



Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Provider Manual

Updated March 30, 2022

Table of Contents

Section 1: Health Advantage.....	4
Section 2: General Information	10
Section 3: Roles and Responsibilities.....	22
Section 4: Arkansas Health Care Payment Improvement	25
Section 5: Claims Filing andInformation	27
Section 6: Claims Payment,.....	64
Copayments, Coinsurance, andDeductibles:	69
Fee Schedule and Allowances:	73
Member Financial Obligations:	75
Refunds:	77
Remittance Advice:	78
Reimbursement:	79
Section 7: Codes and Coding Edits.....	80
Section 8: Consolidated Appropriations Act (CAA)	90
Section 9: Coverage Policiesand Procedures	96
Section 10: COVID-19 Information	103
Section 10: COVID-19 Update	104
Section 11: Hospital and	105
Section 12:ICD-10	121
Section 14: Member / PatientInformation	136
Section 15: Mental Health Services	147
Section 16:Modifiers.....	151
Section 17: Network Termsand Conditions	162
Section 18: Patient Protection and Affordable Care Act.....	167
Section 19:Pharmacy	173
Medications and Supplies Not Covered:	177
Section 20:Products	180
Health Advantage Traditional	181
Self-Insured Group Health Plans:	185
Arkansas State Employees	186
Arkansas State Retirees.....	187
Arkansas Public School Employees	189
Arkansas Public School Retirees	190
Section 21: Provider Information	192
Change / Update Information:	196
Forms for Providers	197

Section 22: Provider Profiles.....	198
Focused Review:	199
Physician Profiles	200
Section 23: Special Coding & Billing Issues	201
Section 24: Utilization Review	216
New fax number for hospital precertification services	221
High Tech Radiology Prior Approval:.....	222
Section 25: Miscellaneous	230
Ambulance Services – Medical Transports.....	234
Physical Therapy, Occupational Therapy, Speech Therapy, and Chiropractic Services:	240
Payment reduction for multiple therapy services performed on the same day.....	240
Physical therapy assistants & physical therapy aides	241
Physician Assistants	243
Physical therapy assistants.....	245
Sleep Study Centers:	246
Telemedicine coverage update	247
Transplant Facilities and Procedures:	248

Welcome to Health Advantage

Provider Manual:

Welcome . . . Thank you for becoming a participating provider with Health Advantage.

Health Advantage is the largest Health Maintenance Organization (HMO) in Arkansas covering services for over 200,000 Arkansans. It was established in 1986 and is the only locally owned and operated HMO in the state of Arkansas serving all 75 counties.

Health Advantage's mission is to provide organizations, families, and individuals in each community we serve with the best value in health-benefit plans, predictable service and high satisfaction. Our products and services aim to create high customer value, confidence, peace of mind and an improved quality of life.

What this Manual is Intended to Do:

Health Advantage recognizes that, at times, the administrative requirements of managing a patient's healthcare can be complex. The intent of this Provider Manual is to serve as a source for answers to some of the most common questions providers have about health plan coverage and claims filing procedures, policies and other facts related to administering care to Health Advantage members.

This Provider Manual is not intended as a complete statement of all provider-related policies, procedures, or standards of Health Advantage. The Provider Manual outlines certain, but not all, policies and procedures adopted by Health Advantage with respect to provider participation, claims filing, and related subjects. Other policies and procedures, not reflected in this Manual, are published regularly in the Providers' News, on the Health Advantage website for providers and members, in our member benefit certificates or health plans, or in other special publications, letters, or notices, including but not limited to credentialing standards, appeals policies and procedures, network terms and conditions, and provider contracts.

A Word About Our Affiliated Companies:

This Provider Manual is created and published by Health Advantage, an Arkansas health maintenance organization (HMO). This Provider Manual contains numerous references to networks, products or services of other companies that are affiliated with but separate and distinct from Health Advantage. Most of the participating providers are already very familiar with these affiliated companies and their networks, products and services; nevertheless, in order to be sure that all providers understand the references in this Manual to affiliated companies and their networks, products and services, a brief summary of the affiliated companies and their relationship to Health Advantage is located in the "Products" section.

Health Advantage wants providers to understand that while these companies are affiliated with us, they are separate organizations with their own Boards of Directors, officers, and operations, as well as policies and procedures. Providers, who wish to participate in any network of these separate, but affiliated companies, must meet the terms and conditions, and execute the participation agreements, required by these separate, affiliated companies.

If you need assistance, please contact the appropriate regional office. A dedicated staff of trained professionals will provide the health plan coverage and claims knowledge and experience needed to address your questions and service requests.

Section 1: Health Advantage

Section 1: Health Advantage

Disclaimer:

Health Advantage makes no representations or warranties with respect to the content hereof. Further, Health Advantage reserves the right to revise this publication without obligation of Health Advantage to notify any person of such revision or changes.

Updates to any part of this Manual may be made by Health Advantage at any time. Health Advantage may give notice of such updates in a variety of ways, depending on the nature of the update, including issuance of a letter to providers, publication in the *Providers' News* newsletter or other publications of Health Advantage, or posting to the Health Advantage Web site, www.healthadvantage-hmo.com.

Special Note: This Manual is provided for the convenience of providers participating in any Health Advantage network. Nothing in this manual shall be interpreted as guaranteeing coverage of any service, treatment, drugs or supplies because coverage or non-coverage is always governed exclusively by the terms of the member's health benefit plan. Accordingly, in case of any question or doubt about coverage, providers should always review the member's particular health benefit plan.

Any five-digit physician's current procedural terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright by the American Medical Association. All Rights Reserved.

Unless otherwise indicated, any reference in this Manual to "company", shall be deemed to refer to Health Advantage.

Last update: March 30, 2022

Section 1: Health Advantage

Regional Offices:

The main office of Health Advantage is located at 5 Allied Drive in Little Rock. Health Advantage operates full-service regional offices serving seven designated geographic areas of the state. The [Regional Offices](#) (headquartered in Fayetteville, Fort Smith, Hot Springs, Little Rock, Jonesboro, Pine Bluff and Texarkana) offer sales, customer service, utilization review and provider relations services to counties in their parts of the state.

Click [here](#) to view the regional map.

Section 1: Health Advantage

Medical Directors

Office Location	Medical Director	Address	Phone & Fax
<u>Arkansas Blue Cross and Blue Shield Corporate Office</u>	Chief Medical Officer Dr. Mark Jansen mtjansen@arkbluecross.com	Arkansas Blue Cross 601 South Gaines St. Little Rock, AR 72201	(501) 378-2309 (501) 378-5699 fax
<u>Arkansas Blue Cross and Blue Shield Corporate Office</u>	Corp Medical Director-Internal Affairs Dr. Herbert (Bert) H. Price, III hhprice@arkbluecross.com	Arkansas Blue Cross 5 Allied Drive Little Rock, AR 72202	(501) 502-1049 (501) 378-2855 fax
<u>Arkansas Blue Cross and Blue Shield Corporate Office</u>	Dr. Randal Hundley rfhundley@arkbluecross.com	Arkansas Blue Cross 601 South Gaines St. Little Rock, AR 72201	(501) 688-0716 (501) 378-2720 fax
<u>Arkansas Blue Cross and Blue Shield Corporate Office</u>	Dr. William Fiser wpfiser@arkbluecross.com	Arkansas Blue Cross 601 South Gaines St. Little Rock, AR 72201	(501) 688-0723
<u>Arkansas Blue Cross and Blue Shield Corporate Office</u>	Health Equity and Public Programs Dr. Creshelle Nash cnash@arkbluecross.com	Arkansas Blue Cross 601 South Gaines Little Rock, AR 72201	(501) 399-3986
<u>Arkansas Blue Cross and Blue Shield Corporate Office</u>	Medicare Advantage and Senior Products Dr. Thomas Becker tebecker@arkbluecross.com	Arkansas Blue Cross 5 Allied Drive Little Rock, AR 72202	(501) 502-1362
<u>Central Region Little Rock</u>	Dr. John Brineman jrbrineman@arkbluecross.com	Arkansas Blue Cross 5 Allied Drive Little Rock, AR 72202	(501) 502-1330 (501) 379-4664 fax
<u>Northeast Region Jonesboro</u>	Dr. Elaine Gillespie eagillespie@arkbluecross.com	Arkansas Blue Cross 2110 Fair Park Blvd., Suite 1 Jonesboro, AR 72401	(870) 974-5790 (870) 974-5713 fax
<u>Northwest Region Springdale</u>	Dr. Cygnet Schroeder-Bise Caschroeder-bise@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	(479) 379-5159 (479) 527-2323 fax
<u>Northwest Region Springdale</u>	Vice President Clinical Strategy and Population Health Dr. Joanna Thomas jmthomas@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	(479) 973-6623 (501) 378-2855 fax
<u>Northwest Region Springdale</u>	Dr. Mark Enderle maenderle@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	(479) 973-6619 (501) 378-2304 fax
<u>Northwest Region Springdale</u>	Dr. Melissa Kizilos mmkizilos@arkbluecross.com	Arkansas Blue Cross 5288 W. Don Tyson Parkway Springdale, AR 72762	(501) 210-6520
<u>Southwest Region Texarkana</u>	Dr. Michael Martin mrmartin@arkbluecross.com	Arkansas Blue Cross 1710 Arkansas Blvd.	(501) 399-3942 (870) 974-5713 fax

		Texarkana, Arkansas 71854	
<u>Southwest Region</u> <u>Texarkana</u>	Dr. Kristin Lower kflower@arkbluecross.com	Arkansas Blue Cross 1710 Arkansas Blvd. Texarkana, Arkansas 71854	(501) 396-8683
<u>South Central Region</u> <u>Hot Springs</u>	Dr. Wallace (Al) Thomas wathomas@arkbluecross.com	Arkansas Blue Cross 1635 Higdon Ferry Road, Suite J Hot Springs, AR 71913	(501) 620-2652 (501) 520-2855 fax
<u>West Central Region</u> <u>Fort Smith</u>	Dr. Cygnet Schroeder-Bise Caschroeder-bise@arkbluecross.com	Arkansas Blue Cross 3501 Old Greenwood Road, Suite 3 Fort Smith, AR 72903	(479) 379-5159 (479) 648-6311 fax

Network Development Representatives:

The [Network Development Representative](#) (NDR) serves as the point of coordination for the provider network activities in the assigned region and supports on-going network operations. The NDR is accountable for maintaining a good effective working relationship with providers in the assigned regions, which includes contracting and education regarding Health Advantage. The NDR is also responsible for assisting providers with specific inquiries and problems which have not been resolved by other inquiries.

Section 1: Arkansas Blue Cross and Blue Shield

Network Development Representatives

Northeast Regional Office Jonesboro

Alison Morrison

2110 Fair Park Blvd, Ste. 1
Jonesboro, AR 72401
Phone: 870-974-5740
Fax: 870-974-5713
E-mail: apmorrison@arkbluecross.com

Counties include: Clay, Craighead, Crittenden, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Mississippi, Poinsett, Randolph, Sharp, St. Francis, Stone, and Woodruff. Also includes Tennessee counties of Shelby, Tipton, Lauderdale and Dyer; and Mississippi county of DeSoto; and Missouri counties of Pemiscot, Dunklin, Butler, Ripley and Oregon.

Northwest Regional Office Fayetteville

Terry Rhoads

516 E. Millsap Road, Ste. 103
Fayetteville, AR 72703
Phone: 479-527-2359
Fax: 479-527-2323
E-mail: tarhoads@arkbluecross.com

Counties include: Baxter, Benton, Carroll, Madison, Marion, Newton, Searcy, and Washington. Also includes Oklahoma counties of Adair and Delaware; and Missouri counties of Barry, Howell, McDonald, Ozark, Stone and Taney.

Southeast Regional Office Pine Bluff

Jason Aud

1800 West 73rd, Bldg #1
Pine Bluff, AR 71613
Phone: 870-543-2945
Fax: 870-543-2919
E-mail: jsaud@arkbluecross.com

Counties include: Arkansas, Ashley, Bradley, Chicot, Cleveland, Dallas, Desha, Drew, Jefferson, Lee, Lincoln, Monroe, and Phillips. Also includes Mississippi counties of Tunica, Coahoma,

Bolivar and Washington; and Louisiana parishes of East Carroll, West Carroll and Morehouse.

Southwest Regional Office Texarkana

Renay Turner

1710 Arkansas Boulevard
Texarkana, AR 71854
Phone: 870-779-9109
Fax: 870-779-9138
E-mail: prturner@arkbluecross.com

Counties include: Calhoun, Columbia, Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Ouachita, Sevier, and Union. Also includes Texas counties of Bowie and Cass; Oklahoma county of McCurtain; and Louisiana parishes of Bossier, Caddo, Claiborne and Webster.

South Central Regional Office Hot Springs

Renay Turner

1653 Higdon Ferry Rd., Ste J
Hot Springs, AR 71913
Phone: 870-779-9109
Fax: 870-779-9138
E-mail: prturner@arkbluecross.com

Counties include: Clark, Garland, Hot Spring, Montgomery, and Pike.

West Central Regional Office Fort Smith

Terry Rhoads

3501 Greenwood Road, Ste. 5
Fort Smith, AR 72903
Phone: 479-527-2359
Fax: 479-527-2323
E-mail: tarhoads@arkbluecross.com

Counties include: Crawford, Franklin, Johnson, Logan, Polk, Scott, and Sebastian. Also includes Oklahoma counties of Adair, Leflore and Sequoyah.

Central Regional Office Little Rock

320 W. Capitol, Suite 900
P.O. Box 2181
Little Rock, AR 72203

Due to the number of providers located in the Central Region, there are two network development representatives to assist our providers. Check the county list for each representative.

Tina Baggett

Phone: 501-379-4680
Fax: 501-379-4655
E-mail: trbaggett@arkbluecross.com

Counties include Cleburne, Perry, Pope, Pulaski*, Van Buren, White and Yell.
* Pulaski County Specialties:

Allergy	Optometry
Anesthesia/Pain & Facility	Orthopedic/Hand
AR Medical Labs	Surgery
Chiropractic	Otolaryngology (ENT)
Dermatology	Pediatric
Infectious Disease	Physical Medicine
Nephrology/ESRDs	Podiatry
Obstetrics/Gynecology	Pulmonary
Ophthalmology	Radiology

Jennifer Shelton

Phone: 501-379-3974
Fax: 501-379-4655
E-mail: jeshelton@arkbluecross.com

Counties include Conway, Faulkner, Grant, Lonoke, Prairie, Pulaski* and Saline.

* Pulaski County Specialties

Cardiology	Plastic and Reconstructive
Family Medicine	Proctology
Gastroenterology	Psychiatry/Psychology
General Surgery	Rheumatology
Internal Medicine	Urology
Hematology/Oncology	

Dental Provider Network Managers — Statewide

USABLE Life
Dental Provider Relations
P.O. Box 1650
Little Rock, AR 72203

Steven Seymour

Phone: 501-235-8486
Fax: 501-208-8299
E-mail: Steven.Seymour@usablelife.com

Counties include: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Carroll, Chicot, Clark, Cleveland, Dallas, Desha, Drew, Garland, Grant, Hot Spring, Jefferson, Lee, Lincoln, Madison, Marion, Monroe, Montgomery, Newton, Perry, Phillips, Pike, Pulaski* Saline, Searcy, Washington, and Yell.

Sheila Ward

Phone: 501-235-8485
Fax: 501-208-8299
E-mail: Sheila.Ward@usablelife.com

Counties include: Calhoun, Clay, Cleburne, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Faulkner, Franklin, Fulton, Greene, Hempstead, Howard, Independence, IZard, Johnson, Lafayette, Lawrence, Little River, Logan, Lonoke, Miller, Mississippi, Nevada, Ouachita, Poinsett Polk, Pope, Prairie, Pulaski* Randolph, Scott, Sebastian, Sevier, Sharp, St. Francis, Stone, Union, Van Buren, and Woodruff.

*Pulaski county is split between both representatives.

Section 2: General Information

Section 2: General Information

How to Contact Health Advantage

Provider Information Lines

The following list of phone numbers is for physicians and medical practitioners:

	Number	ID Number begins or formatted as
State and School Employee Service	501-378-2364 or 1-800-482-8416 (state and school employee policies)	PXG + Y00 and a six-digit number
Health Advantage Service	1-800-843-1329 (HMO policies only)	XCH + K and an eight-digit number
Integrated Health	1-800-451-7302 (Precertification of inpatient admissions only)	
The BlueLine	1-800-676-BLUE (2583) (benefits for all out-of-state policies)	AAA + six to nine numeric digits

Member Service Lines

	Little Rock	Toll Free	Fax
Customer Service (verification of benefits, referral, claims questions)	501-378-2363	1-800-843-1329	501-212-8518
Arkansas State/Public School Employees	501-378-2364	1-800-482-8416	
Arkansas State/Public School Employees Precertification – American Health Holding		1-800-592-0358	
BlueChoice®/HMO Arkansas/Health Advantage HMO (Group Sales Office)	501-379-4644	1-800-605-8301	
Special Delivery		1-800-742-6457	
Away From Home Care Coordinator		1-800-843-1329	
Administration		1-800-843-1329	501-212-8518
Out of Network Referrals	501-378-2363	1-800-843-1329	501-378-6647
Electronic Media Claims (EMC)	501-378-2336		

Email Us

If you have questions about our products or services, you may [submit a question to our Customer Service Department](#). If you have questions or comments about our Web site, you may [email our webmaster](#).

Contact Our Regional Offices

No matter where you go in the state, Health Advantage is nearby. Health Advantage is an affiliate of Arkansas Blue Cross, which maintains seven full-service regional offices located throughout the state.

- [Regional offices](#) Locate the regional office nearest you.
- [Network development representatives](#) Service for health care providers.

Member Information Lines ([En Español](#))

News Media Contact

Max Greenwood: 501-378-2131

Mailing Addresses

Health Advantage
P.O. Box 8069
Little Rock, AR 72203-8069

Claims Submission
P. O. Box 8069
Little Rock, AR 72203-8069

Medical Audit & Review
P.O. Box 3688
Little Rock, AR 72203-3688

A Note Regarding Health Advantage Customer Service

Health Advantage Customer and Provider Service areas exist to allow customers and providers to verify benefits, check the status of claims and make other inquiries. Information, whether provided by a Customer Service Representative or Provider Service Representative, is kept as up-to-date as possible. However, the status of an employer group's contract with Health Advantage may change at any time, as may an individual's employment status. Such changes may not be immediately communicated to Health Advantage. In addition, the processing of a given claim may reveal information that affects the coverage for medical services. For these reasons, no guarantees of coverage can be provided, and verification of benefits does not constitute a guarantee of payment for medical services.

Health Advantage is an Independent Licensee of the Blue Cross and Blue Shield Association and is licensed to offer health plans in all 75 counties in Arkansas.

Section 2: General Information

Definitions:

(These definitions are for general reference and convenience only and are subject to modification by the terms of your provider contract or member health plan or policy which shall control in the event of any conflict.)

ALLOWANCE OR ALLOWABLE CHARGE: when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by Health Advantage, in its sole discretion, to be reasonable. The Health Advantage customary allowance is the basic Allowance or Allowable Charge. However, the Allowance or Allowable Charge may vary, given the facts of the case and the opinion of Health Advantage's medical director.

AMBULATORY SURGERY: is any procedure identified on the ambulatory surgery list, which can be done on an outpatient basis.

BENEFIT PLAN: is a contractual agreement between Health Advantage and an employer group that provides for specific coverage of health services made available to the Members of the group.

BRAND-NAME MEDICATION: means any prescription medication that has a patented trade name separate from its generic or chemical designation.

CASE MANAGEMENT: is a program in which a registered nurse employed by Health Advantage, known as a Case Manager, assists a Member through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a Member. Case management is instituted at the sole option of Health Advantage when mutually agreed to by the Member and the Member's Physician.

COINSURANCE: means the obligation of a Member to pay a portion of an Allowance or Allowable Charge. Coinsurance is expressed as a percentage in the Schedule of Benefits. The Schedule of Benefits sets forth the Coinsurance for services or supplies received from an In-Network Provider and the Coinsurance for services and supplies from Out-of-Network Providers.

NOTE: Because the contract between Health Advantage and an In-Network Provider may include risk sharing arrangements that may involve a portion of the In-Network Provider's compensation or fees being withheld at the time the claim is paid, the actual Coinsurance percentage for which a Member is responsible on any given claim may be higher than the percentages stated in the Schedule of Benefits. The actual Coinsurance percentage is dependent upon the year-end settlement or periodic adjustments between the In-Network Provider and Health Advantage.

COMPOUND MEDICATION: means a medication that is prescribed by the physician and prepared by the pharmacist using multiple ingredients through any route of administration, including intravenous therapy.

CONTRACT YEAR: means the twelve consecutive month period commencing on the Group Enrollment Contract effective date and renewing on the anniversary of that effective date.

COPAYMENT: means the amount required to be paid to an In-Network Provider by or on behalf of a Member in connection with Covered Services. Copayments are listed in the Schedule of Benefits.

COVERED SERVICES: means services for which a Member is entitled to benefits under the terms of this Group Policy and Evidence of Coverage.

DEDUCTIBLE: is the amount of eligible expenses a covered person must pay before payment of benefits is commenced by the payer under the person's health plan or policy.

DEPENDENT: Any member of a Subscriber's family who meets the eligibility requirements of Evidence of Coverage who is enrolled under the contract and for whom Health Advantage has received premium.

EMERGENCY SERVICES: means health care services required to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that a condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. In order to qualify as Emergency Care, health care services must be sought within forty-eight (48) hours of the onset of the illness or Accidental Injury.

EVIDENCE OF COVERAGE: means the certificate of insurance containing the benefits, conditions, limitations and exclusions of the Group Insurance Contract plus the Schedule of Benefits and any amendments signed by an Officer of Health Advantage.

FORMULARY: means a specified list of covered prescription medications that is maintained by Arkansas Blue Cross. This list is subject to change.

GENERIC MEDICATION: means any chemically equivalent reproduction of a brand-name medication whose patent has expired. A prescription medication must have a price at least 20 percent lower than the brand-name medication in order to qualify as a generic medication for reimbursement purposes.

GROUP SERVICE AGREEMENT: is the contract, which sets forth the terms of enrollment, membership, payment, and coverage, under which a Group may obtain health services for its Members.

HOSPITAL: means an acute general care hospital, a psychiatric hospital or a rehabilitation hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law or approved by the Board of Directors of the company: hospitals owned or operated by state or federal agencies, convalescent homes or hospitals, homes for the aged, sanitariums, long-term care facilities, infirmaries or any institution operated mainly for treatment of long-term chronic disease. For complete details, see the member's applicable benefit plan or policy.

IMPERATIVE CARE: means care a member receives while traveling outside the service area for an unexpected illness or injury that cannot wait until the member returns to the service area. the member can call 1-800-810-BLUE for participating providers in their area; claims will be reviewed upon receipt to determine if they meet urgent/emergent guidelines.

INPATIENT STATUS: is defined as a hospital stay greater than twenty-four (24) hours or greater than twelve (12) hours plus an overnight stay while receiving medically necessary treatment unless the stay is related to uncomplicated ambulatory surgery.

MAINTENANCE MEDICATION means a specific prescription medication exceeding a one-month supply that has been designated as a maintenance medication by the company for ongoing therapy of a chronic illness. For complete details, see the member's applicable benefit plan or policy.

MAINTENANCE or SUPPORTIVE CARE: is care that is delivered after the acute phase of a condition has passed and maximum therapeutic benefit has occurred. Maintenance care is treatment to promote optimal function in the absence of significant symptoms. Supportive care is treatment for a chronic condition for which recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continual care.

MEDICAL DIRECTOR: A physician designated by Health Advantage to service as Health Advantage Medical Director, and to provide among other things, utilization review.

MEMBER means any person who satisfies the eligibility requirements and financial obligations to qualify for coverage of health care services under a health plan issued or administered by Health Advantage.

MEMBER APPEAL: means a request to change a previous decision made by Health Advantage in which the Member is financially responsible

NON-COVERED SERVICES: Any service not covered under the terms, conditions, exclusions and limitations of a Member's Evidence of Coverage with Health Advantage.

OUT-OF-AREA SERVICES: means those services provided outside the Service Area in a location outside the state of Arkansas where covered medical services are not available through In-Network Providers.

OUTPATIENT CARE: means all care received including services, supplies and medications in a physician's office, outpatient surgery center, x-ray or laboratory, the member's home or at a hospital where the member receives services but is not admitted to the hospital.

PARTICIPATING HOSPITAL is a hospital with which Health Advantage maintains contractual arrangements to provide comprehensive hospital services to all members. Please refer to the provider directory for the names of participating hospitals, physicians and providers. See your provider contract for complete definitions and details.

PARTICIPATING PHARMACY means a licensed pharmacy which has a written agreement to provide pharmacy services to Health Advantage participants as provided in the benefit certificate.

PARTICIPATING PHYSICIAN means a licensed Doctor of Medicine or osteopathy, who has a contract with Health Advantage to provide health services to members. Please refer to the provider directory for the names of participating hospitals, physicians and providers. See your provider contract for complete definitions and details.

PARTICIPATING PROVIDER: Please refer to the provider directory for the names of participating network hospitals/physicians/providers.

PHYSICIAN means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health interventions at the time and place such intervention is rendered. For complete details, see the member's applicable benefit plan or policy.

PLAN: means the Subscriber health benefit Plan established by your Employer. The terms of the Plan are set forth in the Group Contract between Health Advantage and your Employer.

PRECERTIFICATION: is the process whereby inpatient admissions are reviewed for an initial determination of whether hospitalization is medically necessary, or whether needed services could be provided in an outpatient or other alternative setting. Precertification does not guarantee payment, but means only that, based on information provided to Health Advantage, coverage for the admission (and for the initial number of inpatient days authorized for reimbursement), will not be denied solely on the basis of lack of medical necessity for inpatient treatment. Coverage and payment to all providers is always subject to member eligibility, payment of premiums and all other terms and conditions of the member's health plan. NOTE: Pre-Certification is not required for Health Advantage plans. Check your patient's ID card or health plan to determine applicability of pre-certification requirements.

PREFERRED DRUG LIST is an abridged list of covered prescription medications selected by Health Advantage that are subject to lower copayments and coinsurance. For complete details, see the member's applicable benefit plan or policy.

PRESCRIPTION means an order for drugs, medicines or medications by a physician to a pharmacy for the benefit of and use by a covered person of Health Advantage. For complete details, see the member's applicable benefit plan or policy.

PRESCRIPTION MEDICATION means any medication or pharmaceutical that has been approved by the U.S. Food and Drug Administration, can be obtained only by a physician order, and bears the label — "Caution: Federal Law prohibits dispensing without a prescription." For complete details, see the member's applicable benefit plan or policy.

PRIMARY CARE PHYSICIAN (PCP): means an In-Network Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice or Internal Medicine.

PROVIDER APPEAL: means a request to change a previous decision made by Health Advantage in which the Member is not financially responsible.

REFERRAL: means an authorization to cover services issued by the Member's Primary Care Physician.

SERVICE AREA: is the state of Arkansas.

SUBSCRIBER: means a person who is directly employed by the Employer for Full-Time Employment. This person must reside in the United States and be paid for full-time work in the conduct of the Employer's regular business. No director or officer of the Employer shall be considered a Subscriber unless he meets the above conditions.

TARGET LENGTH-OF-STAY (TLOS): is the target for each hospital admission that will be assigned and communicated at the completion of the notification process that many Health Advantage benefit plans require upon hospital admission. The assigned TLOS will be assigned using InterQual Decision Support Criteria.

Section 2: General Information

Helpful Reminders:

To assist physician offices in obtaining proper eligibility, coverage and benefits information regarding Health Advantage members, a list of helpful reminders is provided below:

- When a member calls to schedule an appointment, please ask about insurance information.
- When a member arrives at your office, please ask to see their Health Advantage identification card.
- Maintain a current copy of the front and back of the member's identification card in their medical file.
- Display a Health Advantage information sign in your office as a reminder for members to show their ID card.
- When possible, collect any copayments the day services are rendered.
- File claims with Health Advantage within 180 days even if Health Advantage is not the primary payer.

If a member does not have a valid identification card, providers may call our Customer Service department or access the [Advanced Health Information Network](#) (AHIN) to obtain the most current membership eligibility information available for Health Advantage, from the employer and/or member.

Section 2: General Information

My BlueLine - The Interactive Voice Response System:

Health Advantage is happy to continue the availability of [My BlueLine](#), the Interactive Voice Response System (IVR). **My BlueLine** recognizes common English to answer questions when you call. When providers call, **My BlueLine** will immediately answer. By simply responding to the questions asked by the system – with no buttons to push – providers can get questions answered quickly and easily without having to wait.

Providers can call 1-800-827-4814, or locally to the Central Arkansas area 501-378-2307, for access to information for Arkansas Blue Cross Blue Shield, Blue Advantage Administrators, Health Advantage and Federal Employees Program (FEP) members.

Note: Continue using the existing telephone numbers for the following:

- **Blue Card 1-800-880-0918**

Health Advantage believes this is a great enhancement for providers. Providers will no longer have to call multiple phone lines to get information on a member, depending upon whether the member's coverage is with Arkansas Blue Cross and Blue Shield, Medi-Pak®, BlueAdvantage Administrators, Health Advantage or FEP (Federal Employees Program).

My BlueLine will be able to help providers with questions regarding:

- authorization and information concerning imaging services,
- technical and navigational issues regarding the reform payment portal, and
- content and calculation around the payment initiative report from the reform payment portal.

During regular business hours, callers can request – at any time during the telephone call – to speak to the next available customer service representative. At that time, the caller will be given an option of visiting with a Customer Service Representative with Health Advantage.

My BlueLine is there when you need quick answers to simple questions and is available 24 hours a day, seven days a week.

Items to Remember:

National Provider Identifier (NPI): A caller **must** have their 10-digit NPI and the member's ID number when calling **My BlueLine**.

Using My BlueLine:

Items to Remember:

- **National Provider Identifier (NPI):** A caller must have their 10-digit NPI number and the member's ID number when calling.
- **Clear Speech:** Speak clearly and avoid conversations with others while using the IVR.
- **Speaker Phones:** Avoid use of speaker phone when using the IVR.
- **Headsets:** To eliminate problems with the IVR not recognizing what is spoken, avoid the use of headsets.
- **Multiple Checks:** A caller can check on as many claims or members' eligibility as needed in the same call.
- **Multiple Lines of Business:** Callers can check on Arkansas Blue Cross and Blue Shield, Health Advantage and Blue Advantage Administrators of Arkansas patient information in the same call.
- **Main Menu:** Say "Main Menu" at any time to be transferred to the main menu section.
- **Availability:** The IVR system is available 24 hours a day, 7 days a week.
- **Customer Service:** Say "Customer Service" at any time to transfer to Customer Service. Customer Service Representatives are available during regular working hours.
- **Answering Questions:** Once a caller is familiar with the IVR system, break in and answer the questions before the IVR is finished speaking the questions.
- **Information Provided:** Eligibility information and any benefit information provided is not a guarantee of payment or coverage and is only valid if all coverage criteria is verified when we receive the claim.

Section 2: General Information

Helpful Web Sites:

Name	Website
Advanced Health Information Network (AHIN)	secure.ahin-net.com
American Chiropractic Association	www.acatoday.org
American Occupational Therapy Association	www.aota.org
Arkansas Blue Cross and Blue Shield	www.arkansasbluecross.com
Arkansas Medicare Services	medicare.com/state/arkansas-medicare
Arkansas Chiropractic Association	archiro.org
Arkansas Chiropractic Society	www.archirosociety.com
Arkansas Department of Health	www.healthylarkansas.com
Arkansas Department of Human Services	humanservices.arkansas.gov
Arkansas Foundation for Medicare Care, Inc.	www.afmc.org
Arkansas Hospital Association	www.arkhospitals.com
Arkansas Medical Society	www.arkmed.org
Arkansas Medicaid	medicaid.mmis.arkansas.gov
Arkansas Physical Therapy Association	www.arpta.org
Arkansas State and Public School - Employee Benefits Division	www.dfa.arkansas.gov/employee-benefits-division/arbenefits
Arkansas State Medical Board	www.armedicalboard.org
BlueAdvantage Administrators of Arkansas	www.BlueAdvantageArkansas.com
BlueCard	www.arkansasbluecross.com/providers/bluecard_info.aspx
Centers for Medicare and Medicaid Services	www.cms.gov
Coordination of Benefits Agreement (COBA)	www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page.html
Federal Employee Program (FEP)	www.fepblue.org
Federal Registers online site	www.ofr.gov
GPO (Government Printing Office)	www.gpo.gov
Information on Medicare Manuals	www.cms.gov/manuals
Medical Group Management Association	www.mgma.com
Medicare Training	www.cms.gov/Outreach-and-Education/Learn/Get-Training/Get-training-page.html
NPPES - National Provider Identifier	nppes.cms.hhs.gov
OIG (Office of the Inspector General)	www.oig.hhs.gov

Section 3: Roles and Responsibilities

Section 3: Roles and Responsibilities

The Primary Care Physician:

The role and responsibilities of a PCP are as follows:

- Notify the plan if his/her practice is limited to pediatrics or adults.
- Agree to be listed in the Member's enrollment materials for potential selection by Members. If the PCP is unable to accept new patients, he/she is required to give Health Advantage forty-five (45) days written notice.
- Treat all primary health care needs of each assigned Member. He/she may refer the Member to a network hospital, network outpatient facility or network specialist for covered services. Some plans may not require a referral for in-network services.
- Provide primary health care and coordinate all services received by Members from other providers.
- Ensure that services are available to his/her Health Advantage Members twenty-four (24) hours a day, seven (7) days a week through a telephone access number at a minimum. When a PCP is unable to provide such coverage, he/she must designate an in plan physician to provide services on his/her behalf. It is the PCP's sole responsibility to arrange for reimbursement to the designated covering physician.
- Accept reimbursement as specified in the Physician Agreement.
- Maintain comprehensive medical records and accounting procedures in accordance with accepted professional standards.
- Participate in the Health Advantage referral, utilization management and quality improvement procedures, including out-of-plan treatment, continued stay review (if necessary), discharge planning, case management, internal and external peer review activities and Member appeal resolution procedures.
- Call Health Advantage for review of any out-of-network (OON) referrals.

Section 3: Roles and Responsibilities

The Specialist Physician:

All specialty care, except routine vision, obstetrical and gynecological services, must be coordinated through the PCP to receive reimbursement for services provided.

The role and responsibilities of a Specialist are as follows:

- Coordinate the Member's care through the PCP.
- Perform covered services for Members with a valid referral from the Member's PCP. The PCP may indicate the date span, the number of visits and any restrictions for coverage of specialty services.
- All outpatient services ordered by the Specialist must be rendered through Network Providers of Health Advantage.
- Agree to be listed in the Health Advantage Provider Network Directory that can be accessed online at www.healthadvantage-hmo.com.
- Agree to reimbursement and plan as described in the Specialist Physician Agreement.
- Maintain comprehensive medical records and accounting procedures in accordance with accepted professional standards.
- Abide by referral, utilization management and quality improvement procedures including out-of-network treatment, continued stay review (if necessary), case management, internal and external peer review activities. The Specialist is also expected to assist in discharge planning and Member grievance resolution procedures.
- Call the Health Advantage Customer Service department for review of any Out-of-Network (OON) services.

Please note: Members with a Point of Service (POS), Open Access (OA), or High Deductible plan may receive reduced coverage if the referral procedures are not followed. These programs have different benefit arrangements that may affect the information listed above. Members on open access or high deductible plans do not need a referral for in-network services.

**Section 4:
Arkansas Health Care
Payment Improvement
Initiative (AHCPII)**

Arkansas Health Care Payment Improvement Initiative (AHCPII):

Episode-Based Reimbursement Program

The Episode-Based Reimbursement Program was created in 2012 was part of the Arkansas Health Care Payment Improvement Initiative (AHCPII). The AHCPII was developed as a joint effort between Arkansas Medicaid, QualChoice and Arkansas Blue Cross and Blue Shield, its affiliates and subsidiaries (Arkansas Blue Cross). Click here: [Value-Based Programs](#) for additional information. The link is also accessible on our website www.healthadvantage-hmo.com by selecting the "Providers" tab and "Value-Based Programs" under the "Resource Center" heading.

The Episodes of Care Reimbursement Program links are listed below to identify participation in individual episodes

- [Asthma Exacerbation](#)
- [Cholecystectomy](#)
- [Chronic Obstructive Pulmonary Disease \(COPD\)](#)
- [Colonoscopy](#)
- [Congestive Heart Failure \(CHF\)](#)
- [Coronary Artery Bypass Graft \(CABG\)](#)
- [Hysterectomy](#)
- [Lumbar Spinal Fusion](#)
- [Percutaneous Coronary Intervention \(PCI\)](#)
- [Perinatal Episode Reimbursement Program](#)
- [Pneumonia](#)
- [Tonsillectomy-Adenoidectomy](#)
- [Total Hip & Knee Replacement](#)

Section 5: Claims Filing and Information

Accidental Injuries & Subrogation:

Accidental Injuries:

If a Health Advantage member is involved in an accident, bill in the usual manner, adding the place, date, time, and cause of injury. Health Advantage needs to know the cause of injury to process injury claims. By adding the cause of injury and date of injury to the original claim submission, the provider facilitates a timely and expedited claim process.

If benefits are payable under the terms of any automobile medical, automobile no-fault, homeowners, premises liability, personal injury protection or similar contract of insurance, benefits may be coordinated at the point of final determination of liability.

Subrogation:

Subrogation rights are included in all Health Advantage members' health plans or contracts. This means that if we pay claims for an injury or illness (whether or not it was the result of an accident or some other cause) that was caused by another person who is liable to the member for that injury or illness, we are entitled to recover our payments from the responsible third party or their insurance carrier.

Health Advantage members are obligated to cooperate and to furnish all information needed to identify and pursue a third party or subrogation. If the member fails to cooperate, Health Advantage has the right to recover claim payments and deny benefits. This means a provider's claims may be affected if the member fails to promptly return the C-110 form or otherwise fails to cooperate or seeks to avoid our subrogation interest.

Note: Subrogation investigation and recovery services may be pursued for Health Advantage by a separate subrogation vendor, known as Equian.

Advanced Health Information Network:

Advanced Health Information Network ([AHIN](#)) is an online system that provides advanced functionality, which allows physicians and hospitals to manage their business functions more efficiently. It was one of the first health-information networks in the United States to offer advanced real-time functionality and continues to offer capabilities that are unique within the industry. This functionality is the primary reason that *Hospitals and Health Networks* magazine identified Arkansas Blue Cross as one of the "10 Most Wired Health Plans" in the country.

Assignment of Benefits:

Providers may elect to require that members, before receiving services, execute an assignment whereby any benefits under the member's health plan or contract are assigned to the provider. Granted that a provider is a participating provider in good standing with Health Advantage (not in violation of the provider agreement, the Health Advantage billing and coding guidelines or this Provider Manual) on the date of such assignment, and on the date of the services in question, Health Advantage will honor such assignments and any payments due for the services will be paid directly to the provider rather than to our member.

If providers cease to be a participating provider for any reason, however, Health Advantage reserves the right to decline to accept the assignment; and in such case Health Advantage may, in our discretion, make payment to the member rather than to the provider. Whether or not providers elect to require and receive an assignment from a Health Advantage member, providers agree to release the member from all financial responsibility with respect to that assigned claim, except for applicable copayment, coinsurance and deductible; i.e., providers agree to look exclusively to Health Advantage for payment for all services to the member, except for copayment, coinsurance and deductible (or non-covered services permitted to be billed to members under the terms of your participation agreement).

Claims Filing Rule Reminders for Durable Medical Equipment, Laboratory, and Specialty Pharmacy:

In 2004, the Blue Cross and Blue Shield Association (the Association) revised its BlueCard claims filing rules for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. While these revisions are several years old, the Association has only recently tightened system requirements related to these rules. These rules apply to all provider networks and claims related to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage when claims are being submitted via the "Blue Card" process of the Association, a process used to facilitate the efficient processing of claims for members receiving services outside their local service area or state.

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

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

New message codes on remittance advice for misrouted claims based on filing rules for independent clinical laboratory, durable medical equipment suppliers and specialty pharmacy:

New message codes have been created to handle misrouted claims for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. When claims are not filed according to the previously published filing rules (see the reprinted rules following), the claims will be rejected for one of the following reasons depending on the provider specialty:

- Independent Clinical Laboratory – **Message Code 1290: Claim filed to wrong Plan.** File to the Plan in the state where the specimen is drawn.
- Durable/Home Medical Equipment and Supplies – **Message Code 1291: Claim filed to wrong Plan.** File to the Plan in the state where the equipment was shipped to or purchased in a retail store.
- Specialty Pharmacy – **Message Code 1292: Claim filed to wrong Plan.** File to the Plan in the state where the ordering physician is located.

Health Advantage Customer Service staff will be monitoring claims denied with these message codes and will contact the Home Plans for verification of the denial. Once the information is obtained, Customer Service will reach out to affected providers to determine the steps needed to get the claim processed.

Independent Clinical Laboratory: For clinical lab, the local Blue Cross Plan is defined as the plan in which service area the specimen was drawn. Example: a blood specimen is drawn at a physician's office in Little Rock that participates in the Health Advantage network on a member who has Health Advantage benefit coverage. The lab is sent to New York to be processed and is billed from North Carolina. This laboratory participates in the Health Advantage network. The claim must be billed directly to Health Advantage as the specimen was drawn in Arkansas. The claim will be processed as in network for covered services.

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

The Referring Provider information, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission, is required on claims submitted for clinical lab.

Durable/Home Medical Equipment and Supply: For durable/home medical equipment and supply, the local Blue Cross Plan is the plan in which service area the equipment was shipped to or purchased at a retail store. For example: a member with Health Advantage insurance living in Fort Smith, AR orders diabetic supplies from a mail order supplier in Ohio. The supplier participates in the Host Plan's network in Ohio but not Arkansas. The claim must be filed directly to Health Advantage because Arkansas is where the supplies were shipped. The claim will be processed as out of network for covered services.

The following information is required on claims submitted for durable/home medical equipment:

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

Specialty Pharmacy: For specialty pharmacy, the local Blue Cross Plan is defined as the plan in which service area the ordering physician is located. For example: a physician whose clinic is in Pine Bluff orders specialty drugs for a Health Advantage member who lives in Stuttgart. The specialty pharmacy is located in Jackson, MS and is in the Mississippi Blue Cross and Blue Shield provider networks, but not in any Arkansas Blue Cross or affiliates' networks. The claim must be filed directly to Health Advantage as the ordering physician's practice location is in Arkansas. The claim will be processed as out of network as the specialty pharmacy is not in any Arkansas Blue Cross or affiliates' provider networks. Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission is required on claims submitted for clinical lab:

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

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

ClaimsXten Claims Editing Software:

Health Advantage implemented a new claims editing software, ClaimsXten (CXT), in October 2016. CXT offers two inquiry capabilities, which are accessible through AHIN (Advanced Health Information Network), to provide you with procedure code-specific member coverage and licensed prepayment edit information.

