june 2013

providers' news

A publication for participating providers and their office staffs

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Reporting fraud, waste and abuse

If you suspect any potentially fraudulent activity by a provider, beneficiary or another entity, never confront the person suspected; instead call the FRAUD HOTLINE at 1-800-FRAUD-21 (1-800-372-8321). The Fraud Hotline is available 24 hours a day, 7 days a week. All reports are kept strictly confidential, and callers can remain anonymous.

This applies to Arkansas Blue Cross and Blue Shield, its subsidiaries and affiliate companies, including Medi-Pak® Advantage.

ICD-10 Countdown

15 Months

until the October 1, 2014, ICD-10 compliance deadline.
Will you be ready?

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

Intensity-modulated radiation therapy records request

The medical records request letter for intensity-modulated radiation therapy (IMRT) has been revised. Providers are now asked to submit the dose-volume histograms (DVH) for the 3D conformal radiation therapy technique (3DCRT) plan as well as for the IMRT plan. It is evident by claims submission that IMRT has become widely accepted although there are no published comparative trial results that report a benefit in health outcomes for many of the indications for which it is being used.

It is the intention of Arkansas Blue Cross and Blue Shield to pay for IMRT when the intent of the radiation course of therapy is curative and the accelerated dose is likely to result in toxicity to adjacent normal tissue that can be better protected by IMRT. In less frequent situations, IMRT would be considered appropriate but would need to be substantiated by medical record documentation.

Arkansas Blue Cross continues to receive DVHs that are so small they are illegible. Arkansas Blue Cross has also received the curves but not the legend explaining the curves, or a curve for only one part of the course of therapy, not the total course of therapy. Illegible or inadequate DVH documentation is the primary reason for additional medical records requests resulting in delayed claims processing and payment.

Arkansas Blue Cross now has a dedicated and secure email address (IMRTDVH@arkbluecross.com) where providers may submit a color copy of the DVH directly from the medical records. This email address is only for DVHs. The remainder of the medical record requests should be submitted as usual.

There are only three CPT codes specifically for IMRT: 77301 (planning), 77418 (treatment delivery), and 77338 (treatment devices). Providers are billing CPT codes 77301 and 77338 for stereotactic body radiation therapy (SBRT) which is not considered to be IMRT. Other codes can be used for SBRT. Reimbursement for planning and treatment devices for SBRT will be based on other non-specific CPT codes for those services.

Don't be a victim of identity theft!

Arkansas Blue Cross and Blue Shield's Special Investigations Unit (SIU) has noticed a rise in medical identity theft. Identity theft happens when thieves knowingly and willfully use another person's insurance information to obtain medical services, medical equipment and/or pharmaceuticals. Identity theft also occurs when physicians' prescription pads are stolen and unauthorized prescriptions are written and presented to a pharmacy or when unauthorized prescriptions are called in to a pharmacy.

As a provider, what can you do to prevent this from happening to you? The Special Investigations Unit has the following recommendations:

- Find ways to protect your DEA number, especially when prescriptions are called in to pharmacies.
- Guard your prescription pads.
- Consider implementing a more secure procedure for call-in prescriptions in order to deter possible fraudulent activity.
- Alert local pharmacies with the names of staff/personnel authorized to call in controlled substance prescriptions, and advise them that any deviation from those names should be verified with a pre-identified office manager before filling the prescription.
- Advise staff when calling in prescriptions to provide the pharmacy with patient's full name, date of birth and address to ensure the prescription is not filled under the wrong patient's name.

If you suspect any medications have been prescribed without your authorization/knowledge, please call the Arkansas Blue Cross Special Investigations Unit at 1-800-Fraud21 (1-800-372-8321).

Inpatient claims financial responsibility policy revision

The Blue Cross Blue and Shield Association is taking steps to ensure consistency among all Blue Plans regarding inpatient pre-service review (also known as pre-authorization or pre-certification). This change will take effect July 1, 2014.

Inpatient facilities that fail to obtain pre-authorization or pre-certification when it is required will be financially responsible for any covered services not paid and the member will be held harmless. Not all health plans require inpatient pre-authorization or pre-certification, but where it is required, inpatient providers who fail to obtain it will be financially responsible for any covered services not paid and the member will be held harmless.

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

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

Pre-Certification, Pre-Notification And Eligibility Inquiries

Non-Emergency Admissions

Facility understands and agrees that for health plans that require pre-certification or pre-notification and facility fails to obtain pre-authorization or pre-notification, that facility will hold member harmless of any amounts not paid for covered services.

Emergency Admissions

Facility understands and agrees that for health plans that require pre-certification or pre-notification within 24 hours after admission or by the end of the next working day, if on a weekend or holiday and facility fails to obtain pre-authorization or pre-notification, that facility will hold member harmless of any amounts not paid for covered services.

Hyperbaric oxygen therapy

Arkansas Blue Cross and Blue Shield has received inquiries by facility providers regarding billing HBO therapy using HCPCS code C1300. HCPCS 'C' codes are for services paid using the CMS Hospital Outpatient Payment System. Since Arkansas Blue Cross does not use that system for pricing, we do not recognize the HCPCS 'C' codes, C1000-C9999. The appropriate code to use to bill for HBO therapy is CPT code 99183. A session is defined as 30 minutes. Providers should bill one unit of CPT code 99183 for each 30-minute session of HBO therapy. Also applies to Health Advantage and BlueAdvantage Administrators of Arkansas.

Changes to the Take Care Arkansas/Pre-existing Condition Insurance Plan (PCIP)

Important notice of transition to federally administered PCIP plan

Beginning on July 1, 2013, the federal government will take over administration of the federal high-risk pool in Arkansas, which is also known as the PCIP program. The Arkansas Comprehensive Health Insurance Pool (CHIP) has administered PCIP, with BlueAdvantage Administrators of Arkansas acting as the third-party administrator, since the program commenced in 2010.

PCIP enrollees will not lose coverage because of this change, but to continue their coverage, they must take steps to activate the new federally-run PCIP benefit plan before July 1, 2013. The new plan is scheduled to last through December 31, 2013, subject to availability of federal funds.

As of January 1, 2014, commercial health insurance coverage will be available in Arkansas without exclusions based on pre-existing conditions.

How this Affects Providers – Ongoing Treatment:

If a PCIP enrollee is currently receiving ongoing treatment, they will be mailed guidance about their transition of care from the federal government's National Finance Center around June 10, 2013. In some cases, the PCIP enrollee or their health care provider must obtain prior approval before the new plan will pay for certain services.

Even if a provider already has some of these services and authorizations in place, new authorizations will be necessary under the new plan for any dates of service incurred on or after July 1, 2013, including, but not limited to, inpatient stays that span across the transition period.

There may be situations where a treatment plan is already in process. These will be evaluated on a case-by-case basis. Beginning June 17, 2013, a team of nurses and specialists will be available to help in getting approval for any services that require preauthorization with dates of service after June 30, 2013.

