Providers' News

Arkansas BlueCross BlueShield

To: All Providers

From: Provider Network Operations

Date: September 2002

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

What's Inside?

Articles:

Attachments:

Retraction Of Article From June '02: Re: Handle/File Direct Claims

Due to clarification of Blue Cross and Blue Shield Association guidelines concerning handling of claims for BlueCard, effective July 1, 2002, Arkansas Blue Cross and Blue Shield will **again** forward handle/file claims to the home plan.

Advanced Health Information Network (AHIN): Access Fees Waived

For several years now, the Advanced Health Information Network (AHIN) has been empowering health care professionals with information at the point of service. To date, more than 3,000 physicians and 50 hospitals in Arkansas have gotten "connected" and have taken advantage of this seamless integrated health care network.

Effective Oct. 1, Arkansas Blue Cross and Blue Shield will eliminate user fees for connecting to AHIN; therefore offering the network "free" to health care providers in the state.

AHIN is an on-line system that provides advanced functionality, which allows physicians as well as hospital providers to manage their business functions more efficiently. It was one of the first health information networks in the U.S. to offer advanced real-time functionality and continues to offer capabilities that are unique within the industry.

With AHIN, providers are linked to Arkansas Blue Cross information systems to gain access to eligibility, claims and claim-status data. A unique feature allows claim submission and on-line, real-time correction of erroneous claims. AHIN interfaces with Arkansas and Texas Medicaid systems to allow access to eligibility for these programs.

AHIN is a browser-based system utilizing Netscape Navigator or Internet Explorer, which simplifies installation and maintenance. With the exception of a small program to handle security. Which AHIN supplies free of charge, everything necessary to access the system is already present on most personal computers.

One of the biggest advantages in utilizing AHIN is the processing of claims. Claims, which traditionally required 24 hours or more to be accepted into the payment system for adjudication, can take as little as 15 minutes to process electronically. Errors are identified and, subsequently, corrected more quickly, which results in faster payment.

There is no software to purchase to sign on to AHIN. All that is needed to participate is what a clinic/practice, hospital or office should already have:

- IBM compatible PC (with 540 MB of free space, 64 MB RAM and at least a 56k modem),
- Internet browser (Explorer 5 or 6, or Netscape 4.7 or 6.0), and
- Software operating system including Windows 98, ME or NT or later)

Providers interested in finding out more AHIN or "getting connected," may contact their Arkansas Blue Cross and Blue Shield regional network development representative or visit the Arkansas Blue Cross and Blue Shield Web site at www.ArkansasBlueCross.com for more information and to download a contract. Contracts will be processed on a first-come, first-served basis. Training will be provided statewide and coordinated through the Arkansas Blue Cross regional offices.

Sharon K. Allen Promoted to President of Arkansas Blue Cross and Blue Shield:

The Board of Directors of Arkansas Blue Cross and Blue Shield has approved the promotion of Sharon K. Allen to president and chief operating officer (COO) of the company, effective July 3, 2002. Allen has served as executive vice president and COO since 1997 and has worked for Arkansas Blue Cross for 34 years.

Allen will continue to report to Robert L. Shoptaw, chief executive officer (CEO) of Arkansas Blue Cross and Blue Shield, as will Robert D. Cabe, executive vice president of Legal, Governmental Relations and Communication Services, and P. Mark White, executive vice president and chief financial officer. All other existing reporting lines within the company will remain unchanged.

"It's certainly an honor and a privilege to be afforded the opportunity to serve as president and chief operating officer of Arkansas Blue Cross and Blue Shield," said Ms. Allen. "Thanks to our long-standing relationship with the health care providers of Arkansas, we will continue to achieve together our mission of providing access to health care services at an affordable cost."

The elevation of Allen to the president position was proposed by Shoptaw and unanimously approved by the Board. Shoptaw, who has served as president and CEO since 1993 and has worked for Arkansas Blue Cross for 32 years, continues to lead the company as CEO.

"The Board feels that the change in title is commensurate with Ms. Allen's responsibility for directing current government and private operations, as well as future dealings with the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), and in executing our strategy to secure a number of new Medicare Part A and Part B contracts in other states,"

said Shoptaw. Allen is also the lead corporate executive responsible for provider relationships and joint ventures.

"Sharon Allen has earned this level of recognition based on the positive results she continuously delivers to the benefit of the company and its customers, and is in keeping with Bob Shoptaw's team-building approach in the management of Arkansas Blue Cross and Blue Shield," said Hayes McClerkin, chairman of the Board of Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross and Blue Shield, an Independent Licensee of the Blue Cross and Blue Shield Association, is the largest health insurer in Arkansas, serving more than 860,000 Arkansans. Arkansas Blue Cross and Blue Shield administers the Medicare Part A (hospital benefits) and Part B (physician benefits) programs in Arkansas, as well as the Medicare Part B programs in Louisiana, Oklahoma, eastern Missouri and New Mexico. Arkansas Blue Cross and Blue Shield and its USAble family of companies have more than 2,400 employees.

ABCBS:
Claims Filing Procedure for PPO Primary Care Physician's Office Services – General Practice, Family Practice, Internal Medicine and Pediatrics:

When filing claims for patients who have a PPO encounter fee copayment, it is very important to include all procedures performed during one office visit on the same claim form. Several claims submitted for services on the same date of service, can result in the encounter fee copayment being applied several times causing incorrect payment.

Detecting this error and correcting it delays payment and can be an inconvenience to the patient. Submitting one claim form for all procedures performed during a patient's visit is a simple way to avoid confusion and make sure that full payment is made the first time.

ASE/PSE:
Top Five Most Frequently Occurring Diagnoses:

One of the requirements of the ASE/PSE Health Advantage contract included distribution of Physician Practice Guidelines for the top five (5) most frequently occurring conditions within their population.

