Arkansas Blue Cross and Blue Shield

Providers' News

June 2006

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Please Note:

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

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We're on the Web!
www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com
and **www.fepblue.org**

The *Providers'* News
The Providers' News is a quarterly publication of Arkansas Blue Cross and Blue Shield. Please send your questions or comments about the Providers' News to:

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

Arkansas Blue Cross and Blue Shield Needs Your NPI!

For providers who have already applied and received their National Provider Identifier (NPI), Arkansas Blue Cross and Blue Shield needs it to ensure our payment systems is updated before the NPI deadline.

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

Providers may mail, fax, or email the NPI verification to the Provider Network Operations division of Arkansas Blue Cross.

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

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

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

Representatives from Arkansas Blue Cross and Blue Shield will also collect NPI verification information at provider workshops.

Providers with access to Advanced Health Information Network (AHIN), a program was created to notify Arkansas Blue Cross about a provider's NPI assignment through AHIN. All AHIN users can now select the "NPI Administration" button to submit the NPI. Please check the AHIN bulletin board for instructions.

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

For additional information on NPI, visit the CMS website at ***http://new.cms.hhs.gov/***. Select the "Regulations & Guidelines" link under CMS Programs & Information and "National Provider Identifier Standard" under the HIPAA Administrative Simplification. Click on "How to Apply" which will direct users to a PDF form to print and complete. Providers can also click on the NPPES link or go directly to their web site at ***http://nppes.cms.hhs.gov*** and apply online.

NPI Implementation

The National Provider Identifier (NPI) will be the only provider identifier allowed on HIPAA electronic standard transactions conducted between covered entities on or after **May 23, 2007** by virtue of HIPAA Regulations. Arkansas Blue Cross and Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas and our other affiliated companies will meet all regulatory requirements by the HIPAA compliance date.

Since May 23, 2005, healthcare providers have been able to apply for and be assigned an NPI. Many providers within Arkansas have already received their NPI. In order for Arkansas Blue Cross to identify a provider by their NPI, we must have a record of their NPI on file. The Provider Network Operations division of Arkansas Blue Cross and Blue Shield began actively accumulating the necessary NPI information from providers on March 1, 2006.

Arkansas Blue Cross is aware that conversion to the NPI may be a burden to the provider community. To help minimize that burden, Arkansas Blue Cross will attempt to parallel the transition plan with CMS (the largest provider payer in the country).

CMS is strongly encouraging providers to apply for an separate NPI for each legacy number an organization now uses. Arkansas Blue Cross also encourages organizational providers to apply for an NPI for each Arkansas Blue Cross provider number they currently use.

Individual providers and sole-proprietorships are only allowed one NPI. CMS plans to begin their transition period on October 2, 2006. For those providers that have properly registered their NPI with Arkansas Blue Cross, we will also begin using their NPI on October 2, 2006.

Up until the compliance date of May 23, 2007, Arkansas Blue Cross will accept and process electronic claims transactions that contain the NPI as long as the Arkansas Blue Cross provider number is also included. After the compliance date, only the NPI will be required.

The current CMS 1500 and UB-92 paper claim forms were not designed to accommodate the NPI. New paper claim forms have been approved that will accommodate the NPI. The NUCC has proposed that the new professional paper claims forms be used exclusively after February 1, 2007 with a transition period beginning on October 1, 2006.

NUBC (National Uniform Billing Committee) has proposed the UB-04 Institutional paper claim form be used exclusively after May 22, 2007 with a transition period beginning on March 1, 2007. It is anticipated that Arkansas Blue Cross and it's affiliated companies will accommodate the proposed schedules for these new paper claim forms and will require the NPI on those claims.

AHIN - Extended Hours of Operation

AHIN (Advanced Health Information Network) has extended hours of operation. Please note the updated hours of operation below:

Monday thru Saturday 6 am until midnight.

Coverage Policy Manual Update

The following policies were added and/or revised in the Arkansas Blue Cross and Blue Shield Coverage Policy manual:

- Adoptive Immunotherapy
- Autologous cell therapy for the Treatment of Damaged Myocardium
- Bone Mineral Density Study
- Computed Tomography, Cardiac and Coronary Artery
- Computer-assisted Musculoskeletal Surgical Navigational Orthopedic Procedure
- EKG, Signal Averaged
- Electrical/Electromagnetic Stimulation for the Treatment of Arthritis
- HDC & Allogeneic Stem &/or Progenitor Cell Support-Hodgkin's Disease
- HDC & Autologous Stem &/or Progenitor Cell Support – Neuroblastoma of Childhood
- HDC & Autologous Stem &/or Progenitor Cell Support-Ewing's Sarcoma
- Infliximab (Remicade)
- Leuprolide (Lupron)
- Measurement of Lipoprotein-associated Phospholipase A2 (Lp-PLA2) in the Assessment of Cardiovascular Risk
- Microprocessor-Controlled Prosthetic Knee
- Pharmacogenomic and Metabolite Markers for Patients Treated with Azathioprine (6-MP)
- Photocoagulation of Macular Drusen
- Pulsatile Ocular Blood Flow
- Rituximab (Rituxan) for the Treatment of Rheumatoid Arthritis
- Stem Cell Growth Factors, Granulocyte Colony Stimulating factor
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation
- Vacuum Assisted Closure Device

Physical Therapy & Modifier 59

Correction to an article printed in the June 2005 issue of the Providers' News. An article titled "Modifier 59 Billing Instructions" located on pages 20-24 stated:

"Physical therapy procedures: It is a common practice to provide multiple modalities on the same day. The descriptors provide information on the differences without appending Modifier 59."

Arkansas Blue Cross and Blue Shield has identified one physical therapy situation that requires Modifier 59. If providers performs both CPT Code 97110 (therapeutic exercises) AND 97113 (aquatic therapeutic exercises) as two separate and distinct services on the same date, providers should append Modifier 59 to CPT Code 97110.

Crosswalk from 2005 'G' Codes for Injection, Infusion and Chemotherapy Administration to 2006 CPT Codes

If performed to facilitate infusion or injection, the following services are included and are not reported separately:

- Use of local anesthesia;
- IV start;
- Access to indwelling IV, subcutaneous catheter or port;
- Flush at conclusion of infusion; and
- Standard tubing, syringes and supplies.

When a **significant, separately identifiable Evaluation and Management service is performed**, the appropriate Evaluation and Management service code should be reported utilizing Modifier 25 in addition to the administration code(s). **This requirement will be monitored for compliance.**

The "initial" code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur. Only one "***initial"*** code may be billed for an encounter, unless protocol requires that two separate IV sites must be utilized.

If two separate IV sites must be utilized, Modifier 59 should be appended. Medical necessity of the separate IV site must be documented. Records may be required to document the additional port. The initial codes are 90760, 90765, 90774, 96409, and 96413.

Intravenous or intra-arterial push is defined as:

- An injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe patient; **OR**
- An infusion of 15 minutes or less;

CPT Code 90768 may only be billed **ONCE** per encounter. Records should document the drug(s) administered concurrently.

The subsequent hour codes may only be billed when the infusion time is greater than 30 minutes beyond the one hour increments:

- 91 – 150 Minutes = 1 unit of service
- 151 – 210 Minutes = 2 units of service
- 211 – 270 Minutes = 3 units of service
- 271 – 330 Minutes = 4 units of service
- 331 – 390 Minutes = 5 units of service
- 391 – 450 Minutes = 6 units of service
- 451 – 510 Minutes = 7 units of service
- 511 – 570 Minutes = 8 units of service

The CPT codes for the drugs given may be billed in addition to the administration codes. Each hydration code should be linked to at least one code for pre-packaged fluid and electrolytes. Each other administration code billed should be linked to at least one drug code.

