactivated each month.

Instructions on how to force a password change are listed on page 20 of the **X12N Transaction User Guide** which can be found on any on the Medicare websites:

www.arkmedicare.com
www.lamedicare.com
www.momedicare.com
www.oknmmedicare.com
www.rimedicare.com

Balloon Sinuplasty - Coding

HCPCS Code S2344 – nasal / sinus endoscopy, surgical; with enlargement of sinus ostium opening using inflatable device (i.e., balloon sinuplasty) The use of functional endoscopic sinus surgery (FESS) code is not appropriate to report this service. HCPCS Code S2344 should be used instead.

Some BlueAdvantage Groups to Require Radiology Authorizations

Beginning November 1, 2007, BlueAdvantage Administrators of Arkansas will begin having groups that participate in the radiology prior authorization program. A member's ID card will indicate if his/her group participates in the prior authorization program. The first group to begin the prior authorization process is Southern Bancorp, Inc.

As a reminder, Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage are working with National Imaging Associates, Inc. (NIA) for outpatient imaging management services. Physicians who order high-tech scanning procedures - **PET scans, CT scans, MRI/MRA or Nuclear Cardiology** - for any individual or group member (except ARHealth [where Medicare is primary], FEP, or Medi-Pak) must obtain prior authorization before the scan can be performed.

It is the ordering physician's responsibility to receive prior authorization before ordering one of these high-tech scanning procedures. It is the rendering providers' financial responsibility if a scan is performed without receiving prior authorization.

Complete details are available through the Radiology Management Reference Guide and the Arkansas Blue Cross Clinical Guidelines found on AHIN, the Arkansas Blue Cross, Health Advantage, and BlueAdvantage web sites, and www.RadMD.com.

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

IVR - An interactive voice response system (IVR) allows providers to access information regarding the status of their authorization requests using telephone voice response. Providers may access the IVR system by contacting the NIA Call Center. The IVR system is available 24 hours a day, including weekends and holidays, providing an additional, convenient option for providers to retrieve important authorization information.

Online authorizations — In addition to the NIA Call Center, physicians may receive authorizations for high-tech imaging online through NIA's secure Web portal, RadMD. 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.

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 from 5 a.m. to 11 p.m. (CST), Monday through Friday, and 7 a.m. to Noon (CST) on Saturday.

Health Advantage Withhold

For providers who have withhold/risk arrangements in their contracts, the annual checks will be paid to the same payment location designated for claims payments. For example, if a physician works at multiple locations, then the physician will receive multiple withhold checks.

High-Tech Radiology Services

Arkansas Blue Cross and Blue Shield and its affiliate companies are adding non-hospital based high-tech radiology imaging centers to our networks of participating providers on September 1, 2006. For our purposes, high-tech radiology services are defined as CT scans, magnetic resonance, PET scans or nuclear cardiology.

Should a provider wish to join our networks, they must complete, sign, and return the appropriate contract to the Arkansas Blue Cross office. Providers also need to complete the "Clinic Billing Authorization Form" (located on the *Provider* page of the Arkansas Blue Cross web site) to ensure that we have the most updated information.

The imaging center agreement for high-tech radiology services does not affect the Arkansas Blue Cross network participation agreements for physicians; however, please note that physician billing requirements for high-tech radiology changed per the claims billing guidelines located on the following page.

As of September 1, 2006, providers have been required to use their clinic provider number (**ABCBS # or NPI#**) as the provider rendering the service when billing high tech radiology services. This number should be placed in field 24J on the CMS 1500 form and its equivalent on electronic transactions.