Code-Specific Coverage Inquiry provides information on whether a specific procedure code is covered under a Blue Cross or Health Advantage member's benefit certificate. Coverage information regarding a BlueAdvantage Administrators member's certificate can be obtained from BlueAdvantage Administrators Customer Service at (888) 872-2531.

ClaimsXten is designed to:

- Evaluate billing information and coding accuracy on submitted claims
- Reduce wasteful medical cost
- Increase auto-adjudication rates
- Decrease appeals, rework, and rule creation/maintenance
- Set the foundation to handle new payment methods
- Automate administrative procedures, correct coding and data validation
- Allow for more robust use of history in editing

With a strong clinical foundation, CXT is guided by the coding criteria and protocols in the CPT Manual that are published by the American Medical Association, National Correct Coding Initiative (NCCI), Specialty Society guidelines and industry standards and reflects Arkansas Blue Cross' medical policies. It also incorporates code editing rules based on the HCPCS coding system. CXT will introduce additional automation to aid in the proper editing of claims. This will help evaluate claims for coding accuracy. Claims that are coded inappropriately will continue to be denied as incorrect coding. As with the current claims editing product, not every claim adjudication can be automated; many will continue to require manual review.

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

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

Arkansas Blue Cross has always performed this type of review, and this software will allow us to do so in a much more consistent and efficient way. Claims will process with more consistency and accuracy. CXT is essential for keeping pace with the complex developments in medical technology and the increasingly more specific coding required today. As claims are edited, the software may create additional lines for the claim if warranted. Please note that the NCCI will be used in CXT and these edits will fire before medical policy edits.

AHIN is a HIPAA-compliant, on-line system accessible via the Internet that allows physicians, clinics and hospitals access to patient demographic, eligibility, benefit, claims, claim status and remittance advice information. Claims are received and processed for all payers, including those that do not accept electronic claims. Not already an AHIN customer? Contact AHIN Customer Support at (501) 378-2336 to sign up today.

Contiguous Counties:

Claims filing rules for counties bordering Arkansas

Here is a reminder on the claims filing rules for health care providers located in counties of states that border Arkansas.

If a member has insurance coverage with Health Advantage and if that member receives services from a healthcare provider located in a bordering county who is contracted to be in the provider networks of Health Advantage, the provider must submit the claim directly to Health Advantage. In this scenario, Health Advantage essentially fills both the "Host" and "Home" Plan function, based on the peculiar circumstances of border county proximity and the network participation agreement in place with the out-of-state provider. This rule also applies to Arkansas Blue Cross its members and contracted providers, as well as to health plans administered by Blue Advantage Administrators of Arkansas.

An example would be a physician in Memphis, TN, who provides care to a patient with health plan coverage from Health Advantage. If that physician is in the Health Advantage provider network, the claim must be submitted to Health Advantage in Little Rock.

If a health care provider in a bordering county is not in the Health Advantage provider network but is participating in the networks of the Blue Cross and Blue Shield plan where the provider is located, and that provider renders services to a member with coverage from Health Advantage, the provider must file claims to the local Blue Cross Blue Shield plan as the "Host Plan".

An example would be a physician in Memphis, TN, who provides care to a patient with health plan coverage from Health Advantage. This physician is NOT in the Health Advantage provider network but is in the Blue Cross Blue Shield of Tennessee provider networks. This claim must be submitted to Blue Cross Blue Shield of Tennessee.

If a health care provider located in a county bordering Arkansas, who participates in the Health Advantage provider network renders care to a member with insurance from a Blue Cross Blue and Shield Plan other than Arkansas Blue Cross and its affiliates, the provider must file the claim to the local Blue Cross and Blue Shield Plan, as the "Host Plan".

An example would be a physician in Branson, MO (located in a county bordering Arkansas) who provides care to a member with insurance coverage from Blue Cross Blue Shield of Montana. This claim must be submitted to the local Blue Plan which, for a place of service location in Branson, MO is Anthem Blue Cross and Blue Shield of Missouri. It does not matter whether the physician is in the Anthem Blue Cross and Blue Shield of Missouri provider networks, the claim still must be submitted to the local or "Host Plan".

The exceptions to these rules apply to health care providers for lab, durable medical equipment/medical supplies and specialty pharmacy.

Section 5: Claims Filing and Information

Coordination of Benefits:

When Health Advantage is the secondary carrier, the benefits will be reduced by the amount paid by the primary carrier. The allowable expense is a service that is covered in full or in part by any of the plans covering the person. Non-covered expenses are not coordinated.

Ultimately, it is the member's responsibility to ensure delivery of the EOB from the primary carrier to Health Advantage. However, if the provider receives the EOB from the primary carrier, he or she may forward it to Health Advantage for processing.

When Health Advantage is secondary, a provider has the right to collect the copayment, deductible, or coinsurance and then coordinate benefits with the other carrier. **Please note: If Health Advantage is the secondary payer, providers should submit a claim within the timely filing period.**

If Medicare is primary, the claim will automatically cross over to Health Advantage. Please do not file a separate claim to Health Advantage.

If the provider receives payment in excess of actual charges and has collected a copayment, deductible or coinsurance from the member, the provider should reimburse the member up to but not exceeding the amount of the copayment, deductible or coinsurance. Any additional overpayment for that date of service should be refunded to the secondary carrier.

If the provider contractually participates with other health plan(s), the privilege to collect a copayment may be affected by the agreement with the other health plan(s).

To file secondary claims electronically, reference [Filing Claims Electronically](#) section.

Dual Health Advantage Coverage:

When a member has two Health Advantage policies, the copayments and coinsurance amounts are paid by the secondary plan. Services that are not covered by both the primary and secondary carriers are not coordinated.

If the provider does not participate with the primary carrier but does participate with Health Advantage, all secondary payments will be made directly to the provider as opposed to paying the member.

Secondary paper claims submission

When filing secondary paper claims, a copy of an explanation of benefits (EOB) or remittance advice (RA) showing primary payment must be attached to each individual claim. Multiple claims attached to one copy of an EOB or RA will be returned. The electronic submission of secondary claims is preferred. For assistance in filing secondary electronic claims, please contact your software vendor or contact EDI Operations is 501-378-2336.

Section 5: Claims Filing and Information

Corrected Claims:

The Health Advantage definition of a corrected claim is a claim that has been processed, whether paid or denied, and was refiled with additional charges, a different diagnosis, or any information that would change the way that claim was originally processed. Placing the "Corrected Claim" indication on the claim form when it has not been previously processed will cause a delay in claim adjudication.

Claims returned requesting additional information are NOT to be refiled as corrected claims. These claims have been processed; however additional information is needed to finalize payment. Inappropriate usage of the Corrected Claim form will result in information being returned to the provider or a delay in processing.

Do not use the Corrected Claim form for the following:

- New Claims,
- Appeals,
- Medical Records,
- Invoices,
- Inquiries, or
- Adjustments.

Corrected Claims can be used for all lines of business including BlueCard and FEP. For a Corrected Claim form, click on the following link: [Provider Forms](#).

To file secondary claims electronically, reference [Filing Claims Electronically](#) section.

Electronic Corrected Claims are Accepted

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, FEP and BlueCard accept electronic corrected claims.

To file corrected claims electronically for the CMS 1500 claim form, providers should enter the number 7 in 2300/CLM05-3 and include the ICN number or BlueCard SCCF# of the original claim. The original ICN or SCCF# (Document Control Number - DCN) should be placed in the REF segment of the Loop 2300 with a qualifier of Ref01=F8. If these are not submitted, the claims will be returned as a duplicate.

Providers need to ask their software vendor to open an area within the 2300 loop for the remarks in the NTE segment as to what was corrected on the claim. Arkansas Blue Cross would appreciate receiving a total replacement claim in order for a complete comparison to the original claim along with the explanation in the NTE segment. This will expedite processing time and identify the actual corrections and the reason for the correction for both facility and professional corrected claims. To file corrected claims electronically for the UB claim form, the facility will need to use XX7 type of bill.

If you have questions regarding corrected claims, please contact Customer Service at:

AHIN Customer Support: 501-378-2336
EDI: 501-378-2336 or 866-582-3247

Filing Claims Electronically:

EDI is the acronym for Electronic Data Interchange. EDI is the exchange of information using routine business transactions in a standardized computer format, for example, data interchange between an insurance carrier and a provider. Electronic Data Interchange will save providers time and money and will help better manage their business. Providers may reach Health Advantage EDI Services at (501) 378-2336 or via e-mail at EDI@arkbluecross.com.

How to Enroll:

Providers must have electronic claim software to transmit claims electronically. Software for the transmission of electronic claims may be included in the provider's current practice management system. If a provider currently has a practice management system, contact the software vendor. Otherwise, providers must choose a HIPAA compliant software vendor, billing agent or clearinghouse.

A provider's office must have the following five items to be capable of submitting claims electronically:

1. Computer
2. Modem
3. Software program that has the option of electronic data interchange
4. Printer
5. Telecommunications package

Additionally, a dedicated telephone line for the modem is strongly recommended. If you want to auto post payment information, an Electronic Remittance Advice (ERA) software package will also be needed.

The first step is to fill out a Trading Partner Agreement (TPA) and mail, email or fax it to:

EDI Services Department
P. O. Box 2181
Little Rock, AR 72203-2181

or fax it to 501-378-2265

or email to edi_enrollment@arkbluecross.com

The provider must fill out a TPA even if they choose to use a billing agent or clearinghouse.

Please visit the following websites under Electronic Data Interchange for EDI information and the enrollment documents.

- arkansasbluecross.com
- healthadvantage-hmo.com
- blueadvantagearkansas.com
- usableadmin.com

Once enrolled, providers must test the software unless they utilize a billing agent, clearinghouse or have chosen a Health Advantage EDI approved software vendor.

A provider will be issued a submitter number/user ID by EDI Services before testing the software. Please see the Health Advantage Billing Requirements & Companion Document to assure correct filing of the test or production claims.

Services Available from EDI Services:

The EDI Services' Gateway system is an ASCII/asynchronous communications network that allows interchange of electronic information with Health Advantage. The EDI Services Gateway is available 24 hours a day, seven days a week. Each remote site that is authorized to access the Gateway is assigned a unique user identification number (submitter number). Providers will be given a default password which must be changed the first time the provider logs on and every 30 days thereafter.

Main Menu:

The features that are currently available through the EDI Services Gateway are as follows:

1. UPLOAD (Option 1) - Providers may upload electronic claims file, eligibility/benefit inquiry or claim status request (institutional or professional).
2. DOWNLOAD (Option 2) - Provider may download electronic claims confirmation reports, eligibility/benefit response, claim status response or electronic remittance advice.
3. ARCHIVE (Option 3) - Once read, all files retrieved from the DOWNLOAD Option are automatically archived to a separate location and held for 14 days. Providers may choose Option 3 to download the archived files.

Communication Requirements:

The Gateway allows only asynchronous communications. The following are requirements for this method of transmission:

- A Hayes compatible modem
- Telecommunication software, e.g., HyperTerminal, or something similar
- Terminal type of VT100 or VT100J
- The Health Advantage Gateway submission system can interface using the ASCII/Asynchronous communication protocol.

Communication Configuration Set-up:

The communication configuration should be set-up as follows:

- 28,800 BPS, and 56K
- 2 - Two start bits
- 1 - One stop bit
- 8 - Eight data bits
- N - No parity
- Full duplex should be implemented to allow data to be sent in both directions at the same time
- Emulation - VT100 or VT100J

Sending Claims to Gateway using HyperTerminal:

1. Connect using HyperTerminal
2. Hit Enter (at Blank Screen)
3. Enter User ID. (the beginning alpha character is lower case - Example: eXXXX)
4. Enter Default Password in all Uppercase. Enter.
5. Choose Option 1 to upload a file. Enter.
6. Select File Type. (Example: 4010 837 Institutional) Enter.
7. Choose Protocol. Enter.
8. Go to the Toolbar and select the Transfer option; then select Send File option.
9. Send File Prompt Box will be displayed, select Browse to choose file desired.
10. After choosing desired file; Select Open.
11. The file name will appear in the Send File Prompt Box; Click Send.
12. Hit Enter.
13. Select Option 2 to download acknowledgment file. (HyperTerminal will download file to the path found under Transfer then receive file.)
14. Insert an * (asterisk) beside the file to be uploaded and hit Enter.

15. Choose Protocol. File will automatically begin to download. Repeat this step for each file.
16. Once all files are downloaded, press ESC (Escape) and q (for quit).
17. When ready to log off the HyperTerminal for data transmission, type lo (for log off).

3 Types of Claims Filing Confirmation Reports:

Providers will receive 3 different types of claims filing confirmation reports:

1. Acknowledgment Report (can be downloaded within 15 minutes of transmission);
2. The second report contains TA1, 997 & Batch Processing Report (can be downloaded within the hour);
3. If you submit Private Business and Medicare claims, Medicare will create the R04H99 Report (acceptance and rejected claims) and R06H99 Report (ICN's for accepted claims) for Medicare Part B. Medicare Part A will create an acceptance and rejected report also, both Medicare reports cannot be downloaded until the next business day after transmission.

Provider Changes:

Changes within a provider's office are both necessary and inevitable. As an electronic submitter, providers will need to notify EDI Services of any changes that may occur at a provider's office by sending an e-mail to EDI@arkbluecross.com or faxing the information to (501) 378-2265.

- **Address Changes** – Address changes for electronic submitters must be reported to Provider Enrollment Services (to update a provider number address) and EDI Services (to update an electronic submitter file address).
- **Changes in Contact Person** – EDI must know who to speak to in a provider's office regarding electronic claims.
- **Changes in Physician Staff** – Please notify EDI Services, as well as Provider Network Operations, when a doctor leaves a practice so that he/she can be deleted from the electronic billing information retained in a provider's office. Likewise, if new physicians are added, please let EDI know so the doctor may be added to the electronic billing information retained in the provider's office.
- **System Changes** – Any changes in the software or hardware of a provider's office computer system should be reported to EDI Services. These changes may or may not affect the ability to bill electronically to Health Advantage EDI.

Transition from EDI Gateway to Moveit DMZ

Arkansas Blue Cross and Blue Shield's EDI Services Division has improved the way submitters can transmit and retrieve data. The old dial-up asynchronous communication to the EDI Gateway is being replaced with a new method. Moveit DMZ is government tested and government approved. It safely and securely allows the exchange of electronic data between organizations using an encrypted connection.

An https protocol will be used to quickly, easily, and securely exchange electronic data. Providers who prefer to use a script can do so with SFTP, however EDI will not support scripts. All submitters must have Internet Explorer or other ability to send via Hypertext Transfer Protocol Secure (HTTPS).

Provider should go to [https://www.arkansasbluecross.com/providers/resource-center/health-information-network/electronic-data-interchange-\(edi\)](https://www.arkansasbluecross.com/providers/resource-center/health-information-network/electronic-data-interchange-(edi)) and download the Moveit DMZ User Manual located under Connectivity/Communications. Providers will need to contact EDI for the default password to establish their connectivity. The deadline date to transition is April 15, 2013.

Once providers feel comfortable with Moveit DMZ, they should complete the Moveit DMZ transition form located beneath the user manual on the Arkansas Blue Cross Web site. The effective date is the date providers want to transition from the Gateway to Moveit DMZ.

Providers will not be set up for production until the date indicated on the form. Please send all forms via e-mail at edi@arkbluecross.com or fax to 501-378-2265.

Applies to Arkansas Blue Cross BlueAdvantage Administrators of Arkansas, and Health Advantage.

Initial hospital visits billed by multiple physicians

In March 2012, Arkansas Blue Cross and Blue shield sent notice to providers that only the admitting physician could bill the hospital admission CPT Codes 99221-99223. All other physicians seeing the patient, even if for the first time, were instructed to bill the subsequent hospital CPT Codes 99231-99233. However, most physicians continue to bill the hospital admission codes.

After data analysis and understanding that the consult CPT Codes are not available for providers to use, Arkansas Blue Cross agrees that the physicians providing 'consults' to the hospital patient may bill the first visit using the hospital admission CPT Codes 99221-99223 provided the service meets the requirements set forth by the Centers for Medicare & Medicaid Services (CMS) for this use.

The admitting physician should add Modifier A1 for reporting purposes only. Consulting physicians and subsequent attending physicians should not use the Modifier A1.

Section 5: Claims Filing and Information

Medical Facts Letter:

Certain claim submissions trigger a front-end claim edit that creates a request for additional information. This information is obtained through the use of a medical facts letter that is sent to the provider (see sample letter, below). Listed below are guidelines for completing the medical facts letter.

Guidelines:

- Complete all questions on the medical facts letter regarding pre-existing conditions and answer all questions on our form letter.
- Utilize the appropriate diagnosis procedure codes and try to avoid using vague or unspecified diagnosis and V codes.
- Use the appropriate E&M code for the service rendered and avoid up-coding.
- Do not use Modifier 25 with office visit codes unless there is really a separate identifiable service provided.
- Provide both operative reports if billing as co-surgery.
- Provide the lab results with the normal lab values, when requested for certain medications, including but not limited to; neupogen, epoetin, and parenteral iron.
- Psychiatrists' and psychologists' office staff should enter the correct number of services on the claim depending on the service provided. Some "psych" codes do not have time units and entering the incorrect number of services will result in incorrect payment.
- Submit ALL requested information when requested.

Note: Health Advantage relies on the accuracy, truthfulness, and completeness of all information you supply to us on the medical facts letter to properly adjudicate your claim and the member's benefits. Failure to supply us with full, accurate information may constitute fraud. Your signature on the medical facts letter is required and is looked upon by us as your assurance that the information you provide us is true and correct in all respects and does not present a misleading picture.

Member Cooperation:

How Member Cooperation Affects Provider Reimbursement:

Health Advantage's member health plans and contracts outline certain areas in which we need the member's cooperation to adequately process their claims or provide good customer service. If the member fails to provide that cooperation, in some instances Health Advantage will not be able to determine benefits or may decide to deny benefits for lack of cooperation. The charges for services would then become the member's responsibility.

Because provider reimbursement by Health Advantage is always subject to the terms of the member's health plan or contract, providers should be aware of the terms of the health plan or contract, including those terms that require member cooperation. Providers should encourage our members who are your patients to fully cooperate in furnishing all information needed to properly evaluate and adjudicate their claims.

When Member Fails to Cooperate:

If the member fails to cooperate and Health Advantage must deny claims on that basis, providers will not be entitled to any reimbursement from Health Advantage for the services in question. Areas in which we commonly need and request member cooperation include but are not limited to:

1. Obtaining medical records or other claims -related information;
2. Obtaining information regarding other coverage the member may have (coordination of benefits);
3. Obtaining information regarding the status of a dependent, such as a disabled child or a college student.
4. Obtaining information regarding third party liability (e.g., auto accident), subrogation or work-related injuries.

Member Fraud or Misrepresentation:

If Health Advantage discovers that a member obtained coverage initially by means of an application that misrepresented the member's past medical history or other relevant background, or that a member has filed fraudulent insurance claims, Health Advantage may elect at our discretion to terminate the member's health plan coverage or insurance contract, or to rescind the coverage.

If coverage is rescinded, that action is retroactive to the first date that the member's coverage became effective, even if that date was months or even years before Health Advantage discovered the fraud or misrepresentation. This means that the member, in effect, never had any coverage because the coverage was obtained through fraudulent or material misrepresentation.

Accordingly, providers may be asked to refund prior claims payments made with respect to such a member, and any pending claims with respect to such a member will be denied by Health Advantage on grounds that no coverage existed on the date of service.

Therefore, it is in a provider's best interest to assist Health Advantage in identifying any member fraud or misrepresentation as early as possible, not only to protect all members and the public at large from the costs of such improper activity, but also to protect providers.

Most Common Claim Denials:

Of all the claims submitted to Health Advantage and its affiliates, almost 25% are denied on the first submission because of a problem with the way the claims are filed or due to the lack of necessary information. The top denial reasons are listed below. To help prevent these types of denials, please review the suggestions with each reason for denial:

- 1. Additional information requested from another provider to verify completion/accuracy of enrollment information** – Failure to return any information requested in a timely manner may result in a denial.
- 2. Duplicate charge** - Providers should check each EOP/RA when received. If a provider resubmits the same claim without any changes or corrections, the resubmission will cause a duplicate-claim error. Before resubmitting a claim, check the claims status by calling **My BlueLine** or check the Advanced Health Information Network (AHIN) on-line.
- 3. Information requested from policyholder not received** - Providers should have the member call customer service to provide requested information.
- 4. Medical information required to determine benefits** - For some claims, providers may receive a Bar-Coded fax or letter requesting additional information. Please refer to the bar-coded fax or letter for details on what information is needed. Fax the Bar-Coded letter along with the requested information to Arkansas Blue Cross. The claim will remain closed for the reason noted on the EOP/RA until Arkansas Blue Cross or its affiliates receive the requested information.
- 5. No prior approval on file** – Services that require pre-authorization must be authorized prior to the delivery of services. Authorization numbers must be indicated in Block 23 of the CMS 1500 claim form.
- 6. Patient account number missing** – The patient’s account number must be listed on the claim, or the submission will fail in AHIN.
- 7. Service not submitted within required filing period** - All claims for services must be submitted within 180 days of the date the service is rendered to be eligible for reimbursement. **NOTE:** If providers fail to file a claim within the required 180-day period, providers cannot bill the member for that claim and providers will not receive payment from Arkansas Blue Cross.

If the member fails to provide insurance information within the required 180-day filing period, providers should not file the claim. Providers should hold the member responsible for the payment of the services.

- 8. Service part of an allowance on this or a previous claim** – If the claim for service is considered part of an allowance acknowledged on the claim or a previous claim, the claims will be denied for fragmented charges.

Section 5: Claims Filing and Information

Paper Claims:

Providers are encouraged to utilize the much faster, easier electronic claims processing capabilities available through AHIN and EDI. However, if a provider must use paper claims, the following guidelines apply.

Guide to CMS-1500 Paper Claim Form for Professional Providers:

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

- **Align the Form:** Please align the claim form carefully so that all data falls within the blocks on the claim form. The 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. Claims will be returned if they are not properly aligned.
- **Dates:** Use an 8-digit format for all dates on the claim. For example, enter June 1, 2006 as 06012006. All dates must be valid dates. Some fields require an entry such as DOS, while 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 claims. Please separate all forms carefully.

For providers using bursting equipment, adjust the splitters to precisely remove the pin feed edges. Claims must be submitted on the 08/05 version of the CMS-1500 claim form printed with red "drop out" ink.

Providers may obtain copies of the CMS-1500 claim form through various vendors such as the American Medical Association or the U.S. Government Printing Office.

- **Keep It clean:** Don't print, write, or stamp extra data on the claim form. When correcting errors, use white correction tape only and not white correction fluid.
- **Lines of Service (block 24):** Limit the lines of service to six lines on each claim filed. Placing information in the shaded areas as shown on the NUCC site should be as "FYI" only since the data may not image properly. Health Advantage does not recommend the use of this free form line. However, if it is used, it is critical that the right qualifiers be used.
- **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 and 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 10 Monospace font.

By following these guidelines, providers will assist Health Advantage in meeting its goal of efficient, accurate claims processing.

Rejected Claims:

As part of the change in claims processing, all paper claims are now processed through "front-end" edits that verify eligibility information. Claims that cannot be scanned by OCR will be returned to the provider with an accompanying explanation. Providers will receive a letter for claims that the OCR rejects. Please verify the information on the patient's insurance card prior to submission.

Submit the unacceptable claims as **New** claims. Do not resubmit unacceptable claims as “corrected” claims. Unacceptable claims are rejected prior to acceptance into Health Advantage adjudication system(s), therefore there is no “original” claim to correct on the Health Advantage systems.

Common Causes of Paper Claim Delays or Returns:

- National Provider Identifier missing in blocks 17B, 32A and 33A.
- Invalid Place of Service and Type of Service Codes.
- Invalid CPT or ICD-9 codes.
- Misaligned information on the form. Make sure your information is inside the form blocks.
- Narrative text in numeric fields on the CMS-1500 (HCFA) form.
- Hand-written claims.
- Alpha characters in numbers fields, or
- Invalid member number.

Reminder of printing guidelines for paper claims

Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and Health Advantage encourage providers to file claims electronically since electronic claims are processed faster and more accurately than paper claims. However, in the event that a paper claim form is used, certain guidelines must be followed before the paper claim can be accepted. To ensure the paper claim is accepted and the claims data is read accurately, providers should adhere to the following guidelines:

- Use only red Form CMS-1500 08/05 and red Form UB-04 that confirm to CMS guidelines.
- Align the form carefully so that all data falls within the blocks on the claim form. Please be sure that all line-item information appears on the same horizontal line.
- Do not hand write claim information. Claim information must be printed or typed with black ink. Remember to regularly change your printer ribbon or ink cartridges.
- Keep the form clean by not printing, writing, or stamping extra data on the form. Please refrain from using correction fluid or correction tape. If an error occurs while completing the claim, please complete a new, red claim form for submission.
- Use only UPPERCASE letters for alphabetical entries. Don't mix fonts or use italics, script, percent signs, question marks or parentheses.
- The recommended font for Form CMS-1500 08/05 is 12-point Courier New set at 10 characters per inch (10-pitch), 6 lines per inch. The recommended font for Form UB-04 is 10-point Courier New set at 10 characters per inch (10-pitch) and 6 lines per inch.
- Please separate all forms carefully. Do not fold, staple, or tape claims. Do not place any stickers on the claim form. Remove any pin-feed edges from any continuous feed forms.

Since Optical Character Recognition (OCR) technology is used to convert paper claims to electronic data, paper claim forms that do not comply with these guidelines or are printed too light to be successfully read by OCR equipment may be rejected.

Paper Claims - Step-By-Step Instructions:

The following information is designed to help providers complete the **new** CMS-1500 claim form which is mandated by the National Uniform Claim Committee (NUCC) to meet the requirement for all providers to have a NPI number. Only submit paper claims if electronic claim submission isn't possible.

NOTE: Effective January 1, 2007, all fields indicated as REQUIRED in the following guide must be completed or the claim will be returned to the provider.

Block 1 – Type of Insurance:

Indicate the type of health insurance coverage applicable to this claim: Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA Black Lung, or Other.

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 three letter alpha prefix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in the processing or denial of the claim.

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 Mrs. Mary O'Hara as "OHARA, MARY."

Block 3 - Patient's Date of Birth and Sex (REQUIRED):

Enter the patient's birth date (MM DD CCYY) and sex. A space must be reported between month, day, and year. **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". Using the terms "same" or "self" may result in a claim being rejected.

Block 5 - Patient's Address (REQUIRED):

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 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.

Block 7 - Insured's Address and Telephone (REQUIRED):

Enter the Insured's address and telephone number.

Block 8 – This field is reserved for NUCC use.

Block 9 - Other insured's Name (REQUIRED):

If the patient is covered under another health benefit plan including Arkansas Blue Cross and Blue Shield, BlueAdvantage, or Health Advantage, please enter the full name of the policyholder.

Block 9A - Other insured's Policy or Group Number (REQUIRED):

Enter Other Insured's Policy or Group Number (Note: Do not use a hyphen or space within the policy or group number.)

Block 9B - This field is reserved for NUCC use

Block 9C - This field is reserved for NUCC use

Block 9D - Other Insured's Plan Name or Program Name (REQUIRED):

Enter the other insured's plan name or program name. If recipient has Medicare coverage, enter the word Medicare followed by the Medicare plan name (e.g., Medicare Senior Dimensions, Medicare Senior Care Plus).

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. If any "YES" fields are selected, Block 14 must be populated with the accident date. The appropriate postal abbreviation for the STATE must be supplied if an AUTO ACCIDENT.

Block 10D - This field is reserved for local use

Block 11 - Insured's Policy, Group, or FECA Number (REQUIRED):

Enter the insured's current identification number exactly as it appears on their identification card, including the appropriate three-letter alpha prefix. 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.

Block 11A - Insured's Date of Birth, Sex (REQUIRED):

Enter the 8-digit date of birth (MM/DD/CCYY) of the insured and an "X" to indicate the sex of the insured.

Block 11B - Other Claim ID (Designated by NUCC).

Block 11C - Insurance Plan Name of Program Name:

Enter the insured's plan name or program name as it appears on their identification card.

Block 11D - Is there another health benefit plan?

Enter an "X" in the appropriate box. If marked "Yes", complete 9 and 9 A-D.

Block 12 - Patient's or Authorized Person's signature.

Block 13 - Insured's or Authorized Person's signature.

Block 14 - Date of Current Illness, injury or Pregnancy:

Injury - Enter date the accident occurred; if any YES fields are marked with an "X" in Block 10 (A - C) then Block 14 must be populated with the accident date.

- Illness - Enter for acute medical emergency only and include onset date of condition;
- Injury - Enter the date of the accident
- Chiropractic - Enter the date of the first treatment.
- Pregnancy - Enter date of the last menstrual period (LMP) as the first date.

Block 15 - Other Date:

If patient has had the same or similar illness, enter the date of the onset of illness.

Block 16 - Dates Patient Unable to Work in Current Occupation:

Enter the date range where patient is unable to work in current condition.

Block 17- Name of Referring Physician or Other Source (REQUIRED):

Enter the name (First Name, Middle Initial, and Last Name) and 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 17B - National Provider Identifier (NPI) (REQUIRED):

Enter the NPI of the referring provider, ordering provider, or other source in 17B. **NOTE: Now required for claims filed May 23, 2007 or later.**

Block 18 - Hospitalization Dates Related to Current Services:

Enter admission and discharge dates (MM DD YY format) for inpatient hospitalization related to current services.

Block 19 – Additional Claim Information (Reserved for local use).

Block 20 - Outside lab charges:

If laboratory work was performed outside a provider’s office, enter the laboratory's actual charge to the provider. If the laboratory bills Arkansas Blue Cross directly, enter an "X" in the "NO" box.

Block 21(A-L) - Diagnosis and/or Nature of Illness or Injury (REQUIRED):

Enter the appropriate ICD-9 diagnosis code (up to five digits) for the services performed. Enter up to twelve (12) ICD-9 codes in the spaces indicated A through L. Enter the codes across each line, not down **Do NOT use any punctuation such as a decimal.**

Block 22 – Resubmission Code:

Complete the field to adjust or void a previously paid claim. Otherwise, leave this field blank.

- In the Code area, enter an adjustment or void reason code
- In the Original Reference Number area, enter the last paid Internal Control Number (ICN) of the claim.

Block 23 - Prior Authorization Number:

Enter only one authorization number per claim form. Enter any of the following as assigned by the payer for the current service:

- Prior approval 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.

National Drug Codes (NDC) for drugs – must have N4 qualifier followed by 11 digit NDC code – do not put a space between the qualifier and code; do not use hyphens in the code.

Placing the following information in the shaded areas as shown on the NUCC site should be as "FYI" only since the data may not image properly. Arkansas Blue Cross does not recommend the use of this free form line. However, if it is used, it is critical that the right qualifiers be used.

Narrative description of unspecified codes must have a "ZZ" qualifier followed by the code description – do not put a space between the qualifier and the code.

From the NUCC website:

"To enter supplemental information, begin at Block 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code."

Block 24A-Date(s) of Service (REQUIRED):

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):

Enter the appropriate two-digit code from the "Place of Service" list from the CMS web site for each item used or service performed. The "Place of Service" identifies the location where the service was rendered. POS 11 = Office

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/HCPCS code(s) and applicable modifier(s) 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' an NDC or description must be shown in the shaded area for that line.

Block 24E - Diagnosis Pointer (REQUIRED):

Enter the line-item diagnosis code pointer(s) referencing the appropriate diagnosis code(s) reported in Block 24D. Do not use a range, list primary diagnosis for the 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. **NOTE: Must be whole number.**

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in block 24G of the CMS-1500 claim form. If no units are indicated on the claim, the claim will be denied.

Block 24H – EPSDT/Family Plan (REQUIRED):

For providers that bill Family Planning services, enter "Y" if services were family planning and "N" if they were not.

Block 24I – ID Qualifier (REQUIRED):

- Using NPI in field 24J: Enter "ZZ" in the top, shaded half of the claim line.
- Using API in Field 24J: Enter "N5" in the top, shaded half of the claim line.

Block 24J - Rendering Provider ID Number (REQUIRED):

The individual provider rendering the service should be reported in Block 24J. **The original fields for Block 24J and 24K have combined and re-numbered as Block 24J.** Enter the NPI number in the un-shaded area of the field. **NOTE: NPI is required on claims filed on May 23, 2007 or later.**

Block 25 - Federal Tax ID Number:

Enter the provider of service's or supplier's federal tax ID (employer identification number) or Social Security number. Enter "X" in the appropriate box to indicate which number is being reported. Only one box can be marked.

Block 26 - Patient's Account Number (REQUIRED):

Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Block 27 - Accept Assignment? (REQUIRED):

Enter an "X" in the correct box. Only one box can be marked. "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 the 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 Arkansas Blue Cross is the secondary payer, providers should not submit a claim until payment is received from the primary payer.

Block 30 – Balance Due (reserved for NUCC use):

Block 31 - Signature of Physician / Supplier:

Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF". Enter the eight-digit date (MM/DD/CCYY), 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 state when billing for purchased diagnostic tests. When more than one supplier is used, a separate CMS-1500 claim form should be used for each supplier.

Block 32A National Provider Identifier (NPI) (REQUIRED):

Enter the National Provider Identifier (NPI) number of the service facility. **NOTE: NPI is required for claims filed on May 23, 2007 or later.**

Block 33 - Physician's or Supplier's Billing Name, Address, and Phone:

Enter the provider's or supplier's billing name, address, zip, 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

Block 33A - National Provider Identifier (NPI) (REQUIRED):

Enter the "pay to" National Provider Identifier (NPI) number of the billing provider in Block 33A. **NOTE: The NPI is required for claims filed May 23, 2007 or later.**

Prepay Review of High Dollar Inpatient Claims Changes for 2021 Services

The Blue Cross Blue Shield Association made changes to the high-dollar inpatient claims review for 2021. These changes were adopted by Arkansas Blue Cross and Blue Shield and its family of companies effective January 1, 2021.

The Association, in 2019, began requiring itemized bills for high dollar inpatient claims that were \$250,000 or greater. Arkansas Blue Cross was required to adopt that policy and subsequent updates to the policy. For 2020 the amount was lowered to \$200,000, and upon reviewing the findings and results of this policy, the Association lowered the threshold for 2021 to \$100,000. **Therefore, please remit itemized bills for all inpatient claims of \$100,000 or more if the claim will have a payment that is tied to the billed charge (i.e., not paid wholly by per diem, case rate or diagnosis-related group).** To avoid unnecessary delays or interruption of payments of these claims, providers are asked to submit an itemized bill with any claim that meets these criteria.

Arkansas Blue Cross and its family of companies use the CMS Provider Reimbursement Manual and the UB Editor for guidance, as well as the services of Optum (formerly known as Equian) to conduct this prepay review. Arkansas Blue Cross and the Blue Cross Blue Shield Association will continue to evaluate the results of the prepay review to determine whether the billed amount subject to review should be adjusted.

To minimize the administrative work this change will create for the providers, Arkansas Blue Cross is working to automate an electronic submission format to allow the providers to bill the electronic claim and other supporting documentation simultaneously.

Please contact your network development representative for specifics about submitting itemized bills with the claims.

Note: For questions involving a report's findings, we ask that providers work with Equian/Optum directly. Please review the report and contact Equian/Optum to discuss any inquiries regarding review findings and/or the documentation and explanation necessary to clarify the questioned charges:

Claims Resolution

Email: claimsresolution@equian.com

Direct: 888-895-2254

Additionally, providers may formally dispute a report's findings. Please identify the correspondence as a formal dispute, include the documentation and explanations necessary to clarify the questioned charges, and send the formal written dispute to:

Claims Disputes / Reconsiderations

Email: reconsiderations@equian.com

Fax: 866-700-5769

Mail: Equian, LLC / Attention: Claims Disputes / 600 12th St / Suite 300 / Golden, CO 80401

Provider "Third Party Liability" or "Subrogation" Activities and Member Claims"

Arkansas Blue Cross and Blue Shield would like to provide the following notice regarding applicable claims filing policies and procedures of Arkansas Blue Cross and its affiliate, Health Advantage, in situations in which a third party or their liability carrier are responsible for the injuries an Arkansas Blue Cross or Health Advantage member sustains (generally referred to for shorthand convenience as "Third Party Liability" or "Subrogation" matters). These policies and procedures have been in place for many years but are being restated for emphasis due to increasing Third Party Liability or Subrogation activities of some providers.

Providers are reminded that their network participation agreements obligate them to comply with all claims filing policies and procedures, including those published in Providers' News.

1. Arkansas Blue Cross and Blue Shield and Health Advantage encourage providers to *file all claims*, rather than holding such claims to pursue Third Party Liability or Subrogation. Filing the claim allows quick provision of any available health plan or insurance contract benefits to our members, and provides the fastest payment to providers.
2. Although filing of claims is strongly encouraged and preferred, Arkansas Blue Cross and Health Advantage provider contracts do not *require* that claims be filed with them, and recognize that state law specifically grants a lien to providers for Third Party Liability (i.e., providers can claim a part of any third party recovery the member may otherwise seek or be entitled to recover).
3. While Arkansas Blue Cross and Health Advantage understand this state lien law, and do not purport to change or challenge it, Arkansas Blue Cross and Health Advantage *do* require as an express term of their network participation agreements that participating providers must *not* pursue the *member* for any amounts in excess of the Arkansas Blue Cross or Health Advantage payment ("Excess Amounts") although participating providers may collect applicable member deductible, coinsurance or copayments. This means that while a provider can go after the *third party* or their carrier without violating their network participation agreement, the provider *cannot* attempt to recover "Excess Amounts" from the *member*. Any attempt to bill the member or collect against the member or their assets for Covered Services will be deemed a violation of the network participation agreement.
4. Providers are reminded that network participation agreements impose a 180-day timely filing requirement for all claims, and expressly bar collection – either from Arkansas Blue Cross or Health Advantage *or the member* – on claims not filed within 180 days. Thus, if a provider elects not to file a claim in favor of exclusively pursuing Third Party Liability or Subrogation, if that effort causes a delay in filing the claim past the 180-day filing deadline, providers cannot thereafter bill either the member or Arkansas Blue Cross or Health Advantage for any amount on such claims.
5. Providers are also reminded that while they may elect not to file a claim, members may still file the claim with Arkansas Blue Cross or Health Advantage based on the provisions of their member certificate or evidence of coverage. If the member files a claim that a provider has withheld, Arkansas Blue Cross or Health Advantage will attempt to develop and process that member-submitted claim. Providers are contractually obligated in such circumstances to provide to Arkansas Blue Cross and Health Advantage information needed to evaluate and process the claim. Any payments determined due on such claims will be paid to the provider. Providers may not decline to accept the Arkansas Blue Cross or Health Advantage payment in such situations. If a provider does breach the participation agreement by declining to accept payment, Arkansas Blue Cross or Health Advantage will then make payment to the member. In either case, whether the payment is accepted or declined, and whether payment is made to the provider or the member (following

provider refusal to accept), the provider cannot pursue collection against the member for Excess Amounts.

6. Arkansas Blue Cross and Health Advantage do not take a position regarding a provider's option to
 - a) File claims and receive the Arkansas Blue Cross or Health Advantage payment and also
 - b) Pursue Third Party Liability or Subrogation for the remaining portion of their bills (the Excess Amounts).

The only interest for Arkansas Blue Cross and Health Advantage is in ensuring that providers understand that once they become a participating provider in these networks, they cannot pursue the member for amounts beyond the Arkansas Blue Cross or Health Advantage payments.

7. To the extent that any of the preceding rules of network participation have not been clearly understood or interpreted by any provider or party, this *Providers' News* article shall be deemed to constitute notice of an amendment to the network participation agreement of Arkansas Blue Cross and Health Advantage participating providers.

With respect to Arkansas' FirstSource® PPO and True Blue PPO networks of PPO Arkansas, the same policies and procedures as referenced above shall apply, with the only variation being that PPO Arkansas is not a payer of any claims of self-funded groups that access these networks; accordingly, payment of all such self-funded group claims is always subject to funding and direction of the employer-sponsor as Plan Administrator of such plans.

Splitting Claims

Providers should submit all codes for one place of service on one date of service for payment on one claim. Providers should not submit multiple claims for payment for the same date of service by splitting the codes billed on separate claims. Splitting the claims may cause the claim(s) to pend for manual processing and possibly delay payment.

Timely Filing Guidelines

As a reminder, the following information regarding timely claims filing applies to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage and includes claims for members of other Blue Cross Plans.

Filing Original Claim:

Providers must submit claims for any service, supply, prescription drug, test, equipment, or other treatment within 180 days after such service, supply, prescription drug, test, equipment or treatment is provided. In the case of a claim for inpatient services for multiple consecutive days, a written proof must be submitted no later than 180 days following the date of discharge for that admission.

Resubmitting Claims:

Arkansas Blue Cross and its affiliates also require providers to use this 180-day timely filing limit for re-submitting claims for adjustments, or for submitting additional information on a previously filed claim.

Adjudicated Claims/COB:

Arkansas Blue Cross and its affiliates extends the timely filing requirements to include 180 days after the primary insurer adjudicates the claim. Timely deadline for secondary claims is 180 days from the date processed by the primary carrier.

Member Responsibility:

The 180-day timely filing provision is applicable for both providers and members. When a patient covered by Arkansas Blue Cross or an affiliate does not provide their provider with proof of coverage until after the 180-day timely filing has expired, that patient is responsible for the services and the provider should not bill Arkansas Blue Cross or its affiliates.

All contract holders should have a member identification card and should present their ID card prior to each service. Arkansas Blue Cross and its affiliates encourage all providers to have their patients complete insurance coverage update forms at the time of each service. By completing an insurance coverage update form, patients are given every opportunity to provide up-to-date insurance information.

For questions regarding coverage, providers should refer to **AHIN (Advanced Health Information Network)** for member eligibility and claims status or call The BlueLine, our voice activated response service, available 24 hours a day, 7 days a week.

(This information does not apply to the Federal Employee Program (FEP)).

Timely Filing Requirement

Members covered under health plans sponsored by Health Advantage usually have limitations to the time for which benefits are available after services are rendered. This stipulation, called a “timely-filing” provision, makes prompt submission of claims critical to getting the claim paid.

In most cases, to be eligible for benefits, a claim must be submitted within 180 days of the date services are rendered. Corrected claims must be submitted within 180 days of the original payment date.

Timely Filing Requirements for COB:

In the case of coordination of benefits when Health Advantage is the secondary payer, the claim must be filed within 180 days of the primary payer's determination.

Proof of Timely Filing

Documents submitted as proof of timely filing will only be accepted if computer generated and contain the following information:

- Physician or facility name
- Patient's name and member ID#
- Date of service
- Charged amount
- CPT code
- Date claim was originally filed/resubmitted
- Insurance filed is listed as Health Advantage (Insurance codes are not acceptable unless a memo accompanies the print-out describing the code.)
- If the insurance filed shows a plan other than Health Advantage, a memo should be attached indicating when the provider was notified that the member had other insurance and any circumstances that caused the delay in filing with the correct or the delay in checking the status of the claim. These cases will be reviewed. If the member did not notify the provider of the correct insurance plan, the claim should not be filed, and the member can be billed.