The ***CPT 2006*** manual states: [If] a significant, separately identifiable evaluation and management service is performed by the same physician on the same date of the procedure [i.e. 90670-90799 and/or 96401-96549], the appropriate E&M service code should be reported using Modifier 25. For the same day E&M service, a different diagnosis is not required.

Crosswalk from 2005 'G' Codes to 2006 CPT Codes:

Hydration

2005 HCPCS	2006 CPT	Description
G0345	90760	Intravenous infusion, hydration; initial, up to one hour
G0346	90761	Intravenous infusion, hydration; each additional hour, up to eight hours (List separately in addition to code for primary procedure)

Injections and Infusions (Non-chemotherapy; Other than hydration)

2005 HCPCS	2006 CPT	Description
G0347	90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour
G0348	90766	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour, up to eight (8) hours; (List separately in addition to code for primary procedure); (Report in conjunction with 90765, 90767); (Report 90766 for additional hour (s) of sequential infusion); (Report 90766 for infusion intervals of > 30 minutes beyond 1 hour increments)
G0349	90767	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure); (Report 90767 in conjunction with 90765, 90774, 96409, 96413 if provided as a secondary or subsequent service after a different initial service. Report 90767 only once per sequential infusion of infusate mix)
G0350	90768	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure); (Report 90768 only once per encounter); (Report 90768 in conjunction with 90765, 96413)
G0351	90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial (90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)
	90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial (90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)
G0353	90774	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug (90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)
G0354	90775	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug; (List separately in addition to code for primary procedure); (Use 90775 in conjunction with 90765, 90774, 96409, 96413); (Report 90775 to identify intravenous push of new substance/drug if provided as secondary or subsequent service after a different initial service is provided)
	90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion (For allergy immunizations, see 95004 et seq); (90780 & 90781 were deleted. To report, see 90760, 90761, 90765-90768); (90782 was deleted. To report, use 90772) (90783 was deleted. To report, use 90773); (90784 was deleted. To report, use 90774) (90788 was deleted. To report, use 90772); (90799 was deleted. To report, use 90779)

Crosswalk from 2005 'G' Codes to 2006 CPT Codes (continued) :

Chemotherapy Administration

2005 HCPCS	2006 CPT	Description
G0355	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal antineoplastic
G0356	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic
	96405	Chemotherapy administration; intralesional, up to and including 7 lesions
	96406	Chemotherapy administration; intralesional, more than 7 lesions
		(96408 has been deleted. To report, use 96409)
G0357	96409	Intravenous, push technique, single or initial substance/drug
		(96410 has been deleted. To report, use 96413)
G0358	96411	Chemotherapy administration; intravenous, push technique, each additional substance/ drug (List separately in addition to code for primary procedure) (Use 96411 in conjunction with 96409, 96413)
		(96412 has been deleted. To report, use 96415)
G0359	96413	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug
		(96414 has been deleted. To report, use 96416)
G0360	96415	Chemotherapy administration, intravenous infusion technique; each additional hour, 1 to 8 hours (List separately in addition to code for primary procedure) (Use 96415 in conjunction with 96413) (Report 96415 for infusion intervals of greater than 30 minutes beyond 1-hour increments) (Report 90761 to identify hydration, or 90766, 90767, 90775 to identify therapeutic, prophylactic, or diagnostic drug infusion or injection, if provided as a secondary or subsequent service in association with 96413)
G0361	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump (For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521-96523)
G0362	96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure) (Use 96417 in conjunction with 96413) (Report only once per sequential infusion. Report 96415 for additional hour(s) of sequential infusion)

Member and Provider Appeals or Requests for Reviews

All requests for appeal or requests for review for Arkansas Blue Cross and Blue Shield or Health Advantage claims should be submitted within 180 days of the initial claim denial.

The request should be submitted with a written letter detailing the appeal or review request, the member's name, the identification number, and the date of service. The request should also include any medical records relevant to the appeal or review request.

An appeal request for an Arkansas Blue Cross claim should be marked "Appeal Request" and mailed to:

Arkansas Blue Cross Blue Shield - Appeals Department
Attn: Appeals Coordinator
P.O. Box 2181
Little Rock, AR 72203

A request for an appeal or review for a Health Advantage claim should be mailed to:

Health Advantage - Appeals Department
Attn. Member Response Coordinator
P.O. Box 8069,
Little Rock, AR 72203

The appeal or review request should not be submitted with a Corrected Claim form to the Blue Cross Blue Shield Claims Department or the Health Advantage Claims Department. This will only delay the appeal or review request.

A Member Appeal is an appeal for any claim that is denied and the member is financially responsible for the charges. A Provider Appeal is an appeal for any claim that is denied and the member is not financially responsible for the charges. Member and Provider Appeal processes are located on the Arkansas Blue Cross and Blue Shield and Health Advantage web sites at www.arkbluecross.com or www.healthadvantage-hmo.com.

NUCC Approves Revised Version of the 1500 Health Insurance Claim Form

The National Uniform Claim Committee (NUCC) announces the release of the new version of the 1500 Health Insurance Claim Form (version 08/05) that accommodates the reporting of the National Provider Identifier (NPI). This new version will update the existing 1500 Claim Form (version 12/90), often referred to as the HCFA 1500 or CMS 1500.

The revised 1500 Claim Form has been submitted to the Office of Management and Budget (OMB) for approval for use with federal programs, such as Medicare. The revised form is currently available for testing and transition preparation purposes only. It is not to be used for the official purpose of claims submission at this time.

Although not mandated by law, the NUCC recommends the following timeline for transitioning to the new version of the 1500 Claim Form:

- **October 1, 2006:** Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised (08/05) 1500 Claim Form.

- **October 1, 2006 – February 1, 2007:** Providers can use either the current (12/90) version or the revised (08/05) version of the 1500 Claim Form.

- **February 1, 2007:** The current (12/90) version of the 1500 Claim Form will be discontinued; only the revised (08/05) form will be used. All rebilling of claims should use the revised (08/05) form from this date forward, even though earlier submissions may have been on the current (12/90) 1500 Claim Form.

Because the current 1500 Claim Form (version 12/90) is due to expire with the OMB in March 2006, it will be renewed to allow its continued use during this transition period.

The NUCC began the revisions to the 1500 Claim Form in June 2004 by identifying how to best accommodate the NPI with minimal changes to the current form. Two public comment periods were held to solicit feedback on the proposed changes to the form. All of the revisions made to the form were either NPI related or a significant need for the change was identified.

Form Availability:
Documents related to the release of the new version of the 1500 Claim Form, including the revised form, new reference instruction manual, log of changes to the current form, and the recommended transition timeline are available at www.nucc.org.

The revised 1500 Claim Form available on the NUCC website can not print to its exact specifications unless using a special printer programmed to print forms. To receive copies of the revised form with the specifications needed for testing purposes, please email TFP Data Systems at JRMagdaleno@tfpdata.com.

In addition to revising the 1500 Claim Form, the NUCC has drafted a new reference instruction manual detailing how to complete the updated form. The purpose of this manual is to help standardize nationally the manner in which the form is being completed. A copy of the instruction manual is also available on the NUCC website.

OMB Approval Process:
During the OMB approval process, the revised 1500 Claim Form will be released for two public comment periods. Although the NUCC does not anticipate major additional changes being made to the revised form, it is possible that changes could be made as part of the OMB approval process.