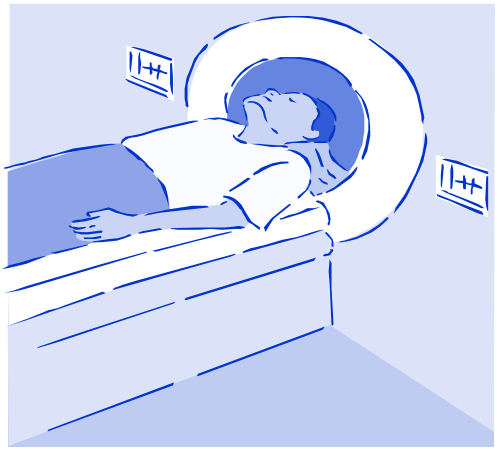
Please remember that all providers must participate in the Preferred Payment Plan (PPP) network before participating in the True Blue PPO network. Providers must also participate in the True Blue network before they can participate in the Health Advantage HMO network.

Failure to sign and return the provider agreement will result in an imaging center becoming a non-participating provider for high-tech radiology. Criteria that an imaging center must meet in order to be in our networks is located on the following pages.

This article will serve as notice that providers have until January 1, 2009 to meet the criteria for the services an imaging center is performing. While Arkansas Blue Cross may allow an imaging center into our networks at this time upon receipt of signed agreements, failure to meet all of the criteria for a respective radiology services will result in immediate termination of the provider agreement on January 1, 2009.

Arkansas Blue Cross has engaged National Imaging Associates (NIA) to assist us in the utilization management of high-tech radiology and to also assist in the assessment of each imaging center's ability to meet our criteria. All contracted imaging centers will be receiving an assessment application packet from NIA, tentatively scheduled for early 2008. Please provide the information requested and follow the instructions about where to return this information.

Arkansas Blue Cross and Blue Shield trusts that an imaging center will want to enter into a contractual relationship with Arkansas Blue Cross and its affiliates, and we look forward to working with you in the future. If you have any questions about this notice, please contact your region's Network Development Representative.



Arkansas Blue Cross and Blue Shield Radiology Provider Assessment Guidelines (Updated September 2007)

The Arkansas Blue Cross and Blue Shield radiology provider assessment guidelines are intended to promote reasonable and consistent safety standards for the provision of imaging services. Arkansas Blue Cross Blue Shield will accept providers into the imaging network if they meet the following guidelines:

Plain Films

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

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

- Licensed Technologist License (individuals trained on the job and licensed under the "grandfather" provision),
- Limited Licensed Technologist License (individuals who have passed the Limited Scope Examination in either chest, extremity, skull/sinus, spine and/or podiatry),
- Temporary License (individuals who have trained on the job and are preparing to take the Limited Scope Examination), or
- Radiologic Technologist License [individuals who have graduated from an accredited Radiologic Technology School and passed the American Registry of Radiologic Technologists (ARRT) Radio-graphy registry exam]. For more information go to www.healthyarkansas.com/rtl/lic_info.html.

Mammography

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

Nuclear Cardiology

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

Failure to achieve accreditation will result in the termination of all provider agreements on January 1, 2009. Any new nuclear cardiology facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

Positron Emission Tomography (PET)

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

Failure to achieve accreditation will result in termination of all provider agreements on January 1, 2009. Any new PET facilities added after January 1, 2009, must be accredited at the time of acceptance into the network.

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

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

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

Medical and Technical Staff Requirements:

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

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and must report any clinically relevant abnormalities of these adjacent structures. In some cases, these structures may be seen only on the localization (scout) images. The technical parameters of a CT or MR examination may be tailored to evaluate specific anatomy or function, but the images obtained also demonstrate adjacent anatomy. For example, cardiac CT or MR examinations include portions of the lungs, mediastinum, spine and upper abdomen, and the evaluation of these structures must be included in the interpreting physician's written report.

- CT and MR studies must be interpreted by a licensed MD or DO, who is board certified or board eligible in radiology or nuclear medicine, or a licensed MD or DO, who has had exposure, training, and experience in the interpretation of CT and MR examinations in their area of expertise, including knowledge of the physics of CT and MR, understanding of radiation generation and exposure, knowledge of scanning principles and modes, knowledge of principles for intravenous contrast administration for safe and optimal imaging, knowledge of recognitions and treatment of adverse reactions to contrast administration, knowledge of principles of image post processing, and knowledge of normal anatomy and pathologic changes of the area being examined.