If a provider attached a claim correction form to the claim with proof of timely filing, this could expedite the process since the scanning system should halt the claim for review.

The following will not be accepted as proof of timely filing:

- Handwritten notes indicating date the claim was filed
- Computer notes with incomplete information
- Insurance codes with no explanation
- Proof of timely filing with a date of service past 180-days from the current date; (Extenuating circumstances may be reviewed by attaching a memo.)
- Dates on the bottom of the claim submitted as proof

If Health Advantage is secondary, the 180-day timely filing starts from the primary carrier's Remittance Advice date of payment or denial.

Section 5: Claims Filing and Information

Transition to CMS-1500 (02/12) claim form

On May 1, 2014, Arkansas Blue Cross and Blue Shield and its affiliates, PPO Arkansas (True Blue and Arkansas' FirstSource® PPO networks) and Health Advantage (Health Advantage HMO network), stopped accepting the (08/05) version of the CMS-1500 professional medical services claim form. All providers who submit claims must now use the new CMS-1500 (02/12) claim form.

For detailed instructions on how to properly complete the new CMS-1500 (02/12) claim form, Arkansas Blue Cross recommends following the National Uniform Claim Committee (NUCC) guidelines. The CMS-1500 (02/12) version guidelines can be found at nucc.org.

If a CMS-1500 (08/05) version claim form is received on or after May 1, 2014, the claim will be rejected, and a notification letter will be sent. The timely filing guideline of 180 days after date of service still applies to claims returned for non-compliance.

The CMS 1500 (02/12) form version contains changes to the layout. The new claim form also has additional required qualifier fields. It is important for providers to use the new layout with the new form. Printing the old claim layout on a new claim form will cause data to be misaligned. Misaligned data and/or missing qualifiers will cause claims to be rejected.

The following fields now require qualifiers:

Box 14: Date of Current Illness, Injury, or Pregnancy. If a date is put in Box 14, the appropriate qualifier indicating the type of date is required. Valid qualifiers include:

Qualifier	Definition
431	Onset of current symptoms or illness
484	Last menstrual period

Box 15: Other Date. If a date is put in Box 15, the appropriate qualifier indicating the type of date is required. Valid qualifiers include:

Qualifier	Definition
454	Initial treatment
304	Latest visit or consultation
453	Acute manifestation of a chronic condition
439	Accident
455	Last x-ray
471	Prescription
090	Report start (assumed care date)
091	Report end (relinquished care date)
444	First visit or consultation

Box 17: Name of Referring Provider or Other Source. If a provider name is indicated in Box 17, the appropriate qualifier indicating the type of provider is required. Valid qualifiers include:

Qualifier	Definition
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Box 21: Diagnosis or Nature of Illness or Injury. An ICD indicator is now required. Use "9" to indicate ICD-9 codes are being used or "0" for ICD-10 codes (which will be required October 1, 2015). Box 21 also now allows for up to 12 diagnosis codes. It is important to only submit the diagnosis code. Providing a description in addition to the code will cause data to be misinterpreted or misaligned and result in a rejected claim. Service line diagnosis pointers (Box 24E) must be letters A through L, which corresponds to the appropriate diagnosis code. Up to 4 pointers can be indicated in Box 24E (e.g., A, CD, BEF, DGKL, etc.) per service line.

Another significant requirement change is "SAME" is no longer accepted when both the patient's (Box 5) and the insured's (Box 7) address is the same. The full address for the insured (Box 7) is always required. If the insured's address (Box 7) is missing, the claim will be rejected. The patient's address (Box 5) is only required if the address is different than the insured. Arkansas Blue Cross recommends both patient and insured addresses are indicated even if they are the same.

Arkansas Blue Cross employs Optical Character Recognition (OCR) technology to collect data from paper claim forms. All claim forms must be printed using Flint Red J-6983 (OCR Red "dropout"), or exact match, ink. Claim data must be printed with black ink. Claim forms that do not comply with NUCC printing standards will be rejected.

[New Qualifier Fields Reference Guide](#)

Section 5: Claims Filing and Information

UB-04 Facility Claims:

Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their web site at www.nubc.org.

Section 5: Claims Filing and Information

Rule and Regulation 43, Clean Claims, and Section 13 Claims:

The Arkansas Insurance Department Rule and Regulation 43 sets standards for timely processing of health insurance claims. Rule and Regulation 43 establishes the maximum number of days that insurance carriers must process "clean claims" and "non-clean claims" or "Section 13 Claims" without incurring penalties. All claims to insurance carriers are subject to this regulation.

Rule and Regulation 43:

Rule and Regulation 43 requires that:

All clean claims submitted electronically 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. For Section 13 Claims, the claim must be determined to be non-clean and returned to the provider or member notified of this determination 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 61st 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.

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 46th 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.

For information and guidelines on filing the CMS-1500 claim form and CMS-1500 anesthesia claim form, and for filing guidelines for Wellness services, please read the following information.

R&R 43 Exceptions: This rule does NOT apply to the Federal Employee Program, Access Only Groups, and some groups administered by BlueAdvantage Administrators of Arkansas.

Clean Claims:

Clean Claims are claims submitted with all information necessary for payer adjudication and that do not require further investigation. 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 supplement 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.

Section 13 Claims:

Section 13 Claims are claims that have been submitted but must be suspended from processing until the insurance carrier receives more information. They are called "Section 13 Claims" because the rules for processing these claims are found in Section 13 of Rule and Regulation 43. Under the terms of Rule and Regulation 43, an insurance carrier must notify the claimant (provider or member) within 30 days of receiving a Section 13 Claim of the need for additional information to process the claim correctly.

Necessary information may include any of 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.

Section 6: Claims Payment, Refunds, and Offsets

Appeals and Re-reviews

Health Advantage requires providers to request a **re-review** of a denied claim (in whole or in part) prior to the submission of an appeal. A re-review request must be submitted with 180 days of the claim denial. The request should include the issue being questioned, the date of service, the patient's name and ID number, the provider's name, and reasons why the provider believes that the claim was incorrectly denied in whole or in part. The request should also include any medical records relevant to the review. The provider may utilize the Claim Reconsideration form as a summary of the request to ensure pertinent information is included. Re-reviews should be submitted to:

Health Advantage
Attn: Customer Service
P.O. Box 8069
Little Rock, AR 72203
Fax: 501-212-8518

If the denial of the service continues to be disputed after the re-review is completed, an appeal may be submitted within 180 days of the reconsideration denial. *Any request received outside this timeframe will not be reviewed.* Providers may appeal an administrative decision or coverage policy decision made by Health Advantage. The appeal request should include the date of service, the issue being appealed, the patient's name and ID number, the provider's name and NPI number, and the reason the provider believes the denial is incorrect. All appeals are reviewed based on the additional information supplied by the provider at the time of the appeal.

There is only one Provider Appeal Review.

The Appeal request should be submitted to:

Health Advantage
Attn. Provider Appeals
P.O. Box 8069
Little Rock, AR 72203
Fax: 501-212-8518

The appeal will be reviewed by the appropriate review department for administrative issues or a Health Advantage Medical Director for coverage policy issues.

The purpose of the Health Advantage Coverage Policy is to inform members and their physicians why certain medical procedures may or may not be covered under Health Advantage health plans. Health Advantage requests that before a provider appeals a claim denial, that they access and review the applicable Health Advantage coverage policy. You may reference the previous section regarding Coverage Policies and Primary Coverage Criteria for more information.

Claims Payment Issues:

While one of Health Advantage's ongoing goals is to minimize the number of claims paid incorrectly, errors are occasionally made. Some of these errors can affect a provider's 1099 earnings and/or a patients' claim history, deductibles, and benefit limits. These situations can result in incorrect information being reported to the IRS and/or incorrect patient benefit determination. Please note:

- Amounts of **issued** provider payee checks are recorded as increases to the 1099 earnings.
- Amounts of **voided** provider payee checks are recorded as decreases to the 1099 earnings.
- Amounts **received from** providers (claims refunds) are recorded as decreases to the 1099 earnings.
- 1099 earnings are accumulated under the Tax Identification Number (TIN) of the **payee**, as recorded in our files at the time of the transaction.

Changes in Name or EIN (Employer Identification Number):

Providers must notify Health Advantage promptly with changes in their EIN or name in order to ensure accurate reporting to the IRS. If the IRS sends Health Advantage a "B-Notice" indicating that the Taxpayer Name and EIN does not match the IRS records, Health Advantage will be required to withhold, and remit to the IRS, 28% of future amounts payable to providers if corrected data is not received within the mandated time frame. Once withheld amounts are remitted to the IRS, they cannot be refunded to providers but will be reported on the 1099 as "Federal Income Tax Withheld."

Deductibles, Benefit Limits, Out-of-Pocket Maximums, & Lifetime Maximums:

Deductibles, benefit limits, out-of-pocket maximums, and lifetime maximums are accumulated by individual members. If erroneous claims are not adjusted appropriately and promptly, subsequent claims may be incorrectly adjudicated.

Please verify that the payee is correct on all checks received prior to negotiating them.

Examples of Payment Errors:

Listed below are examples of some payment situations that can occur, along with procedures recommended to facilitate correction of the data:

- If a provider receives payment for a claim for services that they did not perform: Please refund the amount paid in error. Even if you know to whom the payment should have been made, do not forward the amount to that party. A provider's 1099 can only be corrected if the money is returned and the claim reprocessed to the appropriate party.
- If the patient was paid, and payment should have been made directly to the provider: Please advise the patient to return the check, or refund the amount paid, along with a request to reprocess the payment to the provider. If a provider accepts payment from the patient, Health Advantage could subsequently discover the error and send a request for refund to the member since our records will reflect the member received the payment.
- If a provider was paid, and payment should have been made to the patient: Please refund the payment to Health Advantage (rather than to the patient) along with a request to reprocess the payment to the patient. A provider's 1099 can only be corrected if the money is returned and the claim reprocessed to the appropriate party.
- If a check is made payable to an individual physician, but should have been made payable to the clinic: Please return the check to Health Advantage (rather than depositing the check in the clinic's account) with a request to reprocess the payment to the appropriate provider. A provider's 1099 can only be corrected if the money is returned and the claim reprocessed to the appropriate party.

NOTE: If the check is made payable to an individual physician, the 1099 will be generated in the physician's name, even if they are an employee of the clinic.

Health Advantage recommends providers endorse and deposit all checks as soon as possible after confirming that the payee is correct. Most of the checks from Health Advantage have a preprinted staledate message indicating that the check will be void if not cashed within a specific time frame (usually six months). After that time, the check must be reissued or, in some cases, the claim must be reprocessed.

As a deterrent to fraud and to enhance the quality of copies of cleared checks that might be requested in the future, Health Advantage also recommends that provider endorsements be made in **BLACK** ink and include the bank account number into which the deposit is being made.

Minimize the Time Required To Process a Claim Refund:

To minimize the time required to process a claim refund and to ensure that your 1099 earnings are adjusted accurately:

- **When sending us a requested refund:** Please return the remittance copy of the refund request letter along with the check.
- **When sending us an unrequested refund:** It is not necessary to return the original check and the entire explanation of payment if just one or two patient claims are paid incorrectly. Please enclose copies of the remittance advice/explanation of payment pages with the claims paid in error highlighted and a notation of the reason for the refund **or** enclose the following information for each claim paid in error:
 - 1) Reason for the refund,
 - 2) Patient name,
 - 3) Patient ID number,
 - 4) Date of service,
 - 5) Amount,
 - 6) Provider name (pay to),
 - 7) NPI (pay to), and
 - 8) TIN (pay to).

If the provider is not returning the original check, a separate refund check for each line of business is preferred.

A provider's 1099 earnings can only be corrected if Health Advantage has the specific provider name, NPI, and EIN. If a provider uses the services of a third party for these financial transactions, please instruct the third party administrator to provide this information on each refund.

Please do not combine refunds for Health Advantage, Arkansas Blue Cross, BlueAdvantage, USABLE Administrators, and Medicare. Please do not issue refund checks payable to Arkansas' FirstSource®. Refund checks pertaining to FirstSource® members should be made payable to the appropriate check issuer (which may sometimes be a third party administrator for a self-funded plan): Health Advantage, BlueAdvantage, USABLE Administrators, Arkansas Blue Cross or another outside carrier that accesses the FirstSource® PPO Network with a copy of the remittance advice/explanation of payment.

Note: Federal Employee Program (patient ID# begins with "R") refunds should not be combined with others to Health Advantage in order to comply with new timeliness standards even though the refunds are sent to the same processing location.

The following are the correct addresses to use for claim refunds:

Arkansas Blue Cross and Blue Shield
P.O. Box 2099
Little Rock, AR 72203

Health Advantage
P.O. Box 8069
Little Rock, AR 72203

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203

USABLE Administrators
P.O. Box 1460
Little Rock, AR 72203

Medicare (part A or B)
P.O. Box 8075
Little Rock, AR 72203

Copayments, Coinsurance, and Deductibles:

Copayments, coinsurance and deductibles are all vital components of not only actuarial calculations of premium, but also cost incentives to the member. As required by our provider participation agreements, providers should always bill and collect all copayments, coinsurance, and deductibles directly from the member. As the provider looks solely to Health Advantage for payment of **covered services**, providers should not bill or collect any amount more than the Health Advantage payment except for the applicable copayments, coinsurance, and deductibles.

Providers may collect any amount from members for services that are deemed not meeting the Primary Coverage Criteria (e.g., deemed experimental/investigational) if, and only if, the provider obtains a written statement from the member before any services are provided, acknowledging that the services are not covered by the member's health plan or contract, and the statement specifies the amount of charges for the services. This statement must be signed by the member in advance of any applicable services. This statement will be referred to as a "waiver of health plan liability".

Electronic Funds Transfer (EFT)

Contracted providers may elect to receive claim payments by electronic funds transfer (EFT). When this payment method is selected, it is effective for Arkansas Blue Cross and Blue Shield (except the Federal Employee Program), Health Advantage, BlueAdvantage Administrators of Arkansas, USABLE Administrators and USABLE Life Group Health payment types inclusively. This group is hereinafter referred to as the "related companies".

Enrollment is available through the local Provider Network Development staff. A copy of your EFT contract will be returned for your files after being executed by the Vice President of Financial Services. A single contract may be completed for affiliated entities such as a facility which also maintains an outpatient clinic and the like. However, a separate Appendix - Provider's Bank Information - is required for each of the assigned provider/NPI numbers to whom payments are routinely directed: individual doctor / sole practitioner, facility, clinic, emergency room, etc. This is true even when the same bank information applies to all providers in the 'group'.

After entry is placed into the provider system at Arkansas Blue Cross, there is a fifteen-day waiting or pre-notification period during which time Arkansas Blue Cross ensures that bank routing and account information has been processed accurately. An e-mail notification is sent to the provider advising the approximate start date of EFT payments. Included in this notice is the current "Payment Address" to which the paper remittance will be sent; if this address is not correct, please notify Provider Network Operations in writing immediately. Providers who utilize the AHIN workstation will receive their remittance information in that manner and not through the postal service.

In the event a provider closes or changes bank accounts to which claim payments should be directed, a new Appendix - Provider's Bank Information - is required and a new pre-notification period is established. During this pre-notification period, the provider will receive paper checks.

Arkansas Blue Cross endeavors to maintain the privacy of the provider's financial information and, to that end, has limited all screens containing such information to selected Provider Network Operations and Financial Services staff.

The various related companies' claim payments are validated by Financial Services daily and released to a servicing bank for transfer through the Automated Clearing House (ACH) Network to the provider's bank. Payments are released two days prior to the effective date of the EFT which is the same as the paper check date. Consequently, with EFT payments, your payments reach you faster. Remittance information is posted to the AHIN workstation no later than the EFT effective date. If you use the workstation, paper remittances will not be mailed. Otherwise, a cover sheet indicating that funds have been sent electronically to the provider's financial institution accompanies the paper remittance.

The electronic remittance advice (ANSI 835) is available by contacting EDI Services.

In a continuing 'GO GREEN' business strategy, Arkansas Blue Cross hopes many more providers will sign up for EFT soon. Contact an Arkansas Blue Cross network development representative for an EFT enrollment package. On-line EFT enrollment will be coming soon!

EFT Identifiers:

Over 62% of Arkansas Blue Cross participating providers are now using the Electronic Funds Transfer (EFT) payment method for Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, USABLE Administrators, USABLE Life Group Health, and Wal-Mart payments.

The following is a handy reference for Check / EFT identifiers and payment frequencies to assist providers

in identifying where EFT payments originate.

Arkansas BlueCross BlueShield:

- I T 01 - BlueCard;
- BC 01 - Arkansas Blue Cross and Blue Shield commercial business; and
- MP 01 - Arkansas Blue Cross Medicare Supplement (Medipak) business.

BC 01 and MP 01 pay twice weekly with schedule adjustments for holiday and month-end processing. BlueCard (IT 01) pays weekly.

The Arkansas Blue Cross codes for hard copy check payments are:

- HO - BlueCard,
- GA - Commercial business, and
- MA - Medipak.

BlueAdvantage Administrators of Arkansas:

- US 01 Cross & Shield branded self-funded groups;
- US US USAble Administrators (non-branded self-insured groups)
- US CH Arkansas Comprehensive Health Insurance Plan;
- US 55 USAble Life Group Health; and
- US WM Walmart.

All BlueAdvantage groups pay weekly, except Wal-Mart which pays twice weekly, and have schedule adjustments for holiday and month-end processing. Since each self-insured group generates a separate EFT, there could be multiple US 01 transactions on any given day. The EFT codes for BlueAdvantage are the same as on hard copy check payments.

Health Advantage:

- HA SI - Self-insured;
- HA AR - Arkansas State and Public School Employees; and
- HA ST - Commercial.

Each type of Health Advantage payment is made weekly with schedule adjustments for holiday and month-end processing. Payments for Arkansas State and Public School Employees are released upon receipt of funding. The Health Advantage EFT codes are the same as on hard copy check payments.

Federal Employee Program (FEP):

Arkansas Blue Cross does not make Federal Employee Program (FEP) payments via EFT at this time. Arkansas Blue Cross will be adding EFT payments for FEP before the end of the year. The identifiers are:

- FS - Standard Option
- FB - Basic Option

EFT Requirement

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

Implementing EFT will begin as follows:

1. Effective January 1, 2012, all new provider applicants were required to enroll in EFT, regardless of whether this is a new clinic or an existing practice. For example, if a new physician applies to participate

in any of the networks mentioned above, and the physician is applying to join an already established clinic, that clinic must be paid via EFT.

2. Effective January 1, 2012, all providers making a change to any of their information is required to enroll in EFT. For example, a physician's office needs to change a telephone number within its clinic and submit a change of data form. That change will not be made until the clinic has enrolled in EFT.
3. All participating providers must be enrolled into EFT (excluding dental).

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

Fee Schedule and Allowances:

Health Advantage uses the current version of Relative Value Units (RVU's) based on site of service developed and published by the Center for Medicare and Medicaid Services (CMS).

Health Advantage began using RVU's to establish fees in 1998. RVU's were developed and are maintained under the oversight of CMS, in cooperation with the American Medical Association. In establishing the relative value of health care services, RVU's categorize service delivery into three major components. Physician Work Units reflect the intensity of the service provided, including pre-procedure work, intra-procedure work and post-procedure work. Practice Expense Units include the overhead costs associated with a practice, and Malpractice Expense Units consider the cost of liability insurance as a percentage of a physician's revenue.

To derive a fee for a given service, the RVU for that service must be multiplied by a conversion factor. For the Health Advantage network (Preferred Payment Plan), allowances are calculated using the following:

- Evaluation and management services are based on a conversion factor of \$45;
- Physical medicine services are based on a conversion factor of \$40.00 (The provider discount (i.e., PPO, HMO) does not apply to these services); and,
- All other services are based on a conversion factor of \$59.28.

Note: The conversion factor and all other specifics quoted in reference to the fee schedule/allowance are established at the sole discretion of Health Advantage and are subject to modification without prior notice.

In addition to adopting the latest version of RVU's, the Health Advantage fee schedule uses the site of service of the service delivery in determining the appropriate fee. This methodology provides for variations in the cost of delivering services. For instance, if a physician provides a service in an office setting, that physician must bear the entire expense associated with delivering the service. If this service were delivered in a hospital or ambulatory surgery center, the facility would bear a portion of the cost associated with the provision of services.

The fee schedule recognizes these variations in the cost of providing services, similar to the method CMS currently utilizes for Medicare payments. If the Federal Register indicates N/A (Not Applicable) for the facility or non-facility site of service, Health Advantage will not pay for the service in the "Not Applicable" site of service.

Please Note: The allowance, as defined in the provider participation agreement, means the amount established by Health Advantage as the maximum amount a provider may be reimbursed or collect for services provided to a member. The complete set of Health Advantage allowances is referred to as the "fee schedule".

Health Advantage uses a variety of standards or measurements, at its discretion, to set and periodically adjust the allowance for each covered service, including the Resource-Based Relative Value System (RBRVS). Health Advantage may, at its discretion, change the standards or measurements it uses to establish the allowance for any covered services. Health Advantage also may update its fee schedule or schedule of allowances, at its discretion, from time to time.

Advanced Health Information Network (AHIN):

To provide more information to our participating providers, the Health Advantage Fee Schedule is available on [AHIN](#). If you don't have access to AHIN, please call (501) 378 -2419 or toll free at (866) 582- 3247 for information.

Fee schedule amounts and/or procedure codes can change without notice. Updates will continue to be published in the Providers' News. The existence of a procedure code or fee schedule amount does not mean, nor intend to convey, that a service is covered, payment will be made, or that a particular amount will be allowed.

Pages of the fee schedule can be printed using the printer icon in the tool bar. **Be careful to indicate which page(s) are to be printed or the entire fee schedule will print.**

Member Financial Obligations:

In most situations, Health Advantage members will be responsible for part of a provider's bill for services; and, as the provider agreement with Health Advantage outlines, providers will not waive these member financial responsibilities, (i.e., the member copayment, coinsurance and deductible) as specified in the member's health plan or contract.

Non-Covered Services

Members will generally be exclusively responsible for any non-covered services provided. As specified in the provider agreement, providers may not bill members for services that do not meet Primary Coverage Criteria (e.g., experimental/investigational), unless a member waiver is first obtained. See [Provider Rights and Responsibilities](#) for instructions on member waivers and the documentation required before billing members for such non-covered services.

Please note that except for applicable copayment, coinsurance or deductible, providers are **not** permitted to request or require payment in advance by any of Health Advantage members or from anyone else as a condition of providing services to members.

Billing

Providers are **not** permitted to "balance bill" a member for amounts more than the Health Advantage allowance (member copayment, coinsurance and deductible are deemed part of the allowance for this purpose and should be billed to the member) for covered services. Providers are also responsible for any billing or collection service activities that they may engage, or to whom a provider may assign any accounts receivable or other claims against Health Advantage members.

If Health Advantage finds that a provider, billing service, collection agency, or other agent engaged by a provider has improperly attempted to bill any member or collect any amounts from members in violation of the provider agreement or the guidelines in this Provider Manual, providers are obligated to promptly take all necessary steps to halt any such activity, to ensure that it is not repeated, and to reimburse Health Advantage and the member for any expenses or losses incurred in responding to or defending against the claims or collection actions of any such billing service, collection agency or other agent. Providers may also be excluded from the network for failure to adhere to the member "hold harmless" agreement.

Billing for services to provider family members prohibited

Arkansas Blue Cross and Blue Shield, Health Advantage, and Preferred Provider Networks of Arkansas (formerly USAble Corporation) have published claims-filing policies and procedures that prohibit a participating provider from billing for services provided to any immediate family member. * The immediate family, for this purpose, includes a spouse, parent, child, brother, sister, grandparent, or grandchild, whether the relationship is by blood or exists in law (e.g., legal guardianship).

In addition, all underwritten health plans or policies issued by Arkansas Blue Cross and Health Advantage expressly exclude coverage of services providers perform for immediate relatives. Any claim intentionally or mistakenly filed and that is subsequently paid for such services, requires the billing provider to immediately refund all such payments upon notification.

Section 6: Claims Payment, Refunds, and Offsets

Violation of these policies and procedures and/or failure to make prompt refunds for erroneous payments will subject the offending provider to termination from the networks sponsored by Arkansas Blue Cross, Health Advantage and Preferred Provider Networks of Arkansas. Moreover, a provider's filing of claims for services rendered to immediate relatives (and receiving payment for such claims), is an abusive claims-filing practice that also may constitute fraud and could lead to permanent exclusion from the networks.

***Services to immediate family members include not only those personally performed by the provider, but also any services, equipment, drugs, or supplies ordered by the provider and supplied/performed by another party—including any pharmacy charges resulting from prescriptions written by the provider.**

Previous articles regarding billings for services rendered by providers to immediate family members may be found in the December 2017 and June 2019 issues of *Providers' News*.

Refunds:

While all parties strive for accurate claim adjudication on the first pass, occasionally adjudication mistakes are detected that result in the need to adjust the amount paid. When the adjustment results in a reduction of the claim payment amount, Health Advantage sends the provider notice of any overpayments through a refund request letter as well as on the remittance advice (RA) in the section called "Adjustments". The notice contains patient and claim information including the patient account number for ease of tracking.

While Health Advantage request refunds within 30 days from the date of the letter or RA, Health Advantage prefers that providers allow recover of the overpayment from a future remittance if the provider agrees with the overpayment determination. This will take place after the 30-day period assuming the provider has claims payments to cover any, or all, of the overpaid amount. This requires less administrative work for the provider and Health Advantage.

To close patient accounts timelier, providers may return the letter with a notation "Recoup Immediately," and Health Advantage will initiate the recovery within approximately 10 days assuming the provider has claims payments to cover any, or all, of the overpaid amount. If the provider does not have claim payments sufficient to cover the overpayment during a 90-day period, Health Advantage will send a follow-up requesting a check for the overpaid amount.

Please note that if Health Advantage must offset to recoup duplicate or erroneous payments (overpayments) made to providers, providers are **not** allowed to pursue collection of such offset amounts from the members against whose claims such offsets are made.

Remittance Advice:

A hardcopy Remittance Advice (R/A) may accompany the reimbursement check from Health Advantage for services rendered to our members. If a provider uses a billing service, please send copies of the Remittance Advice to the billing company.

Most of the column headings on the RA are self-explanatory. Those columns labeled "Service" code (type and place), "Remarks" code, and "Payment" code will contain a numerical character.

There are multiple ways to receive a remittance advice:

- Electronic Remittance Advice (ERA) - HIPAA ANSI 835's via EDI services;
- Viewing and printing via the AHIN provider workstation (ANSI 835 type of report);
- Paper remittance advice;

Example of remittance advice:

[Health Advantage](#)

Reimbursement:

Subject to Member's Health Plan or Contract:

Provider reimbursement is subject to the terms of our member's applicable health plan or contract. This means that Health Advantage will pay for any services, supplies, drugs or equipment you provide to our members only as provided in the member's health plan or contract.

If coverage is denied for any reason under the member health plan or contract, providers will not be entitled to reimbursement from Health Advantage for any services to the member. For this reason, providers should be aware of the terms of the health plans or contracts of members you serve as patients.

Each member is issued a copy of their health plan or contract, so providers may request a member to bring a copy to appointments. Providers may also obtain a copy of the member's health plan or contract from Health Advantage upon request. Providers may also obtain information regarding specific Health Advantage Coverage Policies by accessing our Web site at

https://secure.healthadvantage-hmo.com/members/coverage_policy_disclaimer.aspx.

Section 7: Codes and Coding Edits

Billing Codes:

Physician Responsibility in Selecting the Appropriate Billing Code for Medical Procedures:

As additional medical techniques become available, it becomes more important for providers to ensure proper billing and coding of claims for such services.

Choose the Correct Code:

When choosing new ways to bill a procedure or when incorporating medical innovations, providers are responsible for billing a procedure code whose name AND relative work under Resource Based Relative Value Scale matches the service performed. In addition, providers should not fragment services from global procedures (e.g., billing for closing the artery in addition to the cardiac catheterization), nor should physicians choose codes out of context from their CPT section. **It is the physician's responsibility to code correctly regardless of whether or how they utilize any manufacturer's or billing consultant's advice.**

Note: Health Advantage relies on the proper coding to process provider claims and adjudicates the member's benefits. The codes providers select and enter on claims are representations to us that the member's treatment (and your bill) was for the coded diagnosis, not others, and that the provider, in fact, performed the procedures as described in the American Medical Association Current Procedural Terminology (CPT) Manual or the Health Care Procedural Coding System Manual (HCPCS). Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider network participation or other remedial action.

Correct Complete Coding and Payer Policy Reminder

The need for correct and specific diagnosis and procedure coding has never been more important. It's not just a matter of ensuring claims contain a payable diagnosis, it now includes proving to our state and federal regulators that Arkansas needs additional funding to improve the state's health status.

Because Arkansas Blue Cross and Blue Shield and its family of companies are involved in state federal government programs, we must submit our claims data to regulators in order for them to gather health statistics. Coding your claims to the very most specific diagnosis codes is very important in this endeavor. Gone are the days of always using "unspecified" or "not otherwise specified coding." In addition, the clinical documentation of these diagnoses within your medical records is also critical, as these regulators may choose your particular patient in an audit, thereby requiring our request and review of these medical records.

As a reminder, all of our provider network agreements indicate that facilities and providers agree "to accept and comply with the claims filing and coding policies or procedures established by the applicable payer for health plan claims." Most of our policies have been placed in the online provider manual as well as the quarterly newsletter, *Providers' News*.

Our agreements also state that facilities and providers agree "that all reimbursement is subject to all terms, conditions, limitations and exclusions of the member's health plan, and to the application of a payer's coverage policy and coding, billing and claims processing and appeals policies and procedures (Payer Policies and Procedures) as established by payers and as modified from time to time." Our payer policies and procedures and claims filing and coding policies use various coding criteria and protocols including, but not limited to, the CPT Manual published by the American Medical Association, the National Correct Coding Initiative, Specialty Society guidelines and industry coding standards from the Centers for Medicare & Medicaid Services (CMS).

The agreements require that facilities and providers follow these noted industry coding standards.

Refer to the Current CPT Manual:

The Current Procedural Terminology (CPT) manual is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The CPT Manual instructs providers to “select the name of the procedure that most accurately identifies the service performed”.

Refer to the Current HCPCS Manual:

The Health Care Procedure Coding System (HCPCS) manual is designed to offer the basic information regarding coding and billing of medical services, supplies, and procedures using the HCPCS coding system. Do not submit claims using C, K, or T codes.

Note: The CPT and HCPCS manual are commonly used as standardized medical services classification and reporting systems. Health Advantage relies on providers’ accurate use of these systems. However, neither these systems nor any associated manual or guidelines shall be interpreted to govern claims payment or require reimbursement for any code or related service. Coverage or non-coverage of all claims remains subject to the terms and conditions of each member’s health plan or policy.

Category III CPT Codes

Current Procedural Terminology (CPT), the official code book with rules and guidelines from the American Medical Association’s CPT editorial panel, includes a section of Category III CPT Codes. Category III codes are temporary codes created to identify emerging technology services and procedures.

Unlike unlisted or deleted codes, the Category III codes allow data collection for specific emerging technology services. If a Category III code is available, providers must use that code instead of an unlisted or deleted Category I code. The services or procedures represented by Category III codes may not have FDA approval, may not be performed by many health care professionals across the country, and the service or procedure may not have proven clinical efficacy.

Claims filed for services using Category III codes will be denied unless the code is addressed as a covered service in an Arkansas Blue Cross Medical Coverage Policy.

Section 7: Codes and Coding Edits

CodeReview®:

Health Advantage employs the latest in proven computer technology to process claims in a timely and efficient manner.

What is CodeReview®?

CodeReview® is a system that assists the claims processor in evaluating the accuracy of submitted CPT codes by using its clinical knowledge base to detect, correct and document coding inaccuracies on CPT-4 coded claims. It provides consistent and objective claim review by accurately applying coding criteria for the areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology.

CodeReview® is based upon the American Medical Association (AMA) CPT-4 guidelines and has achieved wide national acceptance among HMOs and other third -party payers. CodeReview® results in one of eight types of medically based recommendations to the claims processor:

1. Accept the code(s) as billed;
2. Consider changing the submitted code(s) to comply with generally accepted coding practices that are consistent with the CPT-4 Manual and the opinion of prominent physicians within the specialty;
3. To seek additional information from the physician 's office because of inconsistent information in the claim;
4. Add a code(s);
5. Deny a code(s);
6. Revise a code(s) with a more correct code(s);
7. Exclude a code(s) from a claim; and
8. Supersede a code(s) with a correct code(s).

CodeReview® assists the claims processor in evaluating the accuracy of the coding of the procedure(s), not the medical necessity of the procedure(s). Current coverage policies and contractual requirements will still apply. When a change is made to your submitted code(s), a medical explanation of the reason for the change will be provided. In a few instances where a change is made, it is usually because the CPT-4 Manual indicates that one of the submitted codes should not be used separately when submitted with another code on the claim. This does not mean that the procedure/service was unnecessary; it means that according to generally accepted coding practice, the procedure/service is not coded separately under this circumstance.

Health Advantage believes CodeReview® will assist in processing claims more accurately and consistently. In addition, claims will be paid more quickly and efficiently.

Different Types of Edits and Logic CodeReview® Contains:

There are several different types of edits and logic CodeReview® contains. Below are several examples. CodeReview® edits and logic includes:

Unbundling: When claims are submitted with a global procedure code along with multiple incidental procedures or codes that are an inherent part of performing the global procedure.

Fragmentation: Occurs when a claim includes all the incidental codes separately without listing the more global code. (Note: We do not pay separately for such fragmented charges when applicable CPT codes provide a global code that encompasses the "fragmented" charges.)

Duplicate Procedures: CodeReview®'s knowledge base contains a list of valid procedures that are allowed more than once on the same date of service. Codes not contained on this list are excluded, or replacements are made.

Unlisted Procedure: CodeReview® always questions unlisted services (those codes generally ending in "99") because they are not specific enough to determine what service was actually performed. A description of the code will be requested from the provider through the Medical Review Request System.

Modifier Processing: Modifiers are added to the main procedure code to indicate that the services or procedures have been altered or are different in some way. CodeReview® processes all CPT-4 with modifiers and a few HCPCS modifiers, as part of their processing modifiers edits. A modifier edit is a modifier check based on date of service and appropriateness. For the most part, the way you include modifiers will not change; it is consistent with both AMA and CMS guidelines. However, some may require submission in a different format. An example is modifier 50. CodeReview® is designed to accept bilateral procedures in the following format:

Line 1 - CPT-4 code (primary or one site)

Line 2 - CPT-4 code 50 (additional or a secondary site)

Aged Edit: If a CPT-4 code is defined as age-specific, CodeReview® checks the date of birth or age (whichever is entered) to determine whether on not the appropriate codes are being used.

Gender Edit: CodeReview® checks gender for gender-specific CPT-4 codes to determine whether the code is appropriate.

Place of Service Edit: CodeReview® checks certain procedures to determine where they are performed.

Evaluation and Management Logic: These edits deal primarily with global procedures and E&M services performed as part of these global procedures. These edits follow the current Health Advantage policies.

Clear Claim Connection™: [Clear Claim Connection™](#) is a disclosure tool that will enable providers to access the editing rules and clinical rationale existing in McKesson's CodeReview® auditing product. Clear Claim Connection™ is designed to "mirror" how CodeReview® evaluates code combinations during claims processing. Through this capability the CodeReview® auditing rules, edit clarifications and associated clinical rationale are made available for Health Advantage claims.

Medically Unlikely Edits (MUE's)

The National Correct Coding Initiative (NCCI) includes a set of edits known as Medically Unlikely Edits (MUE's). An MUE represents a maximum number of units-of-service that would be expected to be included in any specific CPT or HCPCS code, and therefore could be medically necessary.

The major purpose for the MUE's is to prevent incorrect payment resulting from erroneous unit entries on claims (for example, it is not rare to receive claims with the number 999 in the units field). The ClaimsXten claims auditing software contains the MUE's, which do not require manually adding medically necessary units-of-service edits for each CPT/HCPCS code.

If more services are submitted than allowed for one date of service for a specific CPT or HCPCS code, the entire line item will be denied. For example, if a claim is for two appendectomies for the same member on the same day, that line item on the claim will be denied.

National Drug Codes Required

Effective Oct. 1, 2020, Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage began requiring the National Drug Code (NDC) when billing for drugs. This requirement was already in place with the Blue Federal Employee program. We are seeing an increased amount of front-end rejections due to this requirement. Below are some ways to prevent common billing errors:

- Bill in the correct format (5-4-2 format per NDC guidelines).
- Don't add NDC to the line item on the claim for an office visit, administration code, lab or x-ray code.
- Bill for the appropriate HCPCS/NDC combination when available instead of a not otherwise specified (NOC) code.
- Don't bill with expired NDC/HCPCS combination, expired NDC code or expired HCPCS code.
- Make sure compounded drugs are covered by the member's plan. Most plans do not cover compounded drugs.

The edit will validate the correct NDC/procedure code/effective date combination and reject the claim if it is not a valid combination. If the line on the claim containing the NDC cannot be validated the entire claim will reject, and the provider must correct the error and resubmit the claim. See June 2020 Providers' News for more information.

Not Otherwise Classified/Unlisted Procedure Codes

Effective immediately, when billing procedure codes that are defined as not otherwise classified or unlisted procedure in the CPT and/or HCPCS coding manuals, a description must be indicated on the claim form and/or electronic record for each code billed. As noted in the December 2009 Providers' News, if the description is not present on the claim form and/or electronic record, it will result in the claims being returned for this information. When the claim is re-filed, including the descriptions, it will be considered a new claim and a corrected claim form does not need to be attached.

Place of Service Code

Place of Service (POS) codes are numeric codes on professional claims that identify where a service was rendered. A list of Place of Service codes is located in the Current Procedural Terminology (CPT) manual.

Place-of-service code for urgent care centers

This is a reminder that urgent care centers should use place-of-service code “20” for claims submission. Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage require all providers to use appropriate claims coding guidelines.

Transitional care management code amendment

The Transitional Care Management (TCM) codes (CPT codes 99495 and 99496) are intended to report management of a transition of a complex patient from one care setting to another, generally from an inpatient to outpatient status. The TCM codes are now reimbursable for any provider who meets the requirements as specified in the CPT manual, specifically including managing transition of the entire patient.

Please note, this service includes communication, medication management, reviewing the discharge records, interaction with other involved professionals, education, and assistance with scheduling follow-up with other providers and community services for all the patient's medical and psychosocial issues. This would generally fall in the purview of the patient's primary care provider.

The CPT code description states:

"The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact and continuous access."

The CPT code manual provides other important details regarding these codes, which includes both an office visit and contact with the patient outside of the office visit with time frames for the face-to-face visit and for initial contact after discharge. These codes are payable to only one provider per discharge and it are not payable to a surgeon during the global period following surgery. These TCM codes are subject to post-pay review.

Section 8: Consolidated Appropriations Act (CAA)

Section 8: Consolidated Appropriations Act

CAA update

The **Consolidated Appropriations Act (CAA)** contains many requirements that have implications for health insurers, health plans, healthcare providers and consumers. We fully anticipate being able to meet our obligation to comply with any of the applicable effective dates of the law's provisions.

Arkansas Blue Cross is analyzing and relying on the legislation's text to guide our preliminary assessments, planning and compliance activities. We continue to closely monitor for additional regulations from the Department of Health & Human Services (HHS) related to the requirements put forth under the CAA so that we will be prepared to comply on the effective dates put out under the forthcoming rules' release(s).

As **background**, below are **general explanations** of some of the items included in the CAA that may impact healthcare providers in some way:

- **Price comparison tools** – This rule is similar to the 2020 Transparency Rule which applied to certain providers/facilities. The CAA requires group health plans and health insurance issuers to provide price comparison tools. It requires group health plans and health insurance issuers to maintain a "price comparison tool" available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider.
- The Tool must be available for 500 covered items and services by **January 1, 2023**, and for all covered items and services by **January 1, 2024**.
- In order to align the enforcement date of the CAA Price Comparison Tool with the enforcement date of the Transparency in Coverage Tool, enforcement of [the CAA price comparison tool] requirement will be deferred . . . until January 1, 2023.

Effective: January 1, 2023

- Advance Explanation of Benefits (EOB) – CAA requires group health plans and health insurance issuers to provide an advance explanation of benefits (EOB) for scheduled services. Requires individual and group health plans to provide a detailed estimate prior to services that are scheduled at least three days in advance. Estimates will be based on mandated notice from providers or members and must be created in three business days or less.
- Effective for providers and facilities: Enforcement of the Advanced EOB requirement deferred pending a rulemaking process.
 - Surprise billing – CAA establishes requirements to protect patients from surprise medical bills received from out-of-network hospitals, freestanding emergency facilities, out-of-network providers at in-network facilities, and out-of-network air ambulance carriers. Provides for patients to be responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain nonemergency situations in which patients do not have the ability to choose an in-network provider. This does not apply where the member chooses to receive services from an out-of-network provider.

Section 8: Consolidated Appropriations Act

- Out-of-network providers and facilities who have provided emergency services or out-of-network providers offering services in an in-network facility where the member would not have the opportunity to know in advance that services would be provided by an out-of-network provider will have requirements to provide notice and receive consent to allow for balance billing.
- Providers and facilities are encouraged to work with their legal representatives to ensure that they will be in compliance with this new law and its requirements.

Effective for plan years: beginning on or after January 1, 2022

- Air ambulance – As a part of the Surprise Billing protections, members who unknowingly receive services from out-of-network (OON) air ambulance providers are protected from out-of-network (OON) cost-sharing and balance billing.
 - Contains requirements for air ambulance providers and plans to both report and submit to the Tri-Agencies a number of metrics on air ambulance services within 90 days of the end of a plan year.

Effective for plan years: starting January 1, 2022

- **Provider directories** – CAA impacts:
 - **Requires providers to update directory information** and provide refunds to enrollees if OON costs are inappropriately applied (in certain circumstances).
 - Requires group health plans and issuers offering group and individual health plans **to establish a verification process to confirm directory information at least every 90 days.** Accordingly, it is very important that healthcare providers respond in a timely manner to health plans who inquire about their provider information – and attest to the information’s accuracy – to avoid possible termination from the health plan’s provider networks due to noncompliance with the requirements of the law
 - If a member provides documentation that they received incorrect information, they are only responsible for in-network cost-sharing.
 - Major point of provisions are data accuracy and data currency that offer members up-to-date and correct provider-related data.

Effective for plan years: starting January 1, 2022

- Mental health parity – CAA requires group health plans and health insurance issuers offering individual or group coverage to perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTL) when applicable to mental health/substance use disorder benefits.