The top five conditions identified in the administrative claims data are as follows:

1. Allergic Rhinitis & Respiratory Symptoms
2. Diabetes and Eye Exams
3. Unspecified Disorders of the Back
4. Hypertension & Ischemic Heart Disease
5. Headache

In an attempt to assist clinicians by providing a consistent approach to the evaluation and treatment of patients, the Employee Benefit Division for the Arkansas State Employees and the Public School Employees has recommended that all participating health plans provide the provider population with credible health care guidelines.

In an effort to reduce the paperwork and redundancy among the health plans, the Employee Benefit Division for the Arkansas State Employees and the Public School Employees has agreed to recognize the Arkansas Wellness Coalition's voluntary effort to enhance consistency and efficiency of care by providing common core principles and implementing nationally recognized standards of care. The Arkansas Wellness Coalition distributed to Arkansas' physicians the Diabetes Mellitus Care Principles in the fall of 2001 and will release Cardiovascular Disease Primary and Secondary Prevention Principles this fall.

For those diagnoses not addressed by the Arkansas Wellness Coalition Principles', the Employee Benefit Division has identified and recommended, and Health Advantage has reviewed and approved, the website for the Institute for Clinical Systems Improvement as a resource for health care guidelines. The website for the Institute for Clinical Systems Improvement is www.icsi.org.

These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.

Health Advantage benefit coverage limitations of guideline recommendations are defined in the individual member's benefit certificate. The member is financially responsible for services and treatment that fall outside their individual health benefit plan.

Auto Med Pay Pilot Terminated

Arkansas Blue Cross and Blue Shield will terminate the Auto Med Pay Pilot Program effective September 1, 2002. After this date, automobile insurers will no longer access Arkansas FirstSource PPO. We do appreciate your participation in this program.

Codes:

CPT Code 82570:

Effective January 1, 2003, the allowance for CPT Code 82570, Creatinine: other source, will be changed to $7.33 Total Component, $.51 Professional Component, $6.82 Technical Component.

CPT Code 90887:

CPT 90887, interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, is located in the "Other Psychiatric Services or Procedures" section of the CPT manual.

The RVU's for CPT 90887 have been redistributed to other psychiatric services. Therefore, Arkansas Blue Cross and Blue Shield and Health Advantage will consider CPT 90887 as a **NON-COVERED** code and denied as a fragmented code. Payment for CPT code 90887 will not allowed.

CPT Code 92100:

When reporting code 92100, the intent is for three or more measurements of intraocular pressure to be performed at different times of day on the same day (that is, a number of measurements separated by many hours). Serial tonometry is performed to monitor pressure over a long period of time to look for a time of day rhythm. CPT code 92100 is not to be used for the simple measurement of tonometry which is done as part of a new patient eye evaluation or return patient eye evaluation.

Payment for code 92100 is restricted to the definition of the code as written in the CPT manual. "Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)."

CPT Code 97601:

CPT 97601, removal of devitalized tissue from wound; selective débridement, without anesthesia [e.g., high pressure water jet, sharp selective débridement with scissors, scalpel and tweezers], including topical application(s) wound assessment, and instructions(s) for ongoing care, per session, was introduced into CPT manual in 2001.

At the time of the introduction of CPT codes 97601 and 97602, they were to be reported by non-physician professionals (e.g., physician assistants, nurse practitioners, enterostomal therapy nurses, wound care nurses, physical therapists) licensed to perform these procedures, and NOT reported in addition to codes 11040-11044. It would not be appropriate to report CPT code 97602 in addition to CPT code 97601 for wound care performed on the same wound on the same date of service.

CPT Changes 2002 revised the language to clarify that CPT 97601 and 97602 were intended to report the treatment provided in the course of an entire treatment session, regardless of the number of wounds or areas treated at the session.

Therefore, CPT 97601 will be listed as a **RESTRICTED** code. It will be non-covered to a physician, as the code is for non-physician providers, and physicians are instructed to bill CPT 11040-11044. CPT 97601 would be non-covered to any non-physician provider other than a physical therapist, as no other non-physician provider who is licensed to perform this service (as described above) is a contracted provider with Arkansas Blue Cross and Blue Shield or Health Advantage.

CPT Code 97602

CPT 97602 (Removal of devitalized tissue from wounds; non-selective débridement, without anesthesia [e.g., wet-to-moist dressings, enzymatic, and abrasion], including topical application(s), wound assessment, and instruction(s) for ongoing care, per session) was introduced into the CPT manual in 2001. This code is currently a "BR" code in the Arkansas Blue Cross and Blue Shield fee schedule.

CPT 97601 and 97602 are to be reported by non-physician professionals (e.g., physician assistants, nurse practitioners, enterostomal therapy nurses, wound care nurses, physical therapists) licensed to perform these procedures, and are NOT reported in addition to codes 11040-11044.

It would not be appropriate to report CPT code 97602 in addition to CPT code 97601 for wound care performed on the same wound on the same date of service. *CPT Changes 2002* revised the language to clarify that CPT 97201 and 97202 were intended to report the treatment provided in the course of an entire treatment session, regardless of the number of wounds or areas treated at the session.

CPT 97602 will be listed as a **RESTRICTED** code. It would be non-covered to a physician, as the code is for non-physician providers, and physicians are instructed to bill CPT 11040-11044. It would be non-covered to any non-physician provider other than a physical therapist, as no non-physician provider who is licensed to perform this service (as described above) is contracted with Arkansas Blue Cross and Blue Shield or Health Advantage.

CPT 97602 would be non-covered to a physical therapist as a fragmented service if billed on the same day of service as any other physical therapy code. If the code is billed as a single code, with no other billing on the same date of service, the code would be allowed by a physical therapist in a facility or non-facility setting, but the allowance would be different.