Instrumentation Requirements:

- If offering cardiac CT applications, a multi-detector row helical CT with at least 16 detector rows and CT slice thickness of 1.5 cm. or less, or an electron beam CT scanner is a requirement. If offering CT coronary artery angiography, a 32 or greater multi-detector row, helical CT with sub-millimeter slices is a requirement.
- MR systems with field strength of 0.7 Tesla or greater will be considered high field systems.
- MR systems with field strength less than 0.7 Tesla will be considered low field strength systems.
- MR systems with field strength of less than 0.3 Tesla will be considered very low field systems and will not be covered.

Additional Provisions and Considerations: Hospital Based / Owned and Physician

Based / Owned Imaging Facility:

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

Data Storage:

The acquired images, post-processed and reconstructed images, and the data set must be stored and available for review according to the state guidelines for main-tenance of patient medical records: Records must be kept for a period of five years from the ending date of service or until all audits, appeal hearings, investigations or court cases are resolved, whichever period is longer. (See AR ADC 016 06 024, Section 204.000B.)

Leased Services:

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

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

Mobile Services:

Providers utilizing mobile services will not be considered for participation except as follows:

FDA certified mobile mammography
Hospitals utilizing mobile services

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

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

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

Site Inspections:

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

Multi-Specialty Group Practice:

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

Billing / Claims Filing Requirements:

Effective September 1, 2006 for Arkansas Blue Cross and Blue Shield, Arkansas' First-Source PPO, True Blue PPO and Health Advantage HMO:

Imaging Centers should use its provider number as the rendering provider when billing services for High-Tech Radiology (defined as CT scans, Magnetic Resonance, PET scans or nuclear cardiology) on the standard electronic trans-actions. Imaging Centers will likewise use its provider number in the appropriate block of the CMS 1500 form as the rendering provider for High-Tech Radiology (the appropriate block for entering provider number is block 24J). All applicable modifiers should be used (e.g. 26 for professional component, "TC" for technical component).

Arkansas Blue Cross and Blue Shield prefers that Imaging Centers do not submit claims for total component on one line for High-Tech Radiology. Arkansas Blue Cross prefers that professional and technical services be split and billed on two separate lines; the technical component billed using the Imaging Center's provider number and the professional component billed using the physician's provider number. However, Imaging Centers may bill total component on one line for High-Tech radiology services provided that the Imaging Center - based physician performing the super-vision and interpretation meets requirements described within the Imaging Center provider agreement.

Professional component reimbursement for High-Tech Radiology will only be made to physicians; therefore payment will be made for the professional component only when submitted under a physician's provider number. Physicians billing with modifier TC will receive a denial. Imaging Center claims should be sub-mitted with place of service 11.

This listing of specific claims filing requirements for Imaging Centers is not exclusive or comprehensive of all Arkansas Blue Cross and Blue Shield claims filing or coding policies and procedures. Imaging Centers understand that these specific requirements are in addition to and not a substitute for other Arkansas Blue Cross claims filing and coding policies, all of which Imaging Centers agrees to follow. Imaging Centers further understand and agree that the specific claims filing requirements set forth in this document may be changed or amended as set forth in Claims Filing and Coding Policy section of the Imaging Center Agreement.

Provider Workshops

Conway

Thursday, October 18, 2007 at 9:00 a.m.

University of Central Arkansas

Brewer-Hegeman Conference Center

El Dorado

Tuesday, October 23, 2007 at 1:00 p.m.

Warner Brown Building

460 West Oak Street

Fort Smith

Friday, November 2, 2007 at 9:00 a.m.

St. Edward's Medical Center

Hennesey Room

Hot Springs

Tuesday, November 13, 2007 at 9:00 a.m.

St. Joe's Mercy Health Center

Mercy-McAuley Room

Jonesboro

Thursday, November 15, 2007 at 9:00 a.m.