Effective: February 10, 2021

- Changes to ID Cards – Requires group and individual health plans to identify on insurance cards the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum, and a phone number and website address for consumer assistance information.

Section 8: Consolidated Appropriations Act

Effective: Compliance enforcement deferred to January 1, 2023.

While Arkansas Blue Cross and Blue Shield strives to be helpful, we do not provide legal or regulatory advice or services to third parties. If providers have questions about whether or how a law or regulation applies to them, they should consult with their own legal counsel. We can provide background information and offer our business perspective where we believe it would be helpful – but not legal, regulatory or compliance advice.

We very much appreciate the quality care you provide to the people who count on us for their health coverage. As final rules and guidelines become available, we will be sharing more details about process changes that may affect you and that are required to implement the law's requirements.

Section 8: Consolidated Appropriations Act

Continuity of care provisions

The Consolidated Appropriations Act (CAA) of 2021 contains provisions on continuity of care. Arkansas Blue Cross and Blue Shield, Health Advantage, and Blue Advantage Administrators on behalf of the self-insured plans it administers are working to ensure that our policies, processes and practices conform to these legislated requirements.

Here's a brief summary of how these provisions will apply to our valued healthcare providers and their patients.

For plan years **beginning January 1, 2022**, or thereafter, health plans are required to facilitate continuity of care for covered members who have qualifying conditions.

An individual is considered a **continuing care patient** if they are:

- Undergoing a course of treatment for a serious and complex condition that is life-threatening, potentially disabling or congenital and requires specialized medical treatment to avoid death or permanent harm.
- Undergoing a course of institutional or inpatient care.
- Scheduled to undergo nonelective surgery (including postoperative care).
- Pregnant and undergoing a course of treatment related to the pregnancy.
- Terminally ill and receiving treatment for that illness.

Health plans are required to:

- Notify members in writing of any significant changes in the availability or location of covered services, provider terminations, cessation of services or any other significant changes.
- Allow members to notify the health plan or issuer of their need for transitional care.
- Allow members to elect to continue to receive care from the originating provider (under the same terms and conditions that would have applied had the termination not occurred) for the previously covered services for up to 90 days.

We hope this information will be helpful and minimize disruption as you continue to deliver high-quality care. As always, if you have questions about these provisions, feel to reach out to your designated Arkansas Blue Cross representative.

Section 8: Consolidated Appropriations Act

Update provider directory information

The Consolidated Appropriations Act (CAA) effective January 1, 2022, requires providers to update directory information and provide refunds to enrollees if out-of-network costs are inappropriately applied (in certain circumstances).

In order to ensure accurate provider directory information, the CAA requires group health plans and issuers offering group and individual health plans to establish a verification process to confirm directory information at least every 90 days. **Accordingly, it is very important that healthcare providers respond in a timely manner to Arkansas Blue Cross and Blue Shield when we inquire about their provider information. This includes attesting to the information's accuracy to avoid possible network termination from our provider networks due to noncompliance with the requirements of the law.**

At this time about half of the provider data profiles that are being sent to providers for verification are being ignored by the provider community. **This law requires providers to respond to these requests every 90 days that they are distributed.**

We appreciate your help complying with our requests as we navigate the new CAA requirements together.

Section 9: Coverage Policies and Procedures

Section 9: Coverage Policies and Procedures

Coverage Policy

(Specific to Discrete Procedures or Technologies)

The medical director of Arkansas Blue Cross and Blue Shield has established specific coverage policies addressing certain medical procedures or technologies.

The purpose of a Coverage Policy is to inform members and their physicians why certain medical procedures may or may not be covered under Arkansas Blue Cross and Blue Shield health plans. In addition to these specific Coverage Policies, all Arkansas Blue Cross and Blue Shield health plans or contracts also include more generally applicable coverage standards known as the Primary Coverage Criteria. The Primary Coverage Criteria apply to **ALL** benefits members may claim under their plan, no matter what types of health intervention may be involved or when or where members obtain the intervention. For more specifics on Primary Coverage Criteria, click on the Primary Coverage Criteria link below

Search for a Policy

Please search using one of the options below:

Search by **Keyword**:

Or

Select a **Title**:

Or

Enter a **Coverage Policy number**:

Or

Enter a **Procedure Code (CPT/HCPCS)**:

What You Will See

When you select a policy, you will see its title, category and effective date at the top of the page, followed by a description of the treatment and the actual policy explaining the coverage. At the bottom of the page, you will see related CPT codes and references.

Additional Information

- [What Is The Medical \(Coverage\) Policy?](#)
- [How Coverage Decisions Are Made](#)
- [What Is a CPT Code?](#)
- [Primary Coverage Criteria for Arkansas Blue Cross and Blue Shield Health Plan Benefits](#)

Coverage Policy: Additional Information

What is the Medical or Coverage Policy?

Medical or Coverage Policy means a statement developed by Health Advantage that sets forth the medical criteria for coverage under an Arkansas Blue Cross Evidence of Coverage. Some limitations of benefits related to coverage, drug, treatment, service equipment or supply are also outlined in the Coverage Policy.

The existence of an affirmative Coverage Policy does not certify coverage, nor does it override or replace specific coverage language listed in an individual policy or group health plan. While a procedure, technology or drug may be medically necessary, it still may be specifically excluded under the terms of a member's contract or benefit plan, or the use may be an investigational or experimental use of the service and therefore excluded under the experimental or investigational language of the member's benefit contract or plan.

The absence of a specific coverage policy does not indicate that a service is covered. For example, a new device or a new use of an old device may not have been proven safe and effective, but coverage may also have not been previously requested, thereby providing us an opportunity to study the information on the safety and effectiveness of the new use of the device.

A copy of a specific Coverage Policy is available from Health Advantage upon request at no cost, or a Coverage Policy can be reviewed on the Health Advantage website at www.ArkansasBlueCross.com.

How Are Coverage Decisions Made?

The Arkansas Blue Cross and Blue Shield medical directors, including the regional medical directors, review each Coverage Policy before the policies are implemented. Input is requested from local physicians on each new Coverage Policy. Each existing coverage policy is reviewed for accuracy every two years if the policy restricts coverage of a service, procedure, device or drug.

The following sources of information are consulted for the development of Coverage Policies regarding new or emerging treatments, procedures, devices or drugs:

- Member's Benefit Certificate or Summary Plan Description: Is the service, procedure, device or drug specifically excluded?
- FDA Status: Does the service, device or drug require FDA approval?
- Assessment of the effectiveness and safety published by:
 - Agency for Healthcare Research and Quality
 - American Hospital Formulary Service and/or United States Pharmacopeia Drug Information (USP DI) Compendia: Has the drug been recommended for off-label use?
 - Blue Cross and Blue Shield Association Technology Evaluation Center
 - Cochrane Library of Systematic Reviews
 - Formal technology assessment committees of national medical societies
 - Hayes, Inc. Technology Assessment
 - National Institutes of Health (NIH)
- Results of Phase III clinical trials as published in peer-reviewed, mainstream medical journals
- Position papers of major medical organizations
- Consultation with national medical experts

A similar process is followed for additional new uses of established procedures, devices or drugs to establish Coverage Policies.

What Is a CPT Code?

Current Procedural Terminology (CPT) is a five-digit code for reporting of treatment and diagnostic services performed by physicians. CPT is protected by copyright and trademark owned by the American Medical Association (AMA). Physicians use CPT codes in billing for their services.

Section 9: Coverage Policies and Procedures

Primary Coverage Criteria

The Primary Coverage Criteria apply to **all** benefits a member may claim under a health plan or policy, no matter what types of health intervention may be involved or when or where the intervention is obtained. Health Intervention or Intervention means an item or service delivered or undertaken primarily to:

- Diagnose, detect, treat, palliate or alleviate a medical condition; or
- Maintain or restore functional ability of the mind or body.

Purpose and Effect of Primary Coverage Criteria

The Primary Coverage Criteria are designed to allow Plan benefits for only those health interventions that are proven as safe and effective treatment. Members will receive an Explanation of Benefit (EOB), and Providers will receive an Explanation of Payment (EOP) with claims processing remarks that indicate that a claim was not eligible for benefits since the Primary Coverage Criteria was not met.

Another goal of the Primary Coverage Criteria is to provide benefits only for the less invasive or less risky intervention when such intervention would safely and effectively treat the medical condition or to provide benefits for treatment in an outpatient, doctor's office or home-care setting when such treatment would be a safe and effective alternative to hospitalization. Examples of the types of health interventions that the Primary Coverage Criteria exclude from coverage include such things as the cost of a hospitalization for a minor cold or some other condition that could be treated outside the hospital or the cost of some investigational drug or treatment, such as herbal therapy or some forms of high-dose chemotherapy not shown to have any beneficial or curative effect on a particular cancerous condition.

Finally, the Primary Coverage Criteria require that if there are two or more effective alternative health interventions, the member's health plan or policy should limit its payment to the Allowable Charge for the most cost-effective intervention.

Regardless of anything else in a member's health plan or policy, and regardless of any other communications or materials received in connection with a member's health plan or policy, the member will not have coverage for any service, prescription drug, treatment, procedure, equipment, supplies or associated costs **unless** the Primary Coverage Criteria set forth are met. At the same time, just because the Primary Coverage Criteria are met does not necessarily mean the treatment or services will be covered under a member's health plan or policy. For example, a health intervention that meets the Primary Coverage Criteria will be excluded if the condition being treated is a Pre-Existing Condition excluded by the member's health plan or policy.

Elements of the Primary Coverage Criteria

To be covered, medical services, drugs, treatments, procedures, tests, equipment or supplies (interventions) must be recommended by the member's treating physician and meet all of the following requirements:

1. The intervention must be a **health intervention** intended to treat a medical condition. A *health intervention* is an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body. A *medical condition* means a disease, illness, injury, pregnancy or a biological or psychological condition.
2. The intervention must be **proven to be effective** (as defined below) in treating, diagnosing, detecting or palliating a medical condition.
3. The intervention must be the **most appropriate supply or level of service**, considering potential benefits and harms to the patient. The following three examples illustrate application of this standard (but are not intended to limit the scope of the standard):

- i. An intervention is not appropriate, for purposes of the Primary Coverage Criteria, if it would expose the patient to **more invasive procedures or greater risks** when less invasive procedures or less risky interventions would be safe and effective to diagnose, detect, treat or palliate a medical condition.
 - ii. An intervention is not appropriate, under the Primary Coverage Criteria, if it **involves hospitalization or other intensive treatment settings** when the intervention could be administered safely and effectively in an outpatient or other less intensive setting, such as the home.
 - iii. **Maintenance Therapy** is another example of this standard because under the Primary Coverage Criteria, chiropractor services or other physical therapy, speech or occupational therapy, are not considered appropriate for purposes of coverage if the frequency or duration of therapy reaches a point of maintenance where the patient remains at the same functional level and **further therapy would not improve functional capacity or ambulation**.
4. The Primary Coverage Criteria allows the member's health plan or policy to limit its coverage to payment of the Allowable Charge for the **most cost-effective intervention**. *Cost-effective* means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention. For example, if the benefits and risks to the patient of two alternative interventions are comparably equal, a health intervention costing \$1,000 will be more cost-effective than a health intervention costing \$10,000. *Cost-effective* shall not necessarily mean the lowest price.

Primary Coverage Criteria Definitions

1. Effective Defined.

- A. An **existing intervention** (one that is commonly recognized as accepted or standard treatment or which has gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed **effective** for purposes of the Primary Coverage Criteria if the intervention is found to achieve its intended purpose and to cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. This determination will be based on consideration of the following factors, in descending order of priority and weight:
 - i. Scientific evidence, as defined below (where available); or
 - ii. If scientific evidence is not available, expert opinion(s) (whether published or furnished by private letter or report) of an Independent Medical Reviewer(s) with education, training and experience in the relevant medical field or subject area; or
 - iii. If scientific evidence is not available, and if expert opinion is either unavailable for some reason or is substantially equally divided, professional standards, as defined and qualified below, may be consulted; or
 - iv. If neither scientific evidence, expert opinion nor professional standards show that an existing intervention will achieve its intended purpose to cure, alleviate or enable diagnosis or detection of a medical condition, then Health Advantage in its discretion may find that such existing intervention is not effective and on that basis fails to meet the Primary Coverage Criteria.
- B. A **new intervention** (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed **effective** for purposes of the Primary Coverage Criteria if there is scientific evidence (as defined below) showing that the intervention will achieve its intended purpose and will cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits.

Scientific evidence is deemed to exist to show that a new intervention is **not effective** if the procedure is the subject of an ongoing phase I, II or III trial or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with a standard means of treatment or diagnosis. If there is a lack of scientific evidence

regarding a new intervention, or if the available scientific evidence is in conflict or the subject of continuing debate, the new intervention shall be deemed *not effective*, and therefore not covered in accordance with the Primary Coverage Criteria, with **one exception**, if there is a new intervention for which clinical trials have not been conducted because the disease in issue is rare or new or affects only a remote population, then the intervention may be deemed *effective* if, but only if, it meets the definition of *effective* as defined above.

2. **Scientific Evidence Defined.** *Scientific Evidence*, for purposes of the Primary Coverage Criteria, shall mean only one or more of the following listed sources of relevant clinical information and evaluation:
 - A. Results of randomized controlled clinical trials as published in the **authoritative medical and scientific literature** that directly demonstrate a statistically significant positive effect of an intervention on a medical condition. For purposes of this Definition A, *authoritative medical and scientific literature* shall be such publications as are recognized by Health Advantage, listed in its Coverage Policy or otherwise listed as authoritative medical and scientific literature on the Health Advantage website at www.HealthAdvantage-hmo.com.
 - or
 - B. Published reports of **independent technology or pharmaceutical assessment organizations** recognized as authoritative by Health Advantage. For purposes of this Definition B, an independent technology or pharmaceutical assessment organization shall be considered *authoritative* if it is recognized by Health Advantage, listed in its Coverage Policy, or otherwise listed as authoritative medical and scientific literature on the Health Advantage website at www.HealthAdvantage-hmo.com.
3. **Professional Standards Defined.** *Professional standards*, for purposes of applying the *effectiveness* standard of the Primary Coverage Criteria to an existing intervention, shall mean only the published clinical standards, published guidelines or published assessments of professional accreditation or certification organizations or of such accredited national professional associations as are recognized by the Health Advantage Medical Director as speaking authoritatively on behalf of the licensed medical professionals participating in or represented by the associations.

Health Advantage shall have full discretion whether to accept or reject the statements of any professional association or professional accreditation or certification organization as *professional standards* for purposes of this Primary Coverage Criteria. No such statements shall be regarded as eligible to be classified as *professional standards* under the Primary Coverage Criteria unless such statements specifically address effectiveness of the intervention and conclude with substantial supporting evidence that the intervention is safe, its benefits outweigh potential risks to the patient, and it is more likely than not to achieve its intended purpose and to cure, alleviate or enable diagnosis, or detection of a medical condition.

Application and Appeal of Primary Coverage Criteria

1. The following rules apply to any application of the Primary Coverage Criteria. Health Advantage shall have full discretion in applying the Primary Coverage Criteria, and in interpreting any of its terms or phrases, or the manner in which it shall apply to a given intervention. No intervention shall be deemed to meet the Primary Coverage Criteria unless the intervention qualifies under **all** of the following rules:
 - A. **Illegality:** An intervention does not meet the Primary Coverage Criteria if it is illegal to administer or receive it under federal laws or regulations or the law or regulations of the state where administered.
 - B. **FDA Position:** An intervention does not meet the Primary Coverage Criteria if it involves any device or drug that requires approval of the U.S. Food and Drug Administration (FDA), and FDA approval for marketing of the drug or device for a particular medical condition has not been issued prior to the date of service. In addition, an intervention does not meet the Primary Coverage Criteria if the FDA or the U.S. Department of Health and Human Services or any

agency or division thereof, through published reports or statements, or through official announcements or press releases issued by authorized spokespersons, have concluded that the intervention or a means or method of administering it is unsafe, unethical or contrary to federal laws or regulations. Neither FDA Pre-Market Approval nor FDA finding of substantial equivalency under 510(k) automatically guarantees coverage of a drug or device.

- C. **Proper License:** An intervention does not meet the Primary Coverage Criteria if the health-care professional or facility administering it does not hold the proper license, permit, accreditation, or other regulatory approval required under applicable laws or regulations in order to administer the intervention.
 - D. **Plan Exclusions, Limitations or Eligibility Standards:** Even if an intervention otherwise meets the Primary Coverage Criteria, it is not covered under the member's health plan or policy if the intervention is subject to a Plan exclusion or limitation, or if a member fails to meet eligibility requirements.
 - E. **Position Statements of Professional Organizations:** Regardless of whether an intervention meets some of the other requirements of the Primary Coverage Criteria, the intervention shall not be covered if any national professional association, any accrediting or certification organization, any widely used medical compendium, or published guidelines of any national or international workgroup of scientific or medical experts have classified such intervention or its means or method of administration as *experimental* or *investigational* or as questionable or of unknown benefit. However, an intervention that fails to meet other requirements of the Primary Coverage Criteria shall not be covered, even if any of the foregoing organizations or groups classify the intervention as not *experimental* or not *investigational* or conclude that it is beneficial or no longer subject to question. For purposes of this Definition E, *national professional association* or *accrediting or certifying organization*, or *national or international workgroup of scientific or medical experts* shall be such organizations or groups recognized by Health Advantage, listed in its Coverage Policy, or otherwise listed as authoritative medical and scientific literature on the Health Advantage website at www.HealthAdvantage-hmo.com.
 - F. **Coverage Policy:** With respect to certain drugs, treatments, services, tests, equipment or supplies, Health Advantage has developed specific Coverage Policies, which have been put into writing, and are published on the website at www.HealthAdvantage-hmo.com. If Health Advantage has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that a member received or seeks to have covered, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria.
2. Members may appeal a determination by Health Advantage that an intervention does not meet the Primary Coverage Criteria to the Appeals Coordinator using the procedures for appeals outlined in the member's policy or certificate.

Important Notice for Members: For any health intervention, there are six general coverage criteria must be met in order for that intervention to qualify for coverage under a member's health plan or policy:

1. The Primary Coverage Criteria must be met.
2. The health intervention must conform to specific limitations stated in the member's health plan or policy.
3. The health intervention must not be specifically excluded under the terms of the member's health plan or policy.
4. At the time of the intervention, the member must meet eligibility standards.
5. The member must comply with the applicable provider network and cost-sharing arrangements.

The member must follow the required procedures for filing claims.

Section 10: COVID-19 Information

Section 10: COVID-19 Update

Arkansas Blue Cross and Blue Shield and Health Advantage are committed to the safety and well-being of our members. Since the beginning of the COVID-19 public health emergency, we have been working closely with the state and federal government during the coronavirus outbreak to help our fully insured members get access to the care they need during the coronavirus outbreak.

Status of COVID-19 expanded benefits

At the outset of the COVID-19 public health emergency, Arkansas Blue Cross and Health Advantage temporarily extended a number of voluntary, expanded COVID-19- related benefits and suspended some of our normal practices.

Of course, those measures covered under federal mandates will remain in force until federal officials advise that they may be discontinued. Officials have announced the federal mandate will continue **through April 15, 2022**.

Please note: Decisions about coverage changes for members of self-funded health plans served by BlueAdvantage Administrators of Arkansas or Health Advantage are made by the employers or plan sponsors who fund those self-funded programs. If you have questions about coverage, please call the number on the back of the health plan member ID card.

Here is an updated rundown of the status of COVID-19-related benefits and measures:

- **Coverage (at no cost to our members) of COVID-19 diagnostic tests ordered by healthcare providers.**
This applies to diagnostic testing services that meet primary coverage criteria for COVID-19 as defined by the Centers for Disease Control & Prevention (CDC) and are ordered by a healthcare provider.
- **Waiver of cost-sharing for medical services for our fully insured members whose primary diagnosis is COVID-19.**
This includes COVID-19-specific visits to an in-network medical clinic, urgent care center and/or emergency room and inpatient treatment for which COVID-19 is the primary diagnosis.
- **Suspension of prior authorization for inpatient hospital admissions and outpatient procedures at hospitals and ambulatory surgery centers.**
Prior authorizations for inpatient hospital admissions and outpatient procedures at hospitals and ambulatory surgery centers have been temporarily suspended.

The federally mandated measures for COVID-19 services (e.g., concerning COVID testing and COVID vaccines) will remain in force until the public health emergency is terminated by the federal government. When the termination date for the public health emergency is known, Arkansas Blue Cross will notify healthcare providers 90 days in advance of the measure being discontinued.

If you have questions about the status of COVID-19-related benefits and related member cost-sharing, please contact your Arkansas Blue Cross representative.

Section 11: Hospital and Inpatient Information

Policies and Procedures for Hospital Reimbursement:

Introduction:

The purpose of this portion of the provider manual is to provide information on the Hospital Reimbursement Program of Health Advantage with the specific objectives of explaining the policies and procedures of reimbursement as referred to in the contract with member hospitals. (The remainder of this provider manual continues to apply equally to hospitals, where applicable; this section is meant to address reimbursement issues specific to hospitals only.)

Diagnosis-Related Groups:

These policies and procedures shall be applicable to reimbursement based on diagnosis-related groups (DRGs). This reimbursement system consists of established payment levels for groupings of claims according to medically meaningful characteristics. There are six major criteria utilized in assigning a particular claim to a specific DRG. These consist of:

- The principal diagnosis
- Procedures performed on the patient
- Patient's age
- Patient's sex
- Patient's discharge status
- Multiple diagnosis and complications

Note: Health Advantage uses a variety of methods to establish its allowances, including DRG-based methods, and may change those methods or the definitions or formulas used at any time in its discretion.

Date of Admission versus Member Policy Effective Date:

When the date of admission precedes the effective date of the member's policy, the claim will deny when billed electronically. The claim will be processed manually where payment will begin for the effective date of the policy. Admission dates prior to the date of coverage will be the responsibility of the member or the member's previous insurance carrier.

Section 11: Hospital and Inpatient

Definitions:

Adjusted DRG Amount - The DRG base rate plus any applicable daily allowance.

Contractual Adjustment - The amount of reported charges in excess of the amount allowed under DRG reimbursement which may not be collected from Health Advantage or its policyholder.

Daily Allowance (DA) - An allowance that is added to the DRG base amount for each day the length of stay exceeds the high trim point of the applicable DRG.

Diagnosis-Related Grouping (DRG) - A method of classifying hospital patients by similar diagnosis, procedure, age, sex and discharge status.

DRG Base Amount - The amount as established by Health Advantage that will apply to admissions for selected DRGs where the length of stay is less than the high trim point.

Incentive Rate - A percentage from 0% to 100% which is used in incentive adjustments to those claims where the billed charges are greater than the adjusted DRG amount. Individual hospital rates are determined by a formula applied to claims submission history of the particular hospital.

Inlier - Claims that meet the criteria for being assigned a DRG and do not present any of the factors that would cause it to be considered an outlier.

MAP Determined Allowance - The maximum amount that will be allowed for reimbursement of inpatient claims. This is determined by adding the DRG base amount, any applicable daily allowance and incentive adjustment.

Maximum Allowable Payment (MAP) - The amounts established by Health Advantage as the maximum payment allowances for services provided to its members.

Outlier - Claims that have unique characteristics that are outside established parameters for each DRG. Claims with any of the following are outliers:

- A. Length of stay outside the trim points
- B. Death of patient
- C. Patients leaving against medical advice
- D. Patient transferred to another short-term general hospital

Reported Charges - The amount of charges billed for hospital services that the hospital is willing to accept as payment in full. If a hospital discounts a percentage of billed charges, these deductions should be reflected in the reported charges used to determine reimbursement.

Trim Points - A range of days representing the expected length of a hospital stay for which the DRG base amount is applicable. A claim is considered an "outlier" if the length of stay is greater or less than the trim points.

Section 11: Hospital and Inpatient

Hospital Billing:

Hospitals shall submit claims for hospital services provided to Arkansas Blue Cross and Blue Shield policyholders using the UB-04 paper claim form, magnetic tape or Electronic Media Claim System. All information necessary to adjudicate the claim shall be provided. Any incomplete claim will be returned for additional information or correction.

Inpatient Services:

1. Health Advantage does not recognize distinct units of a hospital. Admissions involving transfer of a patient from one unit of the hospital to another should be billed as a continuous admission on a single claim form.
2. All charges for hospital services provided to Health Advantage members that are obtained from another hospital while an inpatient in the hospital submitting the claim shall be included on the same inpatient billing. A patient cannot be considered an inpatient of one hospital and an outpatient of another hospital at the same time.
3. In computing the number of hospital days provided to a member, the date of admission will be counted, but the day of discharge will not be counted.
4. The hospital will not require payment from any Health Advantage member prior to or following the rendering of a service for amounts in excess of any deductible, coinsurance and noncovered amounts. The hospital will look only to Health Advantage for payment of approved benefits with the exception of coinsurance, deductible and noncovered amounts.
5. Separate claims for mothers and newborn shall be submitted.
6. First interim bills may be submitted by Acute Care hospitals only when the admission extends beyond 60 days. Psychiatric hospitals, Rehabilitation hospitals, and Arkansas Children's Hospital may submit first interim bills when the admission extends beyond fourteen (14) days.

Outpatient Services:

1. Reimbursement for outpatient services directly relating to an inpatient stay (e.g., preadmission x-ray or lab procedures) that were provided 24 hours prior to or 24 hours after the inpatient stay will be included in the DRG/per diem reimbursement for the same inpatient claim. The admission date and period covered should reflect only the inpatient dates of services. Outpatient services that are not related to the inpatient stay may be billed as outpatient even if provided within 24 hours of an inpatient stay.
2. Claims submitted for services provided to an outpatient who was not admitted must be completed with all the required information necessary to adjudicate the charges, including the diagnosis and procedure codes.
3. Separate outpatient claims should be submitted for each date of service.

Payment for selected outpatient services will be made on a global fee basis using the procedures and code number outlined in the Current Procedural Terminology (CPT4). This allowance will include all services associated with the procedure **except** physician services, certified registered nurse anesthetist (CRNA) services, ambulance services, and some implants and prosthetic devices.

Health Advantage will notify the participating hospital 30 days in advance of adjustments to the outpatient maximum payment allowances.

Initial hospital visits billed by multiple physicians

In March 2012, Health Advantage sent notice to providers that only the admitting physician could bill the hospital admission CPT Codes 99221-99223. All other physicians seeing the patient, even if for the first

time, were instructed to bill the subsequent hospital CPT Codes 99231-99233. However, most physicians continue to bill the hospital admission codes.

After data analysis and understanding that the consult CPT Codes are not available for providers to use, Health Advantage agrees that the physicians providing 'consults' to the hospital patient may bill the first visit using the hospital admission CPT Codes 99221-99223 provided the service meets the requirements set forth by the Centers for Medicare & Medicaid Services (CMS) for this use.

The admitting physician should add Modifier A1 for reporting purposes only. Consulting physicians and subsequent attending physicians should not use the Modifier A1.

Observation Beds:

Facility charges for observation beds are to be billed under revenue code 762. Coverage guidelines for observation beds are as follows:

1. Observation bed charges will be recognized from general acute care and critical access hospitals only.
2. Reimbursement for observation bed charges will be limited to one day's semiprivate room allowance.
3. Hospital outpatient surgery fee schedule amount (global allowance) will encompass observation bed charges and related services.
4. Observation bed services that occur within 24 hours of a hospital admission will be considered part of the inpatient hospital billing. The admission date will be the day that the patient is first considered an inpatient. For purposes of precertification (if applicable), the admission will be treated as an emergency so that the 48-hours prior notice requirement will not have to be met. The managed care company following the admission will post the actual admission date to their records.

Requirements for Outpatient Observation Care:

In compliance with the Centers for Medicare and Medicaid Services Medicare Outpatient Observation Notice (MOON), Health Advantage requires all acute care and critical access hospitals to provide written notification and oral an explanation of the notification to patients receiving outpatient observation services for more than 24 hours. Medi-Pak® Advantage members, observation stays require any pre-authorization or pre-notification requirements. The notice and accompanying instructions are available at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>

Section 11: Hospital and Inpatient

Registration of Hospital Room Rates:

All room rates including private, semi-private and special-care units are to be registered with Health Advantage at least annually and when such rates change. These rates should be listed on the [Bed Complement Form](#). The form is used to calculate the average and most prevalent semi-private room allowances. The form is available by clicking on the link [Bed Complement Form](#).

In hospitals with only private rooms, the average semi-private room allowance will be equal to the average, routine Medical/Surgical Private Room Rate.

The rates and changes should be sent to:

Health Advantage
Hospital Reimbursement & Pricing Division
Post Office Box 2181
Little Rock, Arkansas 72203-2181

Please remember, hospitals are responsible for sending charges.

Section 11: Hospital and Inpatient

Hospital Reimbursement:

The Maximum Allowable Payment (MAP) for:

- Inpatient claims - Based on the lesser of reported charges or a MAP-determined allowance.
- Outpatient claims - Based on the lesser of the reported charges or the maximum payment allowance.

The hospital's reported charge as submitted on the claim form will be considered the maximum allowable payment (MAP) when no DRG allowance has been established for a specific DRG or when no MAP has been established for an outpatient service.

Actual payment amounts will be based on benefits of the member's health plan or contract. Amounts related to the policyholder's deductible, coinsurance or non-covered services will be deducted from the MAP. These amounts will become the portion of charges delineated as "Patient Responsibility" on the Remittance Advice.

All payments shall be made on the basis of the rates and allowances in effect on date of admission for inpatient services and date of service for outpatient services. These dates will also be the determining date for changes in participation status of the hospital and application of member contract benefits.

On-site audits may be conducted to verify that the medical records contain sufficient information to support the data indicated on the claim that was used to determine reimbursement. Hospitals will be provided advance notification of the dates and procedures of the audits. The results of the audit will be provided to the hospital administrator and Health Advantage management to determine if adjustments are indicated.

Outliers:

Outliers shall be reimbursed as follows:

1. **Length of Stay Below the Low Trim Point** — Charges will be recognized for medically necessary services up to the MAP-determined allowance for the specific DRG.
2. **Length of Stay Above the High Trim Point** — Charges will be recognized for medically necessary services up to the MAP-determined allowance.
3. **Transfers** — Charges will be recognized for medically necessary services up to the MAP-determined allowance.
4. **Patient Leaving Against Medical Advice** — Charges will be recognized for medically necessary services up to the MAP-determined allowance.

Claims for admissions involving more than one outlier will be paid using the MAP-determined allowance for the most significant outlier.

Outliers Hierarchy:

The hierarchy of outliers is:

Outlier Type	MAP
Days above high trim points	Charges up to MAP determined allowance.
Transfer	Charges up to MAP determined allowance.
Days below the low trim point	Charges up to MAP determined allowance.

Example: A claim with a stay above the high trim point when the patient was transferred to another short-term general hospital will be paid as shown in the second example above.

Daily Allowance:

The daily allowance is a method of sharing the extra cost of an extraordinarily long length of stay by adding to the DRG base amount for each extra day the length of stay exceeds the high trim point.

This allowance is calculated by dividing the DRG base amount by the high trim point for the length of stay. The DRG base amount, daily allowance and trim points will be provided to the participating hospital.

Incentive Payment Rate:

Participating hospitals will be allowed an incentive adjustment for cost -efficient management of inpatient cases. The incentive rate will be calculated using each hospital's historical charge data. The participating hospital will be notified in writing of the incentive rate no later than 30 days prior to the effective date.

The actual method of calculating the incentive payment rate is based on the total differences between reported charges on inliers and outliers compared to the adjusted DRG amounts. The incentive adjustment will only be applied to inpatient claim charges that are in excess of the adjusted DRG amount.

Any hospital with insufficient history to establish an incentive rate will have an initial rate of zero percent until sufficient charge history has been accumulated.

Incentive Rate Calculations:

- A. For each hospital, divide all claims with a DRG base amount.
 1. Normal claims, or inliers, with reported charges over the adjusted DRG amount.
 2. Inliers with reported charges below the adjusted DRG amount.
 3. Outliers with reported charges over the adjusted DRG amount.
 4. Outliers with reported charges below the adjusted DRG amount.
- B. The rate will be calculated as a percentage using:
 1. Amount of reported charges over the adjusted DRG amount for inliers (A1, above).
 2. 50 percent of reported charges below the adjusted DRG amount for both inliers and outliers (A2 and A4, above).
 3. Amount of reported charges over the adjusted DRG amount for outliers (A3, above).
 4. 25 percent of reported charges below the adjusted DRG amount for inliers (A2, above).
- C. Add the lower of B1 or B2 to the lower of B3 or B4. Divide this amount by the sum of B1 and B3 and multiply by 100 percent. This will be the rate.

Examples of Rate Calculation:

INLIERS	EXAMPLE 1	EXAMPLE 2	EXAMPLE 3
A. Reported Charges over adjusted DRG amount	\$25,500	\$50,000	\$60,000
B. Reported Charges under adjusted DRG amount	\$40,000	\$26,000	\$16,000
OUTLIERS			
C. Reported Charges over adjusted DRG amount	\$15,000	\$5,000	\$5,000
D. Reported Charges under adjusted DRG amount	\$5,000	\$44,000	\$44,000
Lower of A or 50% (B + D)	\$22,500	\$35,000	\$44,000
Lower of C or 25%(B)	\$10,000	\$5,000	\$4,000
Sum of Lowers =	\$32,500	\$40,000	\$34,000

(Divided by)			
Sum of A + C =	\$40,000	\$55,000	\$65,000
Rate =	81.25%	72.73%	52.31%

Contractual Adjustment:

- A. Information necessary to calculate contractual adjustment:
1. Total amount of reported room charges
 2. Total amount of reported ancillary charges
 3. Actual length of stay
 4. DRG number
 5. High trim point
 6. DRG base amount
 7. DRG daily allowance
 8. Average semi-private room allowance
- B. The amount of contractual adjustments will be calculated as follows:
1. Add room allowance (the lesser of actual room charges or the length of stay times the average semi-private room allowance) plus reported ancillary charges on the claim to determine the adjusted charges.
 2. Add DRG base amount plus any applicable daily allowance (days above high trim point times daily allowance) to determine the adjusted DRG amount.
 3. Subtract the adjusted DRG amount (#2 above) from the adjusted charges (#1 above) to determine the amount of any excess charges.
 4. Multiply the excess charges (#3 above) by the hospital's incentive rate to determine the incentive adjustment.
 5. Subtract the incentive adjustment (#4 above) from the excess charges (#3 above) to determine amount of contractual adjustment.

Contract benefits will be applied to reported charges on the claim less the amount of contractual adjustment to determine the Health Advantage payment.

If the adjusted DRG amount is equal to or greater than the adjusted charges, there is no contractual adjustment; and contract benefits will be applied to reported charges on the claim.

Example of Contractual Adjustment Calculation:

HOSPITAL NAME:	Arkansas Medical Center
PATIENT NAME:	Jim Public
ADMISSION DATE:	1/24/97
REPORTED CHARGES:	\$8,192.92
ROOM:	\$2,250.00
ANCILLARY	\$5,942.92
LENGTH OF STAY:	9 DAYS
AVERAGE SEMI-PRIVATE ALLOWANCE:	\$250.00
DRG:	089
BASE AMOUNT:	\$6,650
DAILY ALLOWANCE:	\$475

HIGH TRIM:

14 DAYS

Adjusted Charges		Adjusted DRG Rate	
Room Allowance: Lesser of actual room charges or (# days x ASP)		DRG Base Amount	\$6,650.00
\$2,295 Or \$(9 x \$250)	\$2,295.00	Extra Daily Allowance (# days x Daily Allow)	N/A
Reported Ancillary Charges	\$5,242.92		
Total Adjusted Charges	\$8,192.92	Total Adjusted DRG Rate	\$6,650.00
Contractual Adjustment		Payment Calculation	
Adjustment Charges	\$8,192.92	Total Reported Charges	\$8,192.92
Adjusted DRG Rate	\$6,650.00		
Excess Charges	\$1,542.92	Less Contractual Adjustment	\$300.87
Incentive Adjustment (80.5%)	\$1,242.05		
Contractual Adjustment	\$300.87	Contract Benefits Applied To	\$7,892.05

Hospital Discounts:

If a hospital provides discounts below its usual charge for patient services, (i.e., deductibles, copayments, percentage of charges, etc.) the discount should be clearly indicated on the claim form. The discounted amount will be used as the reported charges in determining the maximum allowed payment (MAP).

When the Medicare deductible is discounted, no secondary payer should be listed in Locator 57 on the Medicare UB-04 claim form.

Hospital Appeals Issues

Administrative Decisions:

Hospital appeals of administrative matters (e.g. peer group assignments, amounts for DRG incentive rates, etc.) should be submitted to Hospital Reimbursement and Pricing in writing, setting forth the specific issues of disagreement. Any appeal concerning matters affecting the calculation of incentive rates must be submitted within 30 days after hospital first receives the incentive rate notice and provider analysis report.

Any unresolved issues will be submitted to the Hospital Committee of the Arkansas Blue Cross and Blue Shield Board of Directors. The hospital will be informed of the decision within thirty (30) days of the appeal.

Determination of Non-Covered Services:

The determination of a non-covered hospital service (e.g., diagnostic admission, pre-existing cosmetic, etc.) will be made by applying generally accepted medical standards based on documented facts of the case. When medical records are secured and reviewed, the case may be referred to the hospital's Utilization Review Committee for consideration and recommendations.

If the issue remains unresolved the claim will be referred to the ABCBS Medical Director who will either authorize benefits on the claim or refer it to a recognized medical review entity.

If the Medical Review Committee determines the services are non-covered, the hospital may appeal the decision by appearing before the review committee to present additional information.

If after the appeal, the review committee still determines the services to be non-covered, their decision will be binding.

DRG Assignment:

Hospital appeals pertaining to the DRG assignment on a particular claim may be submitted as follows:

1. Discrepancies caused by incorrect information on the claim form can be corrected by submitting a corrected claim form with bill type 117 in form locator 4. Corrected claims may be reprocessed through the computer system to provide correct member utilization data (e.g., deductible, stop loss, etc.) resulting in the voiding of the original claims and payment of the corrected claim. This information will be reflected on the Remittance Advice.
2. Discrepancies caused by erroneous translation of information from the claim form into the computer system should be submitted to Arkansas Blue Cross and Blue Shield in writing within 60 days of the date of the Remittance Advice.

DRG Weights Calculation Policy:

Each year a copy of the DRG weights is downloaded from the CMS website after the final rule is rendered in the Federal Register. This file is downloaded into an Excel format and is used to process inpatient hospital claims. Previously, the weights are carried to only four decimal places. For 2015, CMS has carried the decimal further than the four decimal places. However, the full calculation is only visible when clicking in the cell on the downloaded CMS spreadsheet. For purposes of consistency, the DRG weight will be rounded to the fourth decimal place in all Arkansas Blue and Blue Shield claims systems. For example, DRG 378 has a DRG weight of 1.002061 and will be rounded to 1.0021.

Inpatient Claims Financial Responsibility Policy

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

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

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

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

Pre-Certification, Pre-Notification, & Eligibility Inquiries

Non-Emergency Admissions - Facility understands and agrees that for Health Plans that require pre-certification or pre-notification and Facility fails to obtain pre-authorization or pre-notification, that Facility will hold Member harmless of any amounts not paid for Covered Services.

Emergency Admissions - Facility understands and agrees that for Health Plans that require pre-certification or pre-notification within 24 hours after admission or by the end of the next working day, if on a weekend or holiday and Facility fails to obtain pre-authorization or pre-notification, that Facility will hold Member harmless of any amounts not paid for Covered Services.

Revenue Code Claims Filing Changes

Effective March 1, 2011, outpatient institutional claims containing revenue codes 0905, 0906, 0912, 0913 and 0915 will require CPT/HCPCS codes in conjunction with these revenue codes. When submitting outpatient claims with these revenue codes (both electronic and paper), facilities must also use the appropriate corresponding CPT codes 90801-90880, 90901, 96101-96120, G0176, G0177, G0396, G0397, G0410 and G0411. Claims submitted without appropriate CPT/HCPCS codes will be rejected and the member will not be responsible. This revision applies to all outpatient UB04 claims submitted to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage.

Also effective March 1, 2011, revenue code 0761 (specialty services – treatment room), will require CPT codes on outpatient claims. Please use the following appropriate CPT code when submitting revenue code 0761: 99201-99205, 99211-99215, 97597, 97598 and 97602. Outpatient claims submitted without the appropriate CPT code in conjunction with revenue code 0761 will be rejected and the member will not be responsible.

Supplies are often used in conjunction with services billed with revenue code 0761. When revenue code 0761 is billed, supplies in conjunction with 0761 should be billed using revenue codes 0270, 0271 or 0272.

In the presence of revenue code 0761, the codes listed below should be used when billing revenues codes 0270, 0271 or 0272. Outpatient claims submitted without these appropriate HCPCS codes will be rejected and the member will not be responsible.

Revenue codes requiring CPT or HCPCS codes

Beginning July 1, 2015, outpatient institutional claims (UB04) containing revenue codes 0480, 0481, 0482, 0483 and 0489 will require CPT/HCPCS codes in conjunction with these revenue codes. The additional CPT/HCPCS codes will be required on both electronic and paper claims. Claims submitted without the appropriate CPT/HCPCS codes will be rejected and the member will not be held responsible. This revision applies to all outpatient UB04 claims submitted to Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage.

Injectable Drug Pricing for Hospital Outpatient Departments

An article was published in the September 2004 issue of Provider's News stating that administration fees for IV infusions, etc., would not be covered for facilities. The article specifically mentioned revenue codes 940 and 949.

It has come to the attention of Arkansas Blue Cross and Blue Shield that this denial has not been applied consistently. In an effort to control costs and to be fair to our providers, Arkansas Blue Cross will begin paying a nominal fee for these services.

Since the reimbursement for the facility practice expense is covered under other revenue codes when provided in the outpatient hospital setting, the reimbursement for the practice expense portion of these services has been removed from the fee schedule amount used for physicians.

Additionally, Arkansas Blue Cross will begin paying hospitals for injectable drugs (J0000-J9999, etc.) based on the Arkansas Blue Cross fee schedule which was developed to reimburse the cost of the medication. Some of the sources of the reimbursement amounts are Average Sales Price (ASP) plus 10% (with a 10% maximum of \$400), wholesale acquisition cost (WAC), 85% of average wholesale price (AWP), or invoice from the provider.

The fee schedule amounts will be the same as the amounts used to reimburse physicians and will be paid at 100% of the Arkansas Blue Cross fee schedule amount. Unlisted J codes will be listed as BR (By Report) and will be reimbursed using one of the sources noted for the drug and dosage provided.

Anytime a valid HCPCS or CPT code is available for the drug given, the HCPCS/CPT code is required to be billed with the appropriate revenue code.

Clinic Visits and Trauma Revenue Codes Billed by a Facility

Arkansas Blue Cross and Blue Shield, Health Advantage and PPO Arkansas do not recognize facility charges for clinic visits or trauma revenue codes. Facility charges for services performed in a clinic should be billed under revenue codes 0510-0519. Trauma revenue codes 0680-0689 will also be denied as non-covered. These services will be denied and charges for these services should not be collected from Arkansas Blue Cross policyholders.

