Arkansas Blue Cross and Blue Shield

Providers' News

December 2007

Inside the December Issue:

Please Note:

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

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

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

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NPI Contingency Period For Institutional Claims Ending

Arkansas Blue Cross and Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas, USAble Administrators and USAble Life is announcing that they will be following the lead of Medicare and will end their NPI contingency period for institutional claims on January 1, 2008.

Arkansas Blue Cross and its affiliates have been closely monitoring the usage of the NPI as the primary identifier on all claims submitted. The usage of the NPI on institutional claims is sufficiently high to merit the end of the NPI contingency period for claims submitted electronically in the HIPAA required 837I format and the recently adopted UB04 paper claims form.

Effective January 1, 2008, all claims received by Arkansas Blue Cross and its affiliates must include an NPI in the primary provider identifier fields on the claim (i.e., the billing and pay-to fields). Providers may continue to submit NPI / legacy pairs in these fields or submit only the NPI. Institutional claims submitted with only a legacy provider identifier in the billing provider field and/or pay-to provider field will be returned as not compliant. However, the legacy provider identifier may continue to be used in other provider fields until May 23, 2008.

Please note that this announcement does **not** pertain to the ending of the NPI contingency period for professional claims. Arkansas Blue Cross and its affiliates are continuing to monitor the NPI adoption rate for professional claims but will likely continue to follow CMS's implementation lead on requiring NPI as a primary identifier. Regardless, Arkansas Blue Cross will end the professional claims contingency period no later than the required date of May 23, 2008

Correct Coding: Sacral Nerve Neurostimulation

CPT procedure codes 64561 and 64581 describe implantation of electrodes to the sacral nerve. The allowance for these procedures includes all electrodes placed. Multiple (51) and Bilateral (50) modifiers are not valid with these procedure codes.

High Tech Radiology Imaging Centers Provider Assessment

Arkansas Blue Cross and Blue Shield has engaged National Imaging Associates (NIA) to assist in the utilization management of high-tech radiology and to also assist in the assessment of each imaging center's ability to meet the Arkansas Blue Cross criteria. All contracted imaging centers will be receiving an assessment application packet from NIA very soon. Please provide the information requested and follow the instructions about where to return this information.

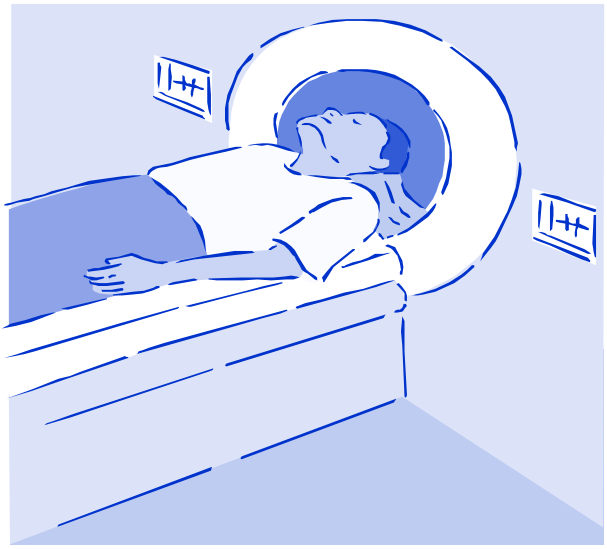
Arkansas Blue Cross Blue Shield, USAble Corporation and Health Advantage also need to announce some revisions in the Diagnostic Imaging Provider Assessment Guidelines and Standards. Based on recent revision to the ICACTL guidelines, we will now accept this accreditation. The revised guideline now reads:

> CT facilities must achieve accreditation by January 1, 2009, by the American College of Radiology (ACR), Intersocietal Commission for the Accreditation of Computed Tomography (CT) Laboratory Operations, or JCAHO (if a CT facility is hospital based and the hospital is accredited by JCAHO, this meets the accreditation requirement).

Also, we will now accept mobile units that meet accreditation requirements. The revised Mobile Services section now reads:

> Mobile services must meet the Provider Assessment Guidelines for the imaging services provided, as described in this document.

Note: Transportable Services – Medical practices that maintain multiple facilities or locations may transport their own equipment from one location to another. This must be clearly detailed on the Privileging Application.



Health Advantage Laboratory Reimbursement Changes

Effective December 1, 2007, Health Advantage laboratory reimbursement for individual physicians will be 80% of the Arkansas Blue Cross and Blue Shield fee schedule for the following counties in central Arkansas: Cleburne, Conway, Faulkner, Grant, Lonoke, Perry, Pope, Prairie, Pulaski, Saline, Van Buren, White, and Yell.

This change in reimbursement also includes the self-funded HMO network.

Pharmacy: 2008 Formulary Changes

The medications listed below will move to the third tier effective January 1, 2008 and will have a higher copayment thereafter. If a member is currently taking one of these medications, the member may choose to pay the higher copayment or the member may change to a comparable medication in the first or second copayment tier.