Once the revised 1500 Claim Form has been officially approved by the OMB, the NUCC will release the final version of the form, which will include the OMB numbers added to the bottom of the form. Approval is expected to take place in Spring 2006.

About the NUCC:
The National Uniform Claim Committee is a voluntary organization whose members include representatives from major provider, payer, health researchers, and other organizations representing billing professionals and electronic standard developers.

NUCC maintains the uniform data set known as the National Uniform Claim Committee Data Set designed for the non-institutional claims. The NUCC is one of the four national organizations named in the 1996 HIPAA Administrative Simplification legislation for a consultative role in establishing administrative standards for health care. The NUCC is also signatory to a Memorandum of Understanding with five other organizations designated by the U.S. Department of Health and Human Services to collectively serve as the Designated Standard Maintenance Organizations (DSMO) to the HIPAA Transaction Standard Implementation Guides.

For more information on the revision of the 1500 Claim Form, visit the NUCC website at www.nucc.org or email Nancy Spector, NUCC Secretary, at nancy.spector@ama-assn.org.

Guide to CMS - 1500 Paper Claim Form For Professional Providers

Revised June, 2006

These guidelines will help providers prepare claims for Optical Character Recognition (OCR) scanning when paper filing claims for Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Administrators.

Align the Form: Please align the claim form carefully so that all data falls within the blocks on the claim form. Provider will be able to keep the form aligned if they 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.

Dates: Use an eight-digit format for all dates. For example, enter June 1, 2006 as 06012006. All dates must be valid dates. Some fields require an entry such as DOS, others are optional.

Dollars and Cents: Please do not 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 the claims. Please separate all forms carefully. For providers using bursting equipment, adjust the splitters to precisely remove the pinfeed edges. Claims must be submitted on the 12/90 version of the CMS 1500 form printed with red “drop out” ink. Providers may obtain copies of the CMS 1500 through various vendors such as the American Medical Association or the U.S. Government Printing Office.

Keep It lean: Please don't print, write, or stamp extra data on the claim form. When correcting errors, please use white correction tape only, not correction fluid.

Lines of Service (block 24): Please limit the lines of service to six lines on each claim filed.

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).**

Print quality: Providers can help ensure that paper claims are accurately processed by checking the quality of the print carefully. Faint printing can cause scanning problems. Please replace printer ribbons or toner regularly and be sure to use the highest quality print setting available.

Ribbons and Fonts: Use only black ribbons in typewriters or printers. Change the ribbons frequently. Although claims can be accepted using a 12-pitch setting, please use a 10-pitch setting. If software supports fonts, please use Courier 12 Monospace font.

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.

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

By following these guidelines, providers will assist Arkansas Blue Cross and Blue Shield in meeting its goal of efficient, accurate claims processing.

NOTE: Effective October 1, 2006, all fields indicated as REQUIRED in the following guide must be completed or the claim will be returned to the provider.

CMS - 1500 Claims Guide: Step-by-Step Instructions

The following information is designed to help providers complete the CMS 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.

NOTE: Effective October 1, 2006, all fields indicated as REQUIRED in the following guide must be completed or the claim will be returned to the provider.

Block 1A - Insured's I.D. # (REQUIRED): Enter the patient's current identification number exactly as it appears on their identification card, including the appropriate alpha pre-fix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in processing or denial of the claim.

When submitting claims for BlueCard (Out-of-Area) Program patients, please be sure to use the three-letter prefix that appears on the patient's identification card.

Block 2 - Patient's Name (REQUIRED): Enter the patient's last name followed by a comma and the first name in all capital letters. An entry in this block is required. Do not include any apostrophes, hyphens, suffixes (like Jr. or Sr.), or titles (such as Mr. or Mrs.) any other marks of punctuation besides the comma. For example, enter Mary O'Hara as "OHARA, MARY."

Block 3 - Patient's Date of Birth and Sex (REQUIRED): Enter the patient's birth date and sex. **Entry in both the date of birth and sex is required.**

Block 4 - Insured's Name (REQUIRED): 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 apostrophes, hyphens, suffixes (like Jr. or Sr.), or titles (such as Mr. or Mrs.) any other marks of punctuation besides the comma. For example, enter Mary O'Hara 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 28 characters in this field.

Block 6 - Patient's Relationship to Insured (REQUIRED): Check the appropriate box for patient's relationship to the insured. Enter an "X" in one of the following boxes:

- **Self** - the patient is the subscriber or insured
- **Spouse** - the husband or wife or qualified partner as defined by the insured's Plan.
- **Child** - minor dependent as defined by the insured's Plan.
- **Other** - stepchildren, student dependents, handicapped children, & 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 by Arkansas Blue Cross and Blue Shield.

Block 7 - Insured's Address and Telephone: Enter the Insured's address and telephone number.

(Continued on page 12)

(Continued from page 11)

Block 9(A-D) - Other insured's Name & Other Information: If the patient is covered under another health benefit plan and Arkansas Blue Cross, Health Advantage, or USAble is the secondary payer, please enter the full name of the policyholder and include all the following information in Blocks 9 (A) - (D).

- Other Insured's Policy or Group Number (Note: Do not use a hyphen or space within the policy or group number.)
- Other Insured's Date of Birth and Sex
- Employer's Name or School Name
- Insurance Plan or Program Name

Block 10 (a-c)-Patient's condition related to? For each category (employment, auto accident, other), insert an "X" in either the YES or NO fields.

Block 11 - Insured's Policy, Group, or FECA Number: Enter the insured's policy or group number as it appears on the insured's health plan ID card. If item number 4 is completed, then this field should be completed.

Block 11A - Insured's Date of Birth, Sex: Enter the 8-digit date of birth (MM/DD/CCYY) of the insured and an X to indicate the sex of the insured.

Block 11D - Is there another health benefit plan? Enter an "X" in the appropriate box. If marked "Yes," complete 9 and 9A-D.

Block 14 - Date of Current Illness, injury or Pregnancy:
- Injury - Enter date the accident occurred;
- Illness - Enter for acute medical emergency only and include onset date of condition;
- Pregnancy - Enter date of the last menstrual period (LMP) as the first date.

Block 17 - Name of Referring Physician or Other Source: Enter the name (First Name, Middle Initial, Last Name) and the credentials of the professional who referred or ordered the service(s) or supply(s) on the claim. Do not use periods or commas within the name.

Block 17A - Other ID Number: If the name of the referring physician is provided in Block 17, it is **REQUIRED** that 17A reflect the proper two-digit qualifier (1B = Blue Shield Provider # or 1G = Provider UPIN) along with the appropriate provider number for the referring physician.

Block 17B - National Provider Identifier: Enter the HIPAA National Provider Identifier Number (NPI) of the referring provider, ordering provider, or other source in 17B.

Block 18 - Hospitalization Dates Related to Current Services: Enter admission and discharge dates for inpatient hospitalization related services.

Block 19 - Reserved for local use.

Block 20 - Outside lab Charges: If laboratory work was performed outside your office, enter the laboratory's actual charge to you. If the laboratory bills Arkansas Blue Cross directly, enter an "X" in the **NO** box.

Block 21(1-4) - Diagnosis and/or Nature of Illness or Injury (REQUIRED): Enter the appropriate ICD-9 diagnosis code (up to four digits) for the services performed.

Block 23 - Prior Authorization Number: Enter any of the following as assigned by the payer for the current service:
- prior authorization number,
- referral number, or
- mammography pre-certification number.

