

# Providers' News



To: All Providers

From: Provider Network Operations

Date: December 1, 2000

Please Note: This newsletter contains information pertaining to Arkansas Blue Cross Blue Shield, a mutual insurance company, its wholly owned subsidiaries and affiliates (ABCBS). 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.

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"Any five-digit Physician's Current Procedural Terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 1999 American Medical Association. All Rights Reserved."

## Health Advantage Referral Reminder

Proper use of the referral process will save time and reduce the number of claims adjustments.

Primary Care Physicians (PCP's) Participating with Health Advantage: For referrals to participating in-network specialist providers, please complete the Health Advantage Specialty referral sheet. Retroactive referrals are discouraged and may not be eligible for benefits. Any request for a referral to a provider not participating with Health Advantage requires prior notification and review for benefits to be authorized.

Specialist providers Participating with Health Advantage: Please remember that in order for your services to be eligible for in-network benefits, you must place the referral number marked on the "scrip" referral sheet in field 23 of the HCFA-1500 form every time. If the referral number is not on each claim, then the service will either be denied or paid at the out-of-network benefit level if the patient has Point of Service (POS) benefits. Retroactive referrals are discouraged and may not be eligible for benefits.

Please note that this does NOT include referrals for Medi-Pak HMO or referrals for providers located in the Southeast or Southwest Regions. Providers located in the Southeast and Southwest Regions should contact Access Health for referrals. If you have any questions, please contact the Regional Office nearest you.

## Arkansas State Employees changes to Fully-Insured with ABCBS and Health Advantage

Effective January 1, 2001 the Arkansas State Employee group changes from self-insured funding to a fully insured funding. **Because of this your 2000 dates of service claims for Arkansas State employees must be filed to ABCBS or Health Advantage by March 31, 2001.** If you do not file by that date claims may not be processed by ABCBS or Health Advantage but will need to be mailed to the state employee benefit agency for

adjudication. This is necessary due to the self funding program ending and to handle the claims "run-out".

### **Benefit Changes for Arkansas State Employees**

Effective January 1, 2001 the Arkansas State Employees Group will be a fully-insured rather than a self-insured group. Additionally, Health Advantage will be offering both an HMO and a POS product to this group. Following are some benefit changes for Arkansas State Employees on the Blue Cross Plan or the Health Advantage Plan that may impact provider reimbursement.

1. All services related to obesity, including gastric bypass, are excluded.
2. Self-inflicted injuries, including drug overdose, are excluded.
3. Physical, Occupational and Speech Therapy are limited to 20 visits per therapy per year.
4. Chiropractic services do not apply toward the physical therapy limitation.
5. Home Health Nurse Visits are limited to \$1000 per year.
6. Annual pap smears and mammograms are covered.
7. Voluntary sterilizations (tubal ligations and vasectomies) will be covered.
8. Infertility services

BC—Infertility services will be covered. In-vitro fertilization is limited to \$15,000 per lifetime. (Prescription drugs for these services are not covered)

HA—Testing and consultations are covered—referral from this PCP is required. All other infertility services are non-covered.

9. Mental Health services

BC—Inpatient days and visits are limited to 20 per year (payable at 80% of the allowable amount).

Out patient visits are limited to 20 per year (payable at 50% of the allowable amount).

HA—Inpatient days and visits are limited to 20 per year (payable at 90% of the allowable amount).

Out patient visits are limited 20 per year \$50 copayment per visit).

#### **(There are no out-of-network Mental Health benefits on the HA POS plan)**

10. Ambulance services are limited to \$1000 per year.
11. TMJ services are limited to \$500 per lifetime.
12. Routine vision exam—HA only (one every 24 months—no referral required)
13. Routine dental services—HA only (one every 6 months—no referral required)

14. Health Advantage provider copayments (in-network services) are as follows:

PCP—\$20 copayment, 0 coinsurance  
OB/GYN (routine visits)—\$20 copayment, 0 coinsurance  
Specialist—\$25 copayment, 0 coinsurance  
Allergy injections or children's immunizations—0 copayment, 0 coinsurance  
Out patient ER Facility/Surgery—\$100 copayment, 0 coinsurance  
Out patient physician care—0 copayment, 0 coinsurance  
Out patient diagnostic testing—0 copayment, 0 coinsurance  
Inpatient Admission Facility—\$250 copayment, 10% coinsurance  
Inpatient physician care—0 copayment, 10% coinsurance  
Physical, Occupational and Speech Therapy—0 copayment, 20%coinsurance  
Durable Medical Equipment—20% copayment, 0 coinsurance (\$10,000 max)  
Home Health Nurse Visits—0 copayment, 0 coinsurance

### **USABLE Update**

The Customer Service unit of USABLE Administrators has been reorganized in order to better serve our member and provider customers. We have customer service teams to service specific geographical regions within our state. We have been able to accomplish this through communications software changes.