This change applies to Arkansas Blue Cross and its affiliate and subsidiary companies. A list of preferred or second-tier medications can be found on the following web sites:

www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com

Note: This pharmacy change does not apply to Federal Employee Program (FEP) members or Medi-Pak® choice products that include prescription drug coverage. For FEP pharmacy information, please contact the Prescription Drug Program at 1-800-624-5060 or the Mail Service Prescription Drug Program.

Tier changes include the following:

Drug Moving to Tier 3	Preferred Formulary Alternatives
Alphagan P	Travatan®; Travatan Z®; Cosopt®; brimonidine
Cenestin	Enjuvia®; generic estrogens
Enablex	Vesicare®; oxybutynin
Estraderm	Vivelle®; Vivelle-Dot®; estradiol patch
Lithium Carbonate	Lithium (generic)
Lithobid	Lithium (generic)
Rythmol SR	Propafenone
Tazorac	Tretinoin cream / gel
Testim	Androgel®
Tilade	Cromolyn sodium
Triglide	Tricor®; fenofibrate
Uniphyl	Theophylline
Vistaril	Hydroxyzine pamoate
Vospire ER	Albuterol

New Health Education Program Coming in 2008: On The Level Youth Diabetes Program

A diagnosis of childhood diabetes usually overwhelms a parent and the child with diabetes. As a provider, you now have two patients - a child with diabetes management needs and a parent who needs solid diabetes education. Arkansas Blue Cross and Blue Shield can help.

On The Level Youth Diabetes Program is a free and voluntary mail-only program that will support a provider's efforts to teach complex diabetes education. The program is available to members of Arkansas Blue Cross and Blue Shield, Health Advantage and eligible BlueAdvantage Administrators of Arkansas groups. Target date for start of the program is February, 2008.

The program is divided into 4 age groups and includes age appropriate printed materials for each age group. The materials are mailed to the parent of the child in the birth to 3 grouping, while both parent and child receive information in the 4 to 17 age levels.

Age-Specific Levels:

- Birth to 3
- 4 to 6
- 7 to 13
- 14 to17

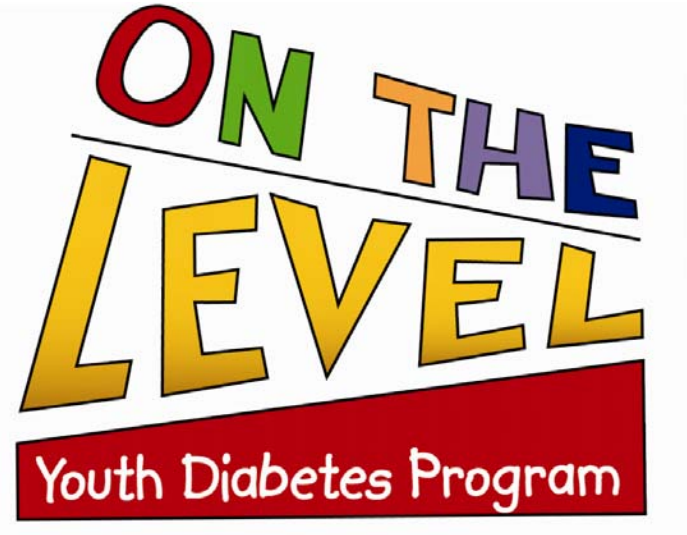
Examples of the free materials parents and patients will receive include:

- Diabetes book specific to child's age;
- Low-literacy and interactive sheets on the basics of diabetes;
- Diaries and health record booklets to track diabetes tests and meal planning;
- "Way to Grow" Growth Chart with immunization schedule;
- Diabetes School & Emergency Management Plans;
- Healthy eating and carbohydrate counting;
- Developmental stages and issues for the child with diabetes;
- Phone and Web resources that follow national diabetes standards of care;
- Life balance and coping tips for children with diabetes and their family members; and
- A Registered Nurse Case Manager to assist the parent with health plan benefits.

Children ages 4 to 17 receive free:

- Age-specific diabetes care booklets, coloring books, interactive sheets, games and puzzles related to the topic of diabetes and fun ways to stay healthy;
- Age-specific magazine series that focuses on mental & physical health.

If you have questions or have a patient and parent that might benefit from this service, please contact Margaret Fizer, RN, at (501) 399-3938 or mafizer@arkbluecross.com. The goal of Arkansas Blue Cross Health Education Program is to support our providers as they help patients learn more about diabetes care.



Arkansas State and Public School Employees: American Health Holding (AHH) Questions & Answers

On October 1, 2007, the State of Arkansas contracted with American Health Holding (AHH) (not associated with Arkansas Blue Cross and Blue Shield or Health Advantage) for precertification for the ARHealth groups (Arkansas State & Public School Employees). From the Fall Provider Workshop meetings around the state, several questions were asked about AHH and the precertification process. Below, are answers to several questions along with helpful information that's been gathered from AHH and Employee Benefits Division (EBD).