If a PCIP enrollee is currently receiving or planning to receive any services in the non-surgical pcip benefit transition summary, they must be re-authorized under the new plan. Preauthorizations will be accepted no earlier than June 17, 2013.

Non-Surgical PCIP Benefit Transition Summary:

If a PCIP enrollee is currently receiving any of the services named below and their need will continue past June 30, 2013, OR if a provider needs to request new services after June 30, 2013, they must contact PCIP Customer Service at 1-800-220-7898 to inquire about benefits. To pre-authorize, follow the instructions in the table below. Requests will take three to five business days for completion.

Services requiring approval	What PCIP enrollees or health care providers need to do to pre-authorize
Cancer Treatment – Non-surgical	If treatment is already in progress, the provider must enter the current treatment into www.eviti.com. All new treatments or changes to treatment require pre-authorization online at www.eviti.com. For assistance, please call Customer Service at 1-800-220-7898, request or enter ext. 3100, and select option 1.
Diabetic Supplies	Purchase diabetic supplies through Express Scripts at 1-800-427-6145. For assistance, please call Customer Service at 1-800-220-7898, request or enter ext. 3100, and select option 3
Durable Medical Equipment	DME must be obtained through a PCIP national contract provider. Prior authorization is required on the services noted below. If a PCIP enrollee is currently renting medical equipment and will need it after June 30, 2013, their provider should call Customer Service at 1-800-220-7898 to transition any rented DME to an approved provider. Please request or enter ext. 3100 and select appropriate option for DME. • Specialty wheelchairs and seating systems, • Specialty beds and mattresses and • Oxygen

Services requiring approval	What PCIP enrollees or health care providers need to do to pre-authorize
Hospital – Inpatient Care **Surgeries/Procedures Medical/Surgical/Mental Health** **Mental Health - Inpatient Care for Mental Health/ Substance Abuse, including Residential and Intensive Day Treatment**	Authorization is required from InforMed for acute inpatient care. Providers/ hospitals should call InforMed at 1-800-242-1025 or fax clinical information to 1-866-315-6314. If a PCIP enrollee is in the hospital as of June 30, 2013, and the stay will continue into July, their provider must call InforMed to pre-authorize the continued stay. Certain surgeries require a medical necessity review. See the attached list of surgeries that require pre-certifications. If you received approval for a surgery or procedure on the attached surgery pre-certification list AND it will take place after June 30, 2013, the provider must obtain re-authorization by following the instructions in the surgery benefit summary table. Once the procedure is approved, the provider will need to contact InforMed to pre-authorize the inpatient stay.
Prosthetics	Authorization is required for prosthetics. To authorize, contact Customer Service at 1-800-220-7898, request or enter ext. 3100, and select option 3. Authorization is not required for mastectomy bras and prosthetics (L8000-L8039) with a diagnosis of breast cancer or post mastectomy or lumpectomy, but you must purchase through GEHA contracted providers. Visit www.pciplan.com to find a list of providers.
Prescription Drugs	PCIP enrollees can purchase prescriptions through Express Scripts/ Medco. To find participating pharmacies, visit www.pciplan.com. Some medications may require approval. For assistance, call 1-800-427-6145. • PCIP enrollees should ask their physician to call Express Scripts/Medco mail services at 1-888-327-9791 to obtain fax instructions. • New prescriptions can be mailed to Express Scripts/Medco P. O. Box 30493 Tampa, FL 33630-3493 • To submit a request to transfer current prescriptions to mail order at www.express-scripts.com. • PCIP enrollees are asked to contact Express Scripts/Medco customer service at 1-800-427-6145 to assistance with transferring their prescription.
Specialty Drugs	Specialty drugs are used to treat some severe medical conditions and are usually administered by injection or infusion. See specialty drug benefits in the PCIP brochure at www.pciplan.com. To obtain these medications, contact Express Scripts/Medco/Accredo at 1-800-803-2523.
Radiology **MRI, MRA, CT, PET, NC**	Authorization from MedSolutions is required. Please call 1-866-879-8317.
Skilled Nursing Facility (SNF), Long-Term Acute Care (LTAC) and Inpatient Rehab	Authorization from OrthoNet is required. PCIP enrollees should ask their provider to call OrthoNet at 1-877-304-4419; Fax: 1-877-304-4409. For assistance, call Customer Service at 1-800-220-7898. If a PCIP enrollee is in a SNF, rehabilitation or LTAC facility as of June 30, 2013, and the stay will continue into July, their provider must call OrthoNet to pre-authorize the continued stay.
Transplant – Cornea and Kidneys	Authorization is not required for cornea or kidney transplants. Authorization from InforMed is required for hospital admissions. PCIP enrollees should ask their your provider/hospital to call InforMed at 1-800-242-1025; Fax: 1-866-315-6314.

(Continued on page 6)

Changes to the Take Care Arkansas/Pre-existing Condition Insurance Plan (PCIP) (Continued from page 5)

Services requiring approval	What PCIP enrollees or health care providers need to do to pre-authorize
Transplant - Other	Authorization is required for all other transplants. For assistance, call Customer Service at 1-800-220-7898, ask for ext. 3100 and ask to speak with a transplant nurse. The nurse will request contact information for your current transplant coordinator to initiate transition plans.

Surgical PCIP Benefit Transition Summary

If a PCIP enrollee is currently receiving any of the surgical services named below OR if new surgical services are needed after June 30, 2013, providers must contact PCIP Customer Service at 1-800-220-7898 to inquire about benefits. To pre-authorize the procedures listed below, follow the instructions in the table. For authorizations, allow three to five business days for materials sent by fax and seven to 10 days by mail.

Services requiring approval	What PCIP enrollees or health care providers need to do to pre-authorize
Back – (Spinal) Surgeries Spinal fusions, Multi-level spinal surgeries	Authorization from OrthoNet is required. PCIP enrollees should ask their provider to get an authorization form at www.pciplan.com. For assistance, call Customer Service at 1-800-220-7898, request or enter ext. 3100 and select option 6.
Experimental/ Investigation Surgery or Treatment	Authorization is required. PCIP enrollees should ask their provider to fax medical records (including CPT codes) to 1-816-257-3255. For assistance, call Customer Service at 1-800-220-7898, request or enter ext. 3100 and select option 6.
Morbid Obesity Surgeries gastroduodenostomy, gastro-enterostomy, gastrogastrostomy, gastrojejunostomy without gastrectomy, inversion of gastric diverticulum, and repair of stomach.	Authorization is required. PCIP enrollees should ask their provider to fax medical records (including CPT codes) to 1-816-434-4420. For assistance, call Customer Service at 1-800-220-7898.

It is critical that providers follow required pre-authorization of benefits procedures for any service listed if treatment is anticipated to occur on or after July 1, 2013. This is necessary even if you were already authorized through the state administered PCIP.

PCIP Benefits

The federally administered PCIP is a new plan with different deductible and cost sharing requirements that begin on July 1.