Please consult the patient's identification card for the appropriate toll free number to access your customer service team. You may also call 1-888-USABLE1.

Also, a reminder that USABLE membership identification numbers consist of nine basic numeric characters. The identification card will also provide the appropriate two digit suffix to this number. Dependent upon participation in specific benefit programs, this number may be preceded by alpha characters also.

### **Lunelle Contraceptive Injection-Health Advantage**

Health Advantage does not cover Lunelle Contraceptive injections. Health Advantage does include coverage for oral contraceptives. Please note that for the Arkansas Public School and Arkansas State Employee Program their prescription drug coverage is not administered by Health Advantage.

### **Maternity Benefits**

Maternity benefits are determined by contract language and are paid accordingly.

The following laboratory procedures are considered standard studies when performed during the course of

pregnancy and are to be reported in addition to codes for pre-natal care:

Hemoglobin (85014, 85022-85027) performed in the first and third trimester;  
ABO/Rh (D) (86900/86901);  
Rh (D) antibody screen (86850);  
VDRL/RPR (86592);  
Hepatitis B Surface Antigen (HbsAg) (87340);  
Gonorrhea culture (87072);  
Chlamydial culture (82110);  
Urine culture (87086);  
Antibody: Rubella/Rubeola/Varicella (86762/86765/86787);  
HIV (86701);  
Coombs (86886);  
Gestational diabetes mellitus screening (82950 or 82951);  
Triple screen (AFP/HCG/Estriol) (82105/84702/82677) may be offered in high-risk pregnancies.

Other laboratory studies during pregnancy are not considered routine and would be a covered service(s) depending on medical necessity. This would be indicated on the claim by use of an ICD-9 code that would support the medical necessity.

Prenatal visits are applied to antepartum contract benefits and are billed with CPT 59425 (4-6 visits) or CPT 59426 (7 or more visits). These codes are billed at the time of delivery.

Delivery codes, CPT 59409 (vaginal delivery) and 59515 (Cesarean delivery), include postpartum care.

**Billing of the all inclusive codes, CPT 59400 and CPT 59510, could result in an incorrect payment as benefits for prenatal visits and delivery may be different.**

There is no routine coverage for obstetrical ultrasounds (76805-76816). Coverage for this study is based on the following criteria:

- 1) Suspect multiple pregnancy;
- 2) Suspect placenta previa (second or third trimester bleeding);
- 3) Suspect abortion or ectopic pregnancy in the first trimester;
- 4) In patients with previous C-section, between 20-30 weeks, to accurately date the pregnancy;
- 5) Probable intrauterine fetal death;
- 6) Intrauterine growth retardation or small for gestational age;
- 7) Previous history of fetal anomalies such as hydrocephalus, spina bifida, etc.;
- 8) Macrosomic infants;

- 9) Maternal age over 35 years;
- 10) Fetal age determination in patients initially seen after the first trimester with unknown last menstrual period date or irregular periods, with discrepancies in uterine size and dates.

These conditions would generally be indicated by the use of an ICD-9 code from the range V230-V239 or 6400\_ to 6489\_.

#### **Botulinum Toxin Type A for Migraine Headache**

This policy applies to all ABCBS companies, subsidiaries and its affiliates

Coverage for the treatment of migraine headaches with Botulinum Toxin Type A (Botox) is available for those patients who meet all of the following criteria:

- 1) Who have IHS-defined headache, with or without aura;
- 2) Who received their first diagnosis of migraine headache before the age of 50 years and had to be able to distinguish migraine from non-migraine headache;
- 3) Have no history of complicated migraine (migrainous infarction; hemiplegic migraine);
- 4) Have no typical migraine pain localized predominantly to the occipital or suboccipital region of the cranium;
- 5) Are not currently or planning pregnancy;
- 6) Have no known allergy to Botulinum A Toxin or its components;
- 7) Have headaches no more frequently than 15 days per month;
- 8) Have failed three or more preventive regimens for migraine headache.

In a randomized controlled study it took approximately three weeks for the botulinum toxin to have an effect and that effect appeared to continue through a 3-month follow-up visit. That same study found no additional effect with the injection of 75 units when compared to the injection of 25 units.