St. Bernard's Regional Medical Center

Auditorium

Little Rock / North Little Rock

Tuesday, October 16, 2007

Session 1 - 9:00 a.m. & Session 2 - 1:00 p.m.

Wyndham Hotel — Riverfront

Mountain Home

Tuesday, October 30, 2007 at 9:00 a.m.

Baxter Regional Hospital

Conference Room

Pine Bluff

Wednesday, November 28, 2007 at 1:00 p.m.

South East Arkansas College

McGeorge Hall - Seminar Room

Texarkana

Monday, October 22, 2007 at 9:00 a.m.

Christus St. Michaels Hospital

Conference Room (North entry)

For additional information regarding provider workshops in your area, contact your regional Network Development Representative

Dry Hydrotherapy

There are several devices (aqua-bed, dry hydro-bed, etc) available that purport to offer the combined benefits of heat, massage, and whirlpool in a 15-20 minute session. There is no need for special attire and there is no requirement for a person to undress. Some manufacturers recommend that services related to treatment with the hydrotherapy bed should be billed with CPT Code 97022 – application of a modality to one or more areas; whirlpool.

The American Chiropractic Association, in the *2007 Chiropractic Coding Solutions Manual,* states CPT Code 97039 – unlisted modality (specify type and time is constant attendance), best describes this combination modality. The work of the whirlpool code includes assisting the patient in and out of the pool, cleaning and disinfecting the equipment.

Arkansas Blue Cross and its affiliates would consider the use of CPT Code 97022 or any other supervised therapy code for the aqua-bed, hydro-bed, or similar treatment to deliver heat, massage, and / or whirlpool to be incorrect coding.

There is a lack of evidence in medical literature that the use of the aqua-bed, hydro-bed, or any similar device is associated with better outcomes compared to traditional methods of physical therapy and thus the use of the device does not meet Primary Coverage Criteria.

Public School Employee (PSE): Preventive Dental Benefits

Please be advised effective October 1, 2007, the Public School medical benefit program will no longer include Preventive Dental benefits. However, many school districts purchase group dental insurance from Arkansas Blue Cross and Blue Shield independent of the state sponsored medical plan.

Claims submitted with dates of service October 1, 2007 and after should be submitted with the Arkansas Blue Cross ID number. The Blue Cross dental prefix is XCD.

Arkansas State & Public School Employees Health Service Fund Withhold Change and Contract Amendment Notice

Health Advantage is one of two Third Party Administrators for the Arkansas State and Public School Group Health Insurance Programs recently chosen to continue to provide claims administration services. Effective October 1, 2007, American Health Holding will begin providing Medical Utilization Management Services for these programs.

Because of this change, the self-funded health services withhold fund risk-sharing arrangements administered by Health Advantage for the Arkansas State Employees and Public School Employees (ASE/PSE) will end as of September 30, 2007. The final settlements will be for the periods of October 1, 2006 through September 30, 2007 for the Public School Program and January 1, 2007 through September 30, 2007 for the Arkansas State Program and ARHealth Retirees Program.

Health Advantage expects final settlements to be completed before the end of 2007. Reimbursement for ASE/PSE claims after September 30, 2007 will be based on the standard Health Advantage allowances, per the terms of applicable provider agreements, and will not include withhold in claims adjudication. For any provider whose Health Advantage provider network agreement currently includes a withhold arrangement, this notice constitutes an amendment to the provider agreement for the purpose of eliminating the withhold as to ASE/PSE claims, effective October 1, 2007.

Please note that this change affects only claims processed for Arkansas State and Public Schools employees and dependents.

