march 2012

providers' news

A publication for participating providers and their office staffs

inside

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.

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

AADE accepted for diabetes self management training

Arkansas Blue Cross and Blue Shield and Health Advantage, along with BlueAdvantage Administrator self funded employer groups have covered Diabetes Self Management Training (DSMT) for quite some time. Per Arkansas Law ACA 23-79-601, the coverage is for one DSMT program. Additional programs may be covered if a member's symptoms or conditions change significantly.

Arkansas Law ACA 23-79-601, also known as Rule 70, indicates the program must be in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association. Effective March 1, 2012 Arkansas Blue Cross and its family of companies will also accept DSMT programs accredited by the American Association of Diabetic Educators (AADE) as being eligible for reimbursement. This reimbursement applies to programs, not individuals certified by AADE.

AADE calls its accreditation the Diabetic Education Accreditation Program (DEAP) and a list of accredited programs may be found at: http://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html

Programs accredited in DEAP who have not been receiving reimbursement by Arkansas Blue Cross and its family of companies will need to complete a provider application and provide proof of accreditation in order to be reimbursed.

Please contact your regional Network Development Representative for further details. A list of representatives is located on the Provider page of the Arkansas Blue Cross Web site at arkbluecross.com.

See related article in the March 2011 edition of *Providers' News* .

Skin and soft tissue substitutes

Arkansas Blue Cross and Blue Shield has noted an increase in utilization of bioengineered skin and soft tissue substitutes for the treatment of chronic ulcers and intra-operative placement for tissue reinforcement. There are many similar products or products that serve the same purpose, some have FDA approval, others do not and some do not require approval for marketing. There are specific HCPCS codes for many of the products and there are CPT codes for their usage.

Arkansas Blue Cross has established a coverage policy, 2012009, for bioengineered skin and soft tissue substitutes that provides coverage, based on member certificate of benefit Primary Coverage Criteria, for those products and indications for which the most information about safety and efficacy is available. There are very few head-to-head trials that report comparisons of different products, although that information would be most helpful. The Agency for Health Care Research and Quality released a draft of a Technology Assessment for Skin Substitutes for Treating Chronic Wounds in December 2011. They found the evidence base for any of the devices to be of low overall strength. Additional information from this document will be included in the coverage policy when the assessment is finalized but that time frame is unknown.

This policy, as well as all other coverage policies, is available at: http://www.arkansas-bluecross.com/members/coverage_policy_disclaimer.aspx?header_image=providers

While available online, this policy is not currently active. Arkansas Blue Cross is soliciting provider comments about this policy and would appreciate submission of any relevant clinical data not referenced in the policy within the next 60 days. Comments may be faxed to 501-378-2855 or emailed to dmlipin@arkbluecross.com. No individual responses will be made to submissions but all information gathered will be reviewed. Arkansas Blue Cross plans to activate this policy on July 1, 2012.

2012 spring provider workshops

Providers interested in attending one of the workshops listed below should contact their Network Development Representative for registration instructions.

Central Region:
North Little Rock
Wyndham Hotel
Thursday, April 12

Morning session:
Registration 8:00 – 8:30 a.m.
Workshop 8:30 – 11:00 a.m.

Afternoon session
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 4:00 p.m.

Northeast Region:
Jonesboro
St. Bernard's Medical Center
Auditorium
Friday, May 18

Morning session:
Registration 8: 00 – 8:30 a.m.
Workshop 8:30 – 11:30 a.m.

Afternoon session:
Registration 12:30 – 1:00 p.m.
Workshop 1:00 – 4: 00 p.m.

Northwest Region:
Mountain Home
Baxter Regional Medical Center
Lagerborg Conference Room
Friday, April 20
Registration 8:00 – 8:30 a.m.
Workshop 8:30– 11:30 a.m.

Northwest Region:
Springdale
Jones Center for Families
Rooms 226-227
Thursday, April 19
Registration 8:00 – 8:30 a.m.
Workshop 8:30– 11:30 a.m.

South Central Region:
Hot Springs
National Park Community College
Martin Eisele Auditorium
Thursday, May 17
Registration 12:30 – 1:00 p.m.
Workshop 1:00 – 4:30 p.m.