CPT Codes 99289 & 99290

CPT 99289 (Physician constant attention of the critically ill or injured patient during an inter-facility transport; first 30 – 74 minutes) and CPT 99290 (each additional 30 minutes) are new codes for 2002.

ABCBS recognizes these 2 codes for payment assuming the services meet the requirements established by Medicare for services provided under HCPCS codes G0240 and G0241. Medicare does not recognize CPT 99289 or 99290. Codes 99289 and 99290 are considered equivalent to CPT 99291 and 99292 in work, practice expense and malpractice expense. However, the AMA CPT descriptor for codes 99289 and 99290 are not equivalent to the descriptor for codes 99291 and 99292.

ABCBS requires that for CPT 99289 and 99290 to be reimbursed, all requirements for CPT 99291 and 99292 must be met except:

1) All time counted towards patient transport time must be face-to-face time spent in actual transport to be counted towards 99289 and 99290; and
2) E&M services delivered in the referring and receiving facilities may be reported under other appropriate E&M codes. If the actual transportation time is less than 30 minutes and/or the service does not meet the requirements of 99291 or 99292, then the physician may report his or her services under the appropriate E&M code (e.g., outpatient visit, emergency visit, prolonged services).

Codes J9217 and J9202:

Arkansas Blue Cross and Blue Shield allowance for Lupron (J9217) will be based on the AWP for Zoladex (J9202) effective January 1, 2003.

Federal Employee Program (FEP): Facility Claims:

When patients are seen in the outpatient facility due to an accident, please complete **Field 32** with the appropriate occurrence code and give the accident date. When claims are submitted with an accident diagnosis and do not have **Field 32** completed, the claim will be denied for the date of accident.

Federal Employee Program (FEP): Mental Health & Substance Abuse Benefits

Mental Health Benefits were changed effective January 1, 2001, due to President Clinton's executive order in June 1999 requiring all carriers that provide healthcare coverage under the Federal Employee Health Benefit Program to implement enhanced benefits for mental health and substance abuse.

In response, Arkansas Blue Cross and Blue Shield contracted with Magellan Behavioral Health (Magellan) to provide managed behavioral health services and a network of behavioral health providers for FEP members in Arkansas. Magellan contracts with the following behavioral health providers: Psychiatrist (MD), Psychologist (Ph.D.), Licensed Clinical Social Worker (LCSW), Psychiatric Nurse (RN) and Licensed Professional Counselors (LPC).

Providers interested in contracting or have questions concerning the credentialing process with Magellan Health should contact the following persons:
Professional providers - Terry Morales (423) 763-5227
Facilities - Gail Reyes (423) 763-5232

Please remember that all benefits are subject to the definitions, limitations, and exclusions in the 2002 BCBS Service Benefit Plan Brochure and are payable only when medically necessary.

What This Means for You and Your Patients:
Members with FEP coverage will either have Standard Option (enrollment code 104 or 105) or Basic Option (enrollment code 111 or 112). The member's ID cards include a Mental Health and Substance Abuse toll-free number 1-800-367-0406 for members and providers to call with questions regarding: contracting, treatment plans, prior approval or pre-certification.

Questions regarding benefits, claims status and payment should be directed to 1-(800) 482-6655 or (501) 378-2531.

To Maximize Benefits for Standard Option, Providers Must Follow These Simple Rules:

- Standard Option enrollment code 104 or 105 - Treatment plans must be submitted and approved prior to the member's ninth visit.
- Treatment plans should be submitted to:
  Magellan Health
  537 Market St., Suite 12
  Chattanooga, TN 37402.
- FEP members may choose to receive care from Non-preferred providers or from the Magellan Health network of Preferred Mental Health Substance Abuse (MHSA) providers.
- When FEP Standard Option members seek care from Magellan health Preferred mental health or substance abuse professionals for covered services who have obtained prior approval, the visit limit and other day maximums are waived and the member's out of pocket costs will be lower.
- Prior approval must be obtained for partial hospitalization or intensive outpatient therapy. Call 1-800-367-0406 before obtaining services for intensive outpatient treatment or partial hospitalization.
- Prior approval must be obtained for partial hospitalization or intensive outpatient therapy. Call 1-800-367-0406 before obtaining services for intensive outpatient treatment or partial hospitalization.

To Receive Benefits for Basic Option, Magellan Health Preferred Mental Health Providers Must Follow These Simple Rules:

- Basic Option enrollment code 111 or 112 - Treatment plans must be submitted prior to the member's first visit.
- Treatment plans should be submitted to:
  Magellan Health
  537 Market St., Suite 12
  Chattanooga, TN 37402.
- Services rendered by a Non-preferred provider are not covered.
- FEP Basic Option members must choose to receive care from the Magellan Health network of Preferred Mental Health Substance Abuse (MHSA) providers.
- When members receive care from Magellan Health Preferred Mental Health providers and prior approval has not been obtained, no benefits will be allowed.
- Prior approval must be obtained for partial hospitalization or intensive outpatient therapy. Call 1-800-367-0406 before obtaining services for intensive outpatient treatment or partial hospitalization.
- Pre-certification must be obtained for inpatient mental or substance abuse hospital services. Call 1-800-367-0406 before obtaining services for inpatient hospitalization.

Federal Employee Program (FEP): Prior Approval:

FEP will only give prior approval under Standard and Basic option for certain services. **Other than these services listed below, the Federal Employee Program will not give Prior Approval or Pre-Service review. In the past, prior approval and pre-service reviews were given for various different services. This service was done as a courtesy.**

Services include:

- Home Hospice care - Contact the case manager in your area before providing services.
- Partial Hospitalization or intensive outpatient treatment for mental health/substance abuse - Contact our vendor Magellan Health 1-800-367-0406 before obtaining services for intensive outpatient treatment or partial hospitalization.