- Medical costs are subject to a $1,000 medical deductible, then to a 30% coinsurance payment by you; office visits are subject to a $25 copayment.
- Pharmacy costs are subject to a $250 deductible for pharmacy coverage. After the deductible, pharmacy costs are subject to copayments or coinsurance payments that differ based on things such as whether drugs are generic, brand name or specialty products.
- Out-of pocket maximum costs for the remainder of the program will be $3,125.
- Changes in benefits. Like CHIP's PCIP plan, the federally administered plan provides comprehensive medical and pharmacy benefits, but some details, including exclusions and limitations, will be different.

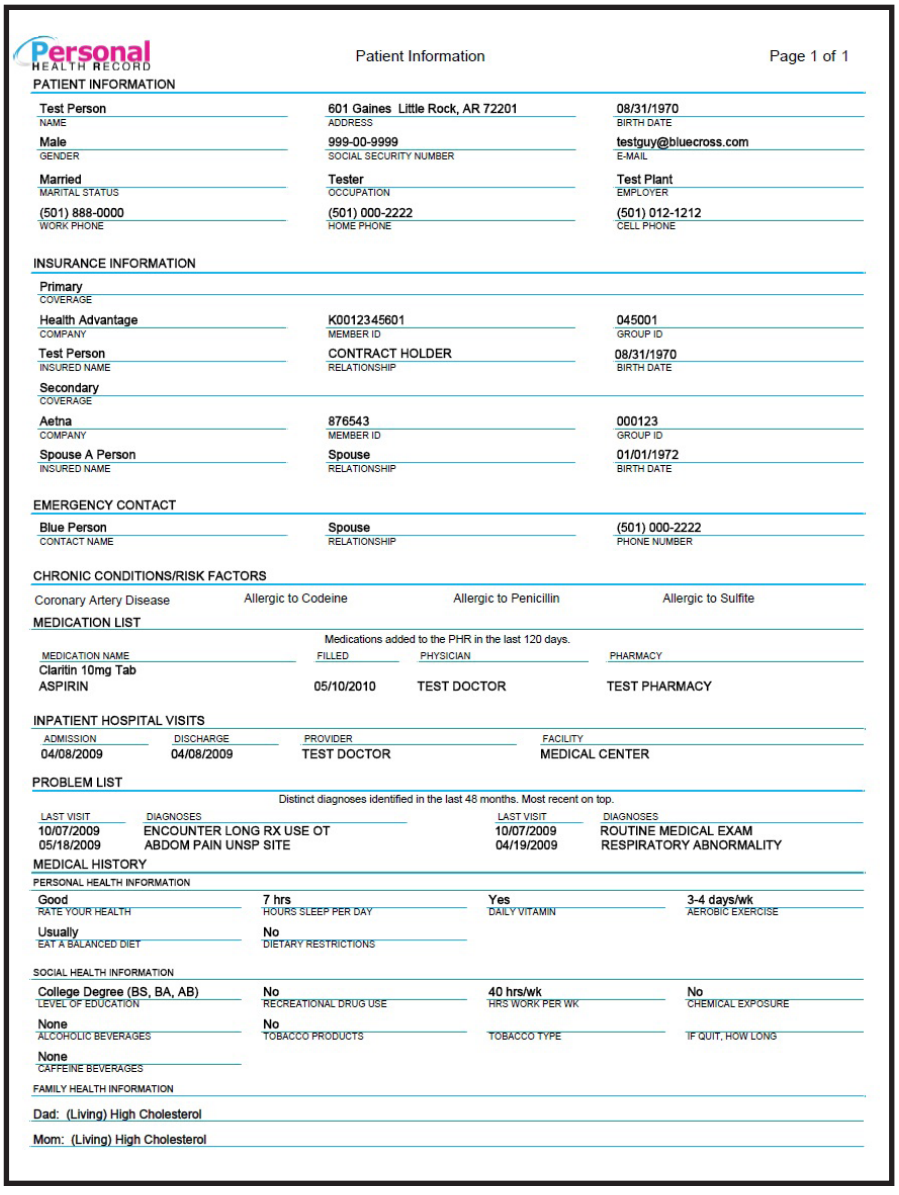
Providers may contact the Plan Administrator at 1-800-220-7898 Monday through Friday 7:00am to 5:30pm Central Time or see their website at www.pciplan.com for benefits information, but preauthorization will not be available until June 17, 2013.

Getting personal health information on patients is now even easier

New functionality within the Arkansas Blue Cross and Blue Shield's Personal Health Record (PHR) is making it easier for providers to get a summary of their patients' medical information. Providers now can enter multiple member IDs and display or print each patient's clipboard information.

The clipboard, located in the PHR, is a summary of patient's information from Arkansas Blue Cross claims data that includes pharmacy, medical procedures and diagnosis. This claims-based data can provide information about a patient's medical services prescriptions received. Members can even enter additional information such as medical, family and social histories not available in the claims data.

Through the PHR, providers have access to reliable information that patients may forget to pass on during an examination or treatment.



Personal HEALTH RECORD — Patient Information — Page 1 of 1

PATIENT INFORMATION

Test Person (NAME)	601 Gaines Little Rock, AR 72201 (ADDRESS)	08/31/1970 (BIRTH DATE)
Male (GENDER)	999-00-9999 (SOCIAL SECURITY NUMBER)	testguy@bluecross.com (E-MAIL)
Married (MARITAL STATUS)	Tester (OCCUPATION)	Test Plant (EMPLOYER)
(501) 888-0000 (WORK PHONE)	(501) 000-2222 (HOME PHONE)	(501) 012-1212 (CELL PHONE)

INSURANCE INFORMATION

Primary (COVERAGE)

Health Advantage (COMPANY)	K0012345601 (MEMBER ID)	045001 (GROUP ID)
Test Person (INSURED NAME)	CONTRACT HOLDER (RELATIONSHIP)	08/31/1970 (BIRTH DATE)

Secondary (COVERAGE)

Aetna (COMPANY)	876543 (MEMBER ID)	000123 (GROUP ID)
Spouse A Person (INSURED NAME)	Spouse (RELATIONSHIP)	01/01/1972 (BIRTH DATE)

EMERGENCY CONTACT

Blue Person (CONTACT NAME)	Spouse (RELATIONSHIP)	(501) 000-2222 (PHONE NUMBER)

CHRONIC CONDITIONS/RISK FACTORS

Coronary Artery Disease — Allergic to Codeine — Allergic to Penicillin — Allergic to Sulfite

MEDICATION LIST

Medications added to the PHR in the last 120 days.

MEDICATION NAME	FILLED	PHYSICIAN	PHARMACY
Claritin 10mg Tab			
ASPIRIN	05/10/2010	TEST DOCTOR	TEST PHARMACY

INPATIENT HOSPITAL VISITS

ADMISSION	DISCHARGE	PROVIDER	FACILITY
04/08/2009	04/08/2009	TEST DOCTOR	MEDICAL CENTER

PROBLEM LIST

Distinct diagnoses identified in the last 48 months. Most recent on top.