How to contact American Health Holding:

- www.AmericanHealthHolding.com
- Telephone: 1-800-592-0358
- Report difficulties to Leta Hanks, Supervisor for the Arkansas unit, 1-866-614-4244 x1169 or to the Employee Benefits Division (EBD) at 877-815-1017
- Precertification requests, admission sheets and clinical information may be faxed to 1-866-317-0166

Why does it take up to 2 days to get an authorization from AHH? Authorization can only be made once the required clinical/medical information is received. Once the information is received, AHH proceeds to provide the authorization as quickly as possible, following URAC standards.

Do dialysis centers have to precertify medications? Per EBD, if Procrit, Epogen, or iron injections are given related to dialysis, these drugs would not require precertification. If these drugs are being requested for any other treatment, a precertification is need from AHH.

Why is daily clinical information needed if the admission was approved for 3 days? If the initial stay or concurrent stay information has been received per standards and in a timely manner, daily clinical information is not required. If the information is not received, it is needed to either precert or cert additional days.

Outpatient Services

All outpatient services provided on the same date of service should be billed on the same claim form. This is especially important for surgery services for reimbursement accuracy if additional charges are identified after the original claim is submitted, a corrected claim should be submitted instead of billing a second claim with just the additional charges. Arkansas Blue Cross and Blue Shield has identified over-payments that have resulted from submission of services provided on the same date of service on multiple claim forms. Providers will be notified individually of offsets/ collections as a result of these incorrect submissions

BlueAdvantage Administrators of Arkansas to Implement an Automated Offset Process for Claim Overpayments for the Wal-Mart Account

BlueAdvantage Administrators of Arkansas will implement the following offset process for members covered under the Wal-Mart health plan effective January 1, 2008. Wal-Mart members can be identified by their member identification card which includes the Wal-Mart logo.

When claim overpayments are noted, BlueAdvantage will send a letter to the provider's payment address requesting a refund of the overpaid amount. Details in the refund request letter will be the same as they are today which includes the patient's identification and account numbers, paid date, and check/EFT number.

Providers with questions regarding the refund request should contact Customer Service immediately at the number noted on the refund request letter. Providers can either remit the overpayment amount directly back to BlueAdvantage or have the amount offset from a future payment.

Providers who agree with the overpayment determination and prefer to have the overpayment offset as soon as possible (and thus be able to 'close' the patient's account record more timely), should return the refund request letter with a message "Recoup immediately". The recoup transaction will then take place within ten (10) business days following the receipt of the provider's written instructions.

If BlueAdvantage has not received the refund request after 30-days or if a provider has notified BlueAdvantage to "Recoup immediately", then the amount of the overpayment will be withheld/offset from the provider's next claim payment. The offset details will be reported on the Remittance Advice.

Note: This offset recovery process is only available for BlueAdvantage's Wal-Mart membership at this time.

Wal-Mart Improves the Value Plan

Effective January 1, 2008, Wal-Mart Stores, Inc. will improve the Value Plan with a new feature, the health care credit. Here's how the health care credit works:

- The health care credit is an up-front medical allowance that pays for covered expenses before meeting the annual deductible.
- Associates can choose a $100, $250 or $500 health care credit.
- The health care credit does not cover routine services and other services not covered by the Value Plan.
- Each individual covered by the Value Plan has a separate health care credit.
- The provider should file a claim to the local Blue Plan to receive the payment from the health care credit.
- After the health care credit has been exhausted, claims apply to the annual deductible.
- Once the annual deductible has been met, the Value Plan will pay coinsurance benefits.

To find details of an associate's coverage, please call the number on the back of the member's ID card.

FEP Benefit Changes for 2008

The following are benefit changes for 2008 for the Federal Employees Program (FEP) Service Benefit Plan members. For a complete list of all of the changes, please refer to the FEP website www.fepblue.org

Hearing Aids:

Beginning in 2008, benefits are available for hearing aids, including bone anchored hearing aids, for children up to the age of 22. Benefits are limited to $1,000 per ear per calendar year. In addition, benefits are available for bone anchored hearing aids for adults when medically necessary due to traumatic injury or malformation of the external or middle ear. Benefits for these hearing aids are also limited to $1,000 per ear per calendar year. Benefits were not previously available for hearing aids.

Inpatient / Outpatient Hospital Care:

FEP now provides benefits for inpatient and outpatient hospital care related to the treatment of children up to the age of 22 with severe dental caries.

Home Hospice:

Under the FEP home hospice benefit, benefits are available in 2008 for pre-enrollment visits when provided by a physician employed by the hospice agency. Benefits were not available for this service in the past. In addition, FEP has clarified the prior approval process for home hospice care and the types of services covered under this benefit.