- Organ/tissue transplants - For the following services, send a fax attention to Carolyn Webb 501-378-6647 giving medical necessity with the patients' name and identification number
  - Bone marrow, cord blood stem cell, and peripheral blood stem cell transplants support procedures.
  - Heart
  - Liver
  - Heart-lung
  - Pancreas
  - Single or double lung: only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, and emphysema
  - Double lung: only for patients with end-stage cystic fibrosis
  - Intestinal transplants (small intestine) and the small intestine with the liver or small intestine

with multiple organs such as liver, stomach and pancreas.

- Clinical trials for certain organ/tissue transplants - For the following procedures, we provide benefits only when conducted at a Cancer Research Facility and performed as part of a clinical trial that meets the requirements shown below:
  1. Contact the Blue Cross and Blue Shield Association Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services.
  2. The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered and
  3. The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial.

- Allogeneic bone marrow transplants, syngeneic bone marrow transplants, and allogeneic peripheral blood stem cell transplants for:
  - Multiple myeloma
  - Chronic lymphocytic leukemia
  - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma

- Non-myeloablative allogeneic stem cell transplants:
  - Chronic myelogenous leukemia
  - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia.
  - Advanced Hodgkin's lymphoma.
  - Advanced non-Hodgkin's lymphoma.
  - Advanced forms of myelodysplastic syndromes.
  - Multiple myeloma.
  - Chronic lymphocytic leukemia.
  - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma.
  - Renal cell carcinoma

- Autologous bone marrow transplants and autologous peripheral blood stem cell transplants (collectively referred to as autologous stem cell support) for:
  - Breast cancer
  - Epithelial ovarian cancer
  - Chronic myelogenous leukemia
  - Chronic lymphocytic leukemia
  - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma

If a non-randomized clinical trial meeting these requirements is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at another Plan-designated transplant facility.

Health Advantage:

2002 Update: Preventive Health Guidelines

The *Health Advantage Preventive Health Guidelines* have been updated for 2002. The updated guidelines will be available this fall on the Internet at www.HealthAdvantage-hmo.com.

The *Health Advantage Preventive Health Guidelines* provide plan physicians medical references as a health resource in the prevention and early detection of diseases. The list of preventive services referenced in the guidelines is not exhaustive. Clinicians may wish to add other services on a routine basis after considering the patient's medical history and other individual circumstances.

The guidelines are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. The guidelines reflect recommendations from leading authorities and local practitioners.

Health Advantage benefit coverage for guideline recommendations are defined in the individual member's benefit certificate. The member is financially responsible for services and treatment that fall outside their individual health benefit plan.

The guidelines are divided into the following categories:

- Children's Preventive Health Guidelines
- Adult Preventive Health Guidelines
- Pregnancy Preventive health Guidelines

Screening, immunizations, anticipatory guidance, high-risk sections as well as reference sources are included for each category.

HIPAA:

Special Alert on Transaction Issue – ANSI 278 Referral Certification and Authorization Transaction:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of national standards for electronic transmission of certain health care information, including pre-certification, prior authorization and referral authorization (electronic transactions for these purposes are known under HIPAA as the "ANSI 278" transaction). The compliance deadline for HIPAA transactions regulations is October 16, 2002, unless a covered entity (whether provider or insurer) applies for the one-year extension to October 16, 2003.

Because of problems and issues raised industry-wide with respect to the ANSI 278 standard transaction under HIPAA, Arkansas Blue Cross and Blue Shield and its affiliated companies, Health Advantage and The First Pyramid Life Insurance Company of America/USAble Administrators have applied for the one-year extension on HIPAA transactions compliance.

While we anticipate that Arkansas Blue Cross and Blue Shield and affiliated companies will be ready with full HIPAA transactions compliance on the other standard electronic transactions mandated by HIPAA (including regular claims submission, claims status inquiries, etc.), we will *not* implement the ANSI 278 standard transaction until the extended deadline of October 16, 2003.

Please be advised that for pre-certification of hospital admissions, prior authorizations of medical necessity for services, or referral authorizations (where required under the Member's health plan) Arkansas Blue Cross and Blue Shield and its affiliated companies will **NOT** be accepting or responding to any electronic 278 transmissions until October 2003.

In the meantime, until October 16, 2003 (or further notice from us), please continue to pre-certification, prior authorizations or referral information utilizing the current process. If you attempt to send any ANSI 278 electronic inquiry to Arkansas Blue Cross and Blue Shield prior to October 16, 2003, please be aware that it will NOT be a valid inquiry and may not even be capable of being identified or acknowledged due to systems incompatibility.

Any provider/billing agent who wants to begin sending HIPAA formatted transactions on or after 10/16/2002, should contact the Electronic Data Interchange (EDI) department at (501) 378-2417 or toll free (866) 582-3247 to arrange for testing, contract execution and security arrangements, prior to engaging in HIPAA transaction exchange.

HIPAA:
What You Need To Do:

In 1996, Congress passed into law the *Health Insurance Portability and Accountability Act* (HIPAA). This act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. This law enables the entire health care industry to communicate electronic data using a single set of standards.

HIPAA means three things: security, privacy and transactions. Health care providers and suppliers, who conduct business electronically, are urged to consider what steps need to be taken to update their software to conform to the new standards outlined by HIPAA.

The EDI Services of Arkansas Blue Cross and Blue Shield is now accepting HIPAA electronic claims test files and urges you to contact your software vendor, clearinghouse, or billing agent to inquire regarding HIPAA compliance. If a provider utilizes a clearinghouse, the clearinghouse will send the test file to Arkansas Blue Cross and Blue Shield; the same process is applicable for a provider using a billing agent.

If you are ready to begin HIPAA testing for electronic claims filing, please contact EDI Services at (501) 378-2419 or toll free at 1-(866) 582-3247 for a testing schedule and ask about the Arkansas Blue Cross and Blue Shield *HIPAA X12 User's Guide*. The HIPAA Test Schedule must be completed and returned to EDI Services before testing can begin.