ARHealth Open Access Plan for State and School Employees and Retirees

Effective October 1, 2007 for Public School members and January 1, 2008 for Arkansas State Employees and State and School Retirees, the only option for Health Advantage members is the ARHealth Open Access plan. The Health Advantage HMO plan and the Arkansas Blue Cross and Blue Shield PPO are no longer available. Members previously enrolled in the HMO or PPO plan were automatically transitioned to the **Health Advantage Open Access** plan unless the member elected another health care vendor associated with State plan

Please request a copy of the new ID card to confirm the member's correct ID number. The new ID cards will contain the Health Advantage logo, the new prefix PXG and the pre-certification number. A copy of the ID card appears on page 25 of this publication.

Arkansas State and Public School Employees Utilization Management Changes

The Employee Benefits Division (EBD) has contracted with American Health Holding (AHH), not associated with Health Advantage, to provide utilization management services for the Arkansas State and Public School active employees and retirees. The utilization management services will include pre-certification, pre-determination and concurrent review.

Pre-determination will verify the member is active with the plan and if the service being requested is a covered benefit of the plan. AHH will maintain contact with the hospital providers to approve additional hospital days when a member's medical status changes and additional days are warranted by concurrent review.

Providers should contact AHH at 1-800-592-0358 to obtain authorization for the services listed below. This number also appears on the members ID card. It the member's responsibility to verify or make certain that the procedure has bee approved to avoid problems with the claim payment.

AHH must be notified prior to providers rendering the following services:

1. **Acute Inpatient includes Medical, Surgical, Obstetrics, Mental Health, Substance Abuse**
   - AHH will refer MH/SA calls to CorpHealth.
2. **Medical Rehabilitation**
3. **Skilled Nursing Facility (SNF)**
4. **Hospice Inpatient**
5. **Neuro/Psych Residential Treatment**
6. **Residential Mental Health/Substance Abuse**
   - AHH will refer calls to CorpHealth.
7. **Outpatient Surgery**
   - Pre-certification is required for the following procedures:
     i. Bunionectomy
     ii. Cochlear implants
     iii. ESWT
     iv. IDET
     v. Lithotripsy
     vi. Septoplasty
     vii. Strabismus repair
     viii. UPPP
     ix. Varicose vein excision and ligation
     x. Blepharoplasty and/or brow lift
     xi. Gynomastia reduction
     xii. Lipectomy
     xiii. Mammoplasty (reduction or augmentation)
     xiv. Panniculectomy
     xv. Pectus excavatum repair
     xvi. Radial keratotomy
     xvii. Rhinoplasty
     xviii. Ventral hernia repair
     xix. Procedures related to TMJ/TMD
8. **Outpatient Diagnostic**
   - Pre-certification is required for the following procedures:
     i. MRI
     ii. CT
     iii. MRA
     iv. PET Scan
9. **Outpatient Physical Therapy, Speech Therapy, Occupational Therapy**
   - AHH will Auto-Cert the initial 15 visits, additional visits require review by AHH.
   - AHH nurses will review history to check for and verify number of visits pre-certified for each modality performed at a physician's office, outpatient or home setting.

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10. **Physician Office Physical Therapy, Occupational Therapy, Speech Therapy**
    - AHH will Auto-Cert the initial 15 visits, additional visits require review by clinical staff.
    - AHH nurses will review history to check for & verify number of visits pre-certified for each modality at a physician's office, outpatient or home setting.
11. **Outpatient Mental Health/Substance Abuse**
    - AHH will refer to CorpHealth.
12. **Physician Office Mental Health/ Substance Abuse**
    - AHH will refer to CorpHealth.
13. **Outpatient Pain Management Medication Therapy**
    - Pre-certification is required for pain management narcotic pumps.
14. **Physician Office and Outpatient Medication Therapy**
    - Please refer to the Medications List (bottom of this list) for items requiring pre-certification.
15. **Enteral Feeds**
16. **Home Health Care**
17. **Home Hospice**
    - AHH will collect basic demographic information from caller and a case management trigger goes to EBD.
18. **Durable Medical Equipment (DME) and Prosthetics**
    - Pre-certification is required for prosthetics, DME & DME repairs over $1,000.00.
    - AHH will perform Initial Pre-certification, and (up to) 3 quarterly reviews.
    - AHH will convert rental to purchase when either the purchase price is met or rental is at the 10th month.
    - If services provided by an out of network provider/facility, AHH will notify EBD.
19. **Other Commercial Insurance is Primary (does not apply to Medicare & Workers Comp)**
    - Pre-certification for admissions and services is required if the patient's primary coverage is other than Medicare or Workers Comp.
    - AHH will follow as if Health Advantage is the primary payer.
20. **Transplants**
    - Pre-notification is required for all solid organ and stem cell transplants.
    - All transplants, except kidney & cornea, must be approved by Health Advantage Transplant Coordinator, regardless of approval from AHH. Please contact Health Advantage at 800-225-1891 in addition to contacting AHH.
21. **Injectables / Home Infusions**
    - Please refer to the Medications List (item # 24) for items requiring pre-certification.
22. **Chemotherapy**
    - Pre-certification is required for medical necessity.
23. **TMJ/TMD**
24. **Medications Requiring Pre-certification:**