Block 24 - Supplemental Information: The following are types of supplemental information that can be entered in the shaded areas of Item Number 24.
- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs

Block 24A-Date(s) of Service: Enter date(s) of service, from and to. If only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is only allowed for services on consecutive days. The number of days must correspond to the number of units in 24G.

Block 24B - Place of Service (POS) Code (REQUIRED): In 24B, enter the appropriate two-digit code from the following Place of Service list for each item used or service performed. The Place of Service identifies the location where the service was rendered. **An entry in this block is required.**

Block 24C - EMG Emergency Indicator: Enter "N" for NO and "Y" for YES in the bottom, unshaded area of this field.

Block 24D - Procedures, Services or Supplies (REQUIRED): Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description unless it is an 'unlisted' procedure code. If 'unlisted' a NDC or description must be shown in the shaded area for that line.

Block 24E - Diagnosis Pointer (REQUIRED): 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).

Block 24F - Charges (REQUIRED): Enter the charge for each listed service.

Block 24G - Days or Units (REQUIRED): Enter the units of service rendered for the procedure. Anesthesia services and "special" procedure codes require time units format.

Block 24I - ID Qualifier: Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The other ID# of the rendering provider should be reported in 24J in the shaded area. (1B = Blue Shield Provider #)

Block 24J - Rendering Provider ID Number (REQUIRED): The individual provider rendering the service should be reported in 24J. The original fields for 24J and 24K have been combined and re-numbered as 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the un-shaded area of the field.

Block 25 - Federal Tax ID Number: Enter the provider of service or supplier federal tax ID (employer identification number) or Social Security number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

Block 26 - Patient's Account Number: Enter the patient's account number assigned by the provider of service's or supplier's accounting system. Do not enter hyphens with numbers. Enter numbers left justified in the field.

Block 27 - Accept Assignment? Enter an X in the correct box. Only one box can be marked. The "accept assignment" indicates the provider agrees to accept assignment under the terms of the Medicare Program.

Block 28 - Total charge (REQUIRED): Enter the sum of all line charges.

Block 29 - Amount Paid: Enter total amount the patient or other payers paid on the covered services only. Attach a copy of the other insurer's explanation of benefits (EOB) and complete Block 9.

Please note: If we're the secondary payer, providers should not submit a claim until the primary payer's payment is received.

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Block 31 Signature of Physician or Supplier: Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, “Signature on File,” or “SOF.” Enter either the 6-digit date (MM DD YY), eight-digit date (MM DD YYYY), or alphanumeric date (e.g. January 1, 2006) the form was signed.

Block 32 Service Facility Location: Enter the name, address, city, state, and zip code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier’s name, address, zip code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used for each supplier.

Block 32A National Provider Identifier (NPI): Enter the HIPAA National Provider Identifier (NPI) number of the service facility.

Block 32B - Other ID Numbers: Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and the number. (1B = Blue Shield Provider Number)

Block 33 - Physician’s or Supplier's Billing Name, Address, and Phone: Enter the provider’s or supplier’s billing name, address, zip code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

1st line – Name
2nd line – Address
3rd line – City, State, and Zip Code

33A - National Provider Identifier (NPI): Enter the HIPAA National Provider Identifier (NPI) number of the billing provider in 33A.

33B - Other ID Numbers: Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter spaces, hyphens, or other separators between the qualifier and number.

Waiver of Health Plan Liability

Waivers of Health Plan Liability are used to educate members on services that may not meet the Primary Coverage Criteria of the member’s policy. This applies to all policies under Arkansas Blue Cross and Blue Shield’s various products. Using waivers allows providers to collect for services that may not be deemed as meeting the Primary Coverage Criteria particularly for services designated as experimental/investigational or which are not for the treatment of a medical condition.

It is the provider’s responsibility to inform the member before a service is provided when the service(s) may be considered as not meeting coverage criteria, e.g., which may be experimental or investigational. This process was designed to prevent Arkansas Blue Cross members from unwittingly having and/or paying for services that do not meet coverage criteria, (e.g., are experimental / investigational under the coverage policy) or are cosmetic services and/or procedures.

Providers may collect billed charges from members for services that are deemed as not meeting the Primary Coverage Criteria of the member’s health plan only if the provider obtains a written statement from the member **before** any services are provided. Please follow the guidelines below when obtaining a waiver.

A Valid Waiver Must Include:

1. The CPT code and/or description of service that may be denied,
2. Reason for likelihood of denial: "...this procedure does not meet coverage criteria" or "procedure is considered experimental and/or investigational",
3. Dollar amount of charges for service,
4. Patient's signature, and
5. Signature date.

General Guidelines:

1. Waivers are only required for services considered not meeting coverage criteria or those services considered experimental/ investigational.
2. The patient must sign the waiver **before** the service is performed.
3. "Blanket" waivers are not acceptable. Providers must not require waivers routinely or obtain waivers for all services as a precaution. Waivers should only be used for specific services the provider knows or has reason to believe Arkansas Blue Cross and Blue Shield may deny for failure to meet the Primary Coverage Criteria (e.g., due to the experimental/investigational nature of the service).
4. Patients should not routinely sign a waiver.
5. Providers should not add information to a waiver after it has been signed by the patient.
6. Members should not be asked to sign a **blank** waiver of liability.
7. Each date of service will require a separate waiver.
8. When signing a waiver, a member must understand their responsibility and why a waiver is necessary for the service.

Note: Providers who abuse the waiver procedure or these rules shall be subject to exclusion from the Arkansas Blue Cross network.

When a Patient Won't Sign:

It is the provider's responsibility to inform Arkansas Blue Cross patients when a service or services may be considered not meeting the Primary Coverage Criteria, (e.g., experimental/ investigational under Arkansas Blue Cross coverage policy). This pre-notification process was designed to prevent Arkansas Blue Cross and Blue Shield members from unwittingly having and/or paying for services that do not meet Primary Coverage Criteria (e.g., are experimental/investigational under Arkansas Blue Cross coverage policy).

Providers have access to coverage policies through the Arkansas Blue Cross web site. Coverage policies may be searched by their description, CPT Code, or title. A drop-down box is available listing all coverage policies alphabetically.

When patient is advised of likelihood of a denial, they have two options:

1. Do not have the service rendered.
2. Sign the waiver and be financially liable for payment of the denied service.

If a patient refuses to sign the waiver, providers have two options:

1. Render the service. If it is denied, write off the charge.
2. Do not render the service.

It is important to note that the patient must understand what he or she is signing and why he or she is signing it. Waivers are only required for services considered as not meeting the Primary Coverage Criteria (e.g., experimental/investigational services) or those services that are not provided to treat an actual medical condition (e.g., cosmetic services and/ or procedures).

Sample Waiver:

A sample waiver is located in the Arkansas Blue Cross and Blue Shield Provider Manual located on the "Provider" page on the Arkansas Blue Cross web site at www.arkbluecross.com.

Updated Radiology Authorization Program

Full implementation of the prior authorization for outpatient diagnostic imaging procedures has been delayed until September 1, 2006. Arkansas Blue Cross and National Imaging Associates (NIA) want to add web site authorization capabilities that will streamline the process as well as provide more convenience for providers' offices. The targeted date for the web site functionality is September 1st.

The *Radiology Management Reference Guide*, updated in February 2006 and provides detailed information regarding the new prior authorization program for outpatient diagnostic imaging services, has been placed on Advanced Health Information Network (AHIN) and the Arkansas Blue Cross and Health Advantage Web sites for easy access to help answer questions. Also, watch AHIN for additional updates and improvements regarding the new prior authorization program.