All providers, billing services, and clearinghouses must test the HIPAA compliant format (4010-837) transactions, before moving into production. Because of the volume of tests to review, EDI Services may not be able to provide in-depth assistance for test results. We will let providers know what errors were detected at the segments and loop levels via a 997 functional acknowledgement.

If a submitter has any question if they will be compliant with the HIPAA requirements by the deadline of October 15, 2002, a bill has been passed that allows for an extension. In 2001, President Bush signed into law H.R. 3323, the *Administrative Simplification Compliance Act*.

This law provides a one-year extension for electronic claims submitters to comply with the HIPAA standard transactions and code set requirements from October 16, 2002, to October 16, 2003. This extension is for any covered entity that submits to the Secretary of Health and Human Services a plan of how the entity will come into compliance with the requirements by October 16, 2003.

A model compliance plan and instructions on how to complete and submit a plan may be obtained at www.cms.hhs.gov/hipaa. Arkansas Blue Cross and Blue Shield strongly encourages you complete and submit an extension form. The deadline for filing the extension form is October 15, 2002.

Effective October 16, 2002, all *new* EDI electronic claims submitters not using a current ABCBS EDI Services

approved billing service, clearinghouse, vendor, or software package, who request to begin exchanging inbound EDI claim transactions with ABCBS, must use the HIPAA compliant format.

Once a provider has successfully completed testing the HIPAA compliant format, each entity must complete and return a Trading Partner Agreement (TPA). The TPA covers how each entity will maintain, store, and transmit personal health information. Once EDI Services of Arkansas Blue Cross and Blue Shield receives your TPA and you have passed HIPAA testing, we can then move you into production.

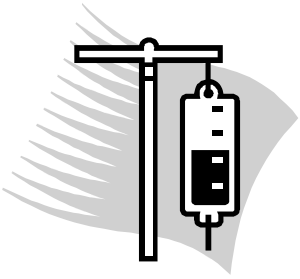
You may find resources and information available at:

- www.aspe.hhs.gov/admnsimp
- www.snip.wedi.org
- www.wpc-edi.com/hipaa
- www.hipaa-dsmo.org

Or, call the HIPAA Administrative Simplification Hotline at (410) 786-4232.

Home Infusion Therapy Contracts:

Arkansas Blue and Cross Blue Shield, Arkansas' FirstSource®, and Health Advantage distributed updated home infusion therapy service (HITS) provider contracts on August 30, 2002. These revised contracts include new contract language as well as incorporate the use of "S codes".



Currently, HITS contracts require the use of local, "home-grown" codes that are not HIPAA compliant and they are being replaced with HCPCS codes that begin with "S." Along with this new coding structure comes a revised pricing schedule. Arkansas Blue Cross and Blue Shield and its affiliates have a targeted goal of eliminating all local codes by December 2002.

The HITS contracts should be signed and returned by November 1, 2002 and have an effective date of December 1, 2002. If you are providing home infusion / home IV therapy services (not Home Health Agencies) and have not received this revised contract, please contact Provider Network Operations at (501) 378-2006.

International "CIO-100 Award" for Technology and Process Integration:

Arkansas Blue Cross and Blue Shield recently received the prestigious "CIO-100 Award" from *CIO* (Chief Information Officer) magazine. The 2002 "CIO-100 Award" recognizes organizations around the world that excel in positive business performance through integrated technologies and processes.

Arkansas Blue Cross and Blue Shield was named among the "best of the best." Other U.S. companies receiving the award include: The Charles Schwab Corporation, Cisco Systems, Dell Computer Corporation, The Dow Chemical Company, Duke Energy, FedEx Corporation, General Electric Company, General Motors Corporation, Goodyear Tire and Rubber Company, IBM Corporation, Lands' End Inc., Nestle USA, Proctor and Gamble Company, UPS, and Wal-Mart Stores Inc. Internationally, there were three honoree companies from North America, three from Europe and one from the Pacific Rim. Arkansas Blue Cross and Blue Shield was one of four companies from the health care industry.

The focus of the "CIO-100 Award" changes annually to provide a vision of ever-changing business trends. This year, *CIO* honors 100 companies that demonstrate "integration" - integrated technologies and procedures to improve products, services and relationships with partners and clients. Companies receiving the award have established uniform, integrated technologies and processes across their enterprise.

"We are thrilled to be a recipient of the 2002 'CIO-100 Award,'" said Robert L. Shoptaw, chief executive officer of Arkansas Blue Cross. "The award acknowledges the successful culmination of almost seven years of a major Information Technology (IT) investment strategy supporting the overall strategic direction of our company. For a company to be successful in today's business environment, it is imperative that it initiates long-term strategies to anticipate and meet customer needs for the future. Information Technology is a means by which the big picture comes into focus for our enterprise and connects all of our operations."

A pivotal component of the Arkansas Blue Cross and Blue Shield "enterprise connectivity" is the new Customer Service Workstation (CSW), which links the company with its affiliates and subsidiaries to integrate the customer services departments of Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Administrators. This results in a single source and single application to answer inquiries across the enterprise. Other departments, including claims,

underwriting, marketing, and management, use the system to receive, route, and resolve customer inquiries through a workflow enabled system.

"The last major project of a multi-year IT integration strategy for Arkansas Blue Cross and Blue Shield was our Inquiry Tracking System and CSW," said Joseph S. Smith, vice president of Private Programs and chief information officer. "The completion of these two projects allows Arkansas Blue Cross and Blue Shield to provide a best-in-class 'customer care center,' addressing the service needs of all customers by supplying customer and patient data in a secure, consistent, and timely manner."