Southeast Region:
Pine Bluff
Harbor Oaks
Tuesday, April 17
Registration 8:30 – 9:00 a.m.
Workshop 9:00 a.m. – Noon

Southwest Region:
Texarkana
Christus St. Michael Medical Center
North Conference room
Thursday, May 10
Registration 1:00 - 1:30 p.m.
Workshop 1:30 - 4:30 p.m.

West Central Region:
Fort Smith
Sparks Regional Medical Center
Sheffield Center
Friday, May 4
Registration 8:00 – 8:30 a.m.
Workshop 8:30 a.m. – Noon

If you have questions regarding a workshop in your area, contact your Network Development Representative.

ABC accreditation accepted for network durable medical equipment providers

The American Board for Certification's (ABC) accreditation for durable medical equipment will now be accepted for participation in the Health Advantage HMO provider network, USAble Corporation's Arkansas' FirstSource®, and True Blue PPO networks. This network standard revision will be effective March 1, 2012.

More details about ABC DME accreditation may be found at www.abcop.org/accreditation/DMEAAD/Pages/Default.aspx

Any durable medical equipment /home medical supply provider with "bricks and mortar" in Arkansas that has ABC durable medical equipment accreditation and would like to join the HMO or PPO provider networks, should contact their respective regional Network Development Representative. A list of representatives may be found at www.arkbluecross.com

Electronic corrected claims are accepted

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, FEP and BlueCard accept electronic corrected claims. What is a corrected claim? A corrected claim is one that has been previously submitted for processing and has been finalized and reported on the provider's remittance advice.

Electronic Submission: To file corrected claims electronically for the CMS 1500 claim form, providers should enter the number 7 in 2300/CLM05-3 and include the ICN number or BlueCard SCCF# of the original claim. The original ICN or SCCF# (Document Control Number - DCN) should be placed in the REF segment of the Loop 2300 with a qualifier of Ref01=F8. If these are not submitted the claims will be returned as a duplicate. Providers need to ask their software vendor to open an area within the 2300 loop for the remarks in the NTE segment as to what was corrected on the claim. In order to expedite processing time and identify the actual corrections and the reason for the correction for both facility and professional corrected claims, Arkansas Blue Cross would appreciate receiving a total replacement claim in order for a complete comparison to the original claim along with the explanation in the NTE segment. To file corrected claims electronically for the UB claim form, the facility will need to use XX7 type of bill.

If you have questions regarding corrected claims, please contact Customer Service at: AHIN Customer Support: (501) 378-2336 EDI (501) 378-2419

NOTE: This article was originally printed in the June 2007 and March 2009 issue of Providers' News

EFT Requirement

Electronic Funds Transfer (EFT) or direct deposit will be required of all participating providers of Arkansas Blue Cross and Blue Shield's Preferred Payment Plan (PPP), Health Advantage's HMO network and USAble Corporation's Arkansas' FirstSource© PPO and True Blue PPO network effective October 1, 2012. This will be a requirement in order to participate in these provider networks beginning October 1, 2012. Dental providers will not be included at this time.

Implementing EFT will begin as follows:

1. Beginning January 1, 2012, all new provider applicants will be required to enroll in EFT, regardless of whether this is a new clinic or an existing practice. For example, if a new physician is applying to participate in any of the networks mentioned previously, and the physician is applying to join an already established clinic, that clinic must be paid via EFT.
2. Beginning January 1, 2012, all providers making a change to any of their information will be required to enroll in EFT. For example, a physician's office needs to change a telephone number within its clinic and submit a change of data form. That change will not be made until the clinic has enrolled in EFT.
3. All participating providers must be enrolled into EFT by October 1, 2012 (excluding dental).

EFT enrollment may be completed on the Advanced Health Information Network (AHIN) or contact your regional Network Development Representative. See the "Claims Payments, Refunds & Offsets" section of the Arkansas Blue Cross Provider Manual at arkansasbluecross.com/providers

Article originally printed in the September 2011 issue of *Providers' News.*

Credentialing standards updates for all networks sponsored by Health Advantage and USAble Corporation

Effective February 16, 2012 the following categories of the networks' credentialing standards for all eligible disciplines have been deleted or revised as follows:

Deleted Standard:
The following standard and associated language is deleted entirely:

State Disciplinary Board/Commission: Disciplinary board action(s) or ongoing sanction(s) are considered to be an issue and must be reviewed by the Credentialing Committee to determine if the practitioner's behavior warrants network restriction, termination, or exclusion. Disciplinary board action(s) include but are not limited to complaints, allegations, or findings regarding sexual misconduct; violations of laws regulating the possession, distribution and control of scheduled drugs; quality of care issues; etc. The foregoing standard shall not preclude USAble Corporation from acting immediately or without Credentialing Committee review as deemed appropriate in its sole discretion with respect to any past or pending disciplinary hearing, action or matter.