LAST VISIT	DIAGNOSES	LAST VISIT	DIAGNOSES
10/07/2009	ENCOUNTER LONG RX USE OT	10/07/2009	ROUTINE MEDICAL EXAM
05/18/2009	ABDOM PAIN UNSP SITE	04/19/2009	RESPIRATORY ABNORMALITY

MEDICAL HISTORY

PERSONAL HEALTH INFORMATION

Good (RATE YOUR HEALTH)	7 hrs (HOURS SLEEP PER DAY)	Yes (DAILY VITAMIN)	3-4 days/wk (AEROBIC EXERCISE)
Usually (EAT A BALANCED DIET)	No (DIETARY RESTRICTIONS)		

SOCIAL HEALTH INFORMATION

College Degree (BS, BA, AB) (LEVEL OF EDUCATION)	No (RECREATIONAL DRUG USE)	40 hrs/wk (HRS WORK PER WK)	No (CHEMICAL EXPOSURE)
None (ALCOHOLIC BEVERAGES)	No (TOBACCO PRODUCTS)	(TOBACCO TYPE)	(IF QUIT, HOW LONG)
None (CAFFEINE BEVERAGES)			

FAMILY HEALTH INFORMATION

Dad: (Living) High Cholesterol

Mom: (Living) High Cholesterol

The clipboard information may reduce the amount of time spent obtaining information, reduce the need for repeated procedures and perhaps help providers anticipate possible harmful drug interactions.

Access to a patient's PHR can be particularly helpful in emergency situations, in new patient encounters, and in dealing with patients unable to adequately communicate prior healthcare experiences.

Even if a provider's office utilizes an electronic health record, the PHR can still be very beneficial by providing data from all medical professionals a patient is encountering. Imagine knowing all medications a patient has filled and the when they were filled.

The PHR also displays treatment opportunities. These health alerts provide information on screenings and certain tests recommended by the U.S. Preventive Services Task Force and tests recommended for monitoring certain diseases such as diabetes, hypertension and COPD.

Providers may access their patient's PHR through a secure website. To request access, contact PHR Customer Support at 1-501-378-3253 or email personalhealthrecord@arkbluecross.com.

Inpatient admission precertification for Walmart & Tyson

Effective July 1, 2013, Arkansas Blue Cross and Blue Shield will launch online access for providers to obtain precertification responses. This will improve the response time for the providers' staff and will allow the requester to answer specific questions and to attach clinical records to the case.

There will be four responses a provider could receive:

1.) Precertification has been approved.
2.) More information is required. Please contact Customer Service at the following number.
3.) Precertification was denied.
4.) Precertification pending. (In this instance, the provider will have the ability to check the status of their request on the BlueAdvantage website.)

To initiate the in-patient admissions precertification, go to www.blueadvantagearkansas.com and select the "Provider" tab on the top menu. Next, select the "Medical Policy and Pre-certification/Pre-authorization" link, which will guide you through the sections needed to determine if an authorization is required.

The following facility types should continue to contact Customer Service for approval and benefits:

- hospice
- extended care facility
- long term acute care
- skilled nursing facility
- transitional care facility
- acute rehabilitation

For Walmart members, these facility types should call 1-866-823-3790, select option 5, then option 1. For Tyson members, call 1-800-452-6199, select option 5, then option 1.

Outpatient diagnostic imaging procedures for Walmart & Tyson

BlueAdvantage Administrators of Arkansas began working with AIM Specialty Health on a new Integrated Imaging Program for outpatient diagnostic imaging procedures on January 1, 2013. Physicians may contact AIM via AIM's provider portal to request or verify an order number. Their website address is www.aimspecialtyhealth.com/goweb.

AHIN

AHIN and EDI electronic mailing list subscription

Have you subscribed to the Advanced Health Information Network (AHIN) and Electronic Data Interchange (EDI) website mailing list? If not, please take a moment to do so.

Subscribing to the EDI and AHIN general mailing list will enable Arkansas Blue Cross and Blue Shield to contact providers when our website has been updated and keep providers informed of important changes for EDI and AHIN. Information will be delivered directly to an email box. Simply complete the form on any of the private business websites to subscribe.

To join the EDI and AHIN email subscription, visit the Arkansas Blue Cross website at: arkansasbluecross.com. On the "Provider" page, select "Electronic Data Interchange" link.

It is important to indicate "Institutional" or "Professional" provider at the bottom of the form to ensure correct notification is received.

Coverage policy manual updates

Since March 2013, the following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. To view entire policies, access the coverage policies located our website at arkansasbluecross.com.

New / Updated Policies:

Policy#	Policy Name
1997146	Chemosensitivity and Chemoresistance Assays, In-Vitro
1997166	PET or PET/CT for Brain Imaging, Non-malignant Disease
1997208	Spinal Cord Neurostimulation for Treatment of Intractable Pain
2001039	PET or PET/CT for Neuroendocrine Tumors
2008010	Advanced Nurse Practitioners
2008015	Clinical Nurse Specialist
2010006	Genetic Test: Predict Toxicity from #5-FU, Dihydropyrimidine Dehydrogenase Gene Mutation
2013008	PET or PET/CT for Soft Tissue Sarcoma, including Gastrointestinal Stromal Tumor (GIST)
2013009	Eyelid Thermal Pulsation for the Treatment of Dry Eye Syndrome
2013010	Genetic Test: PTEN Hamartoma Tumor Syndrome
2013011	Transplant, Composite Tissue Allotransplantation, Hand and/or Face
2013012	Genetic Test: Duchenne and Becker Muscular Dystrophy
2013013	Peripheral Subcutaneous Field Stimulation
2013015	Treatment of Varicose Veins/Venous Insufficiency
2013016	Genetic Testing: Celiac Disease (HLA-DQ) and Lactose Intolerance (C/T-13910)
2013017	Fecal Microbiota Transplantation for the Treatment of Clostridium Difficile

Medi-Pak Advantage

Medicare compliance guidelines

As indicated in Medicare Managed Care Manual (42CFR Parts 422 and 423) Chapter 21- Compliance Program Guidelines and Chapter 9- Prescription Drug Manual, there are specific training and communication requirements that plan sponsors, such as Arkansas Blue Cross and Blue Shield, must communicate to all contracted entities which provide benefits or services to Medicare beneficiaries. As a contracted provider, also known as FDRs (first tier, downstream and related entities), with Arkansas Blue Cross, you are considered an entity that provides services to our Medi-Pak® Advantage PFFS/PPO and Medi-Pak® Rx PDP members.

What you should know as a contracted provider?

The five most important federal fraud and abuse laws that apply to physicians are:

1. False Claims Act (FCA),
2. Anti-Kickback Statute (AKS),
3. Physicians Self-Referral Law (Stark law),
4. Exclusion Authorities, and
5. Civil Monetary Penalties Law (CMPL).

Government agencies, including the Department of Justice, the Department of Health and Human Services, Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. As a Medicare contracted physician, it is critical that you understand these laws, not only because following the law is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from the federal health care programs or loss your medical license from the Arkansas State Medical Board.