Botox	IVIG
Enbrel	Kineret
Epogen	Lovenox
Fragmin	Neupogen
Growth hormone	Procrit
Humira	Remicade
Hyalgan	Supartz
Interferons	Synvisc
IV Iron infusion	TPN

25. **Benefit Exclusions**
    - AHH will NOT pre-certify the following benefit exclusions:
      i. LTACs
      ii. Wound VACs,
      iii. Private Duty Nurse
      iv. Gastric Bypass
      v. LVADs,
      vi. Infertility where diagnosis is confirmed,

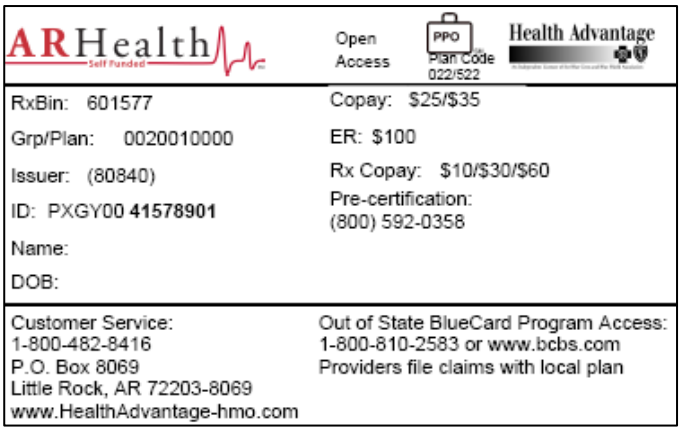
Provider Appeals to AHH: (1-800-592-0358)

- Appeals for services partially approved or denied by American Health Holding (AHH) must be appealed to AHH.

- Services requiring pre-certification through AHH; must be reviewed by AHH prior to an appeal review by AHH.
- *If you have received a claim denial for a pre-certification not being obtained by AHH, you have **30 days** from the date of denial to request a retro-review by AHH.*
- This retro-review must take place prior to an appeal review by AHH. If the retro-review is denied by AHH, you will have 180 days from that denial to request an appeal to AHH.
- If the retro-review is not obtained through AHH, you must appeal to the EBD for an exception to cover the services that were not prior approved.

Provider Appeals to Health Advantage:

- Provider appeals are requests for coverage of services that are a provider write off, i.e. coding policy denials, primary coverage criteria denials (no specific waiver was signed), allowable disputes and timely filing denials.
- These appeals should be submitted to Health Advantage for review. You have 180 days from the initial date of denial to submit a provider appeal.
- The provider appeal procedures are located on the Health Advantage website under the Provider Manual link.



ARHealth ID Cards:

Above is a copy of the new ARHealth ID card. Cards will be issued upon the group renewal—Public Schools effective October 1, 2007 and Arkansas State Employees and State and Public School Retirees effective January 1, 2008. Under the new plan, Public School ID cards have the **prefix PXG** effective October 1, 2007. Arkansas State Employees and Retiree ID cards will have this prefix on January 1, 2008. Members do not have to select a Primary Care Physician (PCP) and referrals to Health Advantage in-network specialists are not required.