Ambulance:

There are two benefit changes for ambulance transportation in 2008. Under both Standard and Basic Options, benefits for ambulance transportation are paid in full, after a $50 per day copayment. Members were previously responsible for a $50 per trip copayment. In addition, benefits are now available for medically necessary emergency care provided at the scene when ambulance transport is not required. Benefits were not provided for this care in the past.

Morbid Obesity:

In 2008, benefits are available for office visits and diagnostic tests related to the treatment of morbid obesity. Previously, benefits were not available for these types of services for the treatment of morbid obesity.

Clarifications:

FEP has clarified information for 2008 in the Service Benefit Plan brochure for:

- Genetic testing benefits;
- Benefits for meningococcal vaccines for adults;
- Benefit limitations for refractions;
- How FEP determined the Plan allowance for Non-member inpatient hospital care and the definition in Section 10 of the 2008 Service Benefit Plan has been changed to reflect this clarification;
- The Service Benefit Plan is the primary payer for services covered by any Federal Employees Dental/Vision Insurance Program (FEDVIP) coverage FEP members have; and
- FEP rights of recovery and subrogation.

2008 Standard Option Only Benefit Changes

Under the Standard Option, the following benefit changes are effective January 1, 2008: For a complete list of all benefit changes, refer to the FEP website www.fepblue.org.

- Medco is now the Pharmacy Benefit Manager for the Mail Service Prescription Drug Program. Benefits for the Mail Service Program have not changed.
- The calendar year deductible for 2008 has increased from $250 to $300 for Self Only coverage and from $500 to $600 for Self and Family coverage.
- Under the Catastrophic Protection Benefit, the maximum in out-of-pocket expenses FEP members pay for deductibles, coinsurance and copayments, is $4,500 per year when

FEP members use Preferred providers and $6,500 per year when FEP members use Non-preferred providers. Previously the maximum was $4,000 for Preferred Provider expenses and $6,000 for Non-preferred provider expenses.

- The coinsurance amount FEP members pay for outpatient care in a Preferred hospital has increased from 10 percent to 15 percent. Benefits for outpatient facility care, except for accidental injury and maternity care, are now paid at 85 percent when the care is provided in the outpatient department of a Preferred hospital. In the past, these benefits were paid at 90 percent.
- In addition, the coinsurance amount FEP members pay for outpatient care in a Non-preferred hospital has increased from 25 percent to 30 percent. In 2008, benefits for these services provided in the outpatient department of a Non-preferred hospital will paid at 70 percent of FEP Plan allowance.

FEP: Basic Consumer Option

What Providers Should Know!

Blue Cross and Blue Shield Service Benefit Plan's is offering a new benefit option in 2008 called the Basic Consumer Option (a sub-option of Basic Option). This sub-option is a high-deductible health plan that encourages Blue Cross and Blue Shield Service Benefit Plan members (FEP) to act as consumers when spending their benefits dollars, much as they do when making any other purchasing decision. For 2008, Basic Consumer Option is offered to federal employees who live in the following four pilot areas: Ohio, Minnesota, Tennessee and Missouri – Kansas City.

Success with Basic Consumer Option requires that all partners in the health care experience be well-informed. Ultimately, our goal is not only to empower Blue Cross and Blue Shield Service Benefit Plan members with the tools needed to be smart health care "shoppers" but to help providers better understand the common features of Basic Consumer Option.

Although Arkansas Blue Cross and Blue Shield Service is not part of the pilot, a member with this option may seek services outside their local plan. If this should occur, providers should find the following information helpful about the distinct features of this plan as well as tips that will guide them when processing claims for these Blue Cross and Blue Shield Service Benefit Plan members.

Basic Consumer Option Key Features:

Network of Providers – Similar to Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option, Basic Consumer Option offers members great access to FEP network of Preferred (PPO) providers. Basic Consumer Option members must see Preferred providers in order to receive benefits, except in certain circumstances, such as emergencies.

New ID card - A valid Blue Cross and Blue Shield Service Benefit Plan Basic Consumer Option ID card is needed with the debit card.

Basic Consumer Option Self only
Basic Consumer Option Family

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Medical services - Basic Consumer Option pays 100% of covered preventive care services not subject to the deductible. Once the deductible is met, Basic Consumer Option pays 100% of the Plan allowance for all other traditional covered services.

Deductible – Basic Consumer Option has a $2,900 calendar year deductible for self only enrollments, and a $5,800 calendar year deductible for self and family enrollments. This deductible must be met before the Traditional medical coverage begins. This deductible includes both medical and pharmacy services.

Financial Components - This high deductible health plan is combined with a tax-favored Health Savings Accounts (HSA) or Health Reimbursement Arrangement (HRA) to help members better manage their healthcare costs.

Debit Card - The card allows members to pay for and track out-of-pocket costs using funds from their HSA. Not all members will have a BlueCross BlueShield debit card. Members may use any form of payment that is accepted by the provider for services.