1. False Claims Act [31 U.S.C. §§ 3729-3733]: It is illegal for providers to submit claims from payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claims filed. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law. Under civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which a person acted in deliberate ignorance or reckless in regard.

2. Anti-Kickback Statute [42 U.S.C. §§ 1320a-7B(b)]: AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal healthcare programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, excessive compensation for medical directorships or consultancies. Criminal penalties and administrative sanctions for violation the AKS include fines, jail terms, and exclusion from participating in the Federal healthcare programs. Under CMPL, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

3. Physician Self-Referral Law [42 U.S.C. § 1395nn]: The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare and Medicaid from entities with which the physician or immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interest and compensation arrangements. The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the federal health care program.

(Continued on page 15)

Medicare compliance guidelines (Continued from page 10)

4. Exclusion Statute [42 U.S.C. § 1320a-7]: OIG is legally required to exclude from participation in all Federal healthcare programs individuals and entities convicted of following types of criminal offenses:

1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid;
2) patient abuse or neglect;
3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and
4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

OIG also has the discretion to exclude individuals and entities on several other grounds, including misdemeanor convictions of the above reference points. Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.

5. Civil Monetary Penalties Law [42 U.S.C. § 1320a-7a]: OIG may seek civil monetary penalties and sometimes exclude for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation. Penalties range from $10,000 to $50,000 per violation. Some examples of CMPL violations include, but are not limited to: presenting a claim that a person knows or should know is an item or services that weren't provided; presenting a claim that the person knows or should know is for an item or service for which payment may not be made and violating AKS.

For more information about these laws and other physician education related to Medicare Compliance, visit http://oig.hhs.gov/compliance/physician-education/index.asp or visit www.arkansasbluecross.com select Provider tab and scroll down to "Resource Center."

Reporting Obligation

If providers know of, or reasonably suspect, a misappropriation of Arkansas Blue Cross assets or any other violation of law, ethical or business policies providers must report the matter. It is the obligation of every employee and individual working on Arkansas Blue Cross's behalf that knows of or reasonably suspects a violation of Arkansas Blue Cross's Code of Conduct to promptly report it. Report may be oral or written, and made to the Confidential Fraud Hotline at 1-877-507-7305 or through the Arkansas Blue Cross Medicare Part C & D Compliance Officer, Shirl Welch at medicarecdcompliance@arkbluecross.com

ASE/PSE

Inpatient pre-certification required

Effective October 1, 2013, the ARBenefits health plan, sponsored by the State and Public School Life and Health Insurance Board and administered by the Employee Benefits Division, will require pre-certification for all inpatient hospital admissions. Determinations for these admissions will be made for medical necessity, appropriate length of stay and level of care based on nationally accepted industry standards, and ARBenefits Coverage Policy. **Failure to obtain appropriate pre-certification will result in the facility writing off the charges for covered services and holding the member harmless.**

BlueCard

BlueCard corrected claim submission

BlueCard accepts both paper and electronic corrected claims. What is a "Corrected Claim"? A "Corrected/Replacement Claim" is a change to a claim that has been previously submitted for processing and has been finalized and reported on the Provider's Remittance Advice (RA).

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

Replacement and/or Corrected Claims filed electronically:

For both Facility and Professional Corrected Claims, in order to expedite processing time and identify the actual corrections and the reason for the correction Arkansas Blue Cross requires a "total replacement" claim in order for a complete comparison to the original claim.

To file corrected claims electronically for the CMS 1500 claim form, the provider must populate 2300/CLM05-3 with a value of 7 and include the ICN number or BlueCard SCCF# of the original claim. The original ICN or SCCF# (Document Control Number DCN) must be placed in the REF segment of the Loop 2300 with a qualifier of Ref 01=F8. If these are not submitted, the claim will be returned as a duplicate. To file corrected claims electronically for the UB claim form, facilities will need to use XX7 type of bill.

Paper Submission:

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

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

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

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

If you have questions regarding Corrected Claims, please contact Arkansas Blue Cross BlueCard customer service at (501) 378-2127 or 800-880-0918 or contact the Advanced Health Information Network (AHIN) Customer Support at (501) 378-2336.

Duplicate claims handling for Medicare crossover

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

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

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Duplicate claims handling for Medicare crossover (Continued from page 10)

Blue Shield.

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

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

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

Commonly Asked Questions:

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

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

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

- If the RA indicates that the claim was crossed over, Medicare has forwarded the claim on behalf of the provider to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to Arkansas Blue Cross.
- If the RA indicates that the claim was not crossed over, submit the claim to Arkansas Blue Cross with the Medicare RA.
- In some cases, the member identification card may contain a COBRA ID number. If so, be certain to include this number on the claim.
- For claims status inquiries, contact Arkansas Blue Cross Customer Service at 1-800-880-0918 or 1-501-378-2127.

When should providers expect to receive payment?

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

What should providers do in the meantime?

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

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

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

Who do providers contact if they have questions?

If you have questions regarding Medicare crossover claims, please call Arkansas Blue Cross BlueCard Customer Service at 1-800-880-0918 or 1-501-378-2127.

BlueCard

Pricing claims for Medicare statutorily excluded services

Effective October 13, 2013, the following Medicare crossover servicing updates are in place for all Blue Plans to more accurately price and process these claims:

- For services that are statutorily excluded by Medicare (i.e., home infusion therapy and hearing aids), providers should submit only those statutorily excluded services to Arkansas Blue Cross and Blue Shield with a GY modifier on each line for the service that is excluded or not covered by Medicare. The GY modifier should be used to indicate that the item or service is statutorily excluded. This will allow Arkansas Blue Cross to apply the contracted rate with the provider to accurately process the claim according to the member's benefits. Also, by submitting statutorily excluded services with a GY modifier directly to Arkansas Blue Cross, providers will receive payment for these services in a more timely manner.
- When a provider submits a claim to Medicare and the services were statutorily excluded and not covered by Medicare, however the member has benefits for those services; providers will receive notification from the Blue Plan with instruction to submit those statutorily excluded services directly to Arkansas Blue Cross. Instructions will be included in either a paper or electronic RA or in a letter from the Blue Plan.
  - Paper RAs and Letters: When receiving paper RA's or letters, providers will receive instructions similar to the message below:
    "This service is excluded or not covered under Medicare. However, the service may be eligible for benefits under other coverage. Please submit this service to your local Plan."
  - Electronic RAs (835):The following HIPAA claim adjustment reason codes and remark codes will be included on the 835 responses:
    - Claim Adjustment Reason Code (CARC) 109: "Claim not covered by this payor/contractor."
    - RA Remark Code (RARC) N837: "Alert: submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information."
    - Group Code: OA

Commonly Asked Questions:

How do providers know if a service is statutorily excluded or not covered by Medicare? Providers are responsible for including the GY modifier on only those services which are statutorily excluded by Medicare.

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

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

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

Who do providers contact if they have questions? If you have questions, please call Arkansas Blue Cross Blue Shield Customer Service at (501) 378-2127 or 1-800-880-0918.