Effective February 1, 2006, physicians who order high-tech outpatient radiology services, including CT, MRI/MRA (Magnetic Resonance Angiography), Nuclear Cardiology or PET, on an outpatient basis for any Arkansas Blue Cross or Health Advantage individual or group member (except Medi-Pak members) must obtain prior authorization (approval) before services can be considered for reimbursement under the member's health plan. Prior approval is not required for emergency, observation department of a hospital, or inpatient services.

BlueAdvantage Administrators of Arkansas groups can elect to add this service on a group-by-group basis, which should be indicated on the member's ID card.

At this time, these services do not apply to members of the Federal Employee Program (FEP) .

The ordering physician is responsible for obtaining the prior authorization. Members (patients) are not responsible for assuring that their ordering physician obtains prior authorization, and participating providers who fail to do so cannot bill members for costs associated with unapproved radiology services.

NIA uses the following criteria to approve or deny a prior authorization request from a physician:

1. American College of Radiology "Appropriateness Guidelines";
2. Specialty society guidelines and diagnostic algorithms;
3. Literature reviews specific to a given test for a given condition or symptom; and
4. Arkansas Blue Cross, Health Advantage and BlueAdvantage (if applicable) coverage policies.

For additional information, please refer to the updated "*Radiology Management Reference Guide*" (located on pages 18–24). Authorization does not guarantee payment if the procedure is not covered under the patient's coverage policy.

Radiology Management Reference Guide

Prior Authorization Fact Sheet:

- A prior authorization program for outpatient diagnostic imaging procedures began on February 1, 2006. Providers will have from February 1 to September 1, 2006, to become familiar with the requirements of the program prior to the full implementation date of September 1, 2006. This correspondence serves as notice of change to the Utilization Review Programs under the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage, True Blue, and the USAble Corporation Arkansas' FirstSource provider agreements.

- The following outpatient services require the new prior authorization*:
  - CT Scan
  - Nuclear Cardiology
  - MRI/MRA
  - PET Scan

  *A separate authorization number is required for each procedure ordered.

- Emergency room, observation department of a hospital, and inpatient imaging procedures do not require prior authorization.

- These services will apply to all Arkansas Blue Cross and Blue Shield members, including those who access the Arkansas' FirstSource and True Blue PPO network, as well as Health Advantage members.

- Customers of BlueAdvantage Administrators of Arkansas can elect to add this program on a group-by-group basis, which would be indicated on the member's ID card.

- These radiology services do not apply to members of the Federal Employee Program (FEP) at this time.

- The ordering physician is responsible for obtaining the prior authorization number for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call.

- Call center hours of operation are Monday through Friday, 7 a.m. to 7 p.m.

- Providers may obtain prior authorization by calling NIA at 1-877-642-0722. (Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact NIA within five business days of the date of service and before the claim is submitted to obtain proper authorization for the studies, which will still be subject to review.)

- Average calls are completed within five minutes. Peak call volume occurs between the hours of 1 p.m. to 6 p.m.

- The NIA's **Guidelines for Clinical Use of Diagnostic Imaging Examinations** were developed from practice experiences, literature reviews, specialty criteria sets and empirical data. NIA's guidelines are located on their website at: **www.RadMD.com**. The guidelines are available in a PDF format that may be printed for future reference.

- **Please note**, just because prior authorization is obtained it does not mean coverage is guaranteed or even available for the particular member or service involved. Coverage is always subject to the specific terms and conditions of the member's health plan or policy, which must be met when the claim is received and reviewed. Such terms and conditions may include but are not limited to lifetime maximums, specific benefit limits or caps in some cases, out-of-network limitations, eligibility requirements such as the timely payment of premiums, and specific health plan or policy exclusions. See the "Pre-Certification" section of your participating provider agreement.

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The Prior Authorization Implementation Recommendations for Ordering Physicians and Participating Facilities: As a participating provider of diagnostic imaging services that require prior authorization, it is essential that providers develop a process to ensure the appropriate authorization number(s) is obtained. The following recommendations are offered for review and consideration in developing a procedure that will be effective for each facility. These recommendations are for informational purposes only.

Ordering Physician:

It is the responsibility of the physician ordering the imaging examination to call NIA for prior authorization. A separate authorization number is required for each procedure ordered.

Emergency room, observation department of a hospital and inpatient imaging procedures do not require prior authorization.

To expedite the authorization process, please have the following information ready before calling the NIA Utilization Management staff **(*Information is required):**

- Name & office telephone number of ordering physician*;
- Member name and ID number*;
- Requested examination*;
- Name of provider office or facility where the service will be performed*;
- Anticipated date of service (if known); and
- Details justifying examination:*
  - –Symptoms and their duration;
  - –Physical exam findings;
  - –Conservative treatment patient already has completed (for example: physical therapy, chiropractic / osteopathic manipulation, hot pads, massage, ice packs, medications);
  - –Preliminary procedures already completed (for example: X-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation); and
  - –Reason the study is being requested (for example: further evaluation, rule out a disorder);

If requested, please be prepared to fax the following information: Clinical notes, Ultrasound reports, Previous CT/MRI reports, Specialist reports/evaluation, and X-ray reports.

Participating Imaging Facilities:

It is the responsibility of the ordering physician to ensure that prior authorization is obtained. The rendering facility should not schedule procedures without prior authorization. For urgent tests, the rendering facility can begin the process, and NIA will follow up with the ordering physician to complete the process.

Procedures performed that have not been properly authorized will not be reimbursed, and the member cannot be balance billed. A separate authorization number is required for each procedure ordered.

Emergency room, observation department of a hospital and inpatient imaging procedures do not require prior authorization. If an emergency clinical situation exists outside of a hospital emergency room, providers should proceed with the examination and call NIA the next business day at 1-877-642-0722 to proceed with the normal review process.

To ensure that authorization numbers have been obtained, the following recommendations should be considered:

- Communicate to all personnel involved in out-patient scheduling that prior authorization is required for the listed procedures.
- If a physician office calls to schedule a patient for a procedure requiring prior authorization, request the authorization number.
- If a provider has not obtained a prior authorization, inform the provider of the requirement and advise the provider to call NIA at the toll-free number, 1-877-642-0722. Facilities may elect to institute a time period in which to obtain the authorization number (for example, one business day).
- If a patient calls to schedule a procedure that requires prior authorization and the patient does not have the authorization number, patient should be directed back to referring physician who ordered the examination.

Frequently Asked Questions:

The following are the most common questions with answers regarding the prior authorization changes from NIA.

Q.1. Is prior authorization from NIA required for all radiological procedures?

A.1. No. Only outpatient CT, MRI/MRA, PET & Nuclear Cardiology procedures require prior authorization.

Q.2. Who is responsible for obtaining prior authorization from NIA?

A.2. Ordering physician is always responsible for obtaining authorization from NIA prior to scheduling procedures.

Q.3. Are there situations that do not require prior authorization from NIA?

A.3. Yes, there are three situations that do not require prior authorization from NIA when billed with the applicable location code:

- When the procedure is ordered as part of emergency room services.
- When the procedure is ordered as part of an observation bed stay.
- When the procedure is ordered as part of an inpatient stay.

Q.4. Is prior authorization required for an emergency situations?

A.4. No. Patients who are directed to the emergency room are exempt from prior authorization. It is not necessary for any-one to call NIA retrospectively to authorize any imaging procedure performed during an emergency room visit.

Q.5. How is Observation/Rapid Treatment handled?