Revised Standards:
The following revised standards and their associated language were added to the credentialing standards:

License and Disciplinary Status:
All wording under this heading is deleted and replaced with the following new wording, under the new heading of "License": "All participating practitioners must hold and maintain continuously a current, active and unrestricted license (or licenses, if more than one is required under applicable law or regulation) to practice in the state(s) where the practitioner conducts any medical practice or delivers any health care services, as determined by the applicable disciplinary board or licensing or oversight agency. License restrictions in other states or countries (i.e., states other than the state where a practitioner currently conducts any medical practice or delivers any health care services) may be considered in applying these license standards."

Alcohol or Drug Abuse:
The heading for this standard is revised to refer to "Use or Abuse of Drugs, Alcohol or other Substances" and the wording of this standard is revised to read: "Practitioners shall not use illegal drugs or substances, and shall not abuse alcohol or legal drugs. Practitioners whose use or abuse of any drug or substance, whether legal or illegal, interferes with or impairs their ability to practice medicine or deliver health care services in accordance with accepted standards of care, leads to a lapse in quality, competency or professionalism, or poses a risk to the health or safety of any patient or the public, may be excluded from network participation until such time as they can demonstrate adequate rehabilitation and assurance of appropriate conduct. At a minimum, any practitioner exhibiting substance abuse problems or impairment due to legal or illegal use of alcohol or drugs must establish that he or she has enrolled in a recognized, supervised treatment program approved by the Arkansas State Medical Board or the practitioner's equivalent licensing authority, and must show full compliance with the requirements of any such treatment program. The network-sponsoring organizations may require a minimum period of successful participation in a treatment program before an impaired practitioner is eligible for admission or reinstatement to network participation."

Consumer transparency: helping patients make value-based decisions

As a health insurance company and part of the health care community, it is the responsibility of Arkansas Blue Cross and Blue Shield to deliver information and transparency tools to help make informed and value-based health care decisions. As a provider, you can help direct your patients to these tools, which can help other patients gain valuable information about your practice.

We are a committed partner in the Blue National Transparency Initiative and are actively sharing information about health care services with other Blue Cross and Blue Shield plans throughout the country. The following are examples of consumer transparency tools Arkansas Blue Cross is actively providing to our members:

- **Blue Distinction:** This designation is given to health care facilities that have demonstrated expertise in delivering quality health care in a specific area. The program is raising the bar on patient safety and adding an important new cost-of-care dimension to enhance the program's value to our members. Blue Distinction facilities are identified on the Blue Cross and Blue Shield Association Web site, and on the Web sites of the Blue plan where they are located.
- **National Consumer Cost Tool:** This tool, available now on our member self-service Web sites for Arkansas Blue Cross, Health Advantage and BlueAdvantage Administrators of Arkansas members, gives access to estimated costs for common medical procedures at local health care facilities. Your patients can estimate treatment costs by selecting a category, a medical procedure or service and then entering a ZIP code. The calculator will estimate the cost of that procedure at health care facilities nearest them. It also gives easy to understand descriptions of all of the procedures and definitions. All Blue Cross and Blue Shield plans currently display this information on their Web sites.
- **Patient Review of Doctors**: In mid-January, a patient review of doctors tool went live on our secure member self-service Web sites for members of Arkansas Blue Cross and Health Advantage. These members now have the ability to review a recent visit to a doctor on a consistent rating scale (one to five stars) and provide comments. By July, BlueAdvantage members as well as members of Blue Cross and Blue Shield plans throughout the United States will be able to review doctors. All reviews nationwide (including Arkansas doctors) will be available for viewing through the Blue National Doctor & Hospital Finder later this year. Arkansas doctors will be able to review their patient ratings (if any are available) through the "Find a doctor" directory in May.
- **Blue National Doctor & Hospital Finder:** The national online doctor and hospital finder is an easy-to-use tool that features logistical information on doctors and hospitals throughout the United States as well as quality-based recognition of both doctors and hospitals, an outline of specialties and affiliations and in-depth patient reviews of hospitals nationwide.
- **Physician Quality Measures:** Beginning in July, all Blue plans will be required to submit and display up to 20 physician performance measures to assist members in selecting a doctor. These measures will be displayed in the Blue National Doctor & Hospital Finder by July 2012, as well as the Arkansas "Find a doctor" directory by January 2013.
- ***Blue Physician Recognition:*** This is a new national program that will display physician quality improvement and recognition information to Blue Cross and Blue Shield plan members. This information will be displayed in the Blue National Doctor & Hospital Finder by January 2013.

The move toward consumer transparency is one that should make health care easier to understand, easier to access and will give your patients a better understanding of the choices available within the health care system.

Initial hospital visits billed by multiple physicians

There have been several instances in which more than one physician has been billing initial hospital care with CPT codes 99221-99223 for the same patient on the same date of service. The CPT instructions for these codes indicate that the admitting physician should bill this code for the first inpatient encounter. For initial encounters for the same patient by physicians other than the admitting physician, the appropriate level of codes for subsequent hospital care (CPT codes 99231-99233) should be utilized. (The CPT references consultation codes, however consultation codes were no longer accepted as of April 1, 2010.)

The December 2010 edition of *Provider's News* instructed the admitting or attending physician to use modifier AI for identification purposes when billing initial hospital care codes. The use of the AI modifier does not affect payment; it merely identifies that physician as being the admitting or attending physician for a particular inpatient stay.

Claims filing rule reminders for durable medical equipment, laboratory, and specialty pharmacy

The following article was originally published in the December 2011 [inserted space] issue of Providers' News under the "BlueCard" heading. **While the claims filing policies and rules are required for BlueCard, these same claims filing rules apply to ALL laboratories, durable medical equipment/home medical suppliers and specialty pharmacies. In addition, based on further review of services being submitted for payment, the required claims data elements for durable medical equipment will be required for all Prosthetic and Orthotic providers and the specialty pharmacy required claims data elements will apply to home infusion therapy providers.**

In 2004, the Blue Cross and Blue Shield Association (the Association) revised its Blue Card claims filing rules for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. While these revisions are several years old, the Association has only recently tightened system requirements related to these rules. These rules apply to all provider networks and claims related to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage.

Claims for independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy are filed to the local Blue Cross and Blue Shield Plan (sometimes called the Host Plan). The local Blue Cross Plan is usually defined as the Plan in whose service area the services are rendered. The Blue Plan that issued coverage for a given member, or that contracted with their employer to administer their self-funded health plan, is referred to as the Home Plan.

Please note: Host Plan and Home Plans are in every case independent companies so that the Host Plan is not responsible for funding of any insurance issued by a Home Plan. The Host Plan's role is limited to a claims processing and customer services assistance function with respect to the out-of-state provision of services to the Home Plan's member.

Clinical Lab:

For clinical lab, the local Blue Cross Plan is defined as the plan in whose service area the specimen was drawn.

Example: a blood specimen is drawn at a physician's office in Little Rock that participates in the Health Advantage network on a member who has Health Advantage benefit coverage. The lab is sent to New York to be processed and is billed from North Carolina. This laboratory participates in the Health Advantage network. The claim must be billed directly to Health Advantage as the specimen was drawn in Arkansas. The claim will be processed as in network for covered services.

(Continued from page 7) Claims filing rule reminders for dme, laboratory, & specialty pharmacy

Another example: A blood specimen is drawn in Hot Springs on a member who has health plan coverage administered through BlueAdvantage Administrators of Arkansas. The clinic where the specimen is obtained is not in any Arkansas Blue Cross provider networks. The lab specimen is sent to Denver, CO to be processed and will be billed by the lab from Denver. The lab is also not in any Arkansas Blue Cross or affiliates' provider network. The claim must be billed directly to BlueAdvantage as the specimen was obtained in Arkansas. The claim will be processed as out of network for covered services.

Information required on claims submitted for clinical lab:

- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.

Durable/Home Medical Equipment and Supply

For durable/home medical equipment and supply, the local Blue Plan is the plan in which service area the equipment was shipped to or purchased at a retail store.

For example: a member with Arkansas Blue Cross insurance living in Fort Smith, AR orders diabetic supplies from a mail order supplier in Ohio. The supplier participates in the Host Plan's network in Ohio but not Arkansas. The claim must be filed directly to Arkansas Blue Cross because Arkansas is where the supplies were shipped. The claim will be processed as out of network for covered services.

Information required on claims submitted for durable/home medical equipment:

- Patient's Address, Field 5 on CMS 1500 Health Insurance Claim Form or in loop 2010CA on the 837 Professional Electronic Submission.
- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.
- Place of Service, Field 24B on the CMS 1500 Health Insurance Claim Form or in loop 2300, segment CLM05-1 on the 837 Professional Electronic Submission.
- Service Facility Location Information, Field 32 on CMS 1500 Health Insurance Form or in loop 2310 A (claim level) on the 837 Professional Electronic Submission.

Specialty Pharmacy

For specialty pharmacy, the local Blue Plan is defined as the plan in whose service area the ordering physician is located.

For example: a physician whose clinic is in Pine Bluff orders specialty drugs for a Health Advantage member who lives in Stuttgart. The specialty pharmacy is located in Jackson, MS and is in the Mississippi Blue Cross and Blue Shield provider networks, but not in any Arkansas Blue Cross or affiliates' networks. The claim must be filed directly to Health Advantage as the ordering physician's practice location is in Arkansas.

The claim will be processed as out of network as the specialty pharmacy is not in any Arkansas Blue Cross or affiliates' provider networks. Information required on claims submitted for specialty pharmacy:

- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.

The Blue Card program has always relied on the provider agreement status and pricing of the local Blue Plan and that is still true. The mere fact that a claim is required to be submitted directly to a certain Blue Plan does not obligate any local Blue Plan to offer contracts to any lab, durable medical equipment supplier or specialty pharmacy.

However, the Association's rules for Blue Card have been revised to allow Blue Plans to contract with out of state clinical labs, durable medical equipment suppliers and specialty pharmacies. Each local Blue Plan will make its own decisions related to provider contracting and pricing.

Provider Type	How to file (Required fields)	Where to file	Examples
Independent Clinical Laboratory (any type of non hospital based laboratory) **Types of Service include, but are not limited to:** Blood, urine, samples, analysis, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2310A (claim level) on the 837 Professional Electronic	File the claim to the Plan in whose state the specimen was drawn* * Where the specimen was drawn will be determined by which state the referring provider is located.	Blood is drawn* in lab or office setting located in **Arkansas.** Blood analysis is done in New York. **File to: Arkansas.** *Claims for the analysis of a lab must be filed to the Plan in whose state the specimen was drawn.
Durable/Home Medical Equipment and Supplies (D/HME) **Types of Service include, but are not limited to**: Hospital beds, oxygen tanks, crutches, etc.	**Patient's Address:** • Field 5 on CMS 1500 Health Insurance Claim Form **or** • Loop 2010CA on the 837 Professional Electronic Submission. **Ordering Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2420E (line level) on the 837 Professional Electronic Submission. **Place of Service:** • Field 24B on the CMS 1500 Health Insurance Claim Form **or** • Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. **Service Facility Location Information:** • Field 32 on CMS 1500 Health Insurance Form **or** • Loop 2310C (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store.	A. Wheelchair is purchased at a retail store in Arkansas. **File to: Arkansas** B. Wheelchair is purchased on the internet from an online retail supplier in Ohio and shipped to Arkansas. **File to: Arkansas**
Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2310A (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan whose state the Ordering Physician is located.	Patient is seen by a physician in Illinois who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in Arkansas where the member lives for 6 months of the year. **File to: Illinois**

Coverage policy manual updates

The following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy Manual since December 2011. To view entire policies, access the coverage policies located our Web site at arkansasbluecross.com.

New / Updated Policies:

Policy#	Policy Name
1998026	Insulin Infusion Pumps, External
1997088	Hyperbaric Oxygen Pressurization (HBO)
1998034	Cytoreduction Surgery with Hyperthermic Intraperitoneal Chemotherapy
1998084	Electrophrenic Pacemaker (Diaphragmatic Pacemaker)
1998099	Electrical Stimulation, Deep Brain (e.g. Parkinsonism, Dystonia, Multiple Sclerosis, Post-Traumatic Dyskinesia)
1998118	Surgery for Morbid Obesity
1998153	Cardiac Event Recorder, Insertable Loop Recorder
1998155	Respiratory Syncytial Virus, Immune Prophylaxis with Palivizumab (Synagis)
2000008	HDC & Autologous Stem &/or Progenitor Cell Support-Hodgkin's Disease
2000038	Photodynamic Therapy for Malignancy
2005017	HDC & Allogeneic or Autologous Hematopoietic Stem Cell Support for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma
2006015	Myocardial Damage, Autologous Cell Therapy(progenitor, hematopoietic stem cells, myoblasts)
2006020	Abatacept (Orencia) for Rheumatoid Arthritis
2006026	Genetic Test: Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts & Leukoencephalopathy (CADASIL) (NOTCH3)
2008004	Optical Coherence Tomography_Anterior Eye Segment Imaging
2008007	Cardiac Event Recorder, Mobile Telemetry
2008022	Genetic Test: Cancer of Unknown Primary, Pathwork Tissue of Origin Test, CupPrint and miReview
2008024	Glaucoma Evaluation, Ophthalmologic Techniques
2008025	Stem Cell Growth Factor_Romiplostim (Nplate)
2009023	Pain Management, Radiofrequency Facet Joint Denervation
2010014	Genetic Test: Chromosomal Microarray (CMA) Analysis for Genetic Eval of Patients with Developmental Delay/Intellectual Disability or Autism Spectrum Disorder
2011053	Autism Spectrum Disorder_Early Behavioral Intervention

Policy#	Policy Name
2011072	Aflibercept (Eylea) for Wet Age-Related Macular Degeneration
2011073	Biomarker, Methotrexate Polyglutamates to Predict Response to Methotrexate in Patients with Rheumatoid Arthritis (Avise PG)
2011074	PET or PET/CT for Gastric Cancer
2011075	Allergy Testing, Metal
2011076	Genetic Test: Hypertrophic Cardiomyopathy, Predisposition
2011077	Transcatheter Aortic Valve Implantation
2011078	Microwave Ablation of Tumors
2011079	Neural Therapy
2012001	Functional Anesthetic Discography
2012002	Transcatheter Pulmonary Valve Implantation
2012003	Genetic Test: Mutation Analysis of Thyroid Tissue
2012004	Cerebral Aneurysm, Embolization Device and Stenting
2012005	Genetic Test: Predict Response to Cancer Chemotherapy, Caris Target Now®
2012006	Genetic Test: X-Linked Opitz G/BBB Syndrome, MID1 Mutation Testing

Medi-Pak® Choice

Medi-Pak Advantage claims processing tips for facility owned clinics

Medi-Pak Advantage uses Medicare claims processing guidelines for facility owned clinics. Unlike Arkansas Blue Cross and Blue Shield commercial business, both the facility and the physician can bill Medi-Pak Advantage for services received in these clinics. If the facility is billing for these services, the physician services must be billed with place of service 22 (outpatient facility). In addition, the facility needs to bill Revenue code 510. This allows Medi-Pak Advantage to apply only one copayment for the service and to use the correct fee schedule.

Unfortunately, several facility owned clinics are billing with place of service 11. Please review your systems carefully to make sure that for Medi-Pak Advantage office visit claims the place of service is 22.

Medi-Pak Advantage does assess one copayment for office visits provided in facility owned clinics. Today, that copayment is applied to the facility claim. Medi-Pak Advantage understands that this is a cumbersome process, so beginning with dates of service May 1, 2012 and later, we will be applying the copayment to the physician claim.

Until May 1, it is important that if a provider is collecting the copayment in the physician's office they should transfer that money to the facility so the facility can apply the copayment to the member's account. This eliminates the need for the physician to refund the copayment and the facility to bill for it.

BlueCard®

Case management for BlueCard members

It is the policy of Arkansas Blue Cross and Blue Shield and its affiliated companies such as USAble Corporation and Health Advantage that participating providers should not contact out of state Blue Plans in an attempt to re-negotiate rates/allowances that are not within a provider's contract with Arkansas Blue Cross, USAble or Health Advantage.

However, any services for an out of state member that a provider feels should be case managed can be reviewed with the other Blue Plan for a collaborative process of assessing, planning, facilitating and advocating for options and services to meet an individual's health needs through communication and available resources in order to promote quality and cost-effective outcomes.

The review and determination of benefits, such as through utilization review and utilization management components for Case Management may include:

- Precertification/preauthorization.
- Predetermination.
- Referral management.
- Retrospective review.
- Notification.
- Concurrent review.
- Discharge planning.

If you have any questions, please contact your Network Development Representative or call Arkansas Blue Cross Provider Services.

BlueCard payments based on NPI

Arkansas Blue Cross and Blue Shield and its affiliated companies implemented the National Provider Identifier (NPI) usage in 2008. However, some of our internal systems combine the NPI's use along with locally assigned provider numbers. A system change is required for compliance purposes.

Currently the BlueCard program generates a payment that posts to the Remittance Advice (RA) for each locally assigned provider number. A local provider number can be associated with multiple NPI's. So we currently produce multiple checks for a single NPI.

Effective April 23, 2012, a change will be implemented for BlueCard to generate payments based on the NPI only the Federal Employee Program has had this process in place since 2010.Claims included on the RA will be based on the billing provider's NPI. This could result in professional and facility claims being listed on the same remittance advice because they are billed using the same NPI. If that occurs, the claims will be separated by claim type.

FEP

Using AHIN to check benefits for physical therapy

Remember when physical therapy is being performed in an outpatient facility rather than an office or clinic location, the benefits for these services fall under the member's outpatient hospital benefits rather than physical therapy for applying the correct copayment or coinsurance. If viewing benefits in AHIN providers will want to view outpatient hospital benefits rather than physical therapy benefits.

FEP to implement Claim Check Plus

The Federal Employee Program (FEP) will be implementing a new claims editing software, Claim Check Plus in April 2012. This is the same claims editing software that was announced by Arkansas Blue Cross and Blue Shield in the September 2010 issue of *Providers' News*. This new editing software will affect the way FEP claims are processed consistent with all other lines business at Arkansas Blue Cross.

Claim Check Plus is designed to evaluate billing information and coding accuracy on submitted claims. Claim Check Plus is guided by the coding criteria and protocols in the CPT Manual that are published by the American Medical Association and reflective of the coverage policies of Arkansas Blue Cross and of its affiliates. It also incorporates code editing rules based on the HCPCS coding system.

Claim Check Plus will introduce additional automation to aid in the proper editing of claims which will help evaluate claims for coding accuracy. Claims that are coded inappropriately will be denied as incorrect coding.

Claim Check Plus is designed to spot irregularities, such as unbundling, mutually exclusive procedures and integral procedures. The software evaluates the coding accuracy of the procedure(s), not the medical necessity of the procedure(s). The types of services that will be evaluated include, but are not limited to:

- Policies based on CPT manual
- Policies based on health care coding standards
- Multiple procedures performed on the same day
- Appropriateness of assistants at surgery
- The proper use of modifiers

FEP has always performed this type of review. Claim Check Plus will allow us to do so in a much more consistent and efficient way and claims will process with more consistency and accuracy. Claim Check Plus is essential for keeping pace with the complex developments in medical technology and the increasingly more specific coding required today. As claims are edited, the software may create additional lines for the claim if warranted.

In testing, many inappropriate coding situations were noticed, many involving both CPT and HCPCS modifiers. Some examples are:

- Modifiers 24 and 25 are only valid with E&M procedures;
- If a separate and identifiable service is performed on the same day as an E&M service, providers must report the E&M service with Modifier 25.
- Modifier 77 is not valid with E&M codes.
- Repeat clinical diagnostic laboratory tests should be billed using Modifier 91, not 76.
- Category II codes are supplemental tracking codes. The only modifiers valid with these codes are Modifiers 1P, 2P, 3P and 8P.
- Modifier AT should only be used with procedure codes 98940-98942.
- When the same surgical service is provided on two sides of the body, providers should use the appropriate LT, RT and 50 Modifiers. One on the first line with LT, the second on the second line with Modifiers RT and 50.
- When other than surgical services are provided on both the left and right sides of the body, it is appropriate to use Modifiers LT and RT on separate lines, but is NOT appropriate to use Modifier 50.
- CPT codes 99238 and 99239 should be used to report all services provided to the patient on the day of discharge. It is not appropriate to bill a visit code on the same day as a hospital discharge.
- SS is not an appropriate ambulance modifier. Providers would never take a patient from the scene of one accident to the scene of another accident.
- PI is for PET Scans and is not valid for other services, including E&M.

Please note that the NCCI, National Correct Coding Initiative, will be used in Claim Check Plus. This may result in some differences in payment from what you receive today.

Additional information on the use of modifiers when billing can be found in the June 2011 issue of *Providers' News*

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
36252	$568.56	$0.00	$0.00	$568.56	$0.00	$0.00
36253	$609.39	$0.00	$0.00	$609.39	$0.00	$0.00
36254	$657.51	$0.00	$0.00	$657.51	$0.00	$0.00
37191	$3,075.49	$0.00	$0.00	$373.63	$0.00	$0.00
37192	$2,157.79	$0.00	$0.00	$580.32	$0.00	$0.00
37193	$2,066.64	$0.00	$0.00	$579.94	$0.00	$0.00
37619	$0.00	$0.00	$0.00	$2,677.65	$0.00	$0.00
62369	$153.10	$0.00	$0.00	$53.63	$0.00	$0.00
62370	$164.61	$0.00	$0.00	$71.95	$0.00	$0.00
74174	$672.74	$165.50	$507.24	$0.00	$165.50	$0.00
77469	$0.00	$0.00	$0.00	$482.88	$0.00	$0.00
78226	$381.37	$55.13	$326.23	$0.00	$55.13	$0.00
78227	$519.51	$66.51	$453.00	$0.00	$66.51	$0.00
78491	$1,162.54	$112.02	$1,050.52	$0.00	$112.02	$0.00
78492	$1,191.95	$141.43	$1,050.52	$0.00	$141.43	$0.00
78579	$206.76	$38.31	$168.45	$0.00	$38.31	$0.00
78582	$385.01	$82.98	$302.03	$0.00	$82.98	$0.00
78597	$237.77	$57.22	$180.55	$0.00	$57.22	$0.00
78598	$357.65	$65.08	$292.57	$0.00	$65.08	$0.00
A9576	$1.97	$0.00	$0.00	$0.00	$0.00	$0.00
A9585	$4.15	$0.00	$0.00	$0.00	$0.00	$0.00
E0781	$0.00	$9.26	$0.00	$0.00	$0.00	$0.00
E0791	$0.00	$9.62	$0.00	$0.00	$0.00	$0.00

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
E2402	$0.00	$51.73	$0.00	$0.00	$0.00	$0.00
G4051	$10.97	$0.00	$0.00	$0.00	$0.00	$0.00
J0131	$0.11	$0.00	$0.00	$0.00	$0.00	$0.00
J0152	$103.81	$0.00	$0.00	$0.00	$0.00	$0.00
J1300	$201.87	$0.00	$0.00	$0.00	$0.00	$0.00
J1610	$110.72	$0.00	$0.00	$0.00	$0.00	$0.00
J1725	$2.76	$0.00	$0.00	$0.00	$0.00	$0.00
J2265	$0.54	$0.00	$0.00	$0.00	$0.00	$0.00
J2325	$51.62	$0.00	$0.00	$0.00	$0.00	$0.00
J2353	$126.45	$0.00	$0.00	$0.00	$0.00	$0.00
J2545	$57.31	$0.00	$0.00	$0.00	$0.00	$0.00
J2788	$25.99	$0.00	$0.00	$0.00	$0.00	$0.00
J2997	$47.51	$0.00	$0.00	$0.00	$0.00	$0.00
J3070	$14.91	$0.00	$0.00	$0.00	$0.00	$0.00
J3487	$235.90	$0.00	$0.00	$0.00	$0.00	$0.00
J7180	$7.80	$0.00	$0.00	$0.00	$0.00	$0.00
J7307	$659.42	$0.00	$0.00	$0.00	$0.00	$0.00
J7682	$87.50	$0.00	$0.00	$0.00	$0.00	$0.00
J8560	$42.33	$0.00	$0.00	$0.00	$0.00	$0.00
J9010	$612.65	$0.00	$0.00	$0.00	$0.00	$0.00
J9043	$89.78	$0.00	$0.00	$0.00	$0.00	$0.00
Q4105	$12.41	$0.00	$0.00	$0.00	$0.00	$0.00
Q4107	$103.51	$0.00	$0.00	$0.00	$0.00	$0.00
Q9954	$10.94	$0.00	$0.00	$0.00	$0.00	$0.00
S5520	$75.00	$0.00	$0.00	$0.00	$0.00	$0.00
S5521	$75.00	$0.00	$0.00	$0.00	$0.00	$0.00

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Please Note

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

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