Fee Schedule

Genetic Testing Code Updates

The following genetic testing codes were updated on Arkansas Blue Cross fee schedule.

CPT Code	Allowed
81200	$156.77
81201	$1,000.00
81203	$320.00
81205	$156.77
81206	$108.37
81207	$90.31
81208	$150.17
81209	$68.27
81210	$94.65
81220	$500.00
81221	$101.97
81222	$130.06
81223	$1,200.00
81224	$80.00
81225	$192.15
81226	$289.54
81227	$134.49
81228	$667.90
81229	$667.90
81235	$301.92
81240	$41.41
81241	$68.64
81242	$117.68
81243	$58.19
81244	$39.76
81245	$112.00
81250	$96.47
81251	$283.86
81252	$153.80
81253	$22.72

CPT Code	Allowed
81254	$106.32
81255	$277.46
81256	$93.94
81257	$183.33
81260	$76.31
81261	$152.28
81262	$68.16
81263	$274.55
81264	$343.72
81265	$192.94
81267	$414.94
81268	$275.00
81270	$58.19
81275	$213.42
81280	$2,551.54
81290	$117.68
81291	$107.81
81292	$1,027.08
81293	$134.58
81295	$920.76
81296	$93.94
81298	$1,145.99
81299	$130.06
81301	$320.84
81302	$455.72
81304	$147.41
81310	$58.84
81315	$159.27
81321	$604.86
81323	$88.26

CPT Code	Allowed
81324	$937.12
81330	$156.77
81331	$82.58
81332	$93.94
81341	$68.16
81342	$130.06
81350	$122.11
81370	$325.66
81372	$676.36
81373	$229.24
81374	$113.33
81375	$116.55
81376	$132.93
81377	$112.30
81379	$296.24
81380	$201.28
81381	$229.20
81382	$141.93
81383	$35.10
81400	$70.38
81401	$104.08
81402	$150.59
81403	$286.70
81404	$318.77
81405	$418.51
81406	$664.56
81407	$1,480.00
81408	$1,370.00

Fee Schedule

Fee schedule additions and updates

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

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
74300	$28.96	$28.96	$0.00	$28.96	$28.96	$0.00
74301	$17.60	$17.60	$0.00	$17.60	$17.60	$0.00
74305	$33.91	$33.91	$0.00	$33.91	$33.91	$0.00
76975	$65.60	$65.60	$0.00	$65.60	$65.60	$0.00
77371	$1,212.11	$0.00	$1,212.11	$0.00	$0.00	$0.00
78267	$16.29	$16.29	$0.00	$16.29	$16.29	$0.00
78268	$60.00	$60.00	$0.00	$60.00	$60.00	$0.00
80500	$32.20	$29.03	$0.00	$29.03	$29.03	$0.00
80502	$105.20	$102.03	$0.00	$102.03	$102.03	$0.00
81202	$93.94	$6.58	$87.36	$0.00	$6.58	$0.00
81211	$3,123.17	$218.62	$2,904.55	$0.00	$218.62	$0.00
81212	$535.54	$37.49	$498.05	$0.00	$37.49	$0.00
81213	$656.20	$45.93	$610.27	$0.00	$45.93	$0.00
81214	$1,626.65	$113.87	$1,512.78	$0.00	$113.87	$0.00
81215	$440.45	$30.83	$409.62	$0.00	$30.83	$0.00
81216	$1,951.99	$136.64	$1,815.35	$0.00	$136.64	$0.00
81217	$440.45	$30.83	$409.62	$0.00	$30.83	$0.00
81241	$78.39	$5.49	$72.90	$0.00	$5.49	$0.00
81245	$112.00	$7.84	$104.16	$0.00	$7.84	$0.00
81261	$148.12	$10.37	$137.75	$0.00	$10.37	$0.00
81262	$51.12	$3.58	$47.54	$0.00	$3.58	$0.00
81263	$259.93	$18.20	$241.73	$0.00	$18.20	$0.00
81264	$111.98	$7.84	$104.14	$0.00	$7.84	$0.00
81265	$414.94	$29.05	$385.89	$0.00	$29.05	$0.00
81266	$159.60	$11.17	$148.43	$0.00	$11.17	$0.00
81267	$149.72	$10.48	$139.24	$0.00	$10.48	$0.00
81268	$149.72	$10.48	$139.24	$0.00	$10.48	$0.00
81292	$1,031.33	$72.19	$959.14	$0.00	$72.19	$0.00
81293	$440.45	$30.83	$409.62	$0.00	$30.83	$0.00
81294	$270.00	$18.90	$251.10	$0.00	$18.90	$0.00

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Fee Schedule Updates (Continued from page 16)

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
81295	$831.12	$58.18	$772.94	$0.00	$58.18	$0.00
81296	$440.00	$30.80	$409.20	$0.00	$30.80	$0.00
81297	$270.00	$18.90	$251.10	$0.00	$18.90	$0.00
81298	$1,001.30	$70.09	$931.21	$0.00	$70.09	$0.00
81299	$440.45	$30.83	$409.62	$0.00	$30.83	$0.00
81300	$270.00	$18.90	$251.10	$0.00	$18.90	$0.00
81310	$58.84	$4.12	$54.72	$0.00	$4.12	$0.00
81315	$117.54	$8.23	$109.31	$0.00	$8.23	$0.00
81316	$117.54	$8.23	$109.31	$0.00	$8.23	$0.00
81317	$1,060.00	$74.20	$985.80	$0.00	$74.20	$0.00
81318	$440.45	$30.83	$409.62	$0.00	$30.83	$0.00
81319	$270.00	$18.90	$251.10	$0.00	$18.90	$0.00
81340	$148.12	$10.37	$137.75	$0.00	$10.37	$0.00
81341	$45.44	$3.18	$42.26	$0.00	$3.18	$0.00
81342	$148.12	$10.37	$137.75	$0.00	$10.37	$0.00
81370	$552.75	$38.69	$514.06	$0.00	$38.69	$0.00
81371	$330.84	$23.16	$307.68	$0.00	$23.16	$0.00
81372	$303.64	$21.25	$282.39	$0.00	$21.25	$0.00
81373	$153.08	$10.72	$142.36	$0.00	$10.72	$0.00
81374	$100.00	$7.00	$93.00	$0.00	$7.00	$0.00
81375	$303.43	$21.24	$282.19	$0.00	$21.24	$0.00
81376	$168.00	$11.76	$156.24	$0.00	$11.76	$0.00
81377	$126.20	$8.83	$117.37	$0.00	$8.83	$0.00
81378	$475.00	$33.25	$441.75	$0.00	$33.25	$0.00
81379	$461.00	$32.27	$428.73	$0.00	$32.27	$0.00
81380	$243.64	$17.05	$226.59	$0.00	$17.05	$0.00
81381	$130.00	$9.10	$120.90	$0.00	$9.10	$0.00
81382	$170.00	$11.90	$158.10	$0.00	$11.90	$0.00
81383	$150.00	$10.50	$139.50	$0.00	$10.50	$0.00
85060	$38.30	$38.30	$0.00	$38.30	$38.30	$0.00
85097	$115.97	$72.86	$0.00	$72.86	$72.86	$0.00
86077	$84.00	$79.02	$0.00	$79.02	$79.02	$0.00
86078	$84.45	$79.02	$0.00	$79.02	$79.02	$0.00
86079	$84.00	$78.57	$0.00	$78.57	$78.57	$0.00
88325	$287.65	$196.88	$0.00	$196.88	$196.88	$0.00
88329	$85.72	$56.72	$0.00	$56.72	$56.72	$0.00