Covered services performed in a clinic will be reimbursed when billed on a professional claim.

Implant Billing and Invoice Requirement Change

Effective for dates of service on or after January 01, 2018, there will be no allowance for implant revenue codes 275 or 278 when billing for Outpatient Hospital or Ambulatory Surgical Center (ASC) Surgery.

The provider may appeal this decision to Provider Compensation only if there is more than one device intensive procedure on the claim or the claim contains one of the limited numbers of pass-through codes. In these instances, an invoice will be required to price; there will no longer be threshold amounts.

Please note that in case of an appeal, we will still no longer accept a purchase order in place of a manufacturer's invoice.

Please contact your Network Development Representative with any questions or email the Provider Compensation team at providerreimbursement@arkbluecross.com.

Section 11: Hospital and Inpatient Information

UB-04 Claims

Health Advantage relies on the proper coding to process provider claims and adjudicates the member's benefits. The codes providers select and enter on claims are representations to us that the member's treatment (and your bill) was for the coded diagnosis, not others, and that the provider, in fact, performed the procedures as described in the American Medical Association Current Procedural Terminology (CPT) Manual or the Health Care Procedural Coding System Manual (HCPCS). Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider network participation or other remedial action.

Claims Filing Information:

Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their web site at www.nubc.org.

Scanning UB-04 Claim Forms:

Health Advantage is now scanning the UB 04 claim form (CMS-1450). From our experience with scanning, the following items commonly cause claims to be delayed or rejected on UB 04 claims.

- **All data must be contained within its defined area.**
- **All dollar fields should be blank or have real values.**
- **Do not include \$ or decimal points when reporting charges.**
- **Do not handwrite or put comments on claims.**

Most Common Errors:

This process has also allowed us to process UB 04 claims through edits on the front end before they enter the claim system. The most common errors are:

- No Source of Admission Code in Form Locator 15
- No Patient Status Code in Form Locator 17
- No Provider Number in Form Locator 56 & 57

Form Instructions:

The UB 04 manual is our guide for completing this form.

DATES — Box 6, 10, 12, 31-36, 45, 74-74E. All date fields except Box 10 should be filled out as "MMDDYY". Do **NOT** use "/" "-" or spaces to separate month, day or year. Always put a zero in front of single-digit days or months. Box 10 (birthday) should have a 4-digit year.

BOX 1 - Provider's Name and Address: Do **NOT** type information above Box 1. Always place phone number as last line in this box. Format expected: Line 1 – provider's name; Line 2 – provider's street address; Line 3 – provider's city, state, zip (5 or 9 positions); Line 4 – provider's phone (7 or 10 positions).

BOX 3a - Patient Control Number: Should start on left side of box. Numbers next to bill type can become part of bill type.

BOX 8 a & b - Patient's Name/ID: Enter in 8a the patient's ID and in 8b the patient's last, first and middle initial. No commas, periods or titles.

BOX 9 a-e - Patient's Address: Enter the patient's street address (9a), city (9b), state (9c), zip codes (5 or 9 digits) (9d), and country (9e). Do not use separators such as semi-colons, use spaces.

BOX 38 – Responsible Party's Name and Address: Line 1 –Name (last name, first name) and initial. No periods, commas or titles. Line 2 –Address (street or apt, etc.) Line 3 - Can be a second street, box etc. Line 4 –City, state and zip (5 or 9). Do not enter phone numbers. Phone numbers distort OCR and there is no place to store them on the NSF records.

BOX 46 - Service Units: Enter whole numbers only up to seven numeric digits. Fractions and decimals are not allowed.

BOX 50 –Payer Name: Enter payer's name, left-justified. If Medicare is the primary payer, enter "Medicare" on the line. (Line A – Primary Payer, Line B – Secondary Payer, and Line C – Tertiary Payer)

BOX 56 – National Provider Identifier (NPI): Please left-justify.

BOX 58 – Insured's Name: Enter the last, first, middle initial of the insured. Do not use periods, commas or titles. (Line A – Insured's Name Primary, Line B – Insured's Name Secondary, and Line C – Insured's Name Tertiary)

For complete [instructions on the UB-04 form](#), visit the CMS web site at www.cms.hhs.gov.

Black UB-04 Claim Forms No Longer Accepted

Beginning October 1, 2012, paper claims submitted on black UB-04 (CMS-1450) claim forms will be returned to the provider. Paper facility claims should be submitted on the standard UB-04 claim form with red "drop out" ink. These may be obtained through various print vendors that comply with National Uniform Billing Committee (NUBC) specifications. Arkansas Blue Cross and Blue Shield recommends providers submit claims electronically and avoid using paper claim forms whenever possible.

Section 12: ICD-10

HIPAA changes requiring ICD-10 procedure and diagnosis codes

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) published the “HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD–10–CM and ICD–10–PCS” final rule.

This rule requires that ICD-10 CM diagnosis codes be used instead of ICD-9 CM diagnosis code within all HIPAA electronic transactions beginning on October 1, 2013. This rule also requires that all inpatient procedures be reported using ICD-10 PCS codes instead of ICD-9 CM volume 3 codes beginning on October 1, 2013, as well. Outpatient institutional procedure codes and all professional procedure will continue using CPT 4 and HCPCS codes.

HHS also published the final rule that will require all HIPAA transactions to be transmitted in the ASC X12 5010 format by January 1, 2012. The current ASC X12 4010A1 format will not accommodate the use of ICD-10 codes. With the compliance date for the 5010 formats being January 1, 2012, and the ICD-10 codes becoming the mandate on October 1, 2013, HHS allowed 21 additional months to complete all necessary work to accommodate the ICD-10 codes after the 5010 has become the standard.

When discussing HIPAA compliance with your vendors, please be sure to ask about their strategy for adopting the 5010 standard and the ICD-10 standards for all HIPAA covered transactions. Arkansas Blue Cross and Blue Shield is ready to begin testing 5010 claims transactions now. To begin testing, please contact EDI Services at 501-378-2419 or 1-866-582-3247 for further instructions.

Final ruling released on compliance date

On August 24, 2012, Kathleen Sebelius, secretary of the U.S. Department of Health and Human Services (HHS), announced a final ruling providing a one-year delay—from October 1, 2013, to October 1, 2014—in the compliance date for use of the ICD-10 CM diagnosis and procedure codes. This final ruling required that ICD-10 CM diagnosis codes be used instead of ICD-9 CM diagnosis codes within all HIPAA electronic transactions beginning October 1, 2014. This final ruling also required all inpatient procedures be reported using ICD-10 PCS codes instead of ICD-9 CM volume 3 codes beginning on October 1, 2014. Outpatient institutional procedures and all professional procedures will continue using CPT-4 and HCPCS codes.

Changes to ICD-10 compliance

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which states that the secretary of U.S. Department of Health and Human Services (HHS) may not adopt ICD-10 code sets as the standard for codes sets prior to October 1, 2015. The health care industry is waiting for the HSS to release an interim final rule in the near future that will stipulate a new compliance date for use of ICD-10 code sets.

Arkansas Blue Cross and Blue Shield will continue ICD-10 end-to-end testing efforts with providers and invite them to actively engage and complete ICD-10 testing. Providers are encouraged to visit “ICD-10 Resource Center” in the “Provider” section of our website for more information.

ICD-10 compliance date is October 1, 2015

The U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015, as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10. This new deadline allowed providers, insurance companies and others in the health care industry time to ensure their systems and business processes were ready for the October 1, 2015 compliance deadline.

Arkansas Blue Cross and Blue Shield has been actively performing ICD-10 end-to-end testing with providers and is ready to begin accepting ICD-10 claims coding.

Don't delay. Sign-up for testing now!

Arkansas Blue Cross and Blue Shield is actively performing ICD-10 end-to-end testing with providers and can help you get started. We encourage providers to initiate your ICD-10 testing effort as soon as possible by contacting us at icd10@arkbluecross.com. You may also use icd10@arkbluecross.com for any ICD-10 related inquiries or communication.

Claims without ICD-10 codes will not be paid

By federal mandate, the ICD-10 compliance date was October 1, 2015. As a result, all claims submitted to the Arkansas Blue Cross and Blue Shield and its family of companies for dates of service or discharge dates on or after October 1, 2015 must utilize ICD-10 codes in place of ICD-9 codes. Claims not billed with ICD-10 codes will be rejected.

Claims affected by this change include claims submitted to Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, Health Advantage, Medi-Pak® Advantage, Federal Employees Program, USABLE Administrators, Metallic Plans on the Arkansas Exchange, and includes claims for other Blue Plan members.

Arkansas Medicaid is also planning to do the same and has published a similar update on their site. Arkansas Blue Cross will monitor federal guidelines regarding their compliance and make changes to this policy as needed.

AHIN claims acceptance criteria regarding ICD-10

AHIN will have the following additional criteria to comply with the federal regulation related to ICD-10. Claims not meeting these criteria will be rejected at the time of submission.

Criteria:

All claim types:

- If a claim is submitted with ICD-9 and ICD-10 codes on the same claim, the claim will be rejected.
- ICD codes must have the correct qualifier indicating whether the code is an ICD-9 code or ICD-10 code.
- The October 1, 2015 compliance date applies to both the ICD diagnosis and ICD procedure codes.

Inpatient claims:

- If the discharge date (statement to date) is prior to the compliance date, ICD-9 codes must be submitted for all service lines on claim.
- If the discharge date (statement to date) is on or after compliance date, ICD-10 codes must be submitted for all service lines on the claim.
- For interim bills, the same rules will apply.
- For inpatient claims with admission date prior to compliance date but a discharge date (statement to date) after compliance date, ICD-10 must be submitted on all service lines on the claim.

Professional and outpatient claims:

- If the statement to date or service date is prior to compliance date, ICD-9 codes must be submitted for all service lines on claim.
- If the statement to date or service date is on or after compliance date, ICD-10 codes must be submitted for all service lines on the claim.
- If a claim has service dates both prior to and on or after the compliance date, the claim must be split such that services prior to compliance date are billed on one claim with ICD-9 codes and services on or after compliance date are billed on second claim with ICD-10 codes.

ICD-10 guidelines for paper claim submissions

The federally mandated ICD-10 compliance date of October 1, 2015 applies also to paper claims. All claims submitted to the Arkansas Blue Cross and Blue Shield and its family of companies, including paper claims, must apply the following guidelines to avoid claims from being rejected.

For CMS-1500 (02/12) claim form:

- Claims with dates of service prior to October 1, 2015, must be filed using ICD-9 indicator of nine (9) and ICD-9 diagnosis codes in Box 21. Claims with dates of service on or after October 1, 2015, must be filed using ICD-10 indicator of (0) and ICD-10 diagnosis codes in Box 21.
- Claims cannot have dates of services prior to October 1, 2015 and on or after October 1, 2015. Separate claims must be filed and appropriate ICD codes used based on the October 1, 2015 compliance date.

For UB-04 claim form:

- Claims with a Statement covers period through date in form location FL 6 prior to October 1, 2015, must be filed using ICD-9 indicator of nine (9) in FL 66, ICD-9 diagnosis codes as needed in FL 67, 67A-Q, 69, 70a-c, and 72a-c, and ICD-9 procedure codes as needed in FL 74 and 74a-e. Otherwise, claims with a through date (FL6) on or after October 1, 2015, must be filed using ICD-10 indicator of zero (0) and ICD-10 diagnosis and procedure codes in the appropriate form locations.
- Claims for outpatient facility and services cannot span the October 1, 2015 compliance date. The claims must be split and filed separately with the appropriate ICD codes.”

Claims affected by these guidelines include claims submitted to Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, USAble Administrators, Health Advantage, Medi-Pak® Advantage, Federal Employees Program, Metallic Plans on the Arkansas Exchange, and includes claims for other Blue Plan members.

For detail instructions on how to properly complete the CMS-1500 (02/12) claim form, Arkansas Blue Cross recommends following the National Uniform Claim Committee (NUCC) guidelines located on their website at nucc.org.

Frequently asked questions for ICD-10

End to End Testing

- End to End testing was opened for providers in September 2014 which was published in the September 2014 issue of Providers' News. ICD-10 testing has been open for over a year.
- Arkansas Blue Cross will continue to accept test claims until the October 1, 2015 deadline. However, test claims received after August 31, 2015 may take longer to process and results may not be available before the October 1, 2015 compliance date. Please send an email to ICD10@arkbluecross.com if you wish to participate in testing.

Authorizations

The following is applicable to authorizations for physicians and outpatient services.

Can providers currently pre-authorize services associated with ICD-10 diagnoses? If not, when will Arkansas Blue Cross begin accepting ICD-10 diagnoses when pre-authorizing services? ICD-10s will be accepted starting on the October 1, 2015 compliance date.

If pre-authorization is required for services associated with ICD-9 diagnoses, will services performed on or after the transition date require re-authorization with an ICD-10 code or will ICD-9 pre-authorization received prior to the conversion carry over for those services? Re-authorization will NOT be required. Current pre-authorizations processed with ICD-9 codes will be valid after the compliance date of October 1, 2015.

CMS-AMA Guidance - Clarifications

During July 2015, CMS-AMA published guidance and additional clarifications on the ICD-10 guidelines. This section will try to clarify the guidance to ensure providers are not misled.

- CMS is still asking to submit a valid ICD code. A three-digit code that has additional subdivisions would not be considered valid. The most specific ICD-10 code will be required similar to the way the most specific ICD-9 code is required.
- CMS's guidance applies only to post-payment reviews and hence no change will be made to the claims processing edits. Since this is specific to CMS only, Arkansas Blue Cross will make no changes to claims processing edits as a result of CMS's guidance.

Contact Information

- Providers should contact the AHIN provider services if they experience problems with claims submissions.
- Arkansas Blue Cross customer service team has been trained to handle other ICD-10 related issues along with regular production issues and can be reached by calling the Arkansas Blue Cross customer service phone numbers located on the back of the member's ID card.

Section 13: Medical Records Request

Confidentiality of Member Information:

In accordance with the highest standards of professionalism and as a requirement of each provider's contract with Health Advantage, providers are obligated to protect the personal health information of their Health Advantage members from unauthorized or inappropriate use. All participating providers agree to follow applicable Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, as well as any other confidentiality standards outlined in their provider agreements with Health Advantage.

Routine Needs for Member Information:

At the time of enrollment, Health Advantage members who enroll electronically or by paper, permit Health Advantage to use and disclose their personal health information for routine needs such as:

- Bona fide research purposes,
- Claims processing (payment, denial, investigation),
- Coordination of care,
- Customer service,
- Data processing,
- Fraud/Abuse investigations or reports,
- Health care operations,
- Medical management,
- Performance measurement,
- Provider credentialing or quality evaluation,
- Quality assessment and measurement,
- Regulatory audits or inquiries, subpoenas, or other court or law enforcement procedures,
- Required regulatory reports,
- Routine audits,
- Underwriting, or
- Utilization review

If Information Is Needed for Other Reasons:

If member-specific and identifiable information is needed for reasons other than those listed above under "routine needs," the member must sign specific authorization to release the information. If a member is unable to give prior approval personally, Health Advantage has a process to obtain this consent through a parent's or legal guardian's signature, signature by next of kin, or attorney-in-fact. While specific authorizations are issued, the member has the right to limit the purposes for which the information can be used, and all concerned are obligated to respect that expressed limitation.

Members Rights to Medical Records:

Members have the right to access their medical records; therefore, each practitioner must have a mechanism in place to provide this access. Members must not be interviewed about medical, financial, or other private matters within the hearing range of other patients. Practitioners must have procedures in place for informed consent, storage, and protection of medical records. Health Advantage may verify that these policies/procedures are in place as part of an on-site review process.

Health Advantage Employees:

As a condition of employment, all Health Advantage employees must sign a statement agreeing to hold member information in strict confidence. Physicians and all other Health Advantage participating providers are

also bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information.

Medical Records Requests:

The Medical Records Request System for Health Advantage changed on July 29, 2003 from the traditional method of paper requests to an electronic method.

Certain claim submissions trigger a front-end-claims edit that creates a request for additional information. This information is obtained through the use of medical facts letters, medical questionnaires, or requesting part or all of a member's medical record.

When medical information or treatment information concerning a claim is needed from a provider, an electronic request is sent via fax to the provider. These requests are easy to spot as all have a "bar-coded" section on the first page of the request and an outlined box indicating who requested the information. Once that bar-coded sheet comes back into the system via fax, it is automatically sent electronically to the person requesting the information. The requestor reviews, routes for additional review, or places the claim in line for payment.

All information is stored in an electronic fashion so anyone needing the same information can retrieve and review without re-requesting the same information from a provider a second time.

Guidelines for completing a medical records request:

1. Complete all questions on the request if it is a medical facts or medical questionnaire.
2. Utilize the appropriate diagnosis or procedure codes and try to avoid using vague or unspecified diagnosis and V codes.
3. Use the appropriate E&M code for the service rendered and avoid up -coding.
4. Do not use Modifier 25 with an office visit code unless there is really a separate identifiable service provided.
5. Provide both operative reports if billing as co-surgery.
6. Provide the lab results with the normal lab values, when requested for certain medications, including but not limited to; neupogen, epoetin, and parenteral iron.
7. Psychiatrists' and psychologists' office staff should enter the correct number of services on the claim depending on the service provided. Some "psych" codes do not have time units and entering the incorrect number of services will result in incorrect payment.
8. Submit ALL requested information when requested. Do not send in any information unless we request it from you.

Note: Health Advantage relies on the accuracy, truthfulness, and completeness of all information providers supply on the medical facts letter and the medical questionnaire to properly adjudicate claims and the member's benefits. Failure to supply Health Advantage with full, accurate information may constitute fraud. A provider's signature on the medical facts letter is required and is considered by Health Advantage as a provider's assurance that the information provided is true and correct in all respects and does not present a misleading picture.

It is very important that providers fax the bar -coded sheet first. **Do not use a cover sheet.** Fax the bar-coded sheet face down in the fax machine and make sure the letterhead is downward.

Medical records request fax number

The Medical Records Request (MRR) fax number was changed effective November 1, 2012. The new MRR fax number is (501) 301-1999. Please submit all medical records request responses to the new fax number.

Medical record fax number updates

Providers should notify Health Advantage if there are changes to their medical records request (MRR) fax number. Providers can submit their updated MRR fax number by either completing the “Change of Data” form located on the Health Advantage website or by emailing the corrected fax number to Providernetwork@arkbluecross.com.

Risk adjustment and HEDIS record requirements

The Blue Cross Blue Shield Association requires its member Blue Plans and its Blue Plans’ network participating providers to comply with procedures that support healthcare effectiveness data and information set (HEDIS), risk adjustment, and government required activities around HEDIS and risk adjustment. The Association has employed third party vendors to coordinate medical records requests in support of risk adjustment and HEDIS activities. These activities include:

- Risk adjustment audits.
- Reporting HEDIS measures.
- Communicating coding gaps identified in patient records.
- Compliance with government required activities.

All providers participating in the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, PPO Arkansas’ True Blue PPO and Arkansas FirstSource PPO, Health Advantage HMO, and Medi-Pak Advantage’s PFFS, LPPO and HMO provider networks must follow the needed processes for medical record audits and record requests within the required timeframe.

This notice should be considered a provider contract amendment to the provider network participation agreements listed in the preceding paragraph. This policy has been in effect since January 1, 2014.

Timely Response Requirements

Policy requiring timely response to medical records requests

A. Standard and definition of timely response versus tardy response: As a condition of network participation, providers participating in the Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and the Health Advantage networks must make a timely response to all medical records requests. A response to a medical records request is deemed timely if a complete response, furnishing copies of all requested medical records as defined in the request, is made not later than 60 days after the request was sent to the provider. A tardy response is any response by a provider to a medical records request that is either (a) incomplete or (b) delivered 61 or more days after the request was sent to the provider, or (c) sent by any method other than the required fax bar-coding process described below, unless a provider has arranged in advance, by specific written agreement with the network sponsor, for special handling of the medical records request response.

B. Bar-coded request process, follow-up requests and procedures: Medical records requests are made initially via the Medical Records Request (MRR) system, which is an automated process that includes a bar-coded fax transmission of the request to the provider. Participating providers are required to respond in kind, using a fax and the same bar code to return the requested medical records. This process incorporates a tracking system (via use of the bar code) to avoid duplication of effort and loss of records in the transmission process. Providers who are unable to use the bar-coded fax process for some reason must make arrangements in advance of sending any medical records with the appropriate network sponsor (such arrangements to be evidenced by a signed, written acknowledgment of the network sponsor) for special handling of the medical records request response.

Automatic reminders of outstanding medical records requests are generated by the MRR system on the 20th day following the initial request. A third request/reminder also is generated by the system on the 40th day following the initial request.

C. Consequences of tardy responses: Any participating provider who has more than three tardy responses identified during any 30-day period (regardless of the period in which such medical records requests were made, and regardless of the passage of time involved past 60 days), will receive a warning letter from Medical Audit and Review (or any other appropriate department with knowledge), reminding such provider of the importance of timely responses, including potential implications for network participation status (initial warning letter).

Any participating provider who fails to clear up and fully address all tardy responses within 21 business days after the initial warning letter is sent will be placed on medical records probation for a period of 180 days. Medical Audit and Review will send a letter (or any other appropriate department with knowledge) to such provider, establishing the beginning and end date for such medical records probation (second warning letter).

After a provider has been placed on medical records probation, in order to remain eligible for network participation, such provider must achieve 100 percent timely responses for all medical records requests sent to such provider during the medical records probation period (the 180-day period defined in the second warning letter). A provider who successfully completes the medical records probation period with a 100 percent timely response record reverts to the pre-probation timely response standards and process, except where repeat offender status is designated, as further outlined below. Providers who fail to achieve 100 percent timely responses during the medical records probation period are subject to termination of network participation. If network participation is terminated due to failure to achieve 100 percent timely responses during the

medical records probation period, a terminated provider shall be ineligible to re-apply for network participation for a minimum period of one year.

D. Repeat offender status and process: A provider who repeatedly fails to make timely responses resulting in medical records probation for such provider more often than twice during any two calendar-year period shall be disqualified from network participation as a repeat offender, and will be ineligible to re-apply for network participation for a minimum period of three years from the date of network termination.

E. Acceptable and unacceptable excuses for meeting timely response standard: The network sponsors may, in their sole discretion, and upon written application by the affected provider setting forth all the relevant circumstances, including documentation satisfactory to the network sponsors, recognize certain acceptable excuses for tardy responses.

Such acceptable excuses may include

- a) power outages, natural disasters or computer systems failures not attributable to any fault of the provider and provided no reasonable alternative was available to the provider;
- b) a documented change by the provider in computer systems or transmission equipment (such as major systems replacement or upgrades), if notice of such changes is sent in advance, in writing, to the network sponsors and provided no reasonable alternative was available to the provider;
- c) relocation of the provider's practice location involving disruption to ongoing business operations, if notice of such relocation is sent in advance, in writing, to the network sponsors and provided no reasonable alternative was available to the provider; or
- d) illness or incapacity of the provider and all office staff at the same time that effectively shuts down the provider's practice and prevents timely attention to all business of the provider.

Unacceptable excuses for tardy responses include:

- a) illness or incapacity of the provider, in any case where the provider has office staff, temporary staff, consultants, practice managers, agents or others available to perform administrative functions on his/her behalf; or
- b) illness or incapacity of any office staff of the provider, in any case where other office staff continue to be able to work, or in any case in which the provider's office continues to be open and operating with or without normal staffing, including but not limited to temporary staff, consultants, practice managers, agents or others available to perform administrative functions on her/his behalf;
- c) inclement weather not constituting a natural disaster that prevents operation of the provider's office;
- d) dereliction of duty, negligence, insubordination or malicious or criminal conduct of any employee, consultant, practice manager or agent;
- e) breach of contract, negligence or any other failure or omission of any office management company, practice manager, consultant, independent contractor or agent of provider; or
- f) lack of appropriate record-keeping or insufficient security and management of medical records, including but not limited to failure to keep such records updated, classified, indexed and maintained in providers' own record system or database.

F. Applicants to networks: Any applicant for network participation who has a history of medical records requests and responses as to any network sponsor shall be subject to this policy. If the applicant's history of responses to medical records requests fails to meet the requirements of this policy (e.g., if such applicant is then delinquent in medical records responses because of having more than three tardy responses during any 30 day period, or because of failure to completely address and clear up any tardy responses within 21 business days after the initial warning letter, or because of failure to successfully complete any medical records probation period, or because of being placed on medical records probation more than twice during any two calendar year period) such applicant shall be ineligible to participate in the network until

- a) in the case of an initial warning letter, the tardy responses are completely addressed and cleared up in not less than 21 business days after the initial warning letter;

- b) in the case of failure to successfully complete any medical records probation period, such applicant shall be ineligible to re-apply or participate in the network for a period of one year from the date of the application; or
- c) in the case of having been placed on medical records probation more than twice during any two calendar-year period, such applicant shall be ineligible to re-apply or participate in the network for a minimum period of three years from the date of the application.

Follow Up Letters for Medical Records Requests

Effective May 18, 2011, Health Advantage has discontinued the third (40 day) request/reminder for Medical Records Requests (MRR). Now Health Advantage will send the initial request and one follow-up letter at 20 days. Providers can also view their MRR requests through the 'MRR Search' feature on AHIN. This notice constitutes a change to the "Policy Requiring Timely Response to Medical Records Requests," published originally in Providers' News in the December 2010 edition, deleting the sentence which reads "A third request/reminder is also generated by the system on the fortieth day following the initial request."

Section 14: Member / Patient Information

Section 14: Member / Patient Information

Case Management:

Case management is a personalized, multidisciplinary process that aims to:

- Communicate with members' physicians to facilitate access to benefits under a member's health benefit plan;
- Assess benefit options and opportunities to coordinate care with the multidisciplinary team;
- Maximize the member's insurance benefits;
- Identify benefit options for outpatient or home treatment settings;
- Where appropriate, in the physician's independent professional judgment, to identify and offer members a choice of coverage of cost-effective alternatives to hospitalization; and
- Promote health education;

Health Advantage case management nurses are licensed professionals who use their specialized skills to communicate effectively with physicians regarding member benefit options; they do not, however, provide any medical services or counseling to members. All treatment decisions remain exclusively with the member and his or her physician.

The focal point of case management in all of its roles is to empower patients, giving them and their families' access to a greater understanding of their benefit options, and more personalized attention to their benefit service needs. Case managers enable patients and their families to make informed decisions about accessing their health plan benefits and help patients deal with the complexities of coverage for services in the health care system.

The Health Advantage Case Management Team consists of certified case management registered nurses in each region. To reach your regional case manager, call the appropriate telephone number listed below and request the Medical Management Department.

Regional Office	Toll-Free Number
Central Region	1-800-421-1112
Northeast Region	1-800-299-4124
Northwest Region	1-888-847-1900 or 1-800-817-7726
South Central Region	1-800-588-5733
Southeast Region	1-800-236-0369
Southwest Region	1-800-470-9621 or 1-800-519-2583 for LA, OK, & TX
West Central Region	1-800-299-4060

For more information regarding case management, please see the "Case Management" link located on the "Member's" page on the Health Advantage Web site at: <https://secure.healthadvantage-hmo.com/members/casemanagement.aspx>

Section 14: Member / Patient Information

Health Education Programs

The Health Advantage website provides [health education programs](#) which allow members to speak with a registered nurse about chronic condition management, healthy pregnancy and building a healthier lifestyle.

- [ArkBlue Connect](#) is an app that connects members to case management.
- [Special Delivery](#) is a program that offers education and support for expectant mothers.

Other programs available include personalized health tools that eligible members can connect to by registering for [My Blueprint](#).

Your [regional office](#) can provide further details about local health resources.

Member ID Cards:

Members should present an identification card at the time of service. This card will include certain member information necessary for claim submission and should be transferred to the claim form exactly as presented on the ID card (unless you learn or have reason to know that such information is incorrect).

Is the ID Card an Approval for Service?

The ID card is neither an authorization for service nor a guarantee of payment. The ID card is provided for convenience only. All coverage or eligibility issues must still be decided by referring to the member's contract or health plan, and must be evaluated and confirmed by Health Advantage when a claim is received.

Misuse of the Member ID Card:

Health Advantage is not responsible for any individual member's misuse of an ID card, nor do we have any ability to recall ID cards previously issued when an individual ceases to be eligible for coverage. Members may also mistakenly use outdated ID cards with incorrect information.

Member Appeals:

Members are entitled to appeal claims denials under procedures that are outlined in the member's applicable health plan or contract. All appeals are subject to timely filing and other standards as set forth in the member's health plan or contract.

Health Advantage welcomes a provider's input on member appeals in their role as patient advocate, and Health Advantage does not intend this paragraph or any other statement or activity on our part as discouragement of any advocacy a provider believes is appropriate with respect to member appeals or access to benefits under their health plan or contract. At the same time, Health Advantage does occasionally encounter situations in which it is clear that the member is being used by a particular provider to pursue the provider's own agenda, either to obtain payment for clearly non-covered services, or to simply wage a vendetta against Health Advantage or other payers for perceived grievances or dissatisfaction of the provider.

Fortunately, Health Advantage's relations with providers in general are excellent, so such instances are rare. However, Health Advantage does ask that providers and their staff refrain from upsetting or inciting our members to file appeals in support of their own, separate agenda or when providers are aware that Health Advantage has previously addressed the same coverage question and that the service in question is not covered under Health Advantage health plans or contracts.

If Health Advantage has previously addressed the same coverage issue, it would be appropriate for providers to offer any new or different information on that topic, but it would not be appropriate to simply encourage or participate in repeated member appeals presenting the same information or arguments previously addressed. This situation sometimes has occurred when a particular provider disputes Health Advantage's determination that a treatment, drug or device is experimental/investigational and persists in encouraging and supporting multiple member appeals (involving many different members) regarding the precise same treatment, drug or device, even though Health Advantage has fully reviewed the treatment, drug or device and has determined that it is experimental/investigational under Health Advantage guidelines, as reflected in our member health plans or contracts.

Providers as Authorized Representative for Member Appeals:

Health Advantage will recognize a provider as the authorized representative of a member, thereby permitting the provider to pursue an appeal on behalf of the member, in the following circumstances:

- A. **Urgent Care** If the treatment a provider is administering involves urgent care (where delay of immediate treatment would seriously jeopardize a member's life or health or the member's ability to regain maximum function) we will recognize the provider as an authorized representative to appeal any denial of precertification or prior approval that may be required for coverage under the member's health plan or insurance policy.
- B. **Written Designation by Member** In non-urgent care situations, we will recognize a provider as the authorized representative of the member to pursue an appeal of a claim denial on behalf of the member if the member has executed a written designation of the provider on a form that has been approved by us for this purpose. Approved designation forms may be obtained by contacting Provider Service or a Network Development

Re-Reviews:

Anytime a provider disagrees with the denial of a code or the payment level of a code on a claim, the provider should submit a request for reconsideration by the re-review team in the Medical Audit and Review Services area. Please write Claim Re-review (MARS) on the letter. It is only after the re-review team upholds the denial or level of payment that it would be appropriate to appeal the denial or payment level to the Appeals Coordinator.

Section 14: Member / Patient Information

Member Eligibility Inquiries:

A provider may utilize [AHIN](#) or My BlueLine 24 hours a day or contact Health Advantage Customer Service Department during normal business hours to seek available information on whether a patient is eligible under any of the Health Advantage benefit plans. This information can also be accessed through **My BlueLine** (24 hour Interactive Voice Response system) or on [AHIN](#).

Member Eligibility:

When a customer service representative receives a call regarding eligibility, the customer service representative will ask for the Health Advantage provider number and either the member's name, member identification number, or the member's Social Security number. When member eligibility is determined, the representative can provide the following information to providers:

- Benefits
- Coordination of Benefits Information
- Effective Date of Coverage
- Effective Date of Termination
- Family Members on Policy

Special Note:

Health Advantage cannot give providers any kind of guarantee regarding eligibility. Health Advantage can only give providers the data available to us and reflected on our computer system at the time a provider calls. Many factors beyond the knowledge or control of Health Advantage may affect the eligibility status of a member. Therefore, a provider should not rely on the eligibility data Health Advantage provides as assurance of coverage for the services or service date(s) in question. A provider's best source of the most up-to-date information on eligibility is the patient, who should know employment status and premium -payment history or intention on the date of service. Health Advantage's participating provider agreements specifically address eligibility.

Effects of Prenotification Responses:

Provider understands and agrees that prenotification and any "verification of benefits" or other eligibility inquiries made prior to, at or after admission or provision of any services to members are not a guarantee of payment.

Prenotification means only that Health Advantage has been notified of the hospital admission. Prenotification is required for all out-of-state inpatient hospital admissions, in-state admission to hospitals not in the Health Advantage network, and long-term acute care facilities.

While Health Advantage or its designated representative will endeavor in good faith to report member eligibility information available to Health Advantage within its records or computer systems at the time of admission or provision of services, providers acknowledge and agree that it is not possible to guarantee accuracy of such records or computer entities.

Providers understand and agree that the eligibility of all members and coverage for any services shall be governed by the terms, conditions and limitations of the member's health plan. The member's health plan shall take precedence over any inconsistent or contrary, oral or written representations.

No reimbursement shall be due from Health Advantage for services if, following any inpatient treatment or other services, it is discovered or determined that:

- Premiums had not been paid for a member's coverage,

- A former member was no longer employed and eligible for participation in the health plan at the time of the admission, or
- Coverage had lapsed or terminated for any reason.

Section 14: Member / Patient Information

Member Financial Obligations:

In most situations, our members will be responsible for part of your bill for services; and, as your provider agreement with us outlines, you will not waive these member financial responsibilities, i.e., the member copayment, coinsurance and deductible, as specified in the member's health plan or contract.

Non-Covered Services:

Members will generally be exclusively responsible for any non-covered services you provide, except that, as specified in your provider agreement, you may not bill members for services that do not meet Primary Coverage Criteria or which are experimental/investigational, unless a member waiver, for that specific service is first obtained. See [Provider Rights and Responsibilities](#) for instructions on member waivers and the documentation required before you can bill members for non-covered services that are not experimental/investigational or which do not meet Primary Coverage Criteria.

Please note that except for applicable copayment, coinsurance or deductible, you are not permitted to request or require payment in advance by any of our members or from anyone else as a condition of providing services to members.

Billing:

Providers are not permitted to "balance bill" a member for amounts in excess of the Health Advantage allowance (member copayment, coinsurance and deductible are deemed part of the allowance for this purpose, and should be billed to the member). You are also responsible for any billing or collection service activities that you may engage, or to whom you may assign any accounts receivable or other claims against our members.

If Health Advantage finds that any billing service, collection agency or other agent engaged by you has improperly attempted to bill any member or collect any amounts from members in violation of your provider agreement or the guidelines in this Provider Manual, you are obligated to promptly take all necessary steps to halt any such activity, to ensure that it is not repeated, and to reimburse us and the member for any expenses or losses incurred in responding to or defending against the claims or collection actions of any such billing service, collection agency or other agent.

My BlueLine for Eligibility and Benefits

My BlueLine Provides Eligibility and Benefits Information as outlined below:

Eligibility:

	Health Advantage
Active or Termed	X
Effective Date	X
Termination Date	X

Benefits:

Health Advantage:

- PCP Copay
- Specialty Copay
- In and Out of Network Deductibles
- Outpatient Therapy Visits, Copay and Coinsurance
- DME Maximum amounts, Copay and Coinsurance
- Outpatient Coinsurance
- Out of Network Coinsurance

My BlueLine provides the following claim status information:

	Health Advantage
Allowance	X
Check Number	X
Check Status	X
Check Total	X
Coinsurance	X
Copayment	X
Deductible	X
Denial Reason	X
Paid Amount	X
Pended Reason	X
RA Date	X

Section 14: Member / Patient Information

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 Health Advantage'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 Health Advantage members from unwittingly having and/or paying for services that do not meet coverage criteria, (e.g., services considered as experimental/investigational under the coverage policy) or are cosmetic services/procedures.

Providers may collect billed charges from members for services that are deemed as not meeting the Primary Coverage Criteria, or if the service is considered experimental/investigational, 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 "this procedure is considered experimental and/or investigational",
3. Dollar amount of charges for the 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 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 a waiver 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 Health Advantage 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.
2. Providers should not add information to a waiver after it has been signed by the patient.
3. Members should not be asked to sign a **blank** waiver of liability.
4. Each date of service will require a separate waiver.
5. The member must understand their responsibility when signing a waiver, 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 network.

When a Patient Won't Sign:

It is the provider's responsibility to inform Health Advantage patients when a service(s) may be considered not meeting the Primary Coverage Criteria, (e.g., experimental/ investigational under Health Advantage

coverage policy). This prenotification process was designed to prevent Health Advantage members from unwittingly having and/or paying for services that do not meet Primary Coverage Criteria (e.g., are experimental/investigational under Health Advantage coverage policy). Providers have access to coverage policies through the Health Advantage website. Coverage policies may be searched by description, CPT Code, or title. A drop-down box is also provided listing all coverage policies alphabetically.

When the patient is advised of the likelihood of 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, you 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.

Section 15: Mental Health Services

Section 15: Mental Health Services

New Directions

The Mental Health Parity (MHP) Act requires that mental health benefits be equal to physical health benefits. Member ID cards will include the telephone number of New Directions®, a company providing assistance with mental health services on behalf of Arkansas Blue Cross and Blue Shield, PPO Arkansas and Health Advantage.

Behavioral Health Management:

Arkansas Blue Cross, Health Advantage, and BlueAdvantage have contracted with New Directions® Behavioral Health to perform behavioral health utilization management services. New Directions® is a full-service behavioral health organization and is accredited as an MBHO by NCQA and has URAC accreditation for utilization management.

Inpatient, Partial Hospital and Intensive Outpatient Services:

- Contact New Directions for pre-notification of all inpatient, partial hospital and IOP services.
- New Directions will conduct concurrent stay reviews and will work with your staff to provide discharge planning.

For pre-authorization or pre-notification of behavioral health services for Arkansas Blue Cross, Health Advantage and BlueAdvantage members, contact New Directions at (877) 801-1159. For Walmart associates, call (877) 709-6822

New Directions WebPass:

New Directions now offers a Provider WebPass, allowing providers and office staff to:

- Submit pre-authorization requests
- Submit pre-notification of hospital services
- Contact provider relations
- Update your online profile
- Submit pre-notification

To access the Provider WebPass, go to ndbh.com, select "Provider Section," then select "Provider WebPass."

Before using the New Directions® WebPass System, providers must obtain a user name and password from New Directions® Behavioral Health Provider Relations by downloading the Access Request Form and faxing the completed form to (913) 982-8227. Providers who do not have access to a fax machine please mail the form to:

Network Operations
P. O. Box 6729
Leawood, KS 66206-0729

Please complete this form today to obtain a user name and password. The registration should be completed by New Directions® Behavioral Health within two business days and new login information will be e-mailed at that time.

Claims:

Continue to submit mental health claims via AHIN. Individual policyholders applying for, or already with Arkansas Blue Cross, also may select MHP benefits.

Autism: Applied Behavior Analysis Coverage

On October 1, 2011 and upon renewal of group insurance policies and HMO contracts for 2012, Arkansas Blue Cross and Blue Shield and Health Advantage began covering and administering benefits for Applied Behavioral Analysis (ABA) in accordance with Act 196 of 2011, codified at ACA. §23-99-418, enacted by the General Assembly of the State of Arkansas which mandates coverage of Early Intensive Behavioral Intervention (EIBI), with the following conditions:

1. Applied Behavioral Analysis (ABA) must be ordered for a specific individual diagnosed with autism spectrum disorder (ASD) by a licensed physician or psychologist;
2. ABA must be provided or supervised by a therapist certified by the nationally accredited Behavior Analyst Certification Board;
3. The individual with ASD must be less than eighteen years of age; and
4. ABA shall have an annual limitation of \$50,000 depending upon if the employer group the member is with has selected Mental Health Parity.

The following HCPCS codes should be submitted for ABA services:

- 0359T-0374T codes should be used.

Section 15: Mental Health Services

Residential Treatment Centers

Residential Treatment Centers are licensed by the state health department as Residential Substance Abuse Centers. Arkansas Blue Cross and Blue Shield offers PPP, True Blue, Arkansas First Source and Health Advantage participating agreements for these providers.

Inpatient claims are billed with bill type 86X and room revenue codes 1001 and 1002. Allowances are based on global, all-inclusive per diems that are approved by Facility Reimbursement and Pricing. There is no additional allowance for physician services.

Outpatient Claims will now be allowed from these facilities. Outpatient claims should be billed with bill type 13X and must contain revenue codes 0905, 0906, 0912, 0913 and 0915 which require CPT/HCPCS codes in conjunction with the revenue code(s).

HCPCS codes S0201 (Partial hospitalization services, less than 24 hours, per diem) and S9480 (Intensive outpatient psychiatric services, per diem) are allowed on a global basis and all other services billed with these codes will be rolled up for pricing. S0201 can only be billed with revenue codes 0912 and/or 0913. S9480 can only be billed with revenue codes 0905 and/or 0906.

Benefits for residential treatment center are dependent upon any payable member benefits.

Section 16: Modifiers

Section 16: Modifiers

Modifiers

A modifier allows the reporting physician to indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. For Health Advantage claims filing, modifiers, when applicable, should be indicated by placing the appropriate two-digit number in the indicated space in Block 24D after the usual procedure code.

The applicable modifiers are listed by code and defined in each CPT section. Some common modifiers that always should be considered when filing claims include the following:

Modifier	Definition
21	Prolonged evaluation and management services.
22	Unusual procedural services.
23	Unusual anesthesia.
24	Unrelated evaluation and management service by the same physician during a postoperative period.
25	Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure or other service.
26	Professional component.
27	Multiple outpatient hospital E/M encounters on the same date.
32	Mandated services.
47	Anesthesia by surgeon.
50	Bilateral procedure.
51	Multiple procedures.
52	Reduced Services.
53	Discontinued procedure.
54	Surgical care only.
55	Postoperative management only.
56	Preoperative management only.
57	Decision for surgery
58	Staged or related procedure or service by the same physician during the postoperative period.
59	Distinct procedural service.
62	Two surgeons.
63	Procedure performed on infants.
66	Surgical team.

Modifier	Definition
73	Discontinued out-patient procedure prior to anesthesia administration.
74	Discontinued out-patient procedure after anesthesia administration.
76	Repeat procedure by same physician.
77	Repeat procedure by another physician,
78	Return to the operating room for a related procedure during postoperative period.
79	Unrelated procedure or service by the same physician during the postoperative period.
80	Assistant surgeon.
81	Minimum assistant surgeon.
82	Assistant surgeon (when qualified resident surgeon not available).
90	Reference (outside) laboratory.
91	Repeat clinical diagnostic laboratory test.
92	Alternative laboratory platform testing.
99	Multiple modifiers.
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

Modifiers Impacting Pricing

Some modifiers impact pricing. Listed below are modifiers and their applicable pricing adjustments in the Health Advantage fee schedule, subject to medical necessity.