Botulinum Toxin Type A, 25 units, will be covered per injection session, and repeat injections will be covered no more frequently than every four months.

#### **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: *Kimberly Hartsfield, Editor*

*Arkansas Blue Cross Blue Shield*

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*Little Rock AR 72203*

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**A Guide to  
The HCFA - 1500  
Claim Form**

for professional providers

**December 1, 2000  
Arkansas Blue Cross and Blue Shield**

The Arkansas Insurance Department (AID) Rule and Regulation 43 recently was revised to help ensure the timely processing of health insurance claims-both to benefit health insurance companies and providers. Any claims received on or after January 1, 2001 will be subject to the revised regulation.

The revised regulation defines the number of days that insurance carriers have to process "clean claims" and "non-clean claims" or "Section 13" claims. Clean claims are claims submitted with all information necessary for payer adjudication and that do not require further investigation.

Section 13 claims are those that have been submitted, but must be suspended from processing until the insurance carrier receives more information. An insurance carrier must notify the claimant (provider or member), within 30 days of receiving a claim, what information is required to process the claim correctly.

Necessary information includes the following:

- Information to determine if contract limit or exclusion applies
- Medical information to determine price of medical procedure
- Information to determine eligibility of claimant
- Information to determine if claim is covered by another carrier, government program, workers' compensation or third party
- Information to determine Coordination of Benefits (COB) obligation
- Information to determine if there is fraud or material misrepresentation
- Payment of premiums that were delinquent at the time of claimed services

The AID Rule and Regulation 43 requires that:

1. All clean claims must be processed (paid or denied with notification to provider or member) within 30 days. Clean claims submitted on paper must be processed within 45 days. A clean claim does not include claims on expenses incurred during a period of time when premiums were delinquent; or for benefits under a Medicare supplemental policy if the claim is not accompanied by an explanation of Medicare benefits or the Explanation of Medicare Benefits (EOMB) has not been otherwise received by the insurance carrier.
2. For Section 13 claims, the claim must be determined to be non-clean and returned to the provider or member within 30 days. After the correct information has been provided to the insurance carrier, the insurance carrier then has 30 days to process the claim.

If the insurance carrier does not process a clean claim within 60 days, the insurance carrier must then pay a penalty beginning on the 61<sup>st</sup> day after the claim was filed. The penalty is the amount of the claim multiplied by 12 percent per annum multiplied by the number of days delinquent divided by 365. The late processing penalty will be paid to the provider through an additional check from the insurance carrier.

If the insurance carrier does not process a Section 13 claim within 45 days of receipt of necessary information, the insurance carrier must then pay a penalty beginning on the 46<sup>th</sup> day after the correct information is received. The penalty is the amount of the claim multiplied by 12 percent per annum multiplied by the number of days delinquent divided by 365. The late processing penalty will be paid to the provider through an additional check from the insurance carrier.

For information and guidelines on filing the HCFA 1500 claim form and the HCFA 1500 anesthesia claim form, and for filing guidelines for wellness services, please read the following information.

**NOTE: R&R43**

As in the past, this rule does NOT apply to the Federal Employee Program, Access Only Groups, and some groups administered by USABLE Administrators.

Medical Records Note: In order to comply with R&R 43, ABCBS will be decreasing the days allowed to obtain medical records. Currently we allow a 21 days period before the claim is denied no response, that will change to a 14 day limit beginning January 1, 2001.

**ABCBS HCFA-1500- Instructions**

These guidelines will help you prepare your claims for Optical Character Recognition (OCR) scanning when filing claims for Arkansas Blue Cross and Blue Shield, Health Advantage, and USABLE. If you follow these simple guidelines, we'll be able to process your claims accurately. A correctly completed claim form means quicker payment for your office and no-refiling for you!

**Align the form**

PLEASE ALIGN YOUR FORM CAREFULLY SO THAT ALL DATA FALLS WITHIN THE BLOCKS ON THE CLAIM FORM. YOU'LL BE ABLE TO KEEP YOUR FORM ALIGNED IF YOU CENTER AN "X" IN THE BOXES AT THE TOP RIGHT AND LEFT CORNERS OF THE CLAIM. PLEASE BE SURE THAT ALL LINE-ITEM INFORMATION APPEARS ON THE SAME HORIZONTAL LINE.

**Keep it clean**

Please don't print, write or stamp extra data on the claim form. When you correct errors, please use white correction tape only, not correction fluid.

**Ribbons and fonts**

Use only black ribbons in your typewriter or printer. Change your ribbons frequently. Although we can accept claims using a 12-pitch setting, we prefer that you use a 10-pitch setting. If software supports fonts, please use Courier 12 monospace font.