A.5. Imaging services occurring in the Observation / Rapid Treatment area of a hospital do not require prior authorization nor do these services require the ordering physician to contact NIA within the next business day of rendering the service. These services are easily identifiable in the Companies' claims systems and will be paid without an authorization from NIA.

Q.6. What information does the ordering physician need to expedite a prior authorization call to NIA?

A.6. To expedite the process, please have the following information ready before calling the NIA Utilization Management staff (*Information is required):

- Name and office telephone number of ordering physician*;
- Member name and ID number*;
- Requested examination*;
- Name of provider office or facility where the service will be performed*;
- Anticipated date of service (if known);
- Details justifying examination:*
  - Symptoms and their duration;
  - Physical exam findings;
  - Conservative treatment patient already has completed (for example: physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications);
  - Preliminary procedures already completed (for example: CT's, lab work, ultrasound, scoped procedures, X-rays, referrals to specialist, specialist evaluation);
  - Reason the study is being requested (for example: further evaluation, rule out a disorder).

Q.7. What kind of response time can the ordering physicians expect for prior authorization?

A.7. In many cases, especially when the caller requesting a review has sufficient clinical documentation, authorization can be obtained during the first telephone call. In general, approximately 60-65 percent of the requests will be approved during the initial telephone call. Generally, within two business days after receipt of request, a determination will be made. In certain cases, the review process may take longer if additional clinical information is required to make a determination.

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Q.8. Can NIA handle multiple authorization requests per telephone call?

A.8. Yes.

Q.9. What is the process for obtaining prior authorization from NIA for CT, MRI/MRA, PET or Nuclear Cardiology procedures ordered outside of normal business hours?

A.9. The rendering facility should proceed with the study. The ordering physician should contact NIA within five business days from the date of service and before the claim is submitted and proceed with the authorization process.

Q.10. What is the process for obtaining prior authorization from NIA for emergency procedures ordered at a location other than a hospital emergency room?

A.10. The authorization process will be the same. Studies conducted outside an emergency room setting will require prior authorization.

Q.11. Do physicians have to obtain the prior authorization before they call to schedule an appointment?

A.11. Yes. Physicians should obtain the prior authorization before scheduling patient.

Q.12. Does NIA ask for a date of service when authorizing a procedure?

A.12. At the end of the authorization process, the NIA authorization representative asks where the procedure is being performed and the anticipated date of service. The exact date of service is not required.

Q.13. How long is an authorization # valid?

A.13. The authorization number is valid for 60 days. When a procedure is authorized, NIA uses the date of determination as the starting point for the 60-day period in which the exam must be completed.

Q.14. What if my office staff forgets to call NIA and then goes ahead to schedule an imaging procedure requiring prior authorization?

A.14. It is important to notify office staff and educate them about this new policy. This policy is effective February 1, 2006. Claims for CT, MRI/MRA, PET and Nuclear Cardiology procedures that are not prior authorized will not be paid, and the members must be held harmless if the service is provided by a participating provider.

Q.15. Can the participating rendering facility obtain authorization in the event of an urgent test?

A.15. Yes, if they begin the process, NIA will follow up with the ordering physician to complete the process.

Q16. Who receives the prior authorization number from NIA?

A.16. On completion of the prior authorization process, NIA will notify the ordering physician of the authorization status. If the ordering physician is able to provide sufficient clinical and demographic information at the time of the initial call, a verbal authorization number will be issued. If a authorization request requires additional review, NIA will provide an authorization tracking number that will serve as a means of tracking the status of the process. Once a final determination has been reached, NIA will notify the ordering physician of the decision verbally or in writing (fax or letter). If the ordering physician does not complete the prior authorization process, the status will be "transaction denied for prior authorization non-compliance, no member liability".

Q.17. How can the NIA authorization number be identified?

A.17. The NIA authorization number consists of 11 alphanumeric characters (Example: NYYMMDD####).

Q.18. If there are two authorization numbers associated with the patient encounter, which one should be printed on the claim?

A.18. Any of the two authorization numbers should appear on the claim form. The authorization number not entered on the claim form will be captured internally within the claims system.

Q.19. Which provider(s) are responsible for putting the prior authorization number on the claim(s)?

A.19. The rendering facility and/or clinic and the provider who reads the test.

Q.20. Is an NIA prior authorization number needed for a CT-guided biopsy?

A.20. No.

Q.21. Which PET scans require a prior authorization?

A.21. All PET scans performed in physician offices or on an outpatient basis (non-ER or observation departments) require prior authorization by NIA.

Q.22. What happens if a patient is prior authorized for a CT of the abdomen and radiologist or rendering physician feels an additional study of the pelvis is needed?

A.22. The radiologist or rendering physician should proceed with the pelvic study. If this occurs, the rendering provider should notify the patient's ordering physician of the additional test, as a matter of courtesy and appropriate medical procedure. The original ordering physician should call NIA after the study is provided to proceed with normal review process to receive an additional authorization number.

Q.23. If a patient needs a CT in preparation for radiation therapy, is a prior authorization necessary?

A.23. No.

Q.24. After receiving a prior authorization from NIA, can the ordering physician change the planned procedure, the servicing facility, or the date of the procedure?

A.24. Yes, but the NIA Call Center must be contacted if the planned procedure or the servicing provider changes. The date of the procedure can take place on any date within the 60 days that the authorization number is valid. If the date of service is rescheduled beyond the 60 days, the NIA Call Center must be contacted.

Q.25. Is prior authorization necessary when Arkansas Blue Cross and Blue Shield or Health Advantage is not member's primary insurance?

A.25. Yes.

Q.26. How are procedures that do not require an NIA prior authorization handled?

A.26. These procedures should be handled as they are today.

Q.27. Can providers speak directly with a clinical reviewer or physician (peer-to-peer) level reviewer?

A.27. Once an initial intake process is complete, providers may request to be transferred to the clinical level of review. Initial intake information is necessary to determine member eligibility and to process request.

Q.28. What steps does ordering provider take when an authorization is not given during initial intake process (Level 1)?

A.28. The case will be forwarded to NIA's clinical departments who will review the clinical information submitted. If needed, clinical staff will request via fax, additional clinical information. This information can be faxed to NIA's dedicated clinical fax line. An ordering office might request a hot transfer to a nurse clinical review (Level 2) during the initial request, however, this should only be requested if the office has a clinician who can speak with the NIA nurses and who have additional clinical information that would support the requested study.

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Q.29. If NIA denies the prior authorization of an imaging study, does a provider have the option to appeal the decision?

A.29. Yes, through normal appeal procedures as directed in the denial letter. If NIA makes the decision to deny the request at the end of the telephone call, and the physician does not agree with the decision made by NIA, the physician should request an appeal of the decision from NIA.

Q.30. Is there a way to bypass the NIA recorded announcement?