Provider Data and Decision Support Tools – The Blue Cross and Blue Shield Service Benefit Plan provides information about healthcare providers (such as demographic, provider types/specialties, hospital affiliations, etc.) to members through the Blue Cross and Blue Shield Service Benefit Plan Online Provider Directory, available through www.fepblue.org.

In addition to searching for a provider, decision support tools on cost and hospital profile information (i.e., cost ranges by episode treatment or groupings by conditions, profile data on length of stay, and hospital volumes and complications by procedure) are available through the www.fepblue.org. This information is provided to help members make healthcare decisions.

Provider Tips:

- Carefully determine the member's financial responsibility before processing payment. Providers can access the member's ***accumulated deductible by contacting the customer service department listed on the back of the member's ID card or by using the local plan's online services.

- Ask members for their Basic Consumer Option ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable providers to submit claims with appropriate member information and avoid unnecessary claims payment delays.

- Check eligibility, benefits and claim status by using AHIN or by calling ***My Blue Line*** at 1-800-827-4814 or 501-378-2307. ***My Blue Line*** is available to participating providers 24 hours a day, 7 days a week.

Quick Tip: for faster processing, use electronic capabilities.

- If the member presents a debit card, be sure to verify the out-of-pocket amounts before processing payment. Providers may forego using the debit card and submit the claims to the local plan for processing. The provider

remit will advise the provider of member's responsibilities.

- Providers may use the debit card or any other accepted form as payment for all medical services provided in their office. These services should be billed to the local Plan and should not be applied to the debit card. Any questions about the member's benefits or to request *accumulated deductible information, providers should contact FEP at **(1-800-482-6655)**.
- For services rendered in Arkansas by the FEP BlueCross and BlueShield Service Benefit Plan for Basic Consumer Option members, these claims should be filed to:

  Arkansas Blue Cross and Blue Shield
  P.O. Box 2181
  Little Rock AR 72203

- Services are covered just as they are under the Basic Option. Contact the local Blue-Cross and BlueShield Plan for a complete description of covered benefits, exclusions and limits.

Accumulated deductible information is based on claims received to date; the information is not real-time.

FEP: Timely Filing Guidelines for Preferred and Participating Providers

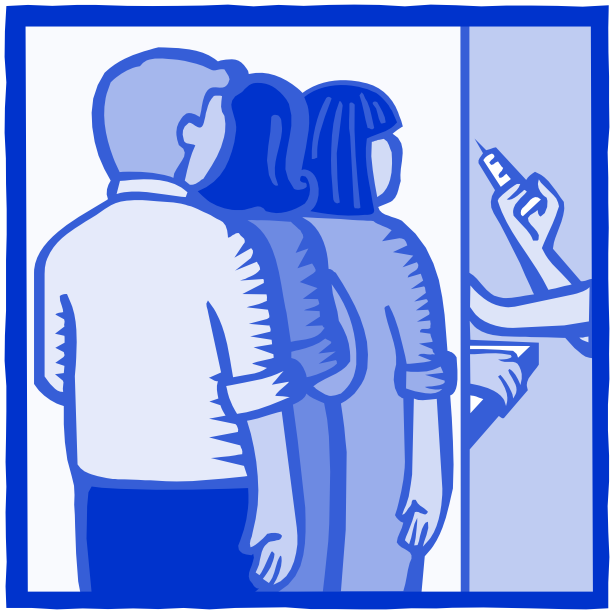
Effective January 1, 2008 process date, for preferred and participating providers, the Arkansas Blue Cross and Blue Shield timely filing claims guideline now applies to FEP.

Change in Flu Vaccine Billing

Arkansas Blue Cross and Blue Shield has added the influenza vaccine to regular benefits rather than wellness. Co-insurance and deductible will not apply, resulting in payment at 100% of the fee schedule amount for the vaccine. The administration of the flu vaccine must be billed with HCPCS procedure code G0008 to be reimbursed at 100% of the fee schedule.

Flu Shot Administration Billing:

- **ADULTS (Over 18):** HCPCS Code G0008 for the administration with diagnosis code V04.81
- **CHILDREN (18 and under):** Use the appropriate CPT Code (90465—90474) for administration with diagnosis code V20.2



Physician Connection

In the summer of 2007, physicians were introduced to two new Quality Initiatives that were planned for roll-out to PPO and HMO members of USAble Corporation and Health Advantage, respectively (as well as to members of their affiliate company, Arkansas Blue Cross and Blue Shield).

The first initiative described was a Web-based tool titled "Physician Connection", designed to measure quality of care in selected areas, and to help physicians identify quality standards in the selected areas, consistent with evidence-based guidelines. The second initiative described was the "Personal Health Record," a claims-based electronic medical record for members and physicians, with "care reminders" linked to the evidence-based guidelines measured in the "Physician Connection" tool.