**Use UPPERCASE**

Use only UPPERCASE letters for alphabetical entries. Don't mix fonts or use italics, script, percent signs, question marks or parentheses.

**Names**

For all blocks requiring names, please omit any titles, such as Mr. or Mrs. **Enter the last name first, followed by a comma and then the first name (Last Name, First Name – for example, Doe, James) – DO NOT USE NICKNAMES**

**Dates**

Use an eight-digit format for all dates. For example, enter July 1, 1999 as 07011999. All dates must be valid dates. Some fields require an entry such as DOS, others are optional.

**Time**

**Use a four-digit format for time, referred to on the form as "units" (see Block 24G). For example, enter one hour and 15 minutes as 0115.**

**Print quality**

You can help ensure that your paper claims are accurately processed by checking the quality of the print carefully. Faint printing can cause scanning problems. Please replace your printer ribbon regularly, and be sure to use the highest quality print setting available.

### Dollars and cents

Please don't use dollar signs in any block. Separate dollars and cents with a blank space. For example, enter \$1,322.00 as 1332 00.

### Forms

Please don't fold, staple or tape your claim. Please separate your forms carefully. If you use bursting equipment, adjust the splitters to precisely remove the pinfeed edges. Claims must be submitted on the 12/90 version of the HCFA 1500 form printed with red "drop out" ink. You may obtain copies of the HCFA 1500 through various vendors, the American Medical Association, or the U.S. Government Printing Office.

### Lines of Service (block 24)

Please limit yourself to six lines on each claim you file.

If you follow these guidelines, we'll be able to process your claims expeditiously.

### The ABCBS HCFA-1500-Step-by-Step Instructions

The following information is designed to help you complete the HCFA 1500. Please only submit paper claims if electronic claim submission isn't possible. Please remember that you only need to fill out the blocks for which we've provided instructions.

#### Block 1 a Insured's I.D. number

Enter the subscriber's current identification number **exactly as it appears on their health insurance identification card, including any alpha or numeric prefix or suffix, if present.** An entry in this block is **required.** Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will be returned to the provider for the correct information.

When submitting claims for BlueCard® Out-of-Area Program (other Blue Cross and Blue Shield Plan members) patients, please be sure to use the three-letter prefix that appears on the identification card.

#### Block 2 Patient's name

Enter the patient's last name followed by a comma and the first name in all capital letters. **Please enter this name exactly as it appears on their card.** An entry in this block is required. Do not include any titles (such as Mr. or Mrs.), suffixes (like Jr. or Sr.), apostrophes, hyphens, or any other marks of punctuation besides the comma. For example, enter the name Mary O'Hara as "OHARA, MARY." **DO NOT USE NICKNAMES**

#### Block 3 Patient's birth date and sex

Enter the patient's birth date in the following format (mm/dd/cc/yy) and sex. Date of Birth is required.

#### Block 4 Insured's name

Enter the last name of the policyholder or subscriber, followed by a comma and the first name. **Please enter this name exactly as it appears on their card.** Do not include any titles (such as Mr. or Mrs.), suffixes (like Jr. or Sr.), apostrophes, hyphens, or any other marks of punctuation besides the comma. **DO NOT USE NICKNAMES.** For example, enter the name Mary always as "OHARA, MARY."

Please don't use the terms "same" or "self" if the insured's name is the same as the patient's name.

**Block 5 Patient's address**

Fill out this block only if the patient's address is different from the insured's address, in Block 7, and please enter no more than 24 characters in this field. Do not use a Post Office Box address unless absolutely necessary.

**Block 6 Patient relationship to insured**

Check the appropriate box for patient's relationship to the insured when block 4 is completed. Enter an "X" in one of the following boxes:

- Self - the patient is the subscriber or insured
- Spouse - the husband or wife of the insured
- Child - children covered under a family contract, who are unmarried and under age 19.
- Other - stepchildren, student dependents, handicapped children, and domestic partners. Please write in appropriate category above the box marked "other." Handicapped children who are incapable of self support may be retained on the family contract beyond age 19 if a written application is approved.

**Block 7 Insured's address**

It's very important to enter the insured's complete address for identification. The zip code is required.

**Block 9(a-d) Other insured's name & other information**

If the patient is covered under any other health benefit plan including; Health Advantage, USABLE or Arkansas BlueCross BlueShield, please enter the full name of the policyholder and include the following information in Blocks 9 (a) - (d).