- Modifiers TC and UE point to the technical component fee schedule amounts.
- Modifiers 26 and RR point to the professional component fee schedule amounts.
- Modifier NU points to the total component fee schedule amount.
- Modifier 22: Increased Services 25% of allowable charges based on documentation that the surgical service provided is greater than that usually required for the procedure.
- Modifier 50: Bilateral Surgery - 50% of allowable charges and services must be billed on two lines.
- Modifier 51: Multiple Surgery - 50% of allowable charges.
- Modifier 52: Reduced Services 67% of allowable charges based on documentation.
- Modifier 53: Discontinued Procedure - 25% of allowable charges.
- Modifier 62: Co-Surgery - 62.5% of allowable charge.
- Modifier 63: Infant Procedure - 120% of allowable charge.
- Modifier 73: Discontinued Procedure - 50% of allowable charge (limited to facility billings).
- Modifier 78: OR Return - 70% of allowable charge.
- Modifier 80: Assistant Surgeon - 20% of allowable charge.
- Modifier 81: 20% of allowable charge.

- Modifier 82: 20% of allowable charge.
- Modifier AS: 20% of allowable charge (limited to specialties 50 and 89; in combination with specialty discount of 75%, results in payment of 15% of allowable).

Arkansas Blue Cross and its family of companies do not recognize modifiers 54, 55, or 56. Providers should bill E&M codes for these services rather than billing the surgery code with these modifiers.

Modifier Usage

When used appropriately, modifiers provide additional information that aids in the adjudication claims. When used inappropriately, modifiers will slow the process of a claim, require manual handling, and usually additional information from a provider's office.

Modifier 25 - Significant, Separately Identifiable Evaluation & Management Service:

Modifier 25 should only be used with Evaluation and Management procedure codes (99201 – 99499), and only when a provider has performed an E&M service that is separate and identifiable from the other procedure(s) provided on the same day.

Modifier 50 – Bilateral Procedure:

Charges must be submitted on **two** lines. The first line should include a descriptive modifier, i.e., LT (left side) or RT (Right side). Modifier 50 should be in the first modifier position on the second line, with the descriptive modifier in the second position.

If a provider bills a bilateral surgery on one line with Modifier 50, the payment will reflect one half of one side. A corrected claim must be submitted to obtain correct payment.

Modifier 51: Multiple Surgical Procedures

The Health Advantage claims systems will automatically assign Modifier 51 to the secondary surgical procedure(s) based on the relative value units assigned to the procedures. Health Advantage will not apply multiple surgery guidelines to procedures exempt from Modifier 51 based on CPT or to add-on codes. Modifier 51 does not apply to these groups of procedures by definition. Addition of Modifier 59 to these procedures will result in manual adjudication of the claim with no change in payment.

AI Modifier

Health Advantage has not accepted consultation CPT Codes 99241-99241 and 99251-99255 since April 1, 2010 as stated in the December 2009 issue of *Providers' News*. Because Health Advantage is no longer accepting the consultation codes, it is important to be able to identify the principal physician of record. The principal physician of record should use modifier AI when billing for hospital and nursing home visits, CPT Codes 99218-99336 and 99304-99306. This modifier will identify the admitting or attending physician who oversees the patient's care while in an inpatient or nursing facility setting. This is an informational only modifier. The AI modifier will not make any changes in processing or amounts payable. Therefore, append any payment modifiers before the AI modifier.

Modifier GT: Via interactive audio and video telecommunication

Modifier GT should be used when billing for telemedicine services except for interpretation of radiology procedures or interpretation of rhythm strips. Since July of 2004, telemedicine has not been covered based on member benefit contract exclusions for Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage and USABLE Administrators.

Modifier PT versus Modifier 33

Modifier PT is used for a colorectal screening test converted to a diagnostic test or other procedure. Modifier PT provides information that the procedure was scheduled to be a screening, but was converted to a diagnostic procedure.

Modifier PT should only be used with the codes for the colonoscopy, flexible sigmoidoscopy or barium enema when initiated as a screening procedure. In these cases, the diagnostic procedure would be billed with Modifier PT. For contracts with Patient Protection and Preventive Care Act (PPACA) coverage, these procedures would be paid without deductible or coinsurance. The Modifier PT should never be used with the anesthesia procedure 00810.

Modifier 33 is used for preventive services. When the primary purpose of the service is delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending Modifier 33 to the procedure.

Modifier 33 is the appropriate modifier to use with anesthesia CPT Code 00810 for a screening colonoscopy whether it is completed as a screening or is converted to a diagnostic procedure. Please see the preventive services newsletter item for a complete list of services that may be billed with Modifier 33.

Section 16: Modifiers

Modifier 59

Modifier 59: Distinct Procedural Service

Modifier 59 continues to be the most misused modifier. Use of modifier 59 should be rare, should only be used when no other modifier is applicable, and should never be used if there is only one service on a claim. Inappropriate use of modifier 59 will delay processing of a claim.

An appropriate use of Modifier 59:

- Two procedures are provided. When entered in Clear Claim Connection via AHIN, one of the procedures denies as inclusive in the other procedure billed.
- The two procedures represent distinct services that will be supported by the medical records.

Inappropriate uses of Modifier 59:

- Evaluation and Management services
- Multiple or bilateral surgery where Modifier 50 or 51 is appropriate
- Single line claims

Modifier 59 Billing Instructions

Under certain circumstances, a physician may need to indicate that a procedure was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

However, when another already established modifier is appropriate, it should be used rather than Modifier 59. Only if no other, more descriptive modifier is available, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used.

Arkansas Blue Cross has received a number of claims in which Modifier 59 has been inappropriately used, (e.g., in instances where only one procedure code is billed for a given date of service). Because Modifier 59 is intended to be used where there is a second or separate procedure performed on the same day, Modifier 59 should never be used when only one procedure code is billed for same date of service,

Modifier 59 is never appropriate for Evaluation and Management (E&M) codes. Modifier 25 is the appropriate modifier to bill when reported with an E&M service on the same day as a procedure code with a 0, 10, or 90-day global to identify a separate and distinct E&M service.

E&M services represent "daily services" and the relative value units for E&M services include some RVUs for the case in which the physician must see the patient more than once in a 24-hour day. In this case, the E&M code that best describes ALL the evaluation and management services provided on that day should be reported.

As a general rule for surgical procedures, if a surgery would be reimbursed based on multiple surgery guidelines without Modifier 59, no additional reimbursement would be warranted with Modifier 59 appended. The inappropriate appending of Modifier 59 will result in additional claim processing time and potential requests for clinical information.

Most billings of Modifier 59 will require the submission of medical records. The medical records should clearly support the distinct and independent status of the procedure to which Modifier 59 has been appended.

Review of Modifier 59:

- Modifier 59 is used to report distinct and separate procedures performed on the same day.
- Modifier 59 should be used with caution since this modifier affects the processing and reimbursement. Modifier 59 is not designed to provide reimbursement for separate procedures that are performed as an integral part of another procedure. Use of Modifier 59 will normally require submission of medical records.
- When a procedure is described in the CPT code descriptor as a “separate procedure” but is carried out independently or is unrelated to other services performed at the same session, the CPT code may be reported with Modifier 59.
- Modifier 59 should not be used when another, more descriptive modifier is available.
- Documentation needs to be specific to the distinct procedure or service clearly identified in the medical record.

There are modifiers available that describe the body location. (i.e., LT and RT, for left and right side. There are others to describe specific Modifier 59 digits, eyelids, etc.) If a modifier is available that specifically describes the body location, that modifier should be used INSTEAD of Modifier 59.

Clear Claim Connection (CCC):

The September 2004 issue of the Providers’ News provided information on Clear Claim Connection (CCC), a new tool available to Health Advantage providers via the Advanced Health Information Network (AHIN) website. This tool should be used to determine the appropriate use of Modifier 59.

The code combination being billed should be entered into CCC, without Modifier 59. If Modifier 51 applies to the secondary procedure, the reimbursement for covered services will be based on 50% of the allowance for the secondary procedure(s). In cases such as this (where CCC indicates that Modifier 59 should be used), Health Advantage will not ordinarily request medical records. While providers may append Modifier 59 to any claim when warranted, they should be aware that doing so will ordinarily trigger a request for medical records, and thus may delay the processing of the claim.

If the secondary procedure would be denied based on CCC and it meets the conditions for billing Modifier 59, Modifier 59 should be appended AND Health Advantage will require submission of medical records in MOST cases. When medical records are needed, they will be requested via the automated Medical Records Request system.

If CCC combines two procedures into one procedure that includes both of the services provided, providers should bill using the one procedure that includes both procedures. An example is CPT Codes 93501 & 93510 which are more accurately reported using CPT Code 93526. Health Advantage receives in excess of 7,500 line items per month with Modifier 59 appended. Health Advantage has reviewed numerous claims submitted with Modifier 59. Listed below are examples of inappropriate billing of Modifier 59.

Modifier 59 is NEVER appropriate with:

- E&M codes (CPT Codes 99200-99499);
- Anesthesia Procedures (CPT Codes 00100 - 01999 [except 01967] and 99100 - 99140);
- Single procedure on the date of service;
- Administration codes corresponding to injection, immunization or vaccine (the administration is paid separately from the code for the drug without addition of Modifier 59);
- Injection codes with multiple units (Providers are expected to bill for the appropriate dosage. If the injection code is for 50 mg and 100 mg is given, providers should bill with 2 units of service. Modifier 59 is not necessary.);
- EVERY administration code on a claim;

- E&M, influenza vaccine, and administration (this combination is acceptable without a Modifier 25 on the E&M and/or without Modifier 59 on the administration code);
- Code Combination in CCC accessed via AHIN, allows all services;
- Code Combination in CCC accessed via AHIN appends Modifier 51 to the secondary procedure(s) (Modifier 59 may be included in situations where it is necessary to identify a different lesion, session, etc., not defined by a more specific modifier. Colonoscopy procedures discussed separately in this newsletter is an example.);
- Code Combination in CCC accessed via AHIN replaces the two codes with one code that describes both services (i.e., CPT Code 93501 + 93510 = 93526);
- One upper and one lower GI Endoscopy procedure (The two procedures address different areas of the body based on definition.);
- E&M plus radiology plus one surgical procedure (In this scenario, Modifier 59 is not appropriate on the surgical procedure. If the E&M code meets the conditions described by Modifier 25, then the appropriate coding is to add Modifier 25 to the E&M procedure.)
- ALL clinical laboratory services billed on one day;
- Line items billed separately with RT and LT modifiers (These modifiers distinguish the different sites without using Modifier 59.);
- E&M and surgery on the same day (If the E&M service meets the conditions of Modifier 25, Modifier 25 should be appended to the E&M service. It is never appropriate to also bill Modifier 59 with the surgical procedure.); and
- Outpatient facility claims where only one surgical procedure was performed. (All ancillary, lab and radiology services will be combined with the surgical procedure and reimbursed.

New modifiers to replace modifier 59

On January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) added four new modifiers to further define Modifier 59. These four new modifiers can be used instead of Modifier 59 (assuming the requirements for Modifier 59 are met.) The new modifiers and their descriptions are noted below. These new modifiers are set up in ClaimsXten to work in the same manner as Modifier 59, but are not included in C3 (Clear Claim Connection). Providers utilizing C3 will need to continue using Modifier 59.

Modifier		Description
XE	Separate encounter	Service that is distinct because it occurred during a separate encounter.
XP	Separate practitioner	Service that is distinct because it was performed by a different practitioner.
XS	Separate structure	Service that is distinct because it was performed on a different organ/structure.
XU	Unusual non-overlapping service	The use of a service that is distinct because it does not overlap usual components or the main service.

Modifier Billings with ClaimsXten

ClaimsXten has some very strict edits on procedure versus modifier. If the modifier is not valid for the procedure, the claim line will be denied. Some examples/guidelines are:

- Modifier 50, bilateral, is not valid on a procedure with bilateral in the description or with PT/OT codes.
- RT or LT is not valid on a procedure with bilateral in the description
- Modifier 26 is not valid with surgical procedures
- Site specific modifiers are not appropriate with Evaluation and Management codes.
- Be sure the modifier is valid by using the CPT and/or HCPCS book.
- Repeat clinical diagnostic lab procedures should be billed with Modifier 91 and NOT with Modifier 76.
- Specific finger modifiers (F1-F9 and FA) are not valid with procedures specific to the hand.
- Specific toe modifiers (T1-T9 and TA) are not valid with procedures specific to the foot.
- Modifier AT is only valid with CPT codes 98940-98943
- Modifiers 24 and 25 are only valid with Evaluation and Management codes.

Modifier 25

Modifier 25: Significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service. It is important to bill modifier 25 with Evaluation and Management code IF a provider is performing an unrelated separate procedure. For example, when providing a minor surgery service, the visit on that day is included in the payment for the procedure.

However, when performing an E&M service unrelated to the minor surgical procedure, providers should append modifier 25 to the E&M code. If it is appended to the surgery code, the surgery line will be denied for incorrect coding. The same criteria applies when providing other procedures, including chemotherapy administration, allergy injections, chiropractic manipulation, etc. The visit is included in the other procedure codes unless it is a separate and identifiable E&M procedure.

Some criteria for the appropriate use of modifier 25:

- Are there signs, symptoms, and/or conditions that the physician must address before deciding to perform a procedure or service?
- Was the evaluation and management of the problem significant and beyond the normal preoperative and postoperative work?
- Is there more than one diagnosis present that is being addressed and/or affecting the treatment or outcome?

Modifier 59

- Modifier 59: Distinct procedural service. A more detailed article regarding modifier 59 was printed in the September 2010 issue of Providers' News. Please refer to that article for complete billing instructions.
- Modifier 59 only applies to non-E&M services. If submitted with an E&M service, the E&M service will be denied as incorrect coding.
- Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.
- No other established modifier is appropriate, i.e., multiple or bilateral surgery.
- Modifier 59 should be used with caution.

When a procedure is described in the CPT code descriptor as a "separate procedure" but is carried out independently or is unrelated to other services performed at the same session, the CPT code may be reported with modifier 59.

Section 17: Network Terms and Conditions

Section 17: Network Terms and Conditions

Network Participation Guidelines

Practitioners requesting participation in the Health Advantage HMO network must agree to follow the network Policies and Procedures and Terms and Conditions and meet the network Credentialing Standards.

Providers who have questions about participation should contact their region's [network development representative](#).

Provider Network Operations provides administrative support for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, PPO Arkansas' True Blue PPO and Arkansas' FirstSource® PPO, and the Health Advantage HMO network.

Provider Network Operations
P.O. Box 2181
Little Rock, Arkansas 72203-2181

Telephone: 501-210-7050
Fax: 501-378-2465
E-mail: providernetwork@arkbluecross.com

Health Advantage

Terms and Conditions for Practitioners:

- [Notice of Payer Policies and Procedures and Terms and Conditions](#) (119 KB PDF): Applicable to all individual network participants and applicants.

Credentialing Standards for Practitioners by Eligible Disciplines:

- [Doctors of Medicine, Doctors of Osteopathy, Oral Surgeons, Psychologists and CRNAs](#)
- [Chiropractors, Optometrists, Podiatrists, Advanced Nurse Practitioners, Certified Nurse-Midwives, Clinical Nurse Specialists, Physician Assistants](#)
- [Pharmacists](#)
- [Physical Therapists, Occupational Therapists, Speech Pathologists, Audiologists, Licensed Professional Counselors, Respiratory Therapists, Licensed Certified Social Workers, Licensed Psychological Examiners, Licensed Dieticians, Certified Orthotists, Certified Prosthetists](#)

Appeal of Declined Application or Network Termination:

- [Network Participation Appeal Policy and Procedures](#)

ABC Accreditation Accepted for Network Durable Medical Equipment Providers

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

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

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

Revision to Payer Policies & Procedures and Terms & Conditions

Applicable for Arkansas' Firstsource® PPO, True Blue PPO and Health Advantage HMO Provider Networks – Publication of Utilization, Quality and Other Practice Data

In this rapidly changing health care environment, health insurers and network sponsors are faced with the challenge of meeting market demand for more information about health care providers.

Consumers now expect to find reliable, standardized comparative performance data for health care providers, procedures and policies as well as data reflecting the performance of providers, including cost and quality ranking where available. Arkansas Blue Cross and Blue Shield, as a sponsor of a health maintenance organization and preferred provider organization networks, (respectively, Health Advantage and PPO Arkansas) is not alone in dealing with market pressure for increased transparency around the cost and quality of medical services our members receive.

In order to address the needs of our customers in this regard, effective February 1, 2012, the published “terms and conditions” for participation in Health Advantage’s HMO network and for PPO Arkansas’ True Blue PPO and Arkansas’ FirstSource® networks will be changed to remove from “Section VII. Publication of Utilization, Quality and Other Practice Data” any references to a provider “opting out” of or otherwise avoiding publication of the provider’s utilization, cost, quality or other practice data. This means that as of February 1, 2012, any provider who participates in the Health Advantage HMO network or in either of the two PPO networks of PPO Arkansas will be subject to publication of any and all utilization, cost, quality or other practice data that Health Advantage or PPO Arkansas may deem meaningful or helpful to publish to their members.

This means that as of February 1, 2012, any provider who participates in the Health Advantage HMO network or in either of the two PPP networks of PPO Arkansas will be subject to publication of any and all utilization, cost, quality or other practice data that Health Advantage or PPO Arkansas may deem meaningful or helpful to publish to their members.

Please note that except for deleting the option of a participating provider to “opt out” of, veto or avoid data publication, all other provisions of Section VII. “Publication of Utilization, Quality and Other Practice Data” shall remain in effect as written, until further notice of any additional modifications.

While “opting out” of data publication is no longer an option for participating providers, physicians will still receive an advance copy of any utilization, cost, quality or other practice data that Health Advantage or PPO Arkansas intend to publish to their membership. Health Advantage and PPO Arkansas will endeavor to provide their information for review 45 days in advance of publication.

Providers who have questions about their data may contact their respective regional Network Development Representative. Currently the available cost and quality data of Arkansas Blue Cross, Health Advantage and PPO Arkansas is only published on My Blueprint, which is a password protected member portal.

The quality information published in My Blueprint currently is summarized to the overall statewide specialty level, not at the individual physician level. The cost information is reported per physician but is rolled up to one overall level, not per procedure.

Effective February 1, 2012, this may switch to individual physician-level reporting, and the cost and quality ratings reflected there may be published in other formats or places accessible to members, employers or other stakeholders of Arkansas Blue, Health Advantage or PPO Arkansas.

Section 17: Network Terms and Conditions

Imaging Centers Purchased by Hospitals

Per the terms of participation for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage HMO network, and PPO Arkansas' True Blue PPO and Arkansas' FirstSource® networks, advanced imaging centers must be accredited by one of the agencies that meets approval per these networks' required accreditation program. This includes advanced imaging centers purchased by another organization, including hospitals.

In most situations, a currently accredited imaging center can simply notify the accrediting agency (e.g. American College of Radiology or Intersocietal Accreditation Commission) and ask for a certificate with the new organization's name applied to it. Arkansas Blue Cross, Health Advantage, and PPO Arkansas will need a copy of the new certificate

Please understand that if the imaging center's new owner is a hospital, the hospital's Joint Commission accreditation does not automatically apply. In order for this to apply, the hospital must be performing both inpatient and outpatient imaging services and the imaging center must have been part of the on-site review performed by the Joint Commission when the accreditation was given.

Imaging centers have 180 days from the date of the new owner's date of purchase to submit the proof of accreditation required to remain in network. Please submit proof of accreditation to:

Provider Network Operations
P. O. Box 2181
Little Rock, AR 72203

If you have questions, or need additional information, please contact you network development representative.

**Section 18:
Patient Protection and
Affordable Care Act
(PPACA)**

Preventive services covered under the Affordable Care Act

Subject to change as regulations and further clarifications are received

For non-grandfathered plans

The Preventive Care Services coverage policy with coding for both ICD-9 and CPT or HCPC's codes is listed in the coverage policy coding instructions for the Preventive Care Services Coverage Policy which can be found in the "Providers" section of Health Advantage Web site, www.arkansasbluecross.com/providers/

Coding for Preventive Services

- Correctly coding preventive care services is key to receiving accurate payment for those services.
- Preventive care services must be submitted with an ICD-9 code that describes encounters with health services that are not for the treatment of illness or injury. Please avoid using general coding such as V70.0.
- These diagnosis codes must be identified as the primary diagnosis code on the claim form.
- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and the patient claims will be paid using their normal medical benefits rather than enhanced preventive care coverage.
- Use CPT coding designated as "Preventive Medicine Evaluation and Management Services" to differentiate preventive services from problem-oriented Evaluation and Management office visits (CPT codes 99381-99397, 99461, 99401-99404, S0610, and S0612). Non-preventive care services incorrectly coded as "Preventive Medicine Evaluation and Management Services" will not be covered as preventive care.

Modifier 33 - Preventive Service:

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be billed with the modifier 33. The correct coding for both ICD-9 and CPT or HCPC code is also required as listed in the coverage policy coding instructions of the Preventive Care Services coverage policy.

Section 18: Patient Protection and Affordable Care Act (PPACA)

**Preventive Care Services Update
Non-Grandfathered/PPACA Wellness Summary**

March 2013, Version 2, 2013-03-01

Over the last several months we have had calls and questions on the differences between the wellness benefits for health coverage established before the Patient Protection and Affordability Act (PPACA) and the PPACA wellness benefits for non-grandfathered health plans. Arkansas Blue Cross and Blue Shield hopes that the following Preventive Care Services Summary in this *Providers' News* will help providers have a clearer understanding of the preventive services covered (these, of course, are subject to change).

The preventive services component of the law requires all "non-grandfathered" health insurance plans cover those preventive medicine services given an "A" or "B" recommendation by the U.S. Preventive Services Task Force (USPSTF). Arkansas Blue Cross has studied these recommendations and has developed a coverage policy on each of these preventive medicine services; please refer to www.arkbluecross.com or www.heathadvantage-hmo.com. Arkansas Blue Cross has added a new AHIN display to assist the provider community in determining the type of wellness benefits a member has Traditional or PPACA.

When a routine service type is selected such as "routine physical", a link will be displayed on AHIN in the Coverage Basis area that will take the user to a site that will contain additional wellness information. The type of wellness (PPACA or traditional wellness) will be displayed in the benefit information section of the service type. (See chart below)

81 Routine Physical Routine medical exams provided by physicians, hospitals, and other healthcare providers.		
	In Network	Out of Network
Coverage Basis	Name: Arkansas Blue Cross Blue Shield Website: http://www.arkansasbluecross.com/members/report.aspx?policynumber=2011066	RSP14
Individual Deductible	\$0.00 Universal deductible does not apply to this service type PPACA Wellness	RSP15
Family Deductible	\$0.00 Universal deductible does not apply to this service type PPACA Wellness \$0.00 (Remaining) PPACA Wellness	RSP16 RSP17
Coinsurance	0% PPACA Wellness	RSP13

In order to comply with PPACA, Women's Preventive Services will be added to many health plans. The change was made to certain employer-sponsored health insurance plans in 2012. The change took place on January 1, 2013 for certain individual health plans.

Arkansas Blue Cross encourages physicians and other providers of preventive services to become familiar with the USPSTF, Bright Futures, and Women's Health Initiative recommendations as well as Arkansas Blue Cross coverage policies. Most of the inquiries we have received are on lab (urinalysis) and other services such as chest x-rays, electrocardiograms, breathing capacity tests, catheter for hystero-graphy, vitamins, B-12 injections, cardiovascular stress tests, CT for bone density, CT for Head/Brain, Removing Ear Wax, Consultations, etc., that are not included in the USPSTF, Bright Futures, or Women's Health Initiative recommendations for screening. These are not part of the Arkansas Blue Cross coverage policy for non-grandfathered/PPACA Preventive Services. Claims for these services, if billed for screening, would be provider write-offs they do not meet the Primary Coverage Criteria or are Not Medically Necessary. These claims will not be a member liability if billed with a preventive diagnosis unless the ordering provider has obtained a signed waiver from the member specifically stating why the requested service would not be covered.

Summary of Arkansas Blue Cross Blue Shield and Health Advantage Coverage Policies

The Federal Patient Protection and Preventive Care Act (PPACA) was passed by Congress and signed into law in March 2010. The preventive services component of the law became effective September 23, 2010. A component of the law requires that all "non-grandfathered" health insurance plans are required to cover those preventive medicine services given an "A" or "B" recommendation by U.S. Preventive Services Task Force (USPSTF).

Plans are not required to provide coverage for the preventive services if they are delivered by out-of-network providers.

Task Force recommendations are graded on a five-point scale (A-E), reflecting the strength of evidence in support of the intervention.

- **Grade A:** There is good evidence to support the recommendation that the condition be specifically considered in a periodic health examination.
- **Grade B:** There is fair evidence to support the recommendation that the condition be specifically considered in a periodic health examination.
- **Grade C:** There is insufficient evidence to recommend for or against the inclusion of the condition in a periodic health examination, but recommendations may be made on other grounds.
- **Grade D:** There is fair evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.
- **Grade E:** There is good evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.

Those preventive services listed as Grade A and B recommendations are covered without cost sharing (i.e., deductible, coinsurance, or co-pay) by Health Plans for appropriate preventive care services provided by an in-network provider. If the primary purpose for the office visit is for other than Grade A or B USPSTF preventive care services, deductible, coinsurance, or copayment may be applied.

The appropriate office visit code should be used for services typically included as part of a normal wellness visit. Evaluation and Management codes for preventive services CPT Codes 99381-99397 will always be considered preventive. CPT Codes 99401-99404, when used to designate a preventive service, must have the applicable wellness/preventive diagnosis code as the primary reason for visit.

Note: CPT Codes 99401-99404 are considered components of CPT Codes 99386-99387 if billed on the same date-of-service.

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be billed with Modifier 33. The correct coding as listed for both ICD-9 and CPT or HCPCS codes in this summary is also required along with Modifier 33. CPT Codes Copyright © 2012 American Medical Association.

Summary of Women's Preventive Services

Effective August 1, 2012, for certain employer-sponsored health insurance plans. The change will take place on January 1, 2013, for certain individual health plans.

- **Well-woman visits:** Annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their doctors determine they are necessary.
- **Gestational diabetes screening:** For women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
- **HPV DNA testing:** Women who are 30 years of age or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of pap smear results.
- **STI counseling, and HIV screening and counseling:** Sexually active women will have access to annual counseling on HIV and sexually transmitted infections (STI's).
- **Contraception and contraception counseling:** Coverage of prescription contraceptives on the drug list (brand contraceptives may have a copayment if a generic is available without a copayment), sterilization procedures and patient education and counseling. Plan B (morning-after pill) when prescribed for members under 18 will be covered. Any drugs used to cause abortion (e.g. RU 486) are not covered. Over-the-counter birth control methods, even if prescribed by a doctor, are not covered.
- **Breast feeding support, supplies and counseling:** Pregnant and postpartum women will have coverage for lactation counseling from applicable health care providers. Manual breast pumps are covered; electric breast pumps and supplies are not covered. NOTE: Pregnancy services including prenatal, delivery and postnatal care subject to member copayments, deductibles and coinsurance.
- **Domestic violence screening:** Screening and counseling for interpersonal and domestic violence will be covered for all women.

Subject to change as regulations and further clarifications are received, please refer to additional clarifications at the end of this article.

For Self-funded plans with SPD language

Certain self-funded plans may have a different list of preventive care benefits. Please refer to the enrollee's plan specific SPD for coverage. Group specific policy will supersede this policy when applicable. This policy does not apply to the Walmart Associates Group Health Plan participants.

Note: Please encourage your patients to update their personal Health Record with information gathered during a preventive visit.

Note: The cost of drugs, medications, equipment, vitamins or supplements that are recommended but not prescribed for preventive measures are generally not covered as a preventive care benefit.

Examples include, but are not limited to:

- A. Aspirin, OTC
- B. Supplements, including but not limited to, oral fluoride supplementation, and folic acid supplementation.
- C. Tobacco cessation products or medications.
- D. Condoms, diaphragms, sponges, spermicides, etc.
- E. Electric Breast Pumps

Aspirin, prescribed by a health care provider with prescribing authority, for prevention of coronary artery disease is covered (DOL/HHS ruling; effective on date of renewal of policy, following 2013-02-20).

FDA approved cervical diaphragms for contraception, prescribed by a health care provider with prescribing authority, for prevention pregnancy, are covered (DOL/HHS ruling; effective on date of renewal of policy, following 2013-02-20).

Coding Guidelines for PPACA Preventive Benefits Plans

Coding Guidelines for PPACA: Other Preventive Services

Section 16: Patient Protection and Affordable Care Act (PPACA)

Habilitative care and modifier SZ

During January 2014, the Patient Protection and Affordable Care Act (PPACA) began requiring all health insurance issuers offering small group health insurance coverage (1-50 fulltime employees) and individual health insurance coverage to include essential health benefits in products offered on and off the Federal Health Insurance Marketplace. Federal law now requires that individual and small group products include the following 10 categories of essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Without a way to identify habilitative services and devices, Modifier SZ was created to help identify habilitative services. Effective for dates of service on and after July 1, 2014, Modifier SZ has been assigned for use in billing for habilitative care.

What are habilitative services? Arkansas' definition of habilitative services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

Coverage of habilitative services: Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

Section 19: Pharmacy

Pharmacy Benefits

Pharmacy Program Advantages

Members' pharmacy benefits are administered through the Health Advantage Pharmacy Program, which eliminates paper claim forms and employs the latest technology for electronic pharmacy claims processing. When members fill their prescription at a participating pharmacy, the Pharmacy Program computer network instantly alerts the pharmacist to the following:

- Any potential harmful interaction of the medication about to be dispensed with any other medication that the patient may already be taking;
- Whether this medication may duplicate another medication the patient is taking;
- Whether the prescribed dosage or strength is appropriate for the age of the patient.

These features help you save money and promote good health and safety.

Common Prescription Benefit Structures

Standard Formulary (Drug List)

The Standard Formulary is a listing of covered medications and the corresponding copayment tier under which the medication is listed. The specific dollar amount of copayment for each medication will vary depending upon the member's policy benefits, but the tier assignment for the medication will be the same for all members. The member's health-plan ID card or drug card will determine the dollar amounts of their copayments. In general, the three copayment levels are:

- **First tier:** Almost all generic medications (lowest copayment of all tiers).
- **Second tier:** Preferred brand-name medications and other lower-cost, brand-name medications (mid-level copayment).
- **Third tier:** High-cost medications or medications classified as non-preferred (highest level of copayment).

Metallic Formulary

The Metallic Drug List corresponds to our Gold, Silver, and Bronze products that are qualified health plans (QHP). The specific dollar amount of copayment for each medication will vary depending upon the member's policy benefits, but the tier assignment for the medication will be the same for all members.

- **First tier:** Preventive medications defined by Health Care Reform that member can obtain for \$0 cost to the member.
- **Second tier:** Almost all generic medications.
- **Third tier:** Preferred brand-name medications and other lower-cost, brand-name medications.
- **Fourth tier:** High-cost medications or medications classified as non-preferred.
- **Fifth tier:** Specialty drugs that may require either special handling and/or storage and may be only purchased through a select specialty pharmacy.

Standard with Step Therapy Formulary

The Standard Step Therapy promotes cost savings through using more generic medications and over the counter products rather than branded prescription drugs. The specific dollar amount of copayment for each medication will vary depending upon the member's policy benefits, but the tier assignment for the medication will be the same for all members.

- **First tier:** Almost all generic medications
- **Second tier:** Preferred brand-name medications and other lower-cost, brand-name medications
- **Third tier:** High-cost medications or medications classified as non-preferred
- **Fourth tier:** Highest plan member copayment. Specialty products are at Tier 4.

Printable Drug List:

The Standard Formulary is a listing of covered medications and the corresponding copayment tier under which the medication is listed. The specific dollar amount of copayment for each medication will vary depending upon the member's health plan or contract level benefits, but the tier assignment for the medication will be the same for all members.

- [Maintenance Drug List](#) [pdf]
- [Metallic formulary](#)
- [2019 Standard with Step Therapy formulary](#) [pdf]
- [2020 Standard with Step Therapy formulary](#) [pdf]
- [Standard with Step Drug List](#) [pdf]
- [Standard/Standard with Step Prior Approval List](#) [pdf] - Medications that require prior approval. For authorization, call **1-877-433-2973**.
- [Prior Approval and Exception Request Form](#) [pdf] – Step therapy and non-formulary exceptions. Fax the form to **501-378-6980**.

Some medications are not covered and therefore not listed on the prescription medication formulary. After review of test results by the Pharmacy and Therapeutics Committee, Arkansas Blue Cross and Health Advantage medical directors, other physicians, and pharmacy professionals, certain medications have not been judged more effective or safe than medications currently on the formulary. Other medications, such as those used for cosmetic purposes, are not covered because of plan exclusions.

Please Note: Other medications may not be covered for a variety of reasons, based on the particular circumstances of the member's condition or the specific terms of the member's health plan or contract. Appearance on the Formulary does not mean that a given medication is necessarily covered for any given member or claim.

How Are Medications Added to the Formulary (Covered Drug List)?

The Health Advantage Pharmacy and Therapeutics Committee makes recommendations regarding preferred and non-preferred medications. The committee includes:

- Arkansas physicians in private practice;
- Medical directors from Arkansas Blue Cross and Blue Shield and Health Advantage;
- Community pharmacists in private practice;
- Pharmacy directors of major Arkansas hospitals;
- Arkansas Blue Cross/Health Advantage pharmacy director.

Pharmacy Directory:

Providers may search for a network pharmacy by using the Network Pharmacy Search. Search for a network pharmacy by name, city, state or zip code. Maps and driving directions are also provided.

For More Information

For more information regarding a member's prescription drug coverage, call:

Health Advantage Members	1-800-863-5567
Arkansas State Employees	1-877-815-1017
Public School Personnel	1-877-815-1017

Exclusions:

Arkansas State Employees (ASE) and Public School Employees (PSE):

Pharmacy benefits for ASE and PSE are administered by EBRX which is not affiliated with Health Advantage.

For Prior Approvals & benefits, call EBRX at 855-757-9526.

Medications and Supplies Not Covered:

The following medications and supplies are not covered under most Arkansas Blue Cross and Blue Shield contracts or health plans. However, some contracts or health plans may cover an item on this list. The final authority on exclusions is the member's specific benefit certificate or health plan. This list is for illustrative purposes only and is not an exhaustive list.

The following medications and supplies are not covered:

1. Medications purchased from a nonparticipating pharmacy, except in an emergency situation.
2. Medications used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered by Arkansas Blue Cross, or for which benefits have been exhausted.
3. Medications for use or intended use which would be illegal, abusive, or are not needed to treat an actual medical condition.
4. Experimental or prescription medications labeled, "Caution: Limited by Federal Law to Investigational Use."
5. Medications which are to be administered to the covered person by a physician or in a physician's office unless authorized by the company.
6. Medications for which, normally (in professional practice), there is no charge.
7. Nonlegend over-the-counter medications (except insulin) which do not, by law, require a prescription order from a physician.
8. Topical vitamin A acid, retinoic acid, tretinoin or similar agents for individuals age 26 and above.
9. Medications dispensed for use by a covered person while such person is in a hospital, extended-care facility, nursing home, convalescent or psychiatric facility or any institution or any medication consumed or administered at the place where it is dispensed.
10. Oral contraceptives that are not part of the formulary.
11. Immunization agents and vaccines.
12. Vitamins or food/nutrient supplements except those which are prescription medications.
13. Medications obtained for weight control.
14. Prescription medications obtained to sustain an addiction or drug dependence.
15. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth or replace lost hair.
16. Medications obtained by unauthorized, fraudulent or abusive use of the identification card.
17. Legend medications that are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given.
18. Fluids, solutions, nutrients or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion.
19. Medications prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.
20. Medical supplies such as colostomy supplies, bandages and similar items.
21. Injectable medications, unless prior approval received from company.
22. Devices or durable medical equipment of any type (even though such devices may require a prescription order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances or similar devices.

Specialty Drugs

The Specialty Drug Program addresses treatment for many complex diseases, including:

- Multiple Sclerosis
- Rheumatoid arthritis
- Hemophilia
- Gaucher disease
- Hepatitis C
- Growth hormone deficiency
- Crohn's disease
- Infertility
- Immunologic disorders
- Pulmonary hypertension
- Cystic fibrosis

The program provides an efficient, cost-effective way for members to receive coverage of injectable and select oral medications.

For more information, visit [Caremark Specialty RX](#). Caremark Specialty RX is the Specialty Drug Program administrator for Health Advantage.

Payment policy for high-cost injectable drugs

Arkansas Blue Cross and Blue Shield and subsidiaries' payment policy for high-cost injectable drugs limits reimbursement to a maximum of \$400 over the cost of the drug. There is an edit for high-cost injectable drugs that are billed at \$6000 or greater. The allowance for the high-cost injectable will be calculated and reimbursed using an ASP + \$400.00 methodology. Even though this policy has been in place since July 2011, it has been inconsistently applied. The addition of Claims Check Plus will allow more accurate and consistent application to pricing of claims for injectable drugs.

Example of calculation:

(Payment Allowance Limits for Medicare Part B Drugs file on CMS.gov, quarterly release)

Medicare Payment Limit /1.06 = ASP

ASP X Units Billed + \$400.00 = Allowance

Arkansas Prescription Monitoring Program requirement

Any provider requesting participation with the Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation networks (collectively, the "Networks") must be registered with the Arkansas Prescription Monitoring Program ("PMP") if that provider holds an active Drug Enforcement Agency ("DEA") certificate and licensure issued to provide healthcare services in Arkansas.

Registration of all current network providers was due on April 1, 2017 in order to comply with the Networks revised credentialing standards. If a provider has not yet registered, network termination letters will be received requesting participation in accordance with the Networks standards. Registration for the PMP is free and takes about five (5) minutes – the registration page can be found online at <https://arkansas.pmpaware.net/login>.

Under the law, a prescriber may designate someone in the facility, such as a nurse, to be that prescriber's delegate for checking the PMP database, once that delegate has also registered. When a prescriber checks the PMP, they become aware of patient issues and can begin discussions leading to safer drug use, better pain management, and treatment for addictions, when appropriate. The Networks require contracted providers in Arkansas to register and encourages use of the Arkansas Prescription Monitoring Program.

Section 20: Products

Health Advantage Traditional

Health Advantage Traditional is an HMO (health maintenance organization). An HMO is a health-care system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee.

Standard Features

With Health Advantage Traditional, you have plan choices that include comprehensive coverage, hassle-free claims processing and benefits that focus on keeping you healthy. Some of our standard features are:

- No deductible
- Preventive health services
- Well-baby care
- Free immunizations
- Routine eye exams
- Wellness discounts
- Optional prescription drug coverage

A variety of copayment and coinsurance plans allow Health Advantage members access to more than 5,000 health professionals and 92 hospitals statewide. (Go to [Provider Directory](#) for complete list.) Presently, these plans only are offered only to employer groups with 51 or more employees. If your group has less than 51 employees, refer to our BlueChoice® Point of Service (POS) or Open Access POS product information.

All Health Advantage health plans provided to employers with 50 or fewer employees include a point-of-service (POS) option. Health Advantage offers health plans without the POS option to employers with more than 50 employees, but only if the employer has an alternative health-benefit plan that gives its employees the ability to elect (at least annually) to receive benefits for health services from "out-of-network providers."

For More Information

Call: Group Marketing, 501-379-4644 or 1-800-605-8301 (toll free)

E-mail: [Customer Service](#)

BlueChoice[®]

Open Access Point of Service (POS)

In response to customer requests for direct access to network providers and a lower-priced health plan, Health Advantage offers a product called Open Access Point of Service (Open Access POS).

Combination Plan

Open Access POS is an innovative plan that combines the characteristics of traditional health maintenance organization (HMO) coverage with the extra provider options of a point-of-service (POS) plan. Like an HMO, Open Access POS provides preventive and routine services and requires copayments for visits to primary care physicians (PCPs). However, Open Access POS members may visit in-network specialty physicians without a PCP referral (PCP selection is recommended but not required). The member controls costs by choosing the level of deductibles, copayments and coinsurance for specialty and hospital services.

What Is Open Access?

Open Access means that members have choices when visiting health-care providers and in using their Health Advantage benefits. Open Access gives members the ability to visit any in-network provider without going through a PCP for a referral and receive the highest level of benefits available under the in-network benefit program. Members also have the option of using out-of-network providers and receiving the out-of-network benefit coverage.

Plan Offerings

- **In-network deductible:** Options include no deductible, \$250, \$500 or \$1,000 in-network deductible. The in-network deductible applies to specialty services, hospital, maternity, rehabilitation, home health and skilled nursing facility services. This deductible applies after the member pays the applicable copayment.
- **Copayments:** These vary depending on service. Standard physician copayment options are \$25 or \$35. The inpatient admission copayment ranges from no copayment to \$500. The outpatient facility copayment is \$100 for outpatient surgery. Benefit determination requires that copayments are always subtracted first, followed by the deductible and coinsurance.
- **Preventive Services:** Primary-care-physician services are not subject to deductible.
- **Emergency Services:** The \$100 copayment and coinsurance are not subject to deductible.
- **Coinsurance:** The in-network options are 10, 20 and 30 percent.
- **Out-of-Network:** Out-of-network services apply after deductibles. Deductible options begin at \$750.
- **Pharmacy:** Options include copayments of \$7/\$30/\$50, \$10/\$30/\$50, or 20 percent coinsurance and copayment of \$10/\$30/\$50. Groups with more than 50 employees may select a \$10/\$20/\$30 copayment option.

For More Information

Call: Group Marketing, 501-379-4644 or 1-800-605-8301 (toll free)

E-mail: [Customer Service](#)

BlueChoice®

Point of Service (POS)

BlueChoice is a point of service (POS) plan offered by Health Advantage. It offers all of the benefits of a traditional HMO, with the added freedom to choose out-of-network services, if the member desires, at an added cost. Under a traditional HMO plan, the member usually pays 100 percent of any out-of-network charges. Under BlueChoice, the member has the option of paying a deductible and/or coinsurance for out-of-network services, plus any balance billing by the provider for charges above the Health Advantage determined allowance. Presently BlueChoice POS is offered to employer groups only; individual coverage plans are not available.

Just as in a traditional HMO, members enrolled in BlueChoice choose a primary care physician (PCP) to coordinate their care. However, when members are seeking medical care, they may visit their designated PCP for the highest benefit option; or they may choose to visit another physician in the network or even outside the network and pay increased out-of-pocket expenses.

BlueChoice members may reduce out-of-pocket expenses by using providers within the network of more than 5,000 health professionals and 92 hospitals. (Go to the [Provider Directory](#) for a complete list.)

With BlueChoice POS, you have plan choices that include comprehensive coverage, hassle-free claims processing and benefits that focus on keeping you healthy. Some of our standard features are:

- No in-network deductible
- Preventive health services
- Well-baby care
- Free immunizations
- Routine eye exams
- Wellness discounts
- Freedom to choose the out-of-network option
- Optional prescription drug coverage

All Health Advantage health plans provided to employers with 50 or fewer employees include a POS option. Health Advantage offers health plans without the POS option to employers with more than 50 employees, but only if the employer has an alternative health benefit plan that gives its employees the ability to elect (at least annually) to receive benefits for health services from "out-of-network providers."