Both quality initiatives have been driven by the federal government's commitment to promote transparent and higher quality health care. Specifically, the Bush administration has mandated that federal health-care agencies must implement programs measuring and comparing quality and cost of physician services. In addition, many employers have requested quality and cost information for the physicians in the networks utilized for their employee health-benefit plans. Consumers also are requesting more cost and quality information, especially with the growth of consumer-directed health plans.

Currently, Arkansas Blue Cross and Blue Shield is introducing a third initiative that also has been driven by the Bush administration and addresses comparison of cost information for physicians. This initiative seeks to measure and compare costs for physician services utilizing claims data submitted to USAble, Health Advantage or Arkansas Blue Cross and Blue Shield by physicians participating in the PPO and HMO networks.

In an attempt to provide a balanced view of every individual physician's cost efficiency, Arkansas Blue Cross and Blue Shield has employed two separate methodologies to evaluate the cost of care. The first is the "Episode Treatment Group" methodology, which is the health insurance industry standard for determining the total *cost per episode* of completed care. For example, for an uncomplicated case of bronchitis, this methodology combines the entire cost of the episode, including the direct management, lab, radiology, and pharmacy charges for an individual patient.

There are more than 700 different "Episode Treatment Groups," classified according to major practice category, and sub typed according to complications, co-morbidity, patient age, etc. From submitted claims data, Arkansas Blue Cross identified the allowed cost of services per episode of care that a physician provided during a three-year period, and derived an *average cost per episode* of care for that physician. Arkansas Blue Cross compared the observed *average cost per episode* of care to that physician's *specialty average cost per episode* of care, for the same mix (classification) of episodes. Arkansas Blue Cross derived an "Episode Treatment Group" cost efficiency index for the specific physician's practice (the observed cost divided by the specialty expected cost per episode of similar care).

The second methodology (again utilizing submitted claims data) is called the "Episode Risk Group," and this methodology derives the *cost per patient*, adjusted for the health risk of the patient. Health risk, or illness burden, is a measure of the relative resources expected to be required for a patient's medical care.

The "Episode Risk Group" methodology reviews a patient's claims history during a prolonged period of time, and combines all episodes of care for that particular patient to assign an annual "risk" score (or rating), based on the patient's co-morbidities, severity of illness, complexity of care and overall condition. The physician's *average cost per patient* with a particular "risk" score (or rating) is compared to the physician's *specialty average cost per patient* with a similar "risk" score (or rating).

Arkansas Blue Cross compared the physician's observed *average cost per patient* to the physician's *specialty average cost per patient* for a similar mix of complicated patients, to derive an "Episode Risk Group" cost efficiency index for the physician's practice. This methodology identifies and adjusts for the sicker patients in a practice, and allows physicians to be compared to other physicians in the same specialty group, who have patients with a similar level of severity of illness, complexity, and morbidity. For statistical validity, Arkansas Blue Cross and Blue Shield analyzed all claims data from a three-year period from members served by Arkansas Blue Cross and Blue Shield, USAble (Blue Advantage Administrators of Arkansas) and Health Advantage.

For "Episode Treatment Groups" Arkansas Blue Cross evaluated physician practices only if they had at least 30 complete episodes of care and, for "Episode Risk Groups," 30 patients during that three-year period. High and low "outlier" episodes of care were eliminated from the cost per episode methodology before the final score was calculated.

For the "Episode Treatment Group" cost efficiency index, outliers were eliminated if allowed costs per episode of care were greater than five times or less than one-fifth the specialty average costs per episode of care. For the "Episode Risk Group" cost efficiency index, Arkansas Blue Cross excluded any member whose allowed costs exceeded $25,000 per year. This adjustment was performed in order to avoid disadvantaging physicians whose patients used significantly higher resources (patients who had extremely costly care or who were extremely sick due to circumstances which the physician had no influence).

Both methods also were adjusted for benefits design. The overall methodology involved comprehensive review, and Arkansas Blue Cross did gain valuable input from the College of Public Health.

Arkansas Blue Cross and Blue Shield analyzed claims and developed a "Physician Cost Efficiency Index" for the following specialties. In 2008, additional specialties will be analyzed and Arkansas Blue Cross and Blue Shield will expand this initiative.

- Allergy/Immunology
- Cardiology
- Cardiovascular Surgery
- Dermatology
- Otolaryngology
- Endocrinology
- Family Practice
- Gastroenterology
- General Surgery
- Internal Medicine
- Neurology
- Neurosurgery
- Obstetrics / Gynecology
- Ophthalmology
- Orthopedics
- Pediatrics
- Pulmonary Medicine
- Urology

The "Physician Connection Cost Efficiency Logic" chart, which will appear on the member Web sites, was determined by evaluating the two methodologies: The "Episode Treatment Group" (determining cost per episode), and the "Episode Risk Group" (determining cost per patient). The "Physician Connection Cost Efficiency Logic" chart, located in the middle of Page 15, explains how the two measures of cost efficiency were used to determine the Physician Cost Efficiency Index.