- (a) Other Insured's Policy or Group Number including USABLE, Health Advantage, or Arkansas Blue Cross and Blue Shield.
- (b) Other Insured's Date of Birth and Sex
- (c) Employer's Name or School Name
- (d) Insurance Plan or Program Name

**Block 10(a-c) Is patient's condition related to?**

**NOTE: Block 14 must be completed if YES indicated in any box.**

For each category (Employment, Auto Accident, Other), insert an "X" in either the YES or NO box. When applicable, attach an explanation of benefits (EOB) or letter from the auto carrier indicating personal injury protection benefits have been exhausted. If there are any "Yes" responses be sure to put a date in Block 14 or the claim will be returned to the provider for this information.

**Block 11d Is there another health benefit plan?**

Enter an "X" in the appropriate box. If yes, block 9 (a-d) must be completed.

**Block 14 Date of current (illness, injury or pregnancy)**

**Note: If YES is indicated in block 10 and/or the diagnosis indicates accident or medical emergency, this field MUST be completed.**

- Injury - Enter date the accident/injury occurred

- Illness - Enter for an acute medical emergency only and include onset date of Condition
- Pregnancy - Enter the LMP
- Surgery - For post-operative visits, please enter the date of surgery

**Block 17 Name of referring physician or other source**

Complete this block when:

- Consultations are performed
- Co-attending care is provided
- A laboratory is rendering services at the physician's request
- Direct supervision is provided; enter the name and license number of the supervised assistant who actually rendered the service
- Patient is referred to a non-panel/network provider

**Block 18 Hospitalization dates related to current services**

Complete only for services related to inpatient hospitalization, enter the admission and discharge dates.

**Block - 19 Reserved for local use**

**Block 20 Outside lab?**

If laboratory work was performed outside your office enter the laboratory's actual charge to you. If the laboratory bills us directly, enter an "X" in the NO box.

**Block 21(1-4) Diagnosis or nature of illness or injury**

Enter the appropriate five-digit ICD.9.CM. diagnosis code for which the services have been performed. Services for treatment of a psychiatric disorder require DSM-111 or DSM-III(R) five-digit codes. You can use up to four codes in priority order. Do not include the narrative description of the code. When searching for codes, always be as specific and accurate as possible. V codes are acceptable when billing for wellness benefits.

**Block 23 Prior authorization number**

Fill out this block for services requiring referrals.

**Block 24A Date(s) of service**

It is very important that you fill out this block correctly. Enter the month, day, year for each procedure or service. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column "G".

**Block 24B Place of Service (POS)**

For Arkansas Blue Cross and Blue Shield claims use the current National Standard Format (NSF) POS codes. The following are POS codes you should use when filling out this block.

- 11 Office
- 12 Home



21	Inpatient Hospital
22	Outpatient Hospital
<b>23</b>	<b>Emergency Room - Hospital</b>
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance Land
42	Ambulance Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

### **Block 24C Type Of Service (TOS)**

For Arkansas Blue Cross and Blue Shield claims use the current National Standard Format (NSF) codes. The following table outlines TOS codes you should use when filling out this block.

- 01 – Medical Care
- 02 – Surgery
- 03 – Consultation
- 04 – Diagnostic X-Ray
- 05 – Diagnostic Lab
- 06 – Radiation Therapy
- 07 – Anesthesia
- 08 – Surgical Assistance
- 09 – Other Medical
- 10 – Blood Charges
- 11 – Used DME
- 12 – DME Purchase
- 13 – ASC Facility
- 14 – Renal Supplies in the Home
- 15 – Alternate Method Dialysis
- 16 – CRD Equipment
- 17 – Pre-Admission Testing
- 18 – DME Rental
- 19 – Pneumonia vaccine
- 20 – Second Surgical Opinion
- 21 – Third Surgical Opinion
- 99 – Other (e.g., used for prescription drugs)

### **Block 24D Procedures, services or supplies**

Complete this field with the current and valid CPT/HCPCS procedure codes and any applicable modifiers to further explain the services rendered.

### **Block 24E Diagnosis “Pointer” code**

Do not show the actual diagnosis code in this block. Enter the line-item diagnosis code as it relates to the services reported in Block 24D. Do not range, list primary diagnosis for service line first. (1,2,3 not 1-3). This requires you to enter the diagnosis code reference number “Pointer” (1, 2, 3, or 4) that corresponds with the diagnosis as entered in Block 21. Use the reference number for the primary diagnosis for why the service was performed. Each service or procedure must have a reference to one of the ICD-9 codes in Block 21.