For More Information:

Call: Group Marketing, 501-379-4644 or 1-800-605-8301 (toll free)

E-mail: [Customer Service](#)

Fully Insured Group Health Plans:

A health plan is fully-insured if it is purchased from an insurance company or other underwriter that assumes full risk for medical expenses. The policy is called "fully insured" because the health carrier assumes the risk of providing coverage to the employees. Fully Insured Plans are ones in which the employer pays a monthly premium to an insurance carrier to assume all of the risk associated with the group insurance claims of their employees. In a fully insured group plan, the health carrier issues a contract, typically called a master contract or policy, to the employer. In it, the health carrier agrees to provide coverage to the employees, subject to various conditions. In turn the employees and their dependents are covered under what are typically called certificates of coverage. The employer may pay all or part of an employee's premium.

Fully Insured:

- Health plan assumes the financial risk of medical expense and prescription drug if applicable;
- Groups pay premiums;
- Groups access the traditional HA network;
 - AWP compliant network

Self-Insured Group Health Plans:

Some employers provide coverage to their employees through a self-insured health care plan. A self-insured group health plan (or a "self-funded" plan as it is also called) is one in which the employer assumes the financial risk for providing health-care benefits to its employees. This means the employer pays for its employees' health care with its own money.

In practical terms, self-insured employers pay for each out-of-pocket expense as it is incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully insured plan. Typically, a self-insured employer will set up a special trust fund to earmark money (corporate and employee contributions) to pay incurred claims.

Most self-insured employers do not process claims internally. Rather, they typically have agreements with an outside vendor who processes claims for them. These vendors are called third party administrators (or TPAs). The third party administrator may be an HMO, insurance company, or nonprofit health services corporation.

Self Funded/Self Insured

- Employer assumes the financial risk of medical expense and prescription drug if applicable.
- Administrative fee paid to Health Advantage
 - Basically outsourced claims, etc. administration to health plan.
- Baptist Health employee group accesses the "employer specific network."
 - Non-AWP compliant network.
- ASE/PSE/ARHealth employee groups access the Health Advantage network.

Arkansas State Employees

Plan Information



Inpatient pre-certification required

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

New Benefits Effective Jan. 1, 2011 ARHealth Health Advantage 2011

Services Provided through Arkansas Employee Benefits Division

The Employee Benefits Division (EBD) of the Department of Finance and Administration administers the ARHealth plan. Find all of the information for your plan by visiting www.arbenefits.org. EBD maintains all member eligibility, including dependent status and required documentation. EBD also is the COBRA administrator for the ARHealth plan.

If you are an active employee with the State of Arkansas, eligibility questions will generally be answered by your Agency Insurance Representative. If you are a COBRA participant, or are considering COBRA, please contact EBD.

Health Advantage

Health Advantage has offered health insurance products to Arkansas state employees and their dependents for more than 10 years. And, we understand the importance of having local access to customer service for you and your family when you want to walk in and speak with someone in person. We're here to help you with [our offices](#) in Texarkana, Little Rock, Hot Springs, Jonesboro, Fort Smith, Pine Bluff and Fayetteville. Please feel free to visit the office nearest you.

ARHealth Health Advantage highlights:

- Referrals are not required for services performed by a doctor or hospital in our networks.
- PCP office visit copayments are \$25, and specialist office visit copayments are \$35.
- In-network and out-of-network coinsurance amounts are 20 percent or 40 percent on most services

Pre-certification: Some services may require advance approval (pre-certification). Please visit the website www.healthadvantage-hmo.com for important information about [pre-certification, appeals and case management](#). Out-of-area information is available by selecting "[General pre-certification/pre-authorization information](#)."

Arkansas State Retirees

Plan Information



Inpatient pre-certification required

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

New Benefits Effective Jan. 1, 2011

Services Provided through Arkansas Employee Benefits Division

The Employee Benefits Division (EBD) of the Department of Finance and Administration is the administrator for the ARHealth Plan. Visit www.arbenefits.org to find information for your plan. EBD maintains all member eligibility, including dependent status and required documentation. EBD also is the COBRA administrator for the ARHealth plan.

If you are a retiree with the State of Arkansas, eligibility questions should be directed to EBD. If you are a COBRA retiree, or are considering COBRA, please contact EBD.

Health Advantage

Arkansas State and Public School Employee Benefits Division (EBD) and Health Advantage began offering the ARHealth plan to retirees with Medicare in 2005. Health Advantage, a subsidiary company of Arkansas Blue Cross and Blue Shield, has offered health insurance products to Arkansas State Employees and their dependents for more than 10 years. We understand the importance of having local access to customer service for you and your family. If you need to walk in and speak with someone, we are there to help you, with [our offices](#) in Texarkana, Little Rock, Hot Springs, Jonesboro, Fort Smith, Pine Bluff and Fayetteville. Please feel free to visit the office nearest you.

If Medicare is not your primary coverage, the ARHealth plan features are as follows:

- Automatic enrollment upon retirement.**
 - No need to select a primary care physician (PCP).
 - Many [preventive services](#) (PDF) covered at 100 percent.
 - Your copayment will be \$25 for PCP visits and \$35 for specialist visits.
 - In-network coinsurance will be 20 percent on many services.
 - You can use any doctor or hospital in the state in the Health Advantage network without a referral.
 - If you elect to use an out-of-network provider within Arkansas, your out-of-network coinsurance will be 40 percent and the out-of-network deductible amount will be \$1000 per individual and \$2,000 per family, with a maximum out-of-pocket expense of \$5,000 per individual and \$10,000 per family.

- If you wish to obtain services from an out-of-state doctor or hospital, visit the [BlueCard® PPO network](#).
- Prescription drug benefits and mental health benefits will remain the same.
- One vision screening will be covered every 24 months with a \$35 copayment.
- One hearing screening will be covered every 36 months with a \$35 copayment.

If Medicare is your primary coverage, the ARHealth plan features remain as follows:

- ☐ **If Medicare is your primary coverage, you will be enrolled in this plan upon retirement.**
 - If you become Medicare eligible during the year, your coverage will be supplemental to traditional Medicare A and B benefits. Send the Employee Benefits Division a copy of your Medicare card as soon as you receive it.
 - Your ARHealth plan will coordinate with any qualified Medicare plan (Medicare A, Medicare B and Medicare C — also called Medicare Advantage plans).
 - No need to select a primary care physician (PCP).
 - You can see any physician — anywhere in the United States.
 - If you are a state retiree, the premium for the ARHealth plan covers your prescription drugs, unlike other Medicare supplemental policies. Under federal guidelines, since state retirees have a qualified prescription plan, they cannot select a Medicare D drug plan, or a part C plan that has prescription coverage.
 - If you are a public school retiree, your ARHealth premium has been substantially reduced to enable you to purchase a Medicare Part D Prescription Drug Plan of your choice.
 - Mental health benefits are covered by Medicare and ARHealth.
 - You will have coverage for one vision exam every 24 months with a \$35 copayment, even if Medicare does not cover it.
 - You will have coverage for one hearing exam every 36 months with a \$35 copayment, even if Medicare does not cover it.
 - Your ARHealth plan now covers hearing aids. The benefit is \$1400 per ear every three years. You may use any supplier you choose.

Pre-certification: Some services may require advance approval (pre-certification). Please visit the website www.healthadvantage-hmo.com for important information about [pre-certification, appeals and case management](#). Out-of-area information is available by selecting "[General pre-certification/pre-authorization information](#)."

BlueCard®

As an ARHealth member through Health Advantage, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your coverage gives you a world of choices through the [BlueCard® Program](#).

Arkansas Public School Employees

Plan Information



Benefits Effective Oct. 1, 2010 through Dec. 30, 2011

Services Provided through Employee Benefits

The Employee Benefits Division (EBD) of the Department of Finance and Administration administers the ARHealth plan. Find all of the information for your plan by visiting www.arbenefits.org. EBD maintains all member eligibility, including dependent status and required documentation. EBD also is the COBRA administrator for the ARHealth plan.

If you are an active employee with the Public Schools, eligibility questions will generally be answered by your School Insurance Representative. If you are a COBRA participant, or are considering COBRA, please contact EBD.

Health Advantage

The health care coverage you select is a very important decision. It's no surprise that more than 60,000 public school employees, retirees and dependents choose Health Advantage, a subsidiary company of Arkansas Blue Cross and Blue Shield. Health Advantage has offered health insurance products to public school employees and their dependents for more than 10 years.

We understand the importance of having local access to customer service for you and your family. If you need to walk in and speak with someone, we are there to help you, with [our offices](#) in Texarkana, Little Rock, Hot Springs, Jonesboro, Fort Smith, Pine Bluff and Fayetteville. Please feel free to visit the office nearest you.

ARHealth Health Advantage highlights:

- No referrals are required for services performed by an in-network provider.
- PCP and specialist office visit copayments are \$25 and \$35.
- In-network and out-of-network coinsurance amounts now are 20 percent and 40 percent on most services.

Pre-certification: Some services may require advance approval (pre-certification). Please visit the website www.healthadvantage-hmo.com for important information about [pre-certification, appeals and case management](#). Out-of-area information is available by selecting "[General pre-certification/pre-authorization information](#)."

BlueCard®

As an ARHealth member through Health Advantage, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your coverage gives you a world of choices through the [BlueCard® Program](#).

Arkansas Public School Retirees

Plan Information



New Benefits Effective Jan. 1, 2011

Services Provided through Arkansas Employee Benefits Division

The Employee Benefits Division (EBD) of the Department of Finance and Administration is the administrator for the ARHealth Plan. You will find all of the benefit/limitation information, forms and contact information for your plan at www.arbenefits.org. EBD maintains all member eligibility, including dependent status and required documentation. EBD is also the COBRA administrator for the ARHealth plan.

If you are a Public School retiree, eligibility questions should be directed to EBD. If you are a COBRA retiree, or are considering COBRA, those questions will also need to be directed to EBD.

Health Advantage

The Employee Benefits Division (EBD) and Health Advantage, a subsidiary company of Arkansas Blue Cross and Blue Shield, partnered in 2005 to offer the ARHealth plan to retirees with Medicare. All Medicare and non-Medicare Arkansas State and Public School Retirees are enrolled automatically in the ARHealth Plan upon retirement.

Health Advantage has offered health insurance products to public school employees and their dependents for more than 10 years. We understand the importance of having local access to customer service for you and your family. If you need to walk in and speak with someone, we are there to help you, with [our offices](#) in Texarkana, Little Rock, Hot Springs, Jonesboro, Fort Smith, Pine Bluff and Fayetteville. These local offices provide services to all the counties within their region.

If Medicare is not your primary coverage, the ARHealth plan features as follows:

- Automatic enrollment upon retirement.**
 - No need to select a primary care physician (PCP).
 - Many preventive services covered at 100 percent.
 - Your copayment will be \$25 for PCP visits and \$35 for specialist visits.
 - In-network coinsurance will be 20 percent on many services.
 - You can use any doctor or hospital in the state in the Health Advantage network without a referral.
 - If you elect to use an out-of-network provider within Arkansas, your out-of-network coinsurance will be 40 percent and the out-of-network deductible amount will be \$1000 per individual and \$2,000 per family, with a maximum out-of-pocket expense of \$5,000 per individual and \$10,000 per family.
 - If you wish to obtain services from an out-of-state provider, visit the [BlueCard® PPO network](#).
 - Your prescription drug benefits and mental health benefits will remain the same.
 - One vision screening will be covered every 24 months with a \$35 copayment.
 - One hearing screening will be covered every 36 months with a \$35 copayment.
 - Hearing aids will be covered — \$1400 per year per every three years. You may use any supplier you choose.

If Medicare is your primary coverage, the ARHealth plan features remain as follows:

- **If Medicare is your primary coverage, you will be enrolled in this plan upon retirement.**
 - If you become Medicare eligible during the year, your coverage will be supplemental to traditional Medicare A and B benefits. Send the Employee Benefits Division a copy of your Medicare card as soon as you receive it.
 - Your ARHealth plan coordinates with any qualified Medicare plan (Medicare A, Medicare B and Medicare C — also called Medicare Advantage or Medicare replacement plans).
 - No need to select a primary care physician (PCP).
 - You can see any physician — anywhere in the United States.
 - If you are a public school retiree, the premium for the ARHealth plan has been substantially reduced to enable you to purchase a Medicare Part D Prescription Drug Plan of your choice.
 - Mental health benefits are covered by Medicare and ARHealth.
 - Your ARHealth plan will cover one vision screening every 24 months, with a \$35 copayment, even if not covered by Medicare.
 - Your ARHealth plan will cover one hearing screening every 36 months, with a \$35 copayment, even if not covered by Medicare.
 - Your ARHealth plan will provide coverage for hearing aids — \$1400 per ear every three years. You may use any supplier you choose.

Pre-certification: Some services may require advance approval (pre-certification). Please visit the website www.healthadvantage-hmo.com for important information about [pre-certification, appeals and case management](#). Out-of-area information is available by selecting "[General pre-certification/pre-authorization information](#)."

BlueCard®

As an ARHealth member through Health Advantage, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your coverage gives you a world of choices through the [BlueCard® Program](#).

Section 21: Provider Information

Fraud and Abuse:

Why is Healthcare fraud a problem?

Fraud and abuse is estimated to account for between 3 and 10 percent of the annual expenditures for health care in the U.S. In 2000 alone, this translated to \$30 billion to \$100 billion. We all pay the price through higher premiums and health care costs.

Provider fraud occurs when a dishonest provider and/or his staff lies on claim forms or medical records with the intention of receiving a payment from Health Advantage to which they were not entitled.

- 80 percent of healthcare fraud is by medical providers, 10 percent is by consumers and the balance is by other sources. *Health Insurance Association of America (1998)*.
- Nearly one of three physicians says it's necessary to game the healthcare system to provide high quality medical care. *Journal of the American Medical Association (2000)*.

How can you protect yourself against member fraud?

Services received by non-covered persons are ineligible for payment. Some common examples of member fraud are:

- Members who do not remove a divorced spouse from coverage.
- Members who lie on their insurance application in order to cover an ineligible dependent such as an overage child, the spouse of common law marriage or a grandchild.
- Members who loan their insurance card to non-insured friends so they can visit a doctor.

Always request a photo id from prospective patients and verify the age with the insurance card.

What are common types of provider fraud?

Some common examples include, but are not limited to:

BILLING FOR NON-RENDERED SERVICES: Filing a claim for services that were not performed.

- Filing a claim for missed appointments.
- Filing a claim for samples or supplies you received free of charge from others.
- Aiding or encouraging any member or other person to file a claim for services that were not actually provided, or which were not provided in the quantity or the manner represented in the claim.

PHANTOM BILLING: Adding otherwise legitimate claims charges for services never performed, or using genuine patient names and health insurance information as the basis for fabricating claims.

- Padding claims with additional services that the Member did not receive.

MEDICALLY UNNECESSARY SERVICES: Performing and/or billing for unnecessary tests, surgeries, and other procedures.

- Characterizing any services as medical in nature when they instead are provided for convenience of the member or their family; such as an excessive hospital stay, or custodial care to provide assistance with activities of daily living, such as bathing, dressing, feeding, personal hygiene,

cooking, cleaning, help with taking medications not required to be administered only by a licensed health professional, etc..

MISREPRESENTING SERVICES: Performing non-covered services and billing them as services that are covered.

- Filing a claim for a service that deliberately fails to supply some data you know or should know would cause that service to be not covered under the Member's health plan or contract.
- Filing a claim with us for services you provide to a member who is your immediate relative (spouse, parents, children, brother, sister) or for whom you act as legal guardian.
- Filing a claim that deliberately fails to supply some data you know or should know would result in denial of the claim.
- Filing a claim for services you know or should know are not covered under the member's health plan or contract.
- Withholding medical information or other data you know is needed and relevant and would likely affect payment of the claim or the amount paid.
- Filing claims for services under a CPT code when the services you provided do not fit the published description for that CPT Code (as published by the American Medical Association).
- Filing claims under a general or "dump code" in the CPT Manual of the American Medical Association when a relevant, specific code is available and the description fits the services provided.
- Failing to report with a claim, information indicating that the injury or condition in question is work-related or occurred in the course of job activity.
- Filing any claim in the name or under the provider number for one person when another person actually performed the services being billed (unless the names of both individuals are disclosed in writing along with the claim, and the actual performer of the services is identified in the claim).
- Obtaining or filing a claim for services that are not actually needed to address any mental or physical ailment or condition.
- Misrepresenting the place where the services were performed, or the nature or licensure of a facility at which the services were performed.
- Failing to disclose any information indicating that services relate to a self-inflicted injury or suicide attempt.
- Filing a claim with us when you do not generally bill for the services in question or when you waive any bill to the member for such services.
- Creating any medical records or office notes after claims have been filed for the services or questions have been raised about the claims.
- Withholding requested medical records relevant to a particular claim or service that is being evaluated for coverage determination.
- Cloned medical record documentation worded exactly like previous medical record entries, which does not take into account patient specific variations.

UNBUNDLING: Charging separately for procedures that are part of a single procedure.

UPCODING: Billing for a higher and more expensive level of service than was actually performed.

- Billing for a 45-minute office visit when only 30 minutes was actually spent with the patient face-to-face.

How can you help?

Health Advantage relies on the accuracy and completeness of the claims and medical records you provide to administer our member's benefits and adjudicate their claims correctly. Here is what providers can do to help:

- Educate office staff filing claims on the importance of accurate and complete information.
- Use the Provider's News to keep abreast of the current coverage policies and claims filing procedures.

- Always request a photo id from prospective patients and match the name and age with the insurance card.
- If you suspect fraud is being committed by a member or another provider, please contact our fraud hotline at **1-800-FRAUD21**. All callers will remain anonymous.

Section 21: Provider Information

Change / Update Information:

Please notify the Provider Network Operations (PNO) division of Health Advantage with **ANY** changes to provider information. Receipt of updated information will assist Arkansas Blue Cross in providing current information to referring physicians and its members.

Health Advantage
Attn: PNO Division
601 Gaines Street
P.O. Box 2181
Little Rock, AR 72203-2181

501-210-7050

501-378-2465 (fax)

providernetwork@arkbluecross.com or contact the [Regional Office](#) in your area.

Forms for Providers

These forms are in portable document format (PDF). Except for the pharmacy forms, you may complete the form online, print, sign and mail to the appropriate address with supporting documents. Contact your [Network Development Representative](#) at the Office Location nearest you for assistance.

- [Arkansas Blue Cross Employees/Dependents/Retirees- Designation for Authorized Appeal Representative Form](#) (PDF)
- [Authorization Form for Clinic/Group Billing](#) (PDF): Use for notification that a practitioner is joining a clinic or group.
- [Baptist Health Employees/Dependents/Retirees- Designation for Authorized Appeal Representative Form](#) (PDF)
- [Claim Reconsideration Request Form](#) (PDF)
- [Designation for Authorized Appeal Representative](#) (PDF)
- [Notice of Payer Policies and Procedures and Terms and Conditions](#) (PDF): Applicable to all individual network participants and applicants.
- [Other Insurance/Coordination of Benefits \(COB\)](#) (PDF): In an effort to reduce the number of claims delayed for the purpose of investigating for other insurance, a COB questionnaire is available for members to provide other insurance coverage information. Please print, complete then mail the COB form to us in order to update your records and prevent claims from being delayed for COB information.
- [Out-of-Network Referral Request FAX Sheet](#) (PDF)
- [Patient Waiver Form](#) (PDF): Use to educate members on services that may not meet the Primary Coverage Criteria of the member's policy. Waivers allow 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.
- [Physician/Supplier Corrected Bill Submission Form](#) (PDF): Use when submitting previously finalized (corrected) bills.
- [Provider Change of Data Form](#) (PDF): Use to report a change of address or other data. Completion of this form DOES NOT create any network participation.
- [Provider Refund Form](#) (PDF): Use this form to submit a claim refund.
- [Specialty Referral](#) (PDF): Participating Primary Care Physicians - for referrals to participating in-network specialist providers.
- [Termination Form for Clinic/Group Billing](#) (PDF): Use for notification that a practitioner is leaving a clinic.

Section 22: Provider Profiles

Focused Review:

Focused Review is a program coordinated with the physician profiling effort to review practice patterns that are compared to a provider's peer norm. Corporate Medical Directors, Regional Medical Directors, Credentialing committee members or any executive may request a provider be placed on focused review.

Each provider placed on focused review will be notified in writing as to:

- Why they are being placed on review,
- For what length of time, and
- What codes and or procedures the review will involve.

A provider on focused review must submit all claims, outlined for review, to Health Advantage and its affiliate companies in paper format with the accompanying medical records as outlined in the information sent with the notification. Once the focused review is complete the provider will be notified in writing when they may resume submitting in electronic format and the findings of the focused review.

Results of Focused Review and the Meaning of Focused Review Termination:

At the end of a focused review period, you may be asked to make specific changes in your billing, coding or claims filing practices, or it could be determined that no changes are needed. Another possibility is that the results of that particular focused review are indeterminate, i.e., that not enough information was obtained to reach a conclusion or formulate any recommended corrective action at that time.

Please note this important qualification to the termination of any particular focused review: the focused review process is designed to look at a specific, limited issue or question that may have been brought to our attention by a variety of methods, depending on the issue or question.

Focused review is not intended as a general review of all possible issues or questions relating to a provider's practice, billings or claims, and the termination of any focused review process should not, therefore, be interpreted as a finding or conclusion regarding the validity or appropriateness of any particular practice. The mere fact that a given focused review process has been completed does not mean that other claims filings or billing practices are not subject to questions or further review; in fact, we constantly attempt to monitor claims and billing practices on an ongoing basis and reserve the right to take further action and conduct additional reviews as indicated by the circumstances.

Physician Profiles

Cost and Quality Profiles for Participating Physicians

The Physician Profile consists of two profiles - Cost and Quality. The first is the Cost Comparison profile which is based on Episode Treatment Groups (ETG's). The comparison of the physician to the specialty peer group is based on allowed dollars.

The second is the Quality Profile which has measures that are drawn from nationally accepted standards of care that are derived from claims data and not medical review of patient claims. Each physician's adherence rate is reported along with the specialty peer group's adherence rate

**To view the current Physician Profile reports,
please select the respective link.**

<u>Physician Profile Manual</u>	
<u>Specialty Cost Comparison</u>	<u>Quality Profile</u>

Purpose of Report(s):

Tool in analyzing physician utilization.

Business Products Included:

Arkansas Blue Cross Blue Shield, Health Advantage, and Blue Advantage.

Source(s) of Data:

CRMS Warehouses.

Dates of Data Inclusion:

Reports have 3 years of incurred data. Information is updated in June and December and contains a six-month lag.

Number of Physician Profile Reports Produced:

To view the number of reports produced in each reporting cycle, contact [Alison Kerr](#).

Section 23: Special Coding & Billing Issues

Anesthesia Billing:

How to Bill for Anesthesia Time When Filing A Paper Form of CMS-1500:

Recently Health Advantage began scanning and imaging paper claims to improve the processing of claims. If a provider files paper claims for anesthesia services, these guidelines will help the claims get processed correctly.

Health Advantage would prefer providers file electronically; but if a provider must file on paper, please follow these guidelines.

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for 1 hour and 22 minutes, this would be indicated as 82 minutes in block 24g of the CMS-1500. If no time units are indicated on the claim, the claim will be denied.

Base Units:

Base unit values have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual preoperative and postoperative care and evaluation. Health Advantage uses the anesthesia base units recommended by the American Society of Anesthesiologists.

Do not report base units in the units field (block 24g) on your claim submissions, report the actual total minutes that anesthesia was administered. The Health Advantage claims processing system automatically determines the base units based on the reported procedure code and modifiers. If a provider's software automatically prints a comment line below the service line with the base units, it will not interrupt the processing of the claim as long as no data prints in the date of service or charge fields.

Time Units:

Anesthesia time involves the continuous actual presence of the anesthesiologist or CRNA and begins when the physician or anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Anesthesia time ends when the anesthesiologist/CRNA is no longer in personal attendance, i.e., when the patient may be safely placed under post-operative supervision. The anesthesiologist/CRNA's should report the total anesthesia time on the CMS-1500 claim form as the sum of the continuous anesthesia block times. The medical record should be documented so that a medical record auditor can see the continuous and discontinuous periods and that the reported total anesthesia time sums to the blocks of continuous time.

Time units are determined on the basis of total minutes. Providers should 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 CMS-1500.

Physical Status Modifiers:

The following physical status modifiers are used to give Health Advantage additional information about the level of complexity of the anesthesia service provided. The points are additional units added to the total time. Providers should bill for only one (1) physical status modifier per procedure.

	POINTS
P1: A normal healthy patient	0
P2: A patient with mild systemic disease	0
P3: A patient with severe systemic disease	1

P4: A patient with severe systemic disease that is constant threat to life	2
P5: A moribund patient who is not expected to survive for 24 hours with or without the operation	3
P6: A declared brain-dead patient whose organs are being removed for donor purposes	0

Anesthesia Reimbursement:

Anesthesia services are paid based on the Anesthesia Relative Value Units. The customary values for reimbursement of anesthesia services are based on the sum of the following components:

- Base units for the primary procedure
- Total time
- Physical status

The following formula is used to determine reimbursement:

(Anesthesia base unit	+	Physical modifying	+	Total time (units))	x	Conversion factor	=	Anesthesia fee allowance	x	Contractual allowance units
For example, 00865P3 performed in total time of 1 hour and 25 minutes:										
(Anesthesia base unit	+	Physical modifying	+	Total time (units))	x	Conversion factor	=	Anesthesia fee allowance	x	Contractual allowance units
7 units	+	1 unit	+	6 units*	=	14 units	x	\$50	=	\$700

Reimbursement would be \$700 X Contract Benefit. In other words, if a provider has agreed to accept 90% of the Health Advantage allowance, their reimbursement would be \$700 X 90% = \$630.00.

*Partial units are rounded to the next whole unit; 1 unit = 15 minutes. So, 85 minutes/ 15 minutes = 13.67 units, which = 14 units.

Documentation Requirements:

Health Advantage does not require the anesthesia record with each claim submission. Do not submit anesthesia records unless it is requested; then follow the instructions in the letter of request. The following are the most common situations in which Health Advantage requests anesthesia notes:

1. Procedures in the Monitored Anesthesia Care policy may require a letter documenting why monitored anesthesia was necessary for the particular patient.
2. Submission of any miscellaneous procedure codes. Most miscellaneous codes end in "999" (i.e., "01999"). The record is required to identify the actual procedure performed, because the code does not provide sufficient information.
3. Anesthesia administered for dental procedures. Since the member's dental-related coverage may be limited, the anesthesia record permits us to make a coverage determination on the particular case.
4. If two different anesthesia services are billed on the same claim, the anesthesia record is needed to document that two different operative sessions occurred on the same day.
5. If a procedure is billed that is not site specific, i.e., removal of a foreign body, Health Advantage may request the anesthesia record to determine the site to ensure coverage should be allowed.
6. If two or more procedures are provided at the same operative session, the anesthesiologist/CRNA should bill using the related anesthesia procedure with the highest base units.

Anesthesia Billing Reminder:

As stated in the Arkansas Blue Cross and Blue Shield provider manual for anesthesia billing:

1. If two different anesthesia services are billed on the same claim, the anesthesia record is needed to document that two different operative sessions occurred on the same day.
2. If two or more procedures are provided at the same operative session, the anesthesiologist/CRNA should bill using the related anesthesia procedure with the highest base units.

When these situations are identified, a medical records request (MRR) form will be sent to providers to document different operative sessions on the same day when two anesthesia services are billed for the same patient on the same day. Arkansas Blue Cross will pay either the anesthesiologist or the CRNA who delivers the anesthesia service, but not both.

Nerve Block

Billing Information for Nerve Block

If a nerve block is used in the pre or post-operative period as pain management following the procedure, the appropriate block code should be billed with Modifier - 59 to indicate the pain block was not part of the anesthesia for the procedure, and Modifier - 51 as multiple procedure rules.

If the nerve block is used as the anesthesia for the procedure, and given along with conscious sedation, the nerve block would be considered the anesthesia and would be allowed. If the nerve block is given prior to or during the procedure, along with deep sedation (for which a general anesthesia code is billed), the nerve block would not be allowed as it would be considered part of the anesthesia for the procedure.

If the nerve block is given in the preoperative setting and only conscious sedation is given during the procedure (i.e., no general anesthesia code is reported), the nerve block is covered as the anesthesia for the procedure.

Billing for Diabetes Self-Management Training (DSMT)

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

When billing for a DSMT program, providers should bill using HCPCS codes G0108 or G0109. All outpatient hospital UB04 claims for DSMT should be submitted with revenue code 942 but also must include HCPCS codes G0108 or G0109. Revenue code 942 always require an HCPCS/CPT code on an outpatient claim; otherwise the claim will be rejected. DSMT services from professional providers should be billed on a CMS 1500 claim form but must also include HCPCS code G0108 or G0109.

Eligible programs for Diabetes Self-Management training must meet the following standards listed below. These guidelines follow the requirements of Arkansas Law ACA 23-79-601 (also known as Rule 70).

- **Compliance:** The program must be in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association. These may be found at <https://care.diabetesjournals.org/content/diacare/early/2017/07/26/dci17-0025.full.pdf>.
- **Required elements:** Elements required to meet minimum standards are:
 - a. Needs assessment
 - b. Education plan
 - c. Education intervention
 - d. Evaluation of learner outcomes
 - e. Plan for follow-up for continuing learning needs
 - f. Documentation
- **Certification:** To qualify for benefits, the provider must provide certification that the insured individual has successfully completed the diabetes self-management training.

Discograms

Correct Billing of Discograms (CPT Codes 72285 and 72295)

There has been some confusion regarding the billing of Discograms. From the CPT Assistant, April 2003, page 27,

“Question: Which CPT codes should be reported for a lumbar discography at L2-3, L3-4, L4-5 and L5-S1 levels? Would the appropriate code be reported more than once since the procedure is performed at four different levels? Is the radiological interpretation an inclusive component to the primary procedure, or is it separately reported?”

AMA Comment:

“The discography procedure performed at the L2-3, L3-4, L4-5 and L5-S1 levels may be reported with CPT code 62290, Injection procedure for discography, each level; lumbar. This code should be reported four times since four levels were imaged. Also, CPT code 72295, discography, lumbar, radiological supervision and interpretation, may be reported four times for the radiological supervision and interpretation as this code can be reported for each lumbar level. If the physician performed only the professional component of the discography, then Modifier 26, Professional component, should be appended to CPT code 72295 to indicate this circumstance. There must be documentation of suspected disease at levels in order to receive payment for numerous provocations.”

If CPT code 72285, discography, cervical or thoracic, radiological supervision and interpretation, is performed on more than one level, it should be billed in the same manner described above.

The provider who is completing the injection should be billing for CPT code 62290 (Injection procedure for discography, each level; lumbar). If a radiologist is then sent an X-ray of the position of the needle to provide a written report for the record, the radiologist should bill code 72295 with Modifier 26 present, not the provider completing the injection. The provider completing the injection should not bill code 72295.

Section 23: Special Billing and Coding Issues

HCPCS: K Codes

Effective January 1, 2014 Health Advantage will start accepting some high dollar HCPCS K codes. The following K codes will be accepted.

HCPCS Code	Description
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom motorized/power wheelchair base
K0014	Other motorized/power wheelchair base
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0607	Replacement battery for automated external defibrillator, garment type only, each
K0608	Replacement garment for use with automated external defibrillator, each
K0609	Replacement electrodes for use with automated external defibrillator, garment type only, each
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds
K0802	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle, not otherwise classified
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds

HCPCS Code	Description
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0824	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0826	Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838	Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840	Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0843	Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0850	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0852	Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0854	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more

HCPCS Code	Description
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0858	Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859	Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862	Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863	Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864	Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0870	Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871	Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0879	Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880	Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0886	Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0898	Power wheelchair, not otherwise classified
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria

Immunoassay for Analytes

Proper Billing of Immunoassay for Analytes

There has been some confusion regarding how providers should be billing CPT code 83516. Therefore, this is a review of the proper billing of immunoassays for analytes. CPT code 83516 is an immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method. CPT code 83516 is a nonspecific code for immunoassay procedures which use highly specific antigen to antibody binding to identify specific chemical substances (analytes) by immunoassay techniques for immunoassay procedures that are not specifically identified in CPT. More specific methods reported with these codes include enzyme immunoassay (EIA), and fluoroimmunoassay (FIA). CPT code 83516 is limited to one unit-of-service unless performed for a separate analyte.

CPT code 83516 is a nonspecific code and may be reported for anti-mullerian antibody determination. This test measures a chemical produced in the body called anti-mullerian hormone, or AMH, which has been shown to provide an accurate snapshot of a woman's egg count. Cost for this procedure will accrue to the total benefit allowance for in vitro fertilization, which is a specific member benefit allowance. Arkansas Blue Cross and Blue Shield's Coverage Policy #1998041 excludes coverage of blood/serum testing (cytotoxic food allergy testing). CPT code 83516 is mutually exclusive with CPT Code 83518. If CPT code 83516 is reported with CPT code 83518, CPT code 83516 is denied as a fragmentation.

If the codes listed below are billed with CPT code 83516, 83516 will be denied as a fragmentation. If CPT code 83516 is performed for an analyte separate from the codes listed below, CPT code 83516 should be reported with Modifier 59.

- **80101** - (Drug screen, single drug class method [e.g., immunoassay, enzyme assay], each drug class) as each code represents qualitative immunoassay for an analyte other than infectious agent antibody or infectious agent antigen.
- **86200** - (Cyclic citrullinated peptide [CCP], antibody), a semi-quantitative/qualitative enzyme-linked immunosorbent assay.
- **86602** - CPT 86793, as all of the latter procedures represent qualitative immunoassays for detection of antibodies for specific infectious agents.
- **86021** - (Antibody identification; leukocyte antibodies), a semi-quantitative/qualitative antibody test.
- **86022** - (Antibody identification; platelet antibodies), a semi-quantitative/qualitative antibody test.
- **86023** - (Antibody identification; platelet associated immunoglobulin assay), a semi-quantitative/qualitative antibody test.
- **86255** - (Fluorescent noninfectious agent antibody; screen, each antibody), a semi-quantitative/qualitative antibody test.
- **86294** - (Immunoassay for tumor antigen, qualitative or semi-quantitative), a semi-quantitative/qualitative antibody test.
- **86318** - (Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method [e.g., reagent strip]), a semi-quantitative/qualitative antibody test.
- **86376** - (Microsomal antibodies [e.g., thyroid or liver-kidney], each), a semi-quantitative/qualitative antibody test.
- **86430** - (Rheumatoid factor; qualitative), a qualitative antibody test.
- **86800** - (Thyroglobulin antibody), a qualitative antibody test.
- **86850** - (Antibody screen, RBC, each serum technique), a semi-quantitative/qualitative antibody test.
- **86870** - (Antibody identification, RBC antibodies, each panel for each serum technique), a semi-quantitative/qualitative antibody test.

Molecular Diagnostics and Cytogenetic Testing

Proper Billing

Health Advantage recently has noticed a significant increase in the number of molecular diagnostic and cytogenetic testing claims received. Many of the claims being filed for these services are filed incorrectly. Effective immediately, Health Advantage no longer will review the denied claims for these services if the claim is billed with any of the molecular diagnostic or cytogenetic testing codes (83890-83914 and 88230-88299) when the claims are submitted without a specific genetic modifier, found in Appendix I of the 2010 Current Procedural Terminology (CPT®) Manual, and the number of probes performed with each code. The following information is what any facility or lab must include on a claim for molecular diagnostic or cytogenetic testing:

- 1) Claims must have the name of the genetic test that was performed along with the reason the test was ordered.
- 2) All of the molecular diagnostic codes (codes contained in the series from 83890-83914) and/or cytogenetic codes (codes contained in the series from 88230-88299) must be included on the claim for that genetic test ordered. In addition, the exact number of probes performed for each molecular diagnostic or cytogenetic code must be appended to the claim.
- 3) The correct genetic modifier, found in Appendix I of the 2010 CPT Manual for the genetic test ordered must be appended to the claim.

If a review of a denied claim is received and the claim was not submitted correctly, a letter will be sent to the provider stating the following:

“Please be advised, the claims will not be paid when submitted unless the proper genetic modifier, which is found in Appendix I of the 2010 CPT Manual, is properly appended to the claim with the molecular diagnostic/cytogenetic testing codes with each code having the number of probes that was performed with each code.”

The claim denial also will be changed to the appropriate code per line of business, indicating the claim was incorrectly coded and the member cannot be held financially responsible.

Pathology Consultation

Billing of Pathology Consultation Codes (CPT Codes 88331 and 88332)

Due to some confusion as to the appropriate manner which CPT code 88331 should be billed, the following is a guideline for the appropriate billing of this code.

CPT code 88331 is the pathology consultation during surgery; first tissue block, with frozen section(s), single specimen. The CPT Assistant July 2000, Page 4 states, "During the course of a surgical procedure, a pathology consultation may be required. Pathology consultations during surgery that involve frozen sections are reported with CPT codes 88331 and 88332." The phrase "...with frozen section(s), single specimen," has caused some confusion over the intent of the code, prompting some to believe that CPT code 88331 can only be used once per surgery, rather than once per specimen. In fact, multiple separately submitted specimens may be received during surgery for frozen section examination for diagnosis or immediate evaluation, resulting in the use of multiple units of 88331.

In order to properly use these codes, the terms "block" and "section" must be defined. A block is a portion of tissue from a specimen that is frozen or encased in a support medium such as paraffin or plastic, from which sections are prepared. A section is a thin slice of tissue from a block prepared for examination. The examination is usually by light microscopy.

When a section from the first block of tissue from a specimen is examined, CPT code 88331 would be used. When sections from subsequent blocks of the same specimen are examined, the appropriate coding is one unit of service of CPT code 88332 for each section examined. If more than one specimen is submitted for consultation, the services for each specimen would be coded as explained above.

Any routine stains (e.g., rapid H&E, Wright) applied to the frozen section are included in CPT codes 88331 and 88332. If other techniques (e.g., fine needle aspiration, touch preparation, examination of a cell sample) are used in the course of a pathology consultation during surgery, they should be reported using appropriate cytology codes. When the definitive permanent section examination is performed, subsequent to the frozen section during surgery, the appropriate surgical pathology code should be reported.

CPT Changes

CPT Changes 2001 Rationale CPT code 88331 was revised to allay confusion regarding the intent of the code. The descriptor of CPT code 88331, "with frozen section(s), single specimen," has caused confusion over the intent of the code prompting some to believe that CPT code 88331 can only be used once per surgery rather than once per specimen. The addition of "first tissue block" to the code descriptor was necessary to prevent misinterpretation.

Therefore CPT code 88331 is restricted to one unit per specimen. If a frozen section is performed on a second block of tissue, CPT code 88331 should be reported with Modifier 59 or the LT or RT Modifiers.

Postoperative Global Period:

Health Advantage uses the postoperative global periods used by Medicare. Each surgical and/or invasive procedure will have a global period of either zero, ten or ninety days. This means that all usual postoperative services occurring within those respective time frames are included in the Health Advantage allowance and reimbursement of the surgical/invasive procedure. Providers will not receive additional payments. Only those related postoperative services that are considered significant and separately identifiable should be billed.

Transitional care management services

Arkansas Blue Cross and Blue Shield and Health Advantage cover the new Transitional Care Management Services (TOC) codes to reimburse for services provided during the critical period of discharge from a facility. These services are billed using CPT code 99495 and 99496.

These CPT codes are billable when an established patient requires moderate or highly complex medical decision-making during a transition of care from an inpatient setting (including acute hospital, rehab hospital, long term acute care, partial hospital, observation status, or skilled nursing/nursing facility).

Reimbursement for these CPT codes requires an attempt to contact the patient within two business days of discharge, culminating in a successful contact (for example by phone) separate from a face-to-face visit. In addition, reimbursement requires that a face-to-face visit occur within seven days of discharge (CPT code 99496) or within 14 days of discharge (CPT code 99495).

This face-to-face visit is part of the TOC service and is not billable separately from the TOC code. The TOC service is payable only once per 30 days. In the event of overlapping hospitalizations within a 30-day period, only one discharge is eligible for TOC reimbursement.

The TOC codes are payable only to primary care providers, including general practice/family medicine, internal medicine, pediatrics, or gerontology. The date of service can be billed either as the date of the face-to-face visit or the date 30 days after discharge (the latter being the Medicare policy).

Treatment of Temporomandibular Joint Disease

Treatment of Temporomandibular Joint Disease is only covered if the member's certificate has a TMJ rider for coverage. The only exception is for an individual contract issued prior to January 1, 2002. Providers should contact customer service for information on whether these benefits are in place and what dollar amount of coverage is available.

Section 24: Utilization Review

Admission Pre-Certification Requirements:

Health Advantage:

Product Line	Admission Pre-Certification	Outpatient Pre-Certification
Health Advantage	Not Required Pre-notification required for out of state, out of network, or Long Term Acute Care Facilities.	Not Required

Admission Pre-Certification:

Admission pre-certification is no longer required for routine hospital admissions which includes surgery and diagnostic testing performed at in-network facilities for Health Advantage. However, if services are performed at an out-of-network facility, outside the state of Arkansas, or at a long term acute care facility, it is the member's ultimate responsibility to notify Customer Service by calling the Customer Service number on the back of the ID card.

Admission Pre-Notification Requirements for Out-Of-State or Out-Of-Network Hospital:

All out-of-state and out-of-network hospital admissions require pre-notification by calling the 800 number located on the member's ID card. In-network and in-state hospital admissions do not require pre-notification. Please be aware when calling to pre-notify an out-of-state or out-of-network admission that the phone menu has changed. Providers must listen to the entire menu to assure calls are being transferred to the appropriate location.

For more information, please call your local Health Advantage office.

Admission Pre-notification/Pre-certification Requirements for Out-Of-State or Out-Of-Network 2011	
Health Advantage	<p>Pre-notification requirement for out-of-network and out-of-state only. Effective Jan. 1, 2011, calls are taken by Health Advantage Customer Service – not HealthIntegrated. Call the phone number on the member ID card, listen to the menu of options, and choose the Health Advantage option after the tone.</p> <p>For Arkansas State and Public School members (ID prefix PXG), Health Advantage administers prior authorization/precertification service requests. Health Advantage is partnering with New Directions Behavioral Health and AIM Specialty Health.</p> <p>For Behavioral Health/Substance Abuse, precertification will need to be obtained by New Directions at 1-877-982-8295.</p>

High Tech Radiology services will need to be precertified by AIM at 1-877-642-0722.

All other medical services that require prior authorization/precertification will need to be obtained by calling Health Advantage at 1-800-482-8416 (internal transfer extension 50158). Outpatient service requests can also be submitted by fax or mail using the form available on the Health Advantage website:

[Prior approval for requested services - Health Advantage \(healthadvantage-hmo.com\)](http://healthadvantage-hmo.com)

Prior Authorizations for Specialty Medications will continue to go through EBRx, and a separate list will be updated as changes occur.