"All inquiries are integrated and tracked through the Inquiry Tracking System, no matter the source (members, groups, physicians, hospitals, other providers) or the form of contact (telephone, letter, e-mail, fax)", said Smith. "Data is accessed from 16 systems, operating on two technology platforms, representing three distinct businesses within the enterprise. Our customer service representatives become 'universal agents' for our customers to handle their inquiries," said Smith.

Prior to this "capstone" project, Arkansas Blue Cross and Blue Shield had placed into production a number of integration-oriented IT systems directed at better serving its customers and providers, including:

- Advanced Health Information Network (AHIN),
- A paper claims Imaging and Optical Character Recognition (OCR) capability,
- Consolidation of backroom operations down to two processing platforms, and
- A major technical infrastructure upgrade.

The recipients of this year's "CIO-100 Award" were selected through a three-step process. First, companies were nominated by industry organizations to fill out an online application form. In addition, *CIO* magazine staff and members of its expert panel nominated companies they deemed best fit the award criteria. A team of *CIO* editors and writers reviewed the application forms and expert recommendations and voted on the final 100. The judging objectives were to recognize positive business performance through integrated technologies and procedures.

Complete coverage of the 2002 "CIO-100 Award" is featured in the August 15, 2002 issue of *CIO* magazine and at www.cio.com.

Modifier – 25:

The Modifier–25 is appended to an Evaluation and Management service (E&M) done on the same day as a surgical procedure with a 0 or 10-day global period when a separately identifiable E&M service is provided.

The use of this modifier is appropriate in two circumstances:

1) The physician is required to do an evaluation of a symptom or sign of a separate problem unrelated to the surgical procedure; or
2) The patient's condition necessitating the surgical procedure requires a separately identifiable E&M service beyond the usual pre- and postoperative care associated with the procedure. Medical record documentation must include information to support the use of Modifier–25.

Medical records from physicians in several different specialties who frequently use Modifier–25 have been reviewed in the past few months. The majority of records would not qualify for additional payment for the E&M service based on the above definition.

E&M services billed with a Modifier–25 must be rendered for a service outside the realm of the surgical procedure done on the same date of service. This E&M service must have all of the components of an E&M service billed without the modifier and must be clearly documented in the medical record.

Multiple Surgery Payment Policy:

For Physician services only: Arkansas Blue Cross and Blue Shield will allow the lower of the submitted charge or 100% of the fee schedule amount for the first surgical procedure (the procedure with the highest RVU) and 50% for the 2nd through 5th surgical procedures. Subsequent procedures will be paid on a "by review" (BR) basis. This policy would apply to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice.

The above payment policy does not apply to those CPT codes that are identified with the symbol "Ç" (add-on codes) or to those codes that are identified with "x" (Modifier – 51 exempt).

Physical Therapy/Occupational Therapy:

Effective 1/1/02, Arkansas Blue Cross and Blue Cross benefits for physical and occupational therapy were changed to an aggregate of 45 visits per member, per calendar year. This change was made to both **GROUP** and **INDIVIDUAL** contracts.

However, it only applies to new contracts effective on or after January 1, 2002 for **INDIVIDUAL** business. Benefits will remain the same, with no maximum, for Individual contracts with effective dates **PRIOR** to January 1, 2002.

PHARMACY:
Three-Tier Formulary Changes:

The three-tier pharmacy copay concept has grown to now cover 90% of all Arkansas Blue Cross Blue Shield and Health Advantage groups. Rising pharmacy expenditures which are based on increasing prescription utilization by members and soaring drug costs continue to be a primary factor contributing to current premium increases. The three-tier copay becomes an attractive method to better align the member's coinsurance to the cost and preferred status of a particular medication.

To lessen confusion, Arkansas Blue Cross and Blue Shield is attempting to make changes only once a year (during October) between the second and third tiers for three-tier copay plans except in the following situations:

- When a single source medication loses its patent protection and a generic becomes available, the brand name medication is moved to the third-tier at that time.
- When a new medication is approved by the FDA and becomes available, a decision is made regarding whether to place the medication in the second or third-tier.

Effective **October 15, 2002,** Arkansas Blue Cross Blue Shield and Health Advantage will implement some medication changes from second-tier status to third-tier. For more information regarding the changes, you can access the Arkansas Blue Cross and Blue Shield website at www.ArkansasBlueCross.com or the Health Advantage website at www.HealthAdvantage-hmo.com

PHARMACY:
Medication Changes:

The following medications will move to the third-tier effective **October 15, 2002:**

Aggrenox	Mirapex
Albenza	Mycobutin
Aldara	Neurontin
Ancobon	Nolvadex
Asacol	Oxycontin
Avinza	Pancrease MT
Biaxin/Biaxin XL	Patanol
Cortenema	Pentasa
Declomycin	Potaba
Depakote/Depakote ER	Prandin
D.H.E. 45	Risperdal
Dovonex	Roxicodone
Duoneb	Suprax
Duragesic	Tambocor
Famvir	Trizivir
Gabitril	Urecholine
Glucophage XR	Vesanoid
Hexalen	Winstrol
Lamictal	

Respiratory Syncytial Virus (RSV) Season:

Benefits are available for coverage of Respiratory Syncytial Virus (RSV) Antibody, SYNAGIS (Palivzumab).

Synagis is FDA approved for the prevention of serious lower respiratory disease caused by RSV in pediatric patients at high risk for RSV disease. Safety and efficacy of Synagis were established in a randomized, placebo-controlled trial of RSV disease prophylaxis among high-risk pediatric patients.

This trial conducted at 139 centers in the U.S., Canada, and the United Kingdom, studied patients less than or equal to 24 months of age with bronchopulmonary dysplasia, and patients with premature birth (less than or equal to 35 weeks gestational age). The safety and efficacy of Synagis have not been demonstrated for treatment of established RSV disease.