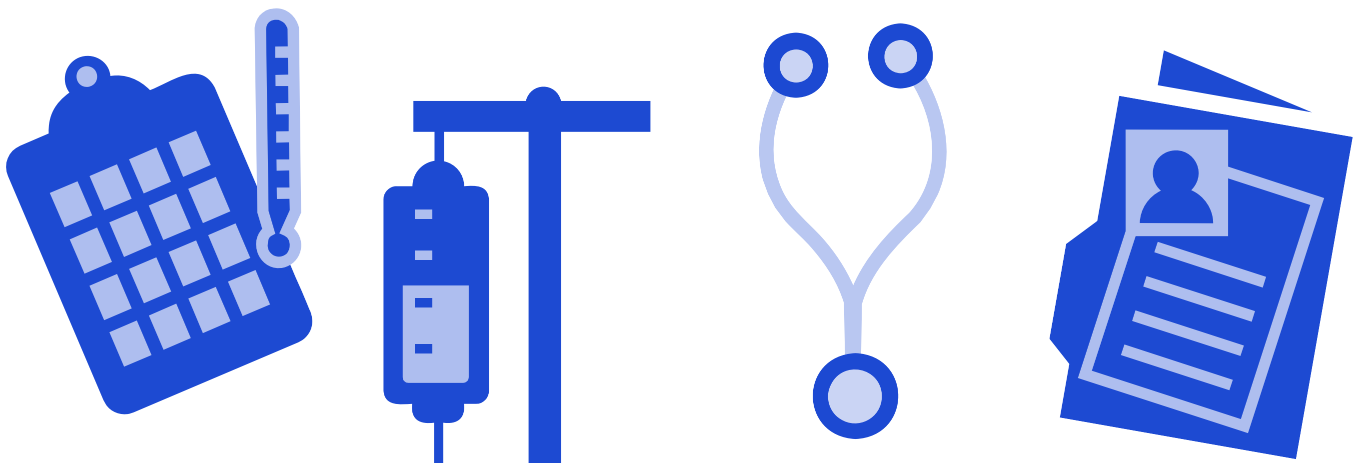
A.30. When dialing into the toll-free number, callers will hear a seven-second system greeting that identifies the NIA Imaging Authorization Service. The short announcement will instruct callers to press option one to initiate a new request for authorization on an imaging exam or option two for the status of a case that was previously called in for authorization. The announcement also will provide information that emergency procedures do not require a prior authorization. The entire greeting may be bypassed by immediately pressing the desired option whenever the announcement starts.

Q.31. If NIA approves a prior authorization of an imaging study, does this guarantee claim payment?

A.31. No. A prior authorization does not guarantee payment or ensure coverage; it means only that the information furnished to NIA at the time indicates that the imaging study that is the subject of the prior authorization meets the Primary Coverage Criteria. A claim receiving prior authorization must still meet all other coverage terms, conditions, and limitations. Coverage for any such prior authorized claim may still be limited or denied if, when the claimed imaging study is completed and Arkansas Blue Cross, BlueAdvantage, and Health Advantage receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date imaging study services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the patient's health plan applies to limit or exclude payment of the claim.

Q.32. What is the toll-free telephone number and hours of operation for the NIA Call Center?

A.32. Providers can reach the NIA Call Center by calling the toll-free number 1-877-642-0722, Monday through Friday, from 7 a.m. to 7 p.m.



Medicare 4.4% Reduction in Payment Reversal Adjustments

The decision to reduce the 2006 Medicare reimbursement to providers was recently reversed by Congress. The Medicare reimbursement to physicians was restored to the 2005 levels. The change only affects professional charges for dates of service between January and February 2006.

Because numerous claims were paid at the reduced reimbursement level, many of these claims will need to be adjusted. If applicable, providers will begin seeing these adjustments on their Remittance Advices during June and July. These claims for Medi-Pak Supplement members and other members are already in Medicare systems and do not need to be resubmitted. Medicare will cross over the claims to Arkansas Blue Cross and Blue Shield.

Thank you in advance for your patience and cooperation as Arkansas Blue Cross makes the necessary adjustments.

Medicare PFFS Advantage

Arkansas Blue Cross Blue Shield submitted an application to the U.S. Government's Center for Medicare and Medicaid Services (CMS) to become a Medicare Advantage Private Fee-For-Service (PFFS) plan sponsor. With CMS's approval, Arkansas Blue Cross will begin enrolling Medicare beneficiaries in its new PFFS plan – known as Medi-Pak® Advantage – on November 15, 2006. The first possible effective date for any Medi-Pak® Advantage policyholder would be January 1, 2007.

Medi-Pak® Advantage is a comprehensive, private fee-for-service Medicare Advantage product that combines the benefits of original Medicare and supplemental coverage as well as prescription drug benefits into one health care coverage plan.

Since Medi-Pak® Advantage is a non-network private fee-for-service plan, members may receive care from any provider that is Medicare eligible and is willing to accept Medi-Pak® Advantage members and the plan's Terms and Conditions. No formal contract is required.

Prior to providing services to a Medi-Pak® Advantage member, providers must agree to the Terms and Conditions of the Plan Payment. When providers choose to extend services to a Medi-Pak® Advantage member, they are acknowledging their agreement and are "deemed" to have a contract with Arkansas Blue Cross and Blue Shield.

When providing services to a Medi-Pak® Advantage member, providers automatically agree to accept the approved amount as payment in full. Payment for covered services will generally be the Medicare allowable, less any member cost-sharing amounts.

Arkansas Blue Cross will be providing additional information on Medi-Pak® Advantage after approval by CMS in the September 2006 issue of *Providers' News* .

Pinnacle Medicare Services Electronic Data Interchange

Save administrative dollars today, go electronic! There is a way to maximize office staff's time and increase efficiency in the work place. Process all of the Medicare transactions electronically today:

- Electronic Claims Filing
- Electronic Remittance Advice
- Medicare Remit Easy Print
- HIPAA Compliant Transactions
- Electronic Funds Transfer

Electronic Claims Filing
Filing claims electronically is easy with Medicare's FREE software. Filing claims in an electronic HIPAA compliant format allows quicker processing compared to paper claims.

PC-ACE Pro 32
PC-ACE Pro 32 is a complete, self-contained, stand-alone Medicare Part A electronic claims processing system that provides real-time comprehensive claims editing which minimizes rejected claims. Also, the PC-ACE Pro 32 system provides automatic code validation (diagnosis, procedures, etc.). Ongoing Medicare updates and enhancements are provided periodically.

Medicare Claims Express (MCE)
MCE is a submission software package that provides the capability to transmit Medicare Part B claims electronically into the American National Standard Institute (ANSI) X12 format. MCE is designed for use on a stand-alone personal computer and is not recommended for network use.

PC Print
PC Print software allows Medicare Part A providers to print the electronic Remittance Advice in a readable format. The software is free and available for download on Pinnacle Medicare Service's web site.

Electronic Remittance Advice (ERA)
On June 1, 2006, Carriers and DMERCs stopped sending standard paper Remittance Advices if providers receive 835s or Electronic Remittance Advice (ERA) transactions.

Medicare Remit Easy Print (MREP)
Medicare Remit Easy Print (MREP) software allows Medicare Part B providers to print the Electronic Remittance Advice in a readable format. The software is free and available for download on Pinnacle Medicare Service's web site.

Health Care Eligibility Benefit Inquiry and Response Transaction (270/271 Transaction Code Set)
Health Care Eligibility Benefit Inquiry and Response Transaction provides real-time beneficiary and eligibility information. To obtain access, providers will need to:

1. Complete the EDI 270 Enrollment Packet and
2. Obtain the necessary telecommunication software from the AT&T reseller.

The current AT&T resellers are:

- IVANS: www.ivans.com
  1-800-548-2675
- McKesson: www.mckesson.com
  1-800-782-7426, option 5 then key option 8

Health Care Claim Status Request and Response (276/277 Transaction Code Set)
Health Care Claim Status Request and Response conveys claim status information on claims received by Medicare. This transaction will help answer questions such as:

- Did you receive my claims?
- Where are my claims in your system?
- What is the status of my claims (paid, rejected, in-process, etc.)?

To take advantage of the 276/277 Health Care Claim Status Request and Response, providers must complete both a:

1. ANSI 4010A1 276/277 Claims Status Inquiry Enrollee Information Form, and
2. Trading Partner Agreement

Electronic Funds Transfer (EFT)
EFT allows Medicare to make payments directly into a providers banking account, so, there is not more waiting for checks in the mail.