### **Block 24F Charges**

Enter the charges for each line with a blank space separating the dollars and cents.  
(e.g., enter 60.00 as 60 00)

### **Block 24G Days or units**

Enter the units of service rendered for the procedure. Anesthesia services and "special" procedure codes require time units format. If you need additional space on the claim form, you may run the information in this block into Block 24H.

### **Block 24K Reserved for local use**

It is **required** that you provide the accurate servicing provider's number. Please follow the example listed below when you enter the servicing provider's identification number and the control letters in Block 24K. If this field is left blank, the claims will be returned to the provider for the needed information.

Example:

Provider Number – 1J2345

Enter on your form as: 1J2345

**Block 25 Federal Tax ID number**

If available, please enter this identification number. If this number changes, notify ABCBS Provider Network Operations, Provider File section at Post Office Box 2181, Little Rock, AR 72203.

**Block 28 Total charge**

Enter the sum of all line charges.

**Block 29 Amount paid**

Report payments you've already received from another insurer. Attach a copy of the other insurer's explanation of benefits (EOB) and complete Block 9. Please note: if we're the secondary payer, you should not submit a claim until you've received the primary payer's payment.

**Block 30 Balance due**

Once you have received payment from another insurer, enter the balance due from us.

**Block 31 Signature of physician or supplier**

Have the physician or supplier sign here unless a signature waiver application has been completed already.

**Block 33 Physician/supplier's billing name, address and phone**

It's **required** that you provide us with the correct billing provider's number. Please follow the example listed below when you enter the provider identification number and the control letters in the GRP# field. If a clinic - enter the Group #. If a solo practitioner - enter the individual provider #. If this field is left blank, the claim will be returned to the provider for the needed information.

Example:

Provider Number - M12345

Enter on your form as: M12345

**Type Of Service Codes 2000**

Beginning	Ending	NSF TYPE	Beginning	Ending	NSF TYPE
A0021	A0999	01	K0105	K0105	12
A4000	A4640	12	K0106	K0118	12
A4641	A4647	04	K0106	K0118	18
A4648	A8999	12	K0119	K0123	09
A9150	A9150	09	K0124	K0136	12
A9500	A9500	04	K0124	K0136	18
A9503	A9503	04	K0137	K0412	12
A9505	A9505	04	K0415	K0418	09
A9507	A9507	04	K0419	K0461	12
A9605	A9605	04	K0462	K0462	12
A9900	A9901	12	K0462	K0462	18
B4000	B9999	12	K0463	K0501	12
B4000	B9999	18	K0503	K0528	09
E0100	E0784	12	K0529	K0530	12
E0100	E0784	18	K0531	K0534	12
E0785	E0785	12	K0531	K0534	18
E0786	E9999	12	L0100	L0119	12
E0786	E9999	18	L0100	L0119	18
G0001	G0001	05	L0120	L1120	12
G0002	G0002	02	L1200	L1290	12
G0003	G0007	05	L1300	L1300	12
G0008	G0010	01	L1300	L1300	18
G0015	G0027	05	L1310	L1499	12
G0030	G0050	04	L1500	L2999	12
G0101	G0103	05	L1500	L2999	18
G0104	G0106	02	L3000	L3100	12
G0107	G0107	05	L3140	L8039	12
G0108	G0109	01	L3140	L8039	18
G0110	G0116	01	L8100	L8239	12
G0120	G0121	02	L8300	L8330	12
G0122	G0122	04	L8400	L8699	12
G0123	G0126	05	L8400	L8699	18
G0127	G0127	02	L9084	L9084	12
G0128	G0129	01	L9900	L9900	12
G0130	G0132	05	L9900	L9900	18
G0141	G0141	05	M0005	M0064	01
G0143	G0148	05	M0075	M0100	01
G0151	G0156	01	M0101	M0101	02
G0159	G0160	02	M0102	M0300	01
G0161	G0165	04	M0301	M0302	05
G0166	G0167	01	P0000	P9999	05
G0168	G0171	02	Q0035	Q0035	05
G0168	G0171	08	Q0068	Q0068	05
G0172	G0172	01	Q0081	Q0086	01
H5300	H5300	01	Q0091	Q0091	05
J0000	J9999	09	Q0092	Q0092	04
J0000	J9999	01	Q0103	Q0104	01
K0000	K0048	12	Q0111	Q0115	05
K0000	K0048	18	Q0132	Q0132	12
K0049	K0049	12	Q0136	Q0157	09
K0050	K0104	12	Q0163	Q0185	09
K0050	K0104	18	97001	99142	01