Patients should receive monthly doses throughout the RSV season. The first dose should be administered prior to commencement of the RSV season. In the

Northern Hemisphere, the RSV season typically commences in November and lasts through April. No clinical data is available from human subjects who have received more than 5 monthly Synagis doses during a single RSV season.

Recent studies performed at Arkansas Children's Hospital and reported to Arkansas Blue Cross and Blue Shield indicates that the RSV season begins in November and ends in April, but this may vary depending on the year (i.e., some years the season may begin in October and end in March).

Arkansas Blue Cross and Blue Shield covers Synagis for a six-month period beginning in the Fall. We do not determine when the provision of the drug should begin, but the drug is covered for only a six-month period.

Those clinical conditions for Synagis are as follows:

- Infants less than two years of age who have chronic lung disease (CLD) who have required medical therapy for their CLD within six months before the anticipated RSV season (any 6 month period beginning in the fall and ending in the spring).
- Infants with a history of prematurity (32 weeks or less gestational age).
- Children born between 32 and 35 weeks with additional risk factors:
  - — Neurologic disease in very low birth weight infants;
  - — Number of young siblings;
  - — Day care center attendance;
  - — Exposure to tobacco smoke at home;
  - — Anticipated cardiac surgery.
- Infants less than two years of age who have chronic lung disease (CLD) who have required medical therapy for their CLD within six months before the anticipated RSV season and/or infants with a history of prematurity (32 weeks or less gestational age) who also have asymptomatic, acyanotic CHD.

Medical necessity documentation must be submitted for prior authorization through the Medical Audit Review department at (501) 378-2414.

Synagis injections can be provided to your office for administration through our specialty medication network pharmacy program, **AdvancePCS SpecialtyRx**™. **AdvancePCS SpecialtyRx**™ is a full-service specialty pharmaceutical provider offering Synagis supply with expert pharmaceutical care management services such as compliance and caregiver education. In addition, **AdvancePCS SpecialtyRx**™ provides claims processing and claims assistance for the member so there is less paperwork for you and your staff. **The member can maximize benefits by obtaining Synagis through AdvancePCS SpecialtyRx**™.

As a reminder, if the member utilizes an out-of-network pharmacy provider, this may result in a substantial out-of-pocket responsibility for the member. Members are liable for amounts in excess of the Allowable Charge billed by Non-plan Providers. The member may reference their Evidence of Coverage for more information or contact their local Customer Service Department.

Three Steps for Ordering Synagis:

1. Review the Coverage Criteria on the **AdvancePCS SpecialtyRx**™ form mailed to your office.
2. Prior Authorization through Medical Audit and Review by calling (501) 378-2414.
3. Complete **AdvancePCS SpecialtyRx**™ Patient Referral Form: SYNAGIS (palivzumab). Fax completed form to Medical Audit Review Services at (501) 378-6674.

To Find Out More About Synagis:

If you have questions or need more information regarding Synagis, please call the toll-free **AdvancePCS SpecialtyRx**™ Customer Service line at 1-(866) 295-2779. For your convenience, **AdvancePCS SpecialtyRx**™ is available Monday through Friday, 7a.m. - 5 p.m. CDT.

Top 10 Things To Know About Health Care Fraud

Did you know health care fraud costs American consumers as much as $1 out of every $7 spent on health care? The National Healthcare Anti-Fraud Association estimates fraud costs Americans about $33 billion to $55 billion annually. That's about 3 to 5 percent of the nation's health care spending.

Blue Cross and Blue Shield Plans saved nearly $250 million last year through aggressive health care fraud investigations, improved coordination, and increased information sharing between private and public law officials.

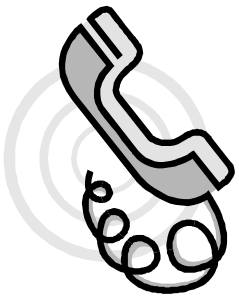
In order to help consumers combat this problem, the Blue Cross and Blue Shield Association is educating the public with a booklet about health care fraud. In it, Blue Cross and Blue Shield Association notes that the majority of people who work in the health care system are honest. However, consumers should be aware of some common schemes, including:

- **Phantom billing –** Charging for services never performed or using real patient names and health insurance information as the basis for fabricating claims.
- **Upcoding –** Charging for a more expensive service such as a visit to a physician when the patient actually saw a nurse or a physician assistant.
- **Doctor shopping –** Bouncing from one doctor to another in order to obtain multiple prescriptions for controlled substances.
- **Providing unnecessary care –** This includes unnecessary tests, surgeries, and other procedures.
- **Misrepresenting services –** Performing uncovered services, but billing insurance companies for different services that are covered.
- **Unbundling –** Charging separately for procedures that are actually part of a single procedure.
- **Masquerading as healthcare professionals –** Delivering health care services when they are not licensed to do so.

Here are some tips on what consumers can do if they suspect health care fraud:

- **Recognize health care scams –** When it sounds "too good to be true," it probably is. Consumers should be cautious of free medical examinations, co-payment waivers, or advertisements stating "covered by insurance."
- **Treat your healthcare card like your credit card –** If lost or stolen, a healthcare card could be used to gain access to prescriptions and services that may permanently appear on your medical history.
- **Closely examine your "Explanation of Benefits" from your health insurer –** Be sure the service billed was the service received when you or a member of your family visited a health care provider. If there is a discrepancy, call the provider first. In most cases, the discrepancy is a clerical error. However, if you are unable to resolve the matter, contact your health plan immediately.

Arkansas Blue Cross and Blue Shield has established a fraud hotline for consumers, physicians, or employees to report possible fraud. The Fraud Line is a completely confidential and professional service for reporting any issues or concerns regarding possible fraud. To report any violations, issues, or concerns, call the Fraud Hot Line toll-free at 1(800) FRAUD21 or (800) 372-8321.