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Fee Schedule Updates (Continued from page 17)

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
93318	$174.55	$174.55	$0.00	$174.55	$174.55	$0.00
93566	$247.17	$68.23	$0.00	$68.23	$68.23	$0.00
93567	$206.12	$76.56	$0.00	$76.56	$76.56	$0.00
93568	$222.53	$69.87	$0.00	$69.87	$69.87	$0.00
94640	$25.77	$12.89	$12.88	$0.00	$0.00	$0.00
94660	$87.52	$58.03	$0.00	$58.03	$58.03	$0.00
95965	$676.88	$676.88	$0.00	$676.88	$676.88	$0.00
95966	$315.55	$315.55	$0.00	$315.55	$315.55	$0.00
95967	$276.95	$276.95	$0.00	$276.95	$276.95	$0.00
95991	$180.38	$63.05	$0.00	$63.05	$63.05	$0.00
99495	$129.37	$0.00	$0.00	$96.09	$0.00	$0.00
99496	$174.31	$0.00	$0.00	$135.36	$0.00	$0.00
A4281	$13.34	$0.00	$0.00	$0.00	$0.00	$0.00
A4282	$2.35	$0.00	$0.00	$0.00	$0.00	$0.00
A4283	$1.00	$0.00	$0.00	$0.00	$0.00	$0.00
A4284	$14.77	$0.00	$0.00	$0.00	$0.00	$0.00
A4285	$5.63	$0.00	$0.00	$0.00	$0.00	$0.00
A4286	BR	$0.00	$0.00	$0.00	$0.00	$0.00
C9130	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9297	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9298	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9734	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9735	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G0431	$99.95	$7.00	$92.95	$0.00	$7.00	$0.00
J9266	$2,835.00	$0.00	$0.00	$0.00	$0.00	$0.00
L8680	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q0507	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q0508	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q0509	BR	$0.00	$0.00	$0.00	$0.00	$0.00
S0265	$25.83	$0.00	$0.00	$0.00	$0.00	$0.00
S0265	$27.46	$0.00	$0.00	$0.00	$0.00	$0.00
S0268	$0.00	$0.00	$0.00	$3,530.26	$0.00	$0.00
S2083	$87.68	$0.00	$0.00	$62.34	$0.00	$0.00
S3722	$285.00	$19.95	$265.05	$0.00	$19.95	$0.00
S3833	$1,921.95	$134.54	$1,787.41	$0.00	$134.54	$0.00
S3834	$440.45	$30.83	$409.62	$0.00	$30.83	$0.00

Fee Schedule

Injection Code Updates

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

CPT/HCPC Codes	Allowed
90371	$116.59
90375	$214.79
90376	$210.82
90585	$122.15
90586	$122.15
90632	$52.47
90670	$151.80
90675	$230.86
90691	$63.35
90703	$37.86
90714	$21.17
90717	$78.06
90732	$75.25
A9576	$2.12
A9577	$2.35
A9578	$2.19
A9579	$2.12
A9581	$13.88
A9583	$12.45
J0129	$23.52
J0130	$597.84
J0132	$3.32
J0133	$0.02
J0135	$510.19
J0150	$6.38
J0152	$113.93
J0178	$1,019.72
J0180	$146.48
J0207	$325.27

CPT/HCPC Codes	Allowed
J0220	$214.11
J0221	$159.77
J0256	$4.08
J0257	$4.09
J0278	$1.04
J0280	$0.95
J0285	$16.58
J0287	$11.73
J0290	$1.71
J0295	$1.98
J0348	$1.08
J0360	$3.00
J0364	$34.18
J0400	$0.50
J0456	$2.22
J0470	$30.94
J0475	$182.16
J0480	$2,414.10
J0490	$39.82
J0500	$31.68
J0515	$24.29
J0558	$3.93
J0561	$4.95
J0585	$5.68
J0587	$11.25
J0588	$4.63
J0595	$0.97
J0597	$32.38
J0598	$49.15

CPT/HCPC Codes	Allowed
J0610	$0.75
J0630	$65.30
J0636	$0.40
J0640	$4.90
J0641	$1.89
J0670	$1.26
J0690	$0.81
J0692	$2.66
J0694	$5.57
J0697	$3.41
J0702	$5.93
J0706	$0.32
J0712	$0.86
J0713	$2.41
J0718	$5.36
J0720	$27.21
J0725	$13.61
J0735	$23.43
J0740	$787.44
J0770	$12.85
J0780	$4.73
J0800	$3,133.27
J0834	$71.34
J0840	$2,309.76
J0881	$3.47
J0882	$3.47
J0885	$10.80
J0886	$10.80
J0894	$35.45

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Injection Code Updates (Continued from page 19)

CPT/HCPC Codes	Allowed
J0897	$14.79
J1000	$7.74
J1020	$3.28
J1030	$3.08
J1040	$5.96
J1070	$4.96
J1080	$6.00
J1100	$0.10
J1110	$40.89
J1120	$29.96
J1160	$1.67
J1162	$1,087.66
J1165	$0.53
J1170	$1.87
J1200	$0.82
J1205	$214.09
J1212	$87.56
J1230	$7.42
J1240	$5.23
J1245	$0.87
J1250	$8.26
J1260	$4.87
J1265	$0.49
J1267	$0.51
J1270	$1.80
J1290	$329.83
J1300	$209.16
J1325	$14.74
J1327	$26.99
J1335	$32.84
J1364	$15.44
J1380	$9.46
J1410	$142.19
J1438	$250.86

CPT/HCPC Codes	Allowed
J1440	$288.34
J1441	$457.50
J1450	$4.19
J1451	$6.48
J1453	$1.79
J1458	$369.60
J1459	$37.52
J1460	$24.82
J1557	$38.70
J1560	$248.16
J1566	$34.44
J1568	$32.76
J1569	$39.34
J1570	$67.06
J1572	$36.94
J1580	$1.23
J1610	$119.65
J1626	$0.45
J1631	$20.17
J1640	$13.80
J1644	$0.22
J1645	$11.49
J1650	$3.02
J1652	$4.26
J1670	$287.79
J1720	$5.00
J1740	$157.56
J1742	$171.32
J1743	$489.17
J1745	$77.24
J1750	$12.63
J1756	$0.30
J1786	$43.54
J1790	$3.44