Need More Information?

- Filing Claims Electronically
- Medicare Remit Easy Print
- PC Print
- Health Care Eligibility Benefit Inquiry and Response Transaction
- Health Care Claim Status Request and Response Transaction

Visit your state's Medicare web site or contact Electronic Data Interchange (EDI) Services at 1-866-582-3247.

Medicare web sites:
Arkansas – www.arkmedicare.com
Louisiana – www.lamedicare.com
Missouri – www.momedicare.com
New Mexico – www.oknmmedicare.com
Oklahoma – www.oknmmedicare.com
Rhode Island – www.rimedicare.com

For more information regarding EFT, visit your state's Medicare web site or contact the Provider Enrollment Department:

- Arkansas/Rhode Island (Part A) 1-501-918-7494
- Arkansas/Rhode Island (Part B) 1-866-582-3251
- Louisiana – 1-866-794-0466
- Missouri – 1-866-419-9460
- Oklahoma/New Mexico - 1-866-582-3251

Pinnacle Medicare Services
Electronic Data Interchange (EDI) Services
601 South Gaines Street – 4 South
Little Rock, AR 72203

Phone: 1-866-582-3247
Fax: 1-501-378-2265
E-mail: edi@arkbluecross.com

Medicare Update: Impact of CR 5047

The following summary is a synopsis of the impact of Medicare Change Request (CR) 5047 which implements Section 5203 of the Deficit Reduction Act of 2006:

- A hold will be placed on Medicare payments for ALL Part A & B claims (e.g., initial claims, adjustment claims, and MSP claims) for the last 9 days of the Federal fiscal year (i.e., September 22 - September 30, 2006).
  - In essence, no payments on claims will be made September 22 - 30, 2006. Providers need to be aware of these payment delays, which **are mandated by Section 5203 of the Deficit Reduction Act (DRA) of 2006**.
  - **All** claims held as a result of this one-time policy that would have otherwise been paid on one of these 9 days will be paid on **October 2, 2006**.
  - Accelerated payments using normal procedures will be considered.
- No interest will be accrued or paid and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.
- **This policy applies only to claims subject to payment**. It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments, cost reports settlements, and other non-claim payments.

Fee Schedule Updates

The following CPT4 and HCPCS Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule.

Effective March 15, 2006:

HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
Q9952	$2.89	$0.00	$0.00	$0.00	$0.00	$0.00
Q9953	$30.41	$0.00	$0.00	$0.00	$0.00	$0.00
Q9954	$8.98	$0.00	$0.00	$0.00	$0.00	$0.00
Q9956	$40.42	$0.00	$0.00	$0.00	$0.00	$0.00
Q9957	$61.89	$0.00	$0.00	$0.00	$0.00	$0.00
Q9958	$0.29	$0.00	$0.00	$0.00	$0.00	$0.00
Q9959	$1.83	$0.00	$0.00	$0.00	$0.00	$0.00
Q9960	$1.24	$0.00	$0.00	$0.00	$0.00	$0.00
Q9961	$0.32	$0.00	$0.00	$0.00	$0.00	$0.00
Q9962	$0.36	$0.00	$0.00	$0.00	$0.00	$0.00
Q9963	$0.23	$0.00	$0.00	$0.00	$0.00	$0.00

Effective April 1, 2006:

HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
A0420	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Effective April 19, 2006:

HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
J9160	$1,404.30	$0.00	$0.00	$0.00	$0.00	$0.00

Effective April 26, 2006:

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
J0180	$128.25	$0.00	$0.00	$0.00	$0.00	$0.00
J0215	$27.20	$0.00	$0.00	$0.00	$0.00	$0.00
J1931	$24.06	$0.00	$0.00	$0.00	$0.00	$0.00
J3240	$743.13	$0.00	$0.00	$0.00	$0.00	$0.00
J7317	$118.90	$0.00	$0.00	$0.00	$0.00	$0.00
J7320	$201.24	$0.00	$0.00	$0.00	$0.00	$0.00
90378	$661.83	$0.00	$0.00	$0.00	$0.00	$0.00

Effective May 03, 2006:

CPT Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
90680	$31.63	$0.00	$0.00	$0.00	$0.00	$0.00
90719	BR	$0.00	$0.00	$0.00	$0.00	$0.00

Effective May 10, 2005:

HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
S0515	$178.47	$0.00	$0.00	$0.00	$0.00	$0.00

Effective May 23, 3006:

HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
G0105	$601.69	$0.00	$0.00	$462.68	$0.00	$0.00
G0121	$601.69	$0.00	$0.00	$462.68	$0.00	$0.00
J1950	$462.33	$0.00	$0.00	$0.00	$0.00	$0.00
J1441	$306.97	$0.00	$0.00	$0.00	$0.00	$0.00

Effective March 22, 2006, HCPCS Code J9310 was updated in the Arkansas Blue Cross and Blue Shield fee schedule with an allowance of $454.39.

Effective June 7, 2006:

HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
J1441	$304.04	$0.00	$0.00	$0.00	$0.00	$0.00
S8420	$114.26	$0.00	$0.00	$114.26	$0.00	$0.00
S8421	$21.90	$0.00	$0.00	$21.90	$0.00	$0.00
S8422	$76.15	$0.00	$0.00	$76.15	$0.00	$0.00
S8423	$70.86	$0.00	$0.00	$70.86	$0.00	$0.00
S8424	$38.78	$0.00	$0.00	$38.78	$0.00	$0.00
S8425	$18.44	$0.00	$0.00	$18.44	$0.00	$0.00
S8426	$18.44	$0.00	$0.00	$18.44	$0.00	$0.00
S8427	$9.91	$0.00	$0.00	$9.91	$0.00	$0.00
S8428	$29.60	$0.00	$0.00	$29.60	$0.00	$0.00
S8429	$141.01	$0.00	$0.00	$141.01	$0.00	$0.00

The following codes were updated in the Arkansas Blue Cross Fee Schedule:

CPT/HCPCS Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
85097	$171.91	$171.91	$0.00	$82.40	$82.40	$0.00
88188	$123.58	$123.58	$0.00	$123.58	$123.58	$0.00
A4253	$38.51	$0.00	$0.00	$38.51	$0.00	$0.00
A4259	$12.74	$0.00	$0.00	$12.74	$0.00	$0.00

Effective January 1, 2006, the following new CPT-4 code was added in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT Code	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
0159T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule Additions

On April 1, 2006, the following new CPT-4 codes were added to the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT Codes	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
1015F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1018F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1019F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1022F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1026F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1030F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1034F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1035F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1036F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1038F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
1039F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2010F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2014F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2018F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2022F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2024F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2026F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2028F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3006F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3011F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3014F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3017F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3020F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3021F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3022F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3023F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3025F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3027F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

CPT Codes	Total	Professional	Technical	Total SOS	Professional SOS	Technical SOS
3028F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3035F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3037F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3040F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3042F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3046F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3047F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3048F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3049F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3050F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3060F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3061F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3062F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3066F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3072F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3076F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3077F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3078F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3079F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3080F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4025F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4030F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4033F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4035F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4037F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4040F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4045F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4050F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6005F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
S0345	BR	BR	BR	BR	BR	BR
S0346	BR	BR	BR	BR	BR	BR
S0347	BR	BR	BR	BR	BR	BR
S0628	BR	BR	BR	BR	BR	BR

Providers' News

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