USAble Administrators:
Adopts New "Blue" Name

To better identify USAble Administrators as a Blue Cross and Blue Shield affiliated company that provides third-party administrative services to Arkansas companies and their employees, the company is changing its name in mid-November to BlueAdvantage Administrators of Arkansas.

Only the name is changing. Everything else – customer service, staffing, addresses, phone, and fax numbers – will remain the same. Replacement I.D. cards bearing the new name and logo will be reissued to members later this year and in early 2003.

The USAble Administrators Web site, currently found at www.USAbleAdminArkansas.com, will change to www.BlueAdvantageArkansas.com in mid-November. Both the new and old Web site addresses will take you to many helpful services found on this site.

USAble Administrators is Arkansas' largest third-party administrators, serving more than 120,000 employees and their family members. The company processes claims and administers enrollment, as well as benefits, for self-funded groups. Each self-funded group provides the funds from which its employee's claims are paid. The company is an independent licensee of the Blue Cross and Blue Shield Association and is licensed to offer administrative services in all 75 counties in Arkansas.

BlueAdvantage
Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

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
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Little Rock AR 72203
Email: krgreen@arkbluecross.com

CPT CODE CHANGES:

CHANGES EFFECTIVE JULY 1, 2002:

Effective July 1, 2002 the following updates have been made to the Home Health Agency fee schedule.

Code	Description	Previous Allowance	Office Allowance	Site of Service Allowance
Y9121	Aide, per visit	$ 32.00	$ 35.00	$ 35.00
Y9125	RN, per visit	$ 87.00	$ 95.00	$ 95.00
Y9126	LPN, per visit	$ 50.00	$ 53.00	$ 53.00

Fee Schedule Updates:

Previously "BR" Codes:

CPT/HCPCS	TOTAL OFFICE	TOTAL OFFICE PROF	TOTAL OFFICE TECH	TOTAL SOS	TOTAL SOS PROF	TOTAL SOS TECH
26587	$ 1,152.36			$ 1,152.36		
35685	$ 347.35			$ 347.35		
35686	$ 287.32			$ 287.32		
36540	$ 10.00			$ 10.00		
44203	$ 378.82			$ 378.82		
67225	$ 70.52			$ 67.60		
82608	$ 29.70	$ 2.08	$ 27.62	$ 29.70	$ 2.08	$ 27.62
83890	$ 8.31	$ 0.58	$ 7.73	$ 8.31	$ 0.58	$ 7.73
83892	$ 8.31	$ 0.58	$ 7.73	$ 8.31	$ 0.58	$ 7.73
83894	$ 8.31	$ 0.58	$ 7.73	$ 8.31	$ 0.58	$ 7.73
83896	$ 8.31	$ 0.58	$ 7.73	$ 8.31	$ 0.58	$ 7.73
83898	$ 34.76	$ 2.43	$ 32.33	$ 34.76	$ 2.43	$ 32.33
83902	$ 29.42	$ 2.06	$ 27.36	$ 29.42	$ 2.06	$ 27.36
83912	$ 8.31	$ 0.58	$ 7.73	$ 8.31	$ 0.58	$ 7.73
83916	$ 41.69	$ 2.92	$ 38.77	$ 41.69	$ 2.92	$ 38.77
86294	$ 23.93	$ 1.68	$ 22.25	$ 23.93	$ 1.68	$ 22.25
87338	$ 9.51	$ 0.67	$ 8.84	$ 9.51	$ 0.67	$ 8.84
87539	$ 34.14	$ 2.39	$ 31.75	$ 34.14	$ 2.39	$ 31.75
90471	$ 6.41			$ 6.41		
90472	$ 6.41			$ 6.41		
91123	$ 43.12			$ 43.12		
92973	$ 280.91			$ 280.91		
92974	$ 317.04			$ 317.04		
97602	$ 105.60			$ 12.71		
99002	$ 30.00			$ 30.00		
99100	$ 42.00			$ 42.00		
99116	$ 210.00			$ 210.00		
99135	$ 210.00			$ 210.00		
99140	$ 84.00			$ 84.00		
99173	$ 12.22			$ 12.22		
99289	$ 252.56			$ 252.56		
99290	$ 126.28			$ 126.28		
99361	$ 50.00			$ 50.00		
99362	$ 80.00			$ 80.00		

Anesthesia Codes:

CPT/HCPCS	TOTAL OFFICE	TOTAL OFFICE PROF	TOTAL OFFICE TECH	TOTAL SOS	TOTAL SOS PROF	TOTAL SOS TECH
00548	17			17		
00634	25			25		
00635	4			4		
00797	10			10		
01112	5			5		
01215	10			10		
01916	6			6		
01922	7			7		
01924	6			6		
01925	8			8		
01926	10			10		
01932	7			7		
01933	8			8		
01953	1			1		
01963	10			10		
01968	3			3		
01969	5			5		

New HCPCS/DMERC Codes Effective April 1, 2002:

CPT/HCPCS	TOTAL OFFICE	TOTAL OFFICE PROF	TOTAL OFFICE TECH	TOTAL SOS	TOTAL SOS PROF	TOTAL SOS TECH
K0561	3.36			3.36		
K0562	5.68			5.68		
K0563	8.91			8.91		
K0564	BR			BR		
K0565	6.15			6.15		
K0566	8.94			8.94		
K0567	2.57			2.57		
K0568	3.74			3.74		
K0569	5.44			5.44		
K0570	4.89			4.89		
K0571	5.93			5.93		
K0572	0.09			0.09		
K0573	0.36			0.36		
K0574	0.46			0.46		
K0575	0.28			0.28		
K0576	0.28			0.28		
K0577	0.28			0.28		
K0578	0.53			0.53		
K0579	0.12			0.12		
K0580	0.35			0.35		