Case Management Services:

Effective March 1, 2007, Employee Benefits Division (EBD) contracted with PDB Enterprises, not affiliated with Health Advantage, to handle case management for state and school employees. Patient's requiring these services should be referred to EBD at (501) 682-9656 or 1-877-815-1017.

Significant Benefit Changes: (excludes members with Medicare primary coverage)

- Members are not required to select a PCP.
- PCP copayment — $25
- Specialist copayment — $35
- Pre-certification is required for many services. Refer to lists on pages 2 and 3.
- Chiropractic services — $35 specialist copayment and 10% coinsurance.
- High Tech Radiology — $250 copayment and 10% coinsurance per case.
- Infertility Testing — $200 copayment and 10% coinsurance.
- In-Patient and Rehabilitation Admissions — $250 copayment and 10% coinsurance
- Out-Patient Services — $100 copayment and 10% coinsurance
- ER services — $100 copayment
- Physician services 10% coinsurance (provided in an inpatient or outpatient setting)
- Durable Medical Equipment, Prosthetics and covered Orthotics — 20% coinsurance
- Out-of-network coinsurance — 40%
- HMO & PPO Plans are no longer an option.
- Dental and Vision preventive services have been removed.

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The benefit changes (on the previous page) will be implemented with the new plan year for the Public School Employees on October 1, 2007. Arkansas State Employees and State and School Retirees will see these changes effective January 1, 2008. While the benefits changes are effective on the renewal plan year, please remember that the utilization management and pre-certification requirements will be implemented for all State and School members and retirees on October 1, 2007.

Fee Schedule Updates

The following HCPCS codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule effective July 1, 2007.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
S3905	$70.38	$37.48	$32.90	$0.00	$37.48	$0.00
Q4087	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q4088	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q4089	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q4090	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q4091	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q4092	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0553	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0554	BR	$0.00	$0.00	$0.00	$0.00	$0.00
K0555	BR	$0.00	$0.00	$0.00	$0.00	$0.00
S2066	BR	$0.00	$0.00	$0.00	$0.00	$0.00
S2067	BR	$0.00	$0.00	$0.00	$0.00	$0.00
S3800	BR	$0.00	$0.00	$0.00	$0.00	$0.00
S9152	BR	$0.00	$0.00	$0.00	$0.00	$0.00

The following Home Health codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule effective September 1, 2007.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
S9124	$26.50	$0.00	$0.00	$0.00	$0.00	$0.00
S9131	$104.00	$0.00	$0.00	$0.00	$0.00	$0.00

The following CPT and HCPCS codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule effective July 1, 2007.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
44180	$0.00	$0.00	$0.00	$1,371.74	$0.00	$0.00
44186	$0.00	$0.00	$0.00	$964.49	$0.00	$0.00
70555	$1,475.40	$199.77	$1,275.63	$0.00	$199.77	$0.00
78478	$80.65	$28.01	$52.64	$0.00	$28.01	$0.00
78480	$72.07	$16.03	$52.64	$0.00	$16.03	$0.00
90378	$708.32	$0.00	$0.00	$0.00	$0.00	$0.00
90669	$77.69	$0.00	$0.00	$0.00	$0.00	$0.00
90636	$81.33	$0.00	$0.00	$0.00	$0.00	$0.00
Q4092	$31.66	$0.00	$0.00	$0.00	$0.00	$0.00
S3625	$80.00	$0.00	$0.00	$0.00	$0.00	$0.00
S3626	$80.00	$0.00	$0.00	$0.00	$0.00	$0.00

Providers' News

Arkansas Blue Cross and Blue Shield
P. O. Box 2181

Presorted Standard
U.S. Postage Paid
Little Rock, AR
Permit #1913