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Based on the calculations under the methodologies outlined, at the present time approximately 22 percent of network physicians fall in the "less cost efficient" category, and approximately 78 percent of network physicians fall in the "cost efficient" (mid-range) or "more cost efficient" categories.

On the applicable web site for each PPO and HMO member (including Web sites of USAble/ BlueAdvantage Administrators of Arkansas Health Advantage and Arkansas Blue Cross), each physician's cost efficiency index will appear similar to the sample graph located at the bottom of page 15.

Under the terms and conditions of physicians PPO and HMO participating provider agreement, Arkansas Blue Cross is furnishing those providers receiving a rating with a copy of their "Physician Cost Efficiency Index," which is utilization and practice data that Health Advantage and USAble Corporation, the network sponsors, propose to publish to PPO and HMO members, including some who may be their patients.

Physicians may choose not to have this data released for publication. Under their network participation agreement, providers are deemed to authorize release of this information to members unless, within 30 days of the date of the letter, providers notify Arkansas Blue Cross in writing, by certified mail at the following address that the provider declines to permit release of their information to members:

Provider Network Operations
P. O. Box 2181
Little Rock, AR 72203-2181

If Arkansas Blue Cross does not receive written notice of the refusal to release the information for publication by certified mail within 30 days, providers will be deemed to have authorized its publication without further notice or authorization from them, and Arkansas Blue Cross will proceed to publish the information to members.

It is the hope and expectation of Arkansas Blue Cross that providers will want to participate in this initiative to provide meaningful information to the networks' members and their patients. However, if providers should choose for any reason to decline the planned publication of their own efficiency index rating, please understand that Arkansas Blue Cross will need to provide an explanation to members regarding the absence of data.

If a physician chooses for any reason to decline the planned publication of the cost efficiency index rating, the following message will appear in their Provider Directory listing:

'This physician has elected not to publish cost efficiency information about his/her practice on our Web site.'

Since the announcement of the Physician Cost Efficiency Index initiative in November, Arkansas Blue Cross has had questions from providers. As a result, Arkansas Blue Cross realizes that this concept is new to many of their providers and that, realistically, more time should be taken in the implementation process. Arkansas Blue Cross wants to be certain that any legitimate questions or concerns providers may have are given adequate time to be reviewed, and that the introduction of this new initiative is accomplished with maximum understanding and acceptance.

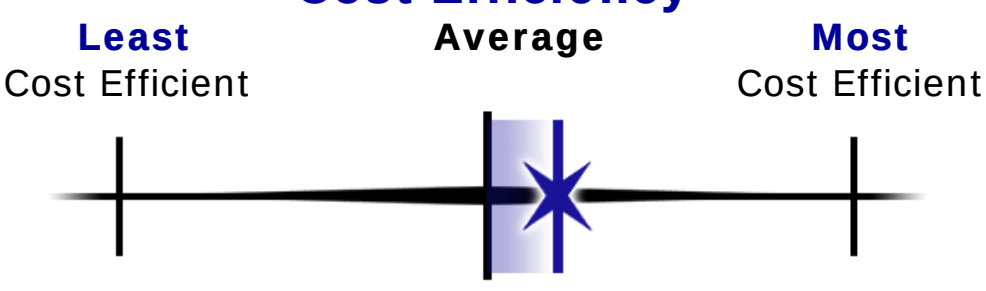
In the next several months, Arkansas Blue Cross plans to address several suggestions regarding the initiative. Arkansas Blue Cross will explore the possibility of establishing a formal, efficient appeals process for physicians to request review of their cost efficiency data. Arkansas Blue Cross also plans to review the statistical validity of the initiative's methodology with leadership from the Arkansas Medical Society. Arkansas Blue Cross is open to the idea of evaluating whether some of the terms recently incorporated into a physician rating program agreement between the New York Attorney General and insurers operating in New York state might be feasible additions to our own program here in Arkansas.

Arkansas Blue Cross and Blue Shield is temporarily delaying implementation of this program for approximately eight weeks to give physicians more time to request, receive, and review their data. Therefore, Arkansas Blue Cross will not post efficiency data on individual physicians on our websites in January 2008. Providers will receive additional correspondence extending the deadline to notify Arkansas Blue Cross if they decline to allow us to publish cost information on our member web site.

PHYSICIAN CONNECTION COST EFFICIENCY LOGIC		Cost*/episode (based on ETG's, or Episode Treatment Groups)		
		Higher than specialty	**Same as specialty**	**Lower than specialty**
Cost*/patient (based on ERG's, or Episode Risk Groups)	**Higher than specialty**	Less cost efficient	Cost efficient (mid-range)	Cost efficient (mid-range)
	NSD (no statistical difference) or same as specialty	Less cost efficient	Cost efficient (mid-range)	More cost efficient
	Lower than specialty	Cost efficient (mid-range)	Cost efficient (mid-range)	More cost efficient

*All reference to Cost includes Allowed Dollars
NOTE: The chart assumes that minimum numbers per physician are met and that statistical testing was applied

Cost Efficiency



NOTE: The graph reflects our opinion regarding relative cost-efficiency of a rated physician, based on services performed, ordered or prescribed by the rated physician, as reflected in claims data available to us. The graph ranks a rated physician on a scale from "Least" to "Most" cost efficient. Cost efficiency ratings are opinions only, based on limited claims data, and do not purport to cover all of a rated physician's practice. Some network-participating physicians may have declined to allow us to report their cost efficiency ratings; in such cases, Physician Connection will note that fact.