Services that require prior authorization/precertification:

Medical Services

Skilled nursing facility
Cognitive rehabilitation
Occupational therapy
Home health services
Inpatient rehabilitation
Physical therapy
Speech therapy
Enteral feeds
Long term acute care hospital (LTACH)
Intensity-modulated radiation therapy (IMRT)
In-patient admissions
Transplant services

Medical Procedures

Septoplasty
UPPP (Uvulopalatopharyngoplasty)
Varicose vein treatment
Blepharoplasty and/or brow lift
Gynecomastia reduction
Mammoplasty
Panniculectomy
Rhinoplasty
Scar revision outside doctor's office
Gastric pacemaker
Bariatric surgery, revisions, reversals (takedown) that require surgical intervention

Durable Medical Equipment

Spinal cord stimulators (implantation and device)
Continuous glucose monitoring devices
Defibrillator vests
Power mobility devices
Wound vac

Behavioral Health/Substance Abuse Services – New Directions

ABA therapy
Residential treatment
Inpatient rehabilitation

	<p>Intensive outpatient treatment Partial hospital /day treatment</p> <p>High Tech Radiology services - AIM Computerized tomography (CT Scan) Computerized tomography – angiography (CTA Scan) Magnetic resonance imaging (MRI) Magnetic resonance angiography (MRA) Positron emission tomography (PET Scan)</p> <p>Acute medical conditions do not require pre-certification.</p>
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Additional Services Requiring Prior Approval

The following services will require prior approval (PA) as of April 1, 2022.

Health Advantage Fully Insured

- Home health visits and hospice **except metallic.**
- Mental health inpatient **except metallic.**
- Prosthodontics services.
- Additional services require PA as part of the Craniofacial Anomaly reconstructive surgery: Sclera contact lenses, including coatings, ocular impressions of each eye; every two years, two hearing aid molds and a choice of two wearable bone conductions, two surgically implantable bone-anchored hearing aids or two cochlear implants **including metallics and the US65 individual plans.**

Health Advantage Exchange

- Additional services require PA as part of the Craniofacial Anomaly reconstructive surgery: Sclera contact lenses, including coatings, ocular impressions of each eye; every two years, two hearing aid molds and a choice of two wearable bone conductions, two surgically implantable bone-anchored hearing aids or two cochlear implants **including metallics and the US65 individual plans.**

Special Note:

Health Advantage cannot give providers any kind of guarantee regarding eligibility — Health Advantage can only give the data available and reflected on our computer system at the time a provider calls. Many factors beyond the knowledge or control of Health Advantage may affect the eligibility status of a given member; therefore, providers should not rely on the eligibility data provided as assurance of coverage for the services or service date(s) in question. A provider's best source for the most up-to-date information on eligibility is the patient, who should know employment status and premium payment history or intention on the date of service.

The Health Advantage participating provider agreements specifically address eligibility, providing the following: Effect of Eligibility and Pre-certification or Pre-Notification Responses — Provider understands and agrees that pre-certification for inpatient treatment, pre-notification or any "verification of benefits" or other eligibility inquiries made prior to, at or after admission or provision of any services to members are not a guarantee of payment.

Pre-certification means only that, based on information provided to Health Advantage (or the applicable payer) or its designated representative at the time of admission, coverage for the admission (and for the initial number of inpatient days authorized for reimbursement) will not be denied solely on the basis of lack of medical necessity (as defined by the member's health plan) for inpatient treatment. Pre-notification means only that Health Advantage (or the applicable payer) has been notified of the admission.

While Health Advantage (or the applicable payer) or its designated representative will endeavor in good faith to report member eligibility information available to Health Advantage within its records or computer systems at the time of admission or provision of services, provider acknowledges and agrees that it is not possible to guarantee accuracy of such records or computer entries. A provider understands and agrees that the eligibility of all members and coverage for any services shall be governed by the terms, conditions and limitations of the member's health plan, which shall take precedence over any inconsistent or contrary oral or written representations.

If, following any inpatient treatment or other services, it is discovered or determined that premiums had not been paid for a member's coverage, that a former member was no longer employed and eligible for participation in the health plan at the time of the admission, or that coverage had lapsed or terminated for any reason specified in the member's health plan, no reimbursement shall be due from Health Advantage (or the applicable payer) for such services.

New fax number for hospital precertification services

Arkansas Blue Cross and Blue Shield is making upgrades to the utilization management services. As a result, the hospital admission fax number is changing. Beginning June 1, 2015, the new hospital admission precertification fax number will be 501-378-2050. Please make sure all clinics and facilities begin using the new fax number on June 1, 2015, when sending precertification clinical information for members of BlueAdvantage Administrators of Arkansas, FEP, and USABLE Administrators.

The fax number is the only change for the utilization management services. The hospital admission precertification phone number is not changing.

Providers who have questions regarding this change should contact their network development representative.

High Tech Radiology Prior Approval:

As a provider, you are no doubt aware of the escalation in the cost of health care. The National Manufacturing Association has concluded that America's standard of living will decrease in the coming years due to the transfer of jobs overseas. One major reason cited for this job loss is the cost of health care borne by American employers.

Most physicians are not aware that the fastest growing area in health care is medical imaging. Health Advantage currently pays approximately the same amount in claims for imaging as for pharmacy, and imaging costs are increasing at a much faster rate.

AIM Specialty Health (AIM):

Arkansas Blue Cross members will receive one CT or MRI for every three people. In addition to the increased financial burden this places on those paying health insurance premiums, the rapid acceleration in radiological imaging is exposing patients to worrisome doses of radiation. For example, each cranial CT Scan with and without contrast delivers the radiation equivalent of 200 chest X-rays, while a chest CT provides 350 chest X-ray equivalents. For these reasons, Arkansas Blue Cross, BlueAdvantage, Health Advantage, and Arkansas PPO have entered into an agreement with AIM Specialty Health, Inc., (NIA) for outpatient imaging management services.

A prior approval program for outpatient diagnostic imaging procedures began February 1, 2006. The prior approval program applies to all Arkansas Blue Cross members, including those who access the True Blue PPO network, as well as all Health Advantage members.

Under terms of the agreement, Arkansas Blue Cross, Health Advantage and BlueAdvantage will retain ultimate responsibility and control over claims adjudication and all coverage policies and procedures. AIM will manage outpatient imaging/radiology services through existing contractual relationships. Claims for imaging services will continue to be processed based upon the terms of the Arkansas Blue Cross Preferred Payment Plan, Health Advantage, PPO Arkansas' True Blue PPO and Arkansas' FirstSource PPO provider agreement(s).

In August 2018, Arkansas Blue Cross and Blue Shield made the decision to transition the administration of advanced diagnostic imaging from National Imaging Associates (NIA) to AIM Specialty Health® (AIM) for its members.

Why the change?

AIM administers services nationwide, which will allow us to serve members outside the Arkansas service area through a single vendor. AIM serves about 50 health plans and related organizations, representing more than 42 million people. The AIM staff of 1,000 associates includes 600 healthcare professionals (licensed in all 50 states, with board certification in more than 20 specialties and subspecialties).

What changes will customers notice?

This transition will be seamless for the vast majority of our fully insured customers. Here are some important notes on the transition:

- **Effective date** – The move from NIA to AIM is effective January 1, 2019.
- **Phone number** – Arkansas Blue Cross purchased the telephone number listed on the back of some member ID cards and will redirect it to AIM. Members or providers calling for diagnostic imaging pre-authorization will follow the same process as before the vendor change. For questions or inquiries:
 - Call AIM Specialty Health toll-free at 1-877-642-0722

- Hours: Monday – Friday [7:00 am to 7:00 pm CST]

Section 22: Utilization Review

- For member inquiries to their network plan, please call the customer service number listed on the member's ID card.
- **ID cards** – No member will receive a new ID card solely because of the move to AIM.
- **Websites** – All of the networks websites are now redirected to link provider to AIM's website.
- Get fast, convenient online service via the AIM **ProviderPortalsSM** (registration required). **ProviderPortal** is available twenty-four hours a day, seven days a week. Go to www.providerportal.com to begin.

The following information is needed to submit a request to AIM:

- Member's identification number, name, date of birth, and health plan
- Ordering provider information
- Imaging provider information
- Imaging exam(s) being requested (body part, right, left or bilateral)
- Patient diagnosis (suspected or confirmed)

Radiology Management Reference Guide:

Prior Approval Fact Sheet:

A prior approval program for outpatient diagnostic imaging procedures was implemented on February 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, PPO Arkansas' True Blue and Arkansas' FirstSource provider agreements.

The following outpatient services require the new prior approval*:

- CT Scan
- Nuclear Cardiology
- MRI/MRA
- PET Scan

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

- Emergency room, observation department of a hospital, and inpatient imaging procedures do not require prior approval.
- 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 approval 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 approval by calling AIM 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 AIM within five business days of the date of service and before the claim is submitted to obtain proper approval for the studies, which will still be subject to review.)

Section 22: Utilization Review

- Average calls are completed within five minutes. Peak call volume occurs between the hours of 1 p.m. to 6 p.m.
- Approvals may be obtained on-line after the user is registered at: www.providerportal.com.
- AIM's guidelines are located on their website at: www.providerportal.com. The guidelines are available in a PDF format that may be printed for future reference.
- Prior approval is not a guarantee of coverage. The radiology services are subject to the member's eligibility and benefit plan provisions.

Please note: just because prior approval 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.

The Prior Approval Implementation Recommendations for Ordering Physicians and Participating Facilities:

As a participating provider of diagnostic imaging services that require prior approval, it is essential that providers develop a process to ensure the appropriate approval 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 AIM for prior approval. A separate approval number is required for each procedure ordered.

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

To expedite the approval process, please have the following information ready before calling the AIM 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 approval is obtained. The rendering facility should not schedule procedures without prior approval. For urgent tests, the rendering facility can begin the process, and AIM will follow up with the ordering physician to complete the process. Procedures performed that have not been properly approved will not be reimbursed, and the member cannot be balance billed. A separate approval number is required for each procedure ordered.

Section 22: Utilization Review

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

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

- Communicate to all personnel involved in outpatient scheduling that prior approval is required for the listed procedures.
- If a physician office calls to schedule a patient for a procedure requiring prior approval, request the approval number.
- If a provider has not obtained a prior approval, inform the provider of the requirement and advise the provider to call AIM at the toll-free number, 1-877-642-0722. Facilities may elect to institute a time period in which to obtain the approval number (for example, one business day).
- If a patient calls to schedule a procedure that requires prior approval and the patient does not have the approval 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 approval changes from AIM.

Q.1. Is prior approval from AIM required for all radiological procedures?

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

Q.2. Who is responsible for obtaining prior approval from AIM?

A.2. The ordering physician is always responsible for obtaining authorization from AIM prior to scheduling procedures.

Q.3. Are there situations that do not require prior approval from AIM?

A.3. Yes, there are three situations that do not require prior approval from AIM 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 approval required for emergency situations?

A.4. No. Patients who are directed to the emergency room are exempt from prior approval. It is not necessary for anyone to call AIM 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 approval nor do these services require the ordering physician to contact AIM 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 AIM.

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

A.6. To expedite the process, please have the following information ready before calling the AIM 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*;

Section 22: Utilization Review

- 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: X-rays, CT's, lab work, ultrasound, scoped procedures, 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 approval?

A.7. In many cases, especially when the caller requesting the 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.

Also, providers can perform authorization requests on line at www.RadMD.com.

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

A.8. Yes.

Q.9. What is the process for obtaining prior approval from AIM 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 AIM 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 approval from AIM 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 approval.

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

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

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

A.12. At the end of the authorization process, the AIM 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 number valid?

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

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

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.

Section 22: Utilization Review

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

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

Q.16. Who will receive the prior approval number from AIM?

A.16. On completion of the prior approval process, AIM 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 the authorization request requires additional review, AIM 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, AIM will notify the ordering physician of the decision verbally or in writing (fax or letter). If the ordering physician does not complete the prior approval process, the status will be **"transaction denied for prior approval noncompliance, no member liability"**.

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

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

Q.18. If two authorization numbers are 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 a prior approval number on the claim(s)?

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

Q.20. Is an AIM prior approval number needed for a CT-guided biopsy?

A.20. No.

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

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

Q.22. What happens if a patient is prior authorized for a CT of the abdomen, and the 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 provider should notify the patient's ordering physician of the additional test the same day, as a matter of courtesy and appropriate medical procedure. The original ordering physician should call AIM after the study is provided to proceed with the normal review process to get an additional authorization number.

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

A.23. No.

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

A.24. Yes, but the AIM 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 AIM Call Center must be contacted.

Q.25. Is a prior approval necessary when Arkansas Blue Cross, Health Advantage or BlueAdvantage (if applicable) is not the member's primary insurance?

A.25. Yes.

Section 22: Utilization Review

Q.26. How are procedures that do not require an AIM prior approval handled?

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

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

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

Q.28. What steps will the ordering provider take when the authorization is not given during the initial intake process (level 1)?

A.28. The case will be forwarded to AIM's clinical departments who will review the clinical information submitted. If needed, the clinical staff will request via fax, additional clinical information. This information can be faxed to AIM's dedicated clinical fax line. An ordering office might request a hot transfer to a nurse clinical review (level2) during the initial request, however, this should only be requested if the office has a clinician who can speak with the AIM nurses and who have additional clinical information that would support the requested study.

Q.29. If AIM denies the prior approval 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 AIM 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 AIM, the physician should request an appeal of the decision from AIM.

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

A.30. When dialing into the toll-free number, callers will hear a seven-second system greeting that identifies the AIM Specialty Health 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 approval. The entire greeting may be bypassed by immediately pressing the desired option whenever the announcement starts.

Q.31. If AIM approves prior approval of an imaging study, does this guarantee payment of the claim?

A.31. No. A prior approval does not guarantee payment or ensure coverage; it means only that the information furnished to AIM at the time indicates that the imaging study that is the subject of the prior approval meets the Primary Coverage Criteria. A claim receiving prior approval 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 AIM Call Center?

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

Section 25: Miscellaneous

Advanced Nurse Registered Practitioners - Certified Nurse Midwives, Clinical Nurse Specialists and Certified Nurse Practitioners

Effective October 1, 2005, Health Advantage expanded its covered services for Advanced Practice Registered Nurses. Advanced Practice Registered Nurses (APRNs) are registered nurses with the advanced education and clinical competency necessary for the delivery of primary health and medical care. Reimbursement for Advanced Practice Registered Nurses (APRN's), which includes Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS) and Certified Nurse Midwives (CNMs), is limited to APRN's who are licensed in the state of Arkansas and have met the requirements for and possess a certificate of prescriptive authority. The APRN must work in collaboration with the physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision.

APRN's providing services for Health Advantage members must comply with the following policy to qualify for reimbursement:

- **The APRN must have a written and signed collaborative agreement and quality assurance plan with a supervising medical doctor (MD) or doctor of osteopathy (DO).** A copy of the agreement must be provided to Health Advantage.
- The APRN must have licensure and be in good standing with Arkansas State Board of Nursing, as well as with all Health Advantage and any networks of its affiliates.
- The APRN must have prescriptive authority.
- The APRN adheres to the collaborative responsibilities by participating as a team member in the provision of medical and health care, interacting with physicians to provide comprehensive care according to established and documented protocols.
- Physicians may continue to bill for appropriate APRN services as "incident to" but cannot bill for services already submitted under the APRN's NPI. "Incident to" requires direct supervision of the physician.
- APRN services submitted by the supervising physician will be paid at the physician level to the physician.
- Services provided by APRN's are limited to those patients presenting problems of low to moderate severity and the medical decision making involved does not exceed that same level. Patients with more severe problems must be referred to physicians.
- The APRN can bill for services in a collaborative practice with a physician, but are limited to the use of E & M CPT codes 99201, 99202 and 99203 for new patients and CPT codes 99211, 99212, 99213, and 99214 for established patients. Current published guidelines for assigning CPT codes to services and documentation to support the "medical necessity" of all services must be met.
- Services performed in an inpatient/acute facility will not be paid.
- The APRN may order diagnostic laboratory and x-ray studies that are medically indicated for the level of service as indicated above in accordance with established and documented protocols.
- The service provided by the APRN must be concordant with the specialty of the supervising physician.
- Physicians may continue to bill for appropriate APRN services as "incident to" but cannot bill for services already submitted under APRN's provider number. "Incident to" requires direct supervision of the physician.
- The APRN must present him/herself so the public and other payers are fully aware of the practitioner's business operations. This includes items such as signage, letterhead and other marketing elements. Practitioner cannot be a network participant if services being provided are eligible to be billed by a facility, institution or other medical entity.
- The APRN must have professional liability coverage as required per network participation agreement (\$1 million/ \$3 million).
- The APRN must meet all other contractual requirements.

Physicians wishing to bill for services provided by an APRN to Health Advantage members should send copies of the APRN's collaborative agreement and quality assurance plan to:

Health Advantage
Division of Medical Management
P.O. Box 2181

Emergency Room Evaluation and Management and Assistant Surgery Services:

The coverage of lower level Emergency Room Evaluation and Management Services and Assistant at Surgery Services have been added to the list of payable services provided by Advanced Practice Registered Nurses effective for dates of service July 1, 2007 or after.

Low level Emergency Room Evaluation and Management codes:

- The normal scenario will be:
 - A physician or physician group is employed by the hospital to staff the emergency room;
 - The Advanced Practice Registered Nurse is employed by the physician / physician group / hospital and has a collaborative agreement with the emergency room physicians.
- Payable services are limited to less complex encounters normally provided by a physician;
- Triage services are not covered as triage services are included in the facility payment;
- If the patient is transferred to an emergency room physician, only the emergency room physician may bill for the ER visit;

Assistant at surgery services:

- Must be billed under the CNP/CNS/CMN provider number with modifier AS in the first modifier position;
- Limited to procedures approved for assistant at surgery coverage.

Copayment changes for Advanced Practice Registered Nurses:

Health Advantage will begin applying primary care copayments during claims adjudication for certain Advance Practice Registered Nurses (APRNs). APRNs must work in collaboration with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision. APRNs must also have a written collaborative practice agreement with a physician.

The distinction between primary care benefits versus specialist benefits will be based on the specialty of the collaborating physician. For example, if the written collaborative practice agreement that has been supplied to Health Advantage by the APRN during the network enrollment process is signed by a primary care physician, then that APRN will be considered a primary care APRN for benefit application/claims adjudication purposes. In most cases, Family Medicine, General Practice, Internal Medicine, and Pediatric Medicine will be considered primary care.

The copayment change was effective on April 1, 2008 for Health Advantage.

Please keep in mind that not all benefit plans make the distinction between primary care services and specialist services and that self-funded employer health plans have the option to implement or reject this benefit.

Allergy Injections:

Provided all the terms and conditions of coverage are met (including, but not limited to, the Primary Coverage Criteria), Allergy injections/services are covered in physician 's office, as well as, in an allergist 's office. The serum for the injection is covered under all Health Advantage plans. Please contact Customer Service for more specific coverage and reimbursement information.

Please note that Health Advantage does not give oral assurance of coverage prior to claims being filed and received. All coverage is always subject to final claim investigation upon receipt of the claim and all related information needed to evaluate the claim for whether it meets coverage criteria under the applicable member health plan or contract.

Coverage for R.A.S.T. testing requires a documentation and prior approval of coverage by Health Advantage.

Up to ten screening RAST tests are covered only for the evaluation of rhinitis, extrinsic asthma, extrinsic allergic alveolitis, pulmonary eosinophilia, atopic dermatitis, urticaria, anaphylactic shock due to adverse food reactions, venom or serum. Even then, they are covered only when certain conditions prevent the performance, or adversely affect the interpretation, of skin tests. Those conditions are:

- Erratic wheezing;
- Hyperreactive skin;
- Urticaria;
- Dermatographism;
- Severe eczema;
- Food anaphylaxis;
- Allergy to latex;
- Patient refuses skin testing;

Patient taking pharmacological drugs that interfere with the interpretation of skin tests and the drugs cannot be discontinued (i.e., antihistamines, tricyclic antidepressants or beta blockers).

Medical record documentation must state which of the above conditions precludes skin testing.

If the above conditions are present, up to 10 screening RAST tests will be covered. If one or more of these is unequivocally positive, up to 30 more RAST tests may be covered. A copy of the positive screening RAST test is normally the only documentation needed with the claim for coverage of the additional 30 RAST tests.

Ambulance Services – Medical Transports

Arkansas Blue Cross and Blue Shield has engaged Alacura Medical Transportation to provide medical transport network development and patient transport coordination services on behalf of our members.

In the past, Arkansas Blue Cross simply maintained a benefit cap (a maximum allowable amount) on billed medical transport services and has not maintained a formal transportation network with a fee schedule of allowable charges, as is done for other healthcare providers and medical services.

However, recent legislation – the Consolidated Appropriations Act of 2021 (CAA) – has prompted us (effective January 1, 2022) to establish a formal medical transport network with its own fee schedule.

That's where Alacura comes in. Alacura's expertise is in developing medical transport networks and working daily with medical professionals to quickly determine the most medically appropriate and cost-efficient mode of transport for each patient's individual situation. Alacura is a nationally recognized player in this field and is working to perform medical transport-related services for a dozen other Blue Cross Blue Shield Association affiliates and another 11 major health plans.

Under this new medical transport benefit, Alacura will operate a medical transport transfer center for Arkansas Blue Cross members that will be available 24 x 7 x 365.

Alacura will develop relationships with medical transport decision-makers at healthcare facilities – notifying them to call Alacura when a transport is needed. In addition, Alacura will proactively reach out to inquire about potential air transports.

Alacura will work in real time with healthcare professionals directly involved in each case to rapidly – often within seconds – agree upon and arrange the most appropriate transport mode.

Medical transport and healthcare facilities may contact Alacura to coordinate transportation or for general information at 1-844-4ALACURA (1-844-425-2287). Additional information can also be found at www.alacura.com.

Healthcare providers who have questions about the new medical transport process may contact their assigned Arkansas Blue Cross representative.

Alacura Medical Transportation is not affiliated with Arkansas Blue Cross and Blue Shield or with the Blue Cross and Blue Shield Association and is an independent company that provides medical transport network management and medical transport coordination services for Arkansas Blue Cross and its members.

Durable Medical Equipment, Prosthesis and Orthotic Appliances and Medical Supplies

Coverage for Durable Medical Equipment (DME), Prosthesis, Orthotics and medical supplies will vary for Health Advantage members, depending upon the benefit plan, and is subject to Medicare coverage guidelines. All covered services must meet the Primary Coverage Criteria and be obtained through a participating Provider listed in the current Health Advantage Provider Directory or web site, unless the member has out of network benefits. Each member's plan may have different items that require prior approval of coverage and may also have an annual limitation. Always contact customer service to access this information.

Any Provider may obtain information about Member benefit coverage by calling the Customer Service Department. Please note that Health Advantage does not give oral assurance of coverage prior to claims being filed and received. All coverage is always subject to final claim investigation upon receipt of the claim and all related information needed to evaluate the claim for whether it meets coverage criteria under the applicable member health plan or contract.

When it is more cost effective, Health Advantage (at its discretion) will purchase rather than lease equipment for Members. Please Note: Health Advantage will not, in any case, be responsible to pay any lease or rental payments in excess of the purchase price of the applicable equipment.

Coverage for DME and prosthetic devices is limited to initial acquisition and replacement or repair when Primary Coverage Criteria is met. Most Health Advantage plans have a \$5,000 calendar year limit on all DME. Check with customer service to see if the member receiving equipment has such a plan. It is the DME or Prosthetic provider's responsibility to assist in the coordination of the overall provision of health care services to Health Advantage members. This responsibility will involve the need to communicate with the member's attending physician, as well as, other providers of care, such as home health agencies, home infusion providers, or hospitals.

Reimbursement will be according to the current Participating Provider contract. Any supplies considered by Health Advantage to be part of the medical service being provided will not be reimbursed separately.

Rentals of Durable Medical Equipment (DME) should be billed using the beginning date of rental (not a date range), units of service of 1, and the Modifier RR.

- Ten monthly rental payments of DME equipment will be considered the same as a purchase of the equipment. Additional DME billings for rental and/or purchase of the item will be denied as duplicate billings.
- Low cost DME items will require purchase rather than rental.
- Satisfaction of the Primary Coverage Criteria is required for high cost DME items.
- Purchase of covered home supplies will be limited to a 90-day supply. The Medicare limitations will be used as a guide.

Excluded from coverage are:

- Personal comfort items,
- Hygiene items,
- All over the counter items,
- Disposable items, or
- Any equipment, devices, and supplies that are not primarily intended for medical use, are not covered.

Section 25: Miscellaneous

Oxygen and Supplies:

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers that oxygen reimbursement is a bundled payment. All options, supplies, and accessories are considered included in the monthly rental payment for oxygen equipment. Separately billed options, accessories or supply items will be denied as unbundling.

Oxygen accessories, including but not limited to trans-tracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the physician. Accessories used with beneficiary-owned oxygen equipment will be denied as non-covered.

Oxygen billing codes:

E1390 and E1392 includes the oxygen concentrator, an integrated battery or beneficiary-replaceable batteries that are capable of providing at least two hours of remote portability at a minimum of 2 LPM equivalency, a battery charger, an AC power adapter, a DC power adapter, and a carrying bag and/or cart. (Rental reimbursement for concentrators will be paid for up to 36 months with a maintenance period the following 24 months)

When code K0738 is billed, code E0431 (portable gaseous oxygen system, rental) must not be used. When code E0433 is billed, code E0434 (portable liquid oxygen system, rental) must not be used.

E1352 is an all-inclusive code consisting of a control unit, flow regulator, connecting hose, and nasal interface (pillows). For questions or more information, please email providerreimbursement@arkbluecross.com.

Ventilators and Supplies:

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers that ventilator reimbursement is a bundled payment. All options, supplies, and accessories are considered included in the monthly rental payment for ventilation equipment. Separately billed options, accessories or supply items will be denied as unbundling.

Reimbursement for ventilators is based on patients meeting the necessary clinical criteria.

Ventilator billing codes:

E0465 - Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)

E0466 - Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

For questions or more information, please email providerreimbursement@arkbluecross.com.

Hearing Aid Billing

Providers always should bill the monaural code (one ear) that applies to the type of hearing aid they are supplying and bill each ear separately. Providers should use Modifiers LT and/or RT on each line, whatever is applicable. One unit of service should be used per claim line. Providers should not submit a claim for a hearing aid until the aid has been placed in the member's ear — not when the order for the hearing aid is placed.

Imaging centers

CT dual auto injector equipment

In the September 2014 issue of Providers' News, Arkansas Blue Cross and Blue Shield and its affiliates, PPO Arkansas and Health Advantage published updated assessment criteria which applies to all participating imaging centers that was effective January 1, 2015. Included in the update was a specific requirement for imaging centers performing CT, CTA and CCTA which outlines the required utilization of dual auto injector equipment for contrast enhanced studies.

The rationale for requiring dual-syringe power injectors for CTs is to minimize the pooling of contrast in the injected extremity. This pooling reduces the effective contrast dose to the target organ being imaged while at the same time exposing the patient to as much as 30 percent unnecessary or non-imaged contrast dose.

As a reminder, Arkansas Blue Cross and its affiliates require all participating imaging centers to have dual-auto injector equipment in place and operational when performing any CT modality which includes CT, CTA and/or CCTA.

Laboratory Services

Physicians need to ensure that contracted reference laboratories are used if specimens are sent outside of a clinic. Arkansas Blue Cross and Blue Shield and all other affiliated companies are receiving claims from labs that are not contracted. It is a contractual obligation that all contracted providers use other contracted providers when making referrals or using outside services.

In addition, Arkansas Blue Cross and all other affiliated companies are receiving claims from out-of-state laboratories that are not contracted. The Blue Cross and Blue Shield Association claims-filing rules require that specimens collected within a Blue Plan's service area be filed directly to that local Blue Plan. Therefore, all specimens collected in Arkansas for all Blue Cross and affiliated companies' members, must be filed directly to Arkansas Blue Cross or its affiliates and subsidiaries. Claims for specimens collected in Arkansas should not be filed directly to another Blue Plan.

Ameritox, Berkeley, Genzyme, Myriad and Prometheus Labs are not contracted with Arkansas Blue Cross nor its local affiliates and subsidiaries.

If a provider needs a higher-level lab service, one that the provider does not believe can be processed within Arkansas, please first consult with some of the national labs with whom we have provider agreements. Some of them own other companies that likely may accommodate your service and are contracted with Arkansas Blue Cross and its family of companies. Please also check our Web sites to ensure that the service being ordered is covered by meeting our primary coverage criteria.

Payment for claims from out-of-network lab providers, both in state and out of state, may be denied, or at a minimum, the member will pay a higher portion.

Effective April 1, 2018, all laboratory service claims submitted require the referring provider name and NPI. The referring provider will need to be a provider registered/enrolled in the provider database of Arkansas Blue Cross or its family of companies. Listing a referring provider who is not registered with Arkansas Blue Cross will result in claim rejection or denial.

Physical Therapy, Occupational Therapy, Speech Therapy, and Chiropractic Services:

As a reminder, Health Advantage evaluates all physical and occupational therapy, whether provided by an independent therapist or by a therapist employed in a physician's office, to determine where such services meet Primary Coverage Criteria.

The treatment must significantly improve the condition of the member being treated in a reasonable period of time, pursuant to nationally established guidelines, not to exceed 60 days of progress without prior approval of coverage, and periodic assessment reports approved by Health Advantage. All services must be furnished in accordance with a written treatment plan established and certified by the treating physician. Services that exceed those guidelines are not covered. Any service that exceeds the established guidelines will be reviewed on an individual basis.

Most Health Advantage benefit certificates limit speech therapy to \$500 of eligible charges and/or 45 visits per calendar year.

Coverage of physical, occupational therapy, speech therapy, or chiropractic services are provided under the member's certificate up to 30 visits per year when Primary Coverage limitations are met. The therapy visits are counted in an aggregate fashion. Maintenance therapy is an exclusion under the member's certificate.

For Terms and Conditions required to obtain a provider agreement, please click the following link. [Network Participation Guidelines](#).

Payment reduction for multiple therapy services performed on the same day

The Centers for Medicare & Medicaid Services (CMS) completed an in-depth analysis of the practice expense of providing physical therapy, occupational therapy, and speech therapy services. Their analysis found that the practice expense of providing two or more modalities on the same day is less than the practice expense cost as reflected by the practice expense RVUs. Arkansas Blue Cross and Blue Shield uses Medicare/CMS RVUs in calculating payment for physical therapy, occupational therapy, and speech therapy services.

On October 13, 2013, Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, and Health Advantage will begin following the Medicare policy of reducing payment for the second and subsequent therapy services when multiple therapy procedures are performed on the same day. Medicare decreased multiple therapy services provided in a facility setting by 25% of the practice expense payment and those in a non-facility setting by 20% of the practice expense payment through March 31, 2013. On April 1, 2013, Medicare reduced the payment by 50% of the practice expense payment for the second and subsequent modalities.

Arkansas Blue Cross, BlueAdvantage, and Health Advantage will reduce the second and subsequent therapy procedures by 20% of the practice expense portion of the procedure, whether provided in a facility setting or a non-facility setting. When these services are provided on multiple days, each line item on the claim for the modality must be for one day only. Date spans for these procedures will not be accepted.

The therapy services included in this reduction are as follows:

CPT Code	Description
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device evaluation
92607	Ex for speech device RX, 1 hour
92609	Use of speech device service
96125	Cognitive test by HC pro
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97003	Occupational therapy, evaluation
97004	Occupational therapy, re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy e.g., microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy

CPT Code	Description
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care management training
97537	Community/work reintegration
97542	Wheelchair management training
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic management and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagnetic TX for ulcers

Physical therapy assistants & physical therapy aides

Physical therapy assistants and physical therapy aides are not recognized as providers under the Arkansas Blue Cross and Blue Shield member benefit contract. Physical therapy codes describing one-on-one contact or constant attendance are covered only when performed by a registered physical therapist or physician. Reimbursement for physical therapy codes that do not require one-on-one contact or constant attendance may be made when services are provided by an assistant working under the supervision of a

registered physical therapist or physician. Physical therapy aides are not a covered provider, even when working under the supervision of a physical therapist.

Physician Assistants

Physician Assistants (PAs) are licensed practitioners with the advanced education and clinical competency necessary for the delivery of primary health and medical care. Physician Assistants (PAs) must possess a certificate of prescriptive authority. The PA must work in collaboration with the physician to deliver health care services with medical direction and appropriate supervision.

PA's providing services to Health Advantage members must comply with the following policy to qualify for reimbursement:

- The PA must have a written and signed collaborative agreement with a supervising medical doctor (MD) or doctor of osteopathy (DO). The collaborative agreement must be with a physician whose specialty mirrors the practice of the PA (e.g., if the PA is practicing primary care medicine, the collaborative agreement must be with a Family Medicine physician or General Internist). A copy of the agreement must be provided to Health Advantage upon request.
- The PA adheres to collaborative responsibilities by participating as a team member in the provision of medical and health care, interacting with physicians to provide comprehensive care according to established and documented protocols.
- Services provided by PA's are limited to those patients presenting problems of low to moderate severity and the medical decision making involved does not exceed that same level. Patients with more severe problems must be referred to physicians.
- Current published guidelines for assigning CPT codes to services and documentation to support the "medical necessity" of all services must be met.
- Services, performed in an inpatient/acute facility, are not covered, with the exception of assistant at surgery services provided when the collaborative physician is present.
- PA's may order diagnostic laboratory and x-ray studies that are medically indicated for the level of service as indicated above in accordance with established and documented protocols.
- The service provided by the PA must be concordant with the specialty of the supervising physician.
- The PA must present him/herself so the public and other payers are fully aware of the practitioner's business operations. This includes items such as signage, letterhead and other marketing elements.

The following billing instructions apply to PAs licensed in Arkansas:

- No payments may be made directly to the PA based on the Arkansas State Medical Board Arkansas Medical Practices Acts & Regulations.
- The line item or rendering provider is listed in Block 24J on paper claims and in Loop 2310B, segment NM108 (NPI qualifier) and segment NM109 (NPI number) on electronic claims.
- The billing/pay to provider is listed in Block 33A on paper claims and in Loop 2010AA (Billing) and in loop 2010AB (Pay To) for electronic claims.
- Services provided in the provider's office and the collaborative physician is present in the office suite:
 - Services provided may be billed by the PA or by the collaborative physician (similar to Medicare's "incident to" guidelines).
 - The collaborative physician's NPI should be used as the line item provider number on CMS 1500 and 837P.
- Services provided in the provider's office and the collaborative physician is NOT present in the office suite:
 - Services should be billed by the provider of service.
 - The PA NPI should be used as the line item provider number on CMS 1500 and 837P.
- Services provided in the Emergency Room department:
 - Lower level ER visits may be billed by the provider of service.
 - This excludes triage and services for patients transferred to an ER physician.
 - The PA NPI should be used as the line item provider number on CMS 1500 and 837P.

- Services provided to patients designated as "inpatients" in a facility and the collaborative physician is NOT present or does not see the patient at another time during that day:
 - Inpatient services are not covered. All services will be denied.
 - The PA NPI used as line item provider on CMS 1500 and 837P.
- Services provided to patients designated as "inpatients" in a facility and the collaborative physician sees the patient with the PA or at another time of day
 - Only one E&M service is covered during a 24 hour day. The collaborative physician must have a brief note on the chart indicating the patient was seen; this visit should be reported under the collaborating physician's NPI.
- Services provided when acting as assistant at surgery in an inpatient or outpatient hospital or ambulatory surgery center:
 - Assistant at surgery is covered only for those CPT surgical codes for which Arkansas Blue Cross Blue Shield allows coverage for Assistant Surgeon.
 - Modifier 'AS' should be used on all line items.
 - The PA NPI should be used as the line item provider number on CMS 1500 and 837P.
- Services provided to a patient in a home setting, when the PA is NOT employed by or contracted to a Home Health agency.
 - Lower level home visits may be billed by the provider of service.
 - The PA NPI should be used as the line item provider number on CMS 1500 and 837P.

Reimbursement to PAs when the PA NPI is submitted as the line item provider is based on 75% of the corresponding physician reimbursement.

Physical therapy assistants

Arkansas Blue Cross and Blue Shield and Health Advantage member benefit certificates do not recognize physical therapy assistants as “providers” as defined in their certificates. However, Arkansas Blue Cross and Health Advantage have determined that for members covered under certificates insured or underwritten by Arkansas Blue Cross or Health Advantage, the services of physical therapy assistants may be covered if all the following conditions are met:

- Services provided by physical therapy assistants must fall within the scope and definition of covered services under the written terms of the member’s benefit certificate;
- Services provided by physical therapy assistants must not fall within the scope or definition of any exclusion in the member’s benefit certificate (other than the definition of “provider”);
- All services provided by physical therapy assistants must be supervised by a licensed physical therapist;
- Physical therapy assistants must hold an active and unrestricted license to perform physical therapy assistants services, in full compliance with applicable state laws and regulations;
- The supervising licensed physical therapist (or hospital employing the supervising licensed physical therapist) must bill for services provided by physical therapy assistants. Physical therapy assistants may not bill separately or directly for any physical therapy assistants services;
- Services provided by physical therapy assistants will not be covered or paid by Arkansas Blue Cross or Health Advantage for their insured or underwritten members if services include any evaluation or assessment services¹ or if services include the physical therapy assistants making clinical judgments or decisions regarding the member’s care or treatment;
- Services provided by physical therapy assistants will not be covered or paid by Arkansas Blue Cross or Health Advantage for their insured or underwritten members if the services include the development, management or furnishing of any skilled maintenance program services¹ or if the services include the physical therapy assistants taking or asserting overall responsibility for services;
- Services provided by physical therapy assistants will not be covered or paid by Arkansas Blue Cross or Health Advantage for their insured or underwritten members if the services are not supervised at the level appropriate to the particular setting involved, meaning that (a) at least general supervision² by a licensed physical therapist is always required and (b) direct supervision³ by a licensed physical therapist is required for any physical therapy assistants services administered outside of a hospital inpatient or hospital outpatient setting.

Special note with respect to self-funded health plans: The preceding standards may or may not apply where self-funded health benefit plan members served by Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, or Health Advantage are concerned. While some self-funded health benefit plans may choose to adopt the same approach as outlined above, others may choose to continue excluding coverage for physical therapy assistants altogether. As with all services to self-funded plan members, providers (and members) must check the terms of the specific, applicable self-funded health benefit plan’s Summary Plan Description in order to determine the specific coverage criteria of the self-funded plan with respect to physical therapy assistants or their services.

Sleep Study Centers:

Freestanding Sleep Study Centers are eligible for payment of the technical component of sleep medicine services effective January 1, 2007. If the Freestanding Sleep Study Centers meet the credentialing standards, they will be considered participating. If the Freestanding Sleep Study Centers do not meet the credentialing standards, they will be considered out of network.

Freestanding Sleep study centers must bill the technical component of sleep medicine procedures for reimbursement. The physician who interprets the study must bill for the professional component. The total components of sleep medicine procedures will be denied as incorrect coding.

Effective January 1, 2009, all facility based sleep study centers must meet the same credentialing standards or be terminated from Network participation.

Home Sleep Studies

Home sleep studies must be billed with the appropriate HCPCS code to distinguish the level of study provided. The appropriate HCPCS codes are:

Code	Description
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

HCPCS Code G0398 is the only level of sleep study covered in the home setting. Home sleep studies billed using CPT code 95806 will be denied as incorrect coding.

Telemedicine coverage update

The Arkansas Blue Cross and Blue Shield coverage policy for telemedicine covers all telemedicine services provided within the allowable scope-of-practice for the provider type performing the service. Specific requirements are noted in the Arkansas Blue Cross coverage policy 2015034, which is available on the Arkansas Blue Cross website.

Q3014 (originating site fee) is allowed in most clinical locations (as specified in the coverage policy); Q3014 is not be allowed for other locations (e.g. home, school, pharmacy) where a patient might be located during an encounter. Providers must use site-of-service 02 on professional claims; on Q3014 claims use the site-of-service where the member is physically located during the encounter. The telemedicine clinician is responsible for ensuring that a HIPAA-compliant audio-visual connection is used, and that an appropriate relationship is in place with the communication service. Email, text (including photographs), or voice-only interactions are not covered.

Telemedicine is allowed only when the service is one which can be performed remotely to the same standard of care that can be provided in a face-to-face visit. See coverage policy 2015034 for a list of codes which are covered when done by telemedicine.

Please contact your Network Development Representative with questions or concerns.

Transplant Facilities and Procedures:

Health Advantage member health plans and contracts require specific coverage approval procedures ("Prior Approval") for all transplants except kidney and cornea transplants. Before any transplant services, including transplant evaluation, are provided, a request for Prior Approval of coverage should be sent to Health Advantage.

In order to be covered, transplants must meet all terms, conditions and limitations of the member's health plan or contract, including but not limited to the Primary Coverage Criteria. In addition, to be covered, a transplant must be the subject of a specific Health Advantage Coverage Policy and the member must meet all of the required criteria necessary for coverage, as set forth in the Coverage Policy and the member's health plan or contract. Providers may access such specific Coverage Policies on the Health Advantage website, click on the link under the "Coverage Policy" section of the on-line version of this Manual.

Reimbursement for covered transplants will be affected by whether an in-network or out-of-network facility is used for the transplant, and member health plans and contracts specify clear limitations on reimbursement. Health Advantage arranges access for its members to the Blue Cross and Blue Shield Association's Blue Quality Centers for Transplant, a nationwide network of participating transplant facilities. Members receive the maximum health plan or contract benefit by utilizing a participating facility. When an out-of-network facility is used, members may be liable for charges by the facility in excess of the Health Advantage Allowance.

Reimbursement includes payment based on a Transplant Global Period and a global payment for all transplant-related services rendered during the Transplant Global Period. No payment will be made for separately-billed services related to the transplant because the global payment is deemed to include payment for all related necessary services (other than non-covered services).

A number of other specific coverage rules and criteria apply to transplants, including but not limited to specific standards for limited coverage of certain donor or harvesting services, autologous transplants, allogeneic transplants and non-myeloablative allogeneic stem cell transplantation. For a complete description of those rules and criteria, please review the transplant provisions of the applicable member health plan or contract, because coverage and any payments to providers are always subject to the health plan or contract terms.

A Note on "Prior Approval": Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the transplant meets the Primary Coverage Criteria requirements set out in the member's health plan or contract. All services, including any transplant receiving Prior Approval, must still meet all other coverage terms, conditions and limitations, and coverage for any transplant receiving Prior Approval may still be limited or denied, if, when the claims for transplant are received by us, investigation shows that a benefit exclusion or limitation applies, that the member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the member's health plan or contract.

Contact for Obtaining Prior Approval: For assistance regarding transplants for our members, and related Prior Approvals, contact Carolyn Webb, RN at 501-378-2386.