Q0186	Q0186	01	96111	96549	01
Q0187	Q0187	09	96552	96552	12
Q1001	Q1005	12	96570	96571	02
Q1001	Q1005	18	99167	99169	12
Q9920	Q9940	9	99170	99170	02
R0070	R0076	04	99171	99171	12
V0000	V2799	01	99173	99173	01
V5000	V5299	05	99175	99192	01
W0009	W0009	01	99193	99194	12
W7230	W7230	02	99195	99199	01
W7240	W7240	02	99201	99240	01
W9122	W9122	01	99241	99275	03
W9123	W9124	01	99276	99499	01
W9220	W9220	02			
W9450	W9450	12			
X9150	X9915	12			
Y9120	Y9120	12			
Y9121	Y9122	01			
Y9123	Y9124	12			
Y9125	Y9130	01			
00100	01999	07			
10000	69999	02			
10000	69999	08			
70010	77260	04			
77261	77799	06			
78000	79999	04			
80048	85094	05			
85095	85095	02			
85096	88169	05			
88170	88179	02			
88180	88239	05			
88240	88291	02			
88299	88299	05			
88300	88499	02			
89005	89399	05			
90281	90911	01			
91000	91299	05			
92012	92015	01			
92018	92019	02			
92020	92499	01			
92500	92599	01			
92950	92971	01			
92975	92998	02			
93000	93499	05			
93500	93660	02			
93700	93726	05			
93727	93727	04			
93728	93740	05			
93741	93744	04			
93745	93999	04			
94010	94799	05			
95004	95199	01			
95805	95999	05			
96100	96105	01			
96110	96110	01			

### Claims Filing Guidelines for Anesthesia - HCFA - 1500

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate a current and valid CPT/HCPCS anesthesia procedure code in field 24d of the HCFA 1500.

#### Time Units

Time units are determined on the basis of total minutes. Providers should always report the total anesthesia time in minutes on the claims. For example, if the total time is 1 hour and 35 minutes, report "95" in the units file (block 24g) of the HCFA Form 1500.

**NOTE: Do not report base units in the units field (block 24g). The claims systems are programmed to include the base units in the overall payment calculations.**

#### Physical Status Modifiers

Physical status modifiers are used to give us additional information about the level of complexity of the anesthesia service provided. The points are additional units added to the total time. Bill for only one (1) physical status modifier per procedure. These modifiers should be indicated in the modifier field in 24d following the CPT/HCPCS anesthesia code. The charges should be included in the overall charge for the anesthesia.

### Claims Filing Guidelines for Wellness Services

#### Preventive Medicine Evaluation (Routine Physical) - Adults

#### **Valid Procedures and Codes: (block 24d – HCFA 1500)**

Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, new patient;

99385	age 18 thru 39 years
99386	age 40 thru 64 years
99387	age 65 years and over

Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, established patient;

99395	age 18 thru 39 years
99396	age 40 thru 64 years
99397	age 65 years and over

#### **Diagnoses and Codes: (block 21 and corresponding pointer in 24e – HCFA 1500)**

V70	General medical examination
V70.0	Routine general medical examination at a health care facility (excludes checkup of an infant or a child)
V70.9	Unspecified general medical examination

## Annual Routine Gynecological Exam

### Valid Procedures and Codes: (block 24d - HCFA 1500)

Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, new patient;

99384	age 12 thru 17 years
99385	age 18 thru 39 years
99386	age 40 thru 64 years
99387	age 65 years and over

Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, established patient;

99394	age 12 thru 17 years
99395	age 18 thru 39 years
99396	age 40 thru 64 years
99397	age 65 years and over

### Diagnoses and Codes: (block 21 and corresponding pointer in 24e – HCFA 1500)

V72.3	Gynecological examination Papanicolaou smear as part of general gynecological examination. Pelvic examination (annual) (periodic)
V76.2	Special screening for malignant neoplasm; cervix
V76.10	Special screening for malignant neoplasms; breast screening, unspecified
V76.11	Special screening for malignant neoplasms; screening mammogram for high-risk patient
V76.12	Other screening mammogram
V76.19	Other screening breast exam
V76.2	Special screening for malignant neoplasms; Cervix

### Routine Pap Smear

Code	Description
88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service)
88142	Cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	With manual screening and rescreening under physician supervision
88144	With manual screening and computer-assisted rescreening under physician supervision
88150	Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision
88155	with definitive hormonal evaluation (e.g., maturation index, karyopknotic index, estrogenic index)
88156	Cytopathology, smears, cervical or vaginal, (the Bethesda System (TBS)), up to three smears; screening by technician
88157	requiring interpretation by physician
88158	With manual cytotechnologist screening and automated rescreening under physician supervision.