Intensity Modulated Radiation Therapy

Based on the increased use of the Intensity Modulated Radiation Therapy (IMRT) in non-covered situations resulting in member liability, effective February 1, 2008 coverage for IMRT services will require Pre-Service Claim Prior Approval.

Arkansas Blue Cross and Blue Shield covers IMRT for the following conditions but prior authorization is required for these covered conditions along with the request for coverage for IMRT for other conditions:

- non-metastatic prostate cancer with dose escalation greater than 75 Gy,
- treatment of radiosensitive tumors of the brain, head, neck, spine and paraspinal regions
- treatment of pleural mesothelioma if done as a component of a curative treatment regimen.

The Coverage Policy can be reviewed on the Arkansas Blue Cross and Health Advantage web sites at:

www.arkbluecross.com
www.healthadvantage-hom.com

Providers requesting a prior authorization for any conditions other than the ones listed above please submit:

- Literature documenting the rationale and effectiveness of IMRT instead of the conventional treatment techniques and literature documenting the increased safety of IMRT rather than conventional treatment techniques.
- The IMRT prescription/plan that includes definition of the field of treatment; the identification of critical structures in proximity to the treatment volume; selection of beam energy; number of ports planned; time/dose plan of therapy; estimated final target dosage; selection or combination of treatment modalities.

Pre-service claims should be submitted to the Arkansas Blue Cross and Blue Shield Medical Audit and Review Services by fax at (501) 378-6647 or mailed to P. O. Box 3688, Little Rock, Arkansas 72203. A claim receiving prior approval as a pre-service claim must still meet all other coverage terms, conditions, and limitations.

Members of BlueAdvantage Administrators of Arkansas can elect to add this prior authorization on a group-by-group basis. For example, the prior authorization does not apply to Wal-Mart members and dependents.

Also, the prior authorization of services does not apply to members of the Federal Employee Program (FEP) or Arkansas State and Public School Employees at this time. **However, the coverage policy for IMRT is applied to claims submitted for these members; therefore, Arkansas Blue Cross and Blue Shield does suggest that providers request a pre-service determination for coverage review**

Anesthesia Update

Effective January 02, 2008, the Arkansas Blue Cross and Blue Shield conversion factor for anesthesia will be increased from $42.00 per unit to $50.00 per unit.

Present On Admission Modifiers

The Present On Admission (POA) data element on electronic claims must contain the letters "POA", followed by a single POA indicator for every diagnosis that is reported. The POA indicator for the principal diagnosis should be the first indicator after "POA," and (when applicable) the POA indicators for secondary diagnoses would follow.

The last POA indicator must be followed by the letter "Z" to indicate the end of the data element (or FIs and A/B MACs will allow the letter "X" which CMS may use to identify special data processing situations in the future).

Note that on paper claims, the POA is the eighth digit of the Principal Diagnosis field (FL 67), and the eighth digit of each of the secondary diagnosis fields (FL 67 A-Q). On claims submitted electronically via 837, 4010 format, providers must use segment K3 in the 2300 loop, data element K301.

Below is an example of what this coding should look like on an electronic claim:

If segment K3 reads as follows: "POAYNUW1YZ," it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnoses. The principal diagnosis was POA (Y), the first secondary diagnosis was not POA (N), it was unknown if the second secondary diagnosis was POA (U), it is clinically undetermined if the third secondary diagnosis was POA (W), the fourth secondary diagnosis was exempt from reporting for POA (1), and the fifth secondary diagnosis was POA (Y).

Medicare began accepting the POA coding on October 1, 2007 and hospital claims must include POA coding after January 1, 2008. The following are the POA Modifiers and their meanings:

Y = Yes, present on admission
N = No, not present on admission
U = No information in the record
W = Clinically undetermined
Unreported/Not Used = Exempt from POA reporting

Listed below are helpful links for information about this POA reporting:

- http://www.nubc.org/public/whatsnew/POA.pdf
- http://www.cms.hhs.gov/Transmittals/Downloads/R1240CP.pdf
- http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf

Advanced Practice Nurses & Physician Assistants – Utilization Standards

In September of 2006 USAble Corporation and HMO Partners, Inc., d/b/a Health Advantage announced an amendment to their network terms and conditions for their respective PPO (Arkansas' FirstSource® and True Blue) and HMO (Health Advantage) provider networks