CPT/HCPC Codes	Allowed
J1800	$3.06
J1815	$0.56
J1817	$5.59
J1930	$37.07
J1931	$29.34
J1940	$2.41
J1950	$707.89
J1953	$0.20
J1955	$7.96
J1980	$16.84
J2020	$40.66
J2060	$0.79
J2150	$1.73
J2175	$2.14
J2210	$4.18
J2270	$4.89
J2271	$0.56
J2275	$2.11
J2278	$6.87
J2280	$3.65
J2300	$1.35
J2310	$15.91
J2315	$2.94
J2323	$12.78
J2325	$56.87
J2353	$136.38
J2354	$1.28
J2355	$267.07
J2357	$25.45
J2360	$6.36
J2370	$1.50
J2400	$23.44
J2405	$0.16
J2410	$2.43

(Continued on page 21)

Injection Code Updates (Continued from page 20)

CPT/HCPC Codes	Allowed
J2425	$13.79
J2426	$7.52
J2430	$11.10
J2469	$20.22
J2501	$1.89
J2503	$1,071.64
J2505	$3,057.80
J2507	$380.42
J2510	$14.27
J2515	$33.86
J2540	$0.63
J2543	$2.44
J2545	$76.73
J2550	$1.66
J2560	$11.29
J2562	$304.31
J2590	$0.66
J2597	$5.82
J2675	$1.45
J2680	$16.51
J2690	$16.95
J2700	$2.34
J2724	$14.30
J2730	$93.10
J2760	$137.82
J2765	$0.64
J2770	$196.08
J2778	$413.63
J2780	$1.68
J2783	$216.49
J2788	$25.97
J2790	$60.79
J2791	$4.98
J2792	$19.34

CPT/HCPC Codes	Allowed
J2794	$5.85
J2795	$0.10
J2796	$51.84
J2800	$36.39
J2805	$63.37
J2810	$0.20
J2820	$27.97
J2916	$3.07
J2920	$1.97
J2930	$2.77
J2997	$54.28
J3000	$14.02
J3010	$0.61
J3070	$28.54
J3095	$2.77
J3101	$75.34
J3105	$2.39
J3120	$4.67
J3130	$9.34
J3230	$18.48
J3240	$1,096.14
J3243	$1.67
J3246	$8.53
J3250	$10.58
J3260	$2.72
J3262	$3.84
J3300	$3.81
J3301	$1.85
J3303	$1.67
J3315	$179.19
J3355	$67.67
J3357	$139.55
J3360	$3.21
J3370	$2.47

CPT/HCPC Codes	Allowed
J3385	$362.57
J3396	$10.71
J3410	$0.99
J3411	$3.75
J3415	$7.71
J3420	$1.48
J3430	$1.60
J3465	$5.06
J3473	$0.33
J3475	$0.20
J3485	$1.56
J3487	$229.79
J3488	$233.67
J7030	$1.12
J7042	$0.49
J7060	$1.09
J7070	$2.18
J7100	$23.36
J7120	$1.02
J7183	$0.96
J7185	$1.10
J7190	$0.95
J7193	$0.99
J7194	$1.14
J7195	$1.31
J7198	$1.71
J7308	$166.43
J7309	$81.82
J7311	$18,650.00
J7312	$203.76
J7321	$92.39
J7323	$170.52
J7324	$174.20
J7325	$12.68

(Continued on page 22)

Injection Code Updates (Continued from page 21)

CPT/HCPC Codes	Allowed
J7326	$603.33
J7501	$169.47
J7502	$3.49
J7504	$734.05
J7506	$0.05
J7507	$1.77
J7509	$0.80
J7510	$0.03
J7511	$550.92
J7515	$0.92
J7516	$33.20
J7517	$1.32
J7518	$3.76
J7520	$12.61
J7525	$143.52
J7605	$5.59
J7606	$6.02
J7608	$2.28
J7611	$0.11
J7612	$0.21
J7614	$0.12
J7620	$0.23
J7626	$4.95
J7631	$0.57
J7665	$0.53
J7682	$105.33
J8510	$6.83
J8520	$9.27
J8521	$30.86
J8530	$0.95
J8540	$0.33
J8560	$54.39
J8600	$8.90
J8610	$0.31

CPT/HCPC Codes	Allowed
J8700	$11.63
J8705	$90.04
J9000	$4.08
J9002	$538.95
J9010	$648.58
J9017	$46.87
J9019	$347.70
J9020	$65.73
J9025	$5.94
J9027	$131.37
J9031	$122.15
J9035	$66.10
J9040	$22.70
J9042	$102.72
J9043	$146.21
J9045	$3.58
J9050	$182.85
J9055	$53.88
J9060	$2.12
J9065	$27.71
J9070	$36.83
J9120	$601.42
J9130	$3.84
J9150	$26.26
J9155	$2.99
J9171	$6.40
J9178	$1.47
J9179	$99.38
J9181	$0.76
J9185	$87.09
J9190	$2.18
J9200	$59.53
J9201	$8.36
J9202	$200.92

CPT/HCPC Codes	Allowed
J9206	$3.53
J9207	$70.30
J9208	$31.02
J9209	$3.03
J9211	$65.22
J9214	$18.08
J9217	$216.12
J9218	$9.22
J9226	$15,844.00
J9228	$132.04
J9230	$160.89
J9245	$1,353.57
J9250	$0.19
J9260	$1.90
J9261	$132.10
J9263	$1.10
J9264	$9.92
J9265	$4.96
J9268	$1,432.19
J9280	$23.13
J9293	$38.81
J9302	$47.14
J9303	$92.82
J9305	$60.28
J9307	$189.91
J9310	$705.05
J9315	$251.86
J9320	$284.24
J9328	$5.02
J9330	$57.04
J9351	$2.45
J9355	$81.69
J9357	$1,079.95
J9360	$1.40

(Continued on page 23)

Injection Code Updates (Continued from page 22)

CPT/HCPC Codes	Allowed
J9370	$4.19
J9390	$10.23
Q0138	$0.67
Q0139	$0.67
Q0162	$0.05
Q0163	$0.03
Q0164	$0.04
Q0165	$0.04
Q0166	$4.31
Q0167	$3.22
Q0168	$14.81
Q0170	$0.05
Q0180	$67.82
Q2009	$0.98

CPT/HCPC Codes	Allowed
Q2017	$334.74
Q2043	$31,314.54
Q3025	$317.64
Q4081	$1.08
Q4101	$41.16
Q4102	$8.54
Q4103	$8.54
Q4104	$19.86
Q4105	$13.95
Q4106	$44.25
Q4107	$101.59
Q4108	$25.09
Q4110	$35.16
Q4111	$7.29

CPT/HCPC Codes	Allowed
Q4112	$369.73
Q4113	$369.73
Q4114	$1,222.93
Q4115	$7.91
Q4116	$32.95
Q4121	$22.81
Q4123	$16.80
Q9956	$38.79
Q9957	$58.19
Q9965	$0.99
Q9966	$0.29
Q9967	$0.17

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providers' news staff

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