88164	Cytopathology, slides,cervial or vaginal, (the Bethesda System) ;manual screening under physician supervision
88165	With manual screening and rescreening under physician supervision

### **Mammograms**

Code	Description
76090	Mammography; unilateral
76091	bilateral
76092	Screening mammography, bilateral (two view film study of each breast)

A screening examination is performed when an individual does not have a sign or symptoms of disease. A diagnostic examination is performed when there are signs or symptoms of a disease.

If during the screening a problem is found, code the screening procedure on one line with the pointer code in 24 E to the screening diagnosis and the diagnostic procedure on a separate line with the pointer code to the appropriate diagnosis code.

### **Child Services**

Preventative Medicine Evaluation and Normal Immunizations

#### **Valid Procedures and Codes: (block 24d – HCFA 1500)**

Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures, new patient;

99381	age under 1 year
99382	age 1 thru 4 years
99383	age 5 thru 11 years
99384	age 12 thru 17 years

Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, a comprehensive examination, Counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory/diagnostic procedures. established patient;

99391	age under 1 year
99392	age 1 thru 4 years
99393	age 5 thru 11 years
99394	age 12 thru 17 years

#### **Valid Diagnosis and Code: (block 21 and corresponding pointer in 24e – HCFA 1500)**

V20.2	Routine infant or child health check Developmental testing of infant or child Immunizations appropriate for age
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Routine vision and hearing test

**Valid Immunization and Codes**

Code	Description
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90645	Hemophilus, influenza b vaccine (Hib) HbOC conjugate (4 dose schedule) for intramuscular use
90646	Hemophilus, influenza b vaccine (hib) PRP-D conjugate, for booster use only, for intramuscular use
90647	Hemophilus influenza b vaccine (Hhib) PRP-OMP conjugate (3 dose schedule) for intramuscular use
90648	Hemophilus influenza b vaccine (Hib) PTP-T conjugate (4 dose schedule) for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DtaP), for intramuscular use
90701	diphtheria and tetanus toxoids and whole cell pertussis vaccine (DPT), for intramuscular use
90702	diphtheria and tetanus toxoids (DT) adsorbed for pediatric use, for intramuscular use
90703	tetanus toxoid adsorbed, for intramuscular or jet injection use
90704	mumps virus vaccine, live, for subcutaneous or jet injection use
90705	measles virus vaccine, live, for subcutaneous or jet injection use
90706	rubella virus vaccine, live, for subcutaneous or jet injection use
90707	measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use
90708	measles and rubella virus vaccine, live, for subcutaneous or jet injection use
90709	rubella and mumps virus vaccine, live for subcutaneous use
90710	measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90712	poliovirus vaccine,(any type(s), (OPV), live, for oral use
90713	poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90716	varicella virus (chicken pox)vaccine, live, for subcutaneous use
90718	tetanus and diphtheria toxoids (Td) absorbed, for adult use, for intramuscular or jet injection use
90719	diphtheria toxoid, use, for intramuscular use
90720	diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DPT-HIB), for intramuscular use
90721	diphtheria, tetanus toxoids, and acellular pertussis vaccine) and Hemophilus influenza B vaccine (DtaP HIB), for intramuscular use
90744	Hepatitis B vaccine; pediatric or pediatric/adolescent dosage, for intramuscular use
90745	Hepatitis B vaccine, infant dosage,for intramuscular use

**Valid Diagnostic Test and Codes:**

**Lab Urinalysis**

Code	Description
81000	Urinalysis, by dip stick or table reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen
81002	non Automated, without microscopy
81003	automated, without microscopy

**Hemoglobin/Hematocrit**

85021	hemogram, automated (RBC, WBC, Hgb, Hct and indices only)
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A screening examination is performed when an individual does not have any signs or symptoms of disease. A diagnostic examination is performed when there are signs or symptoms of a disease.

If during the screening a problem is found, code the screening procedure on one line with the pointer code in 24E to the screening diagnosis and the diagnostic procedure on a separate line with the pointer code to the appropriate diagnosis code.

**Changes to the Remittance Advice  
This applies to ABCBS ONLY.**

Effective for claims received on and after January 1, 2000, when a claim has been closed awaiting receipt of requested information, you will be notified on your Remittance Advice with the appropriate message.

## **UB92 Claims Filing Requirements**

**Please continue to reference the Hospital Association's UB92 manual for claims filing requirements for completing the UB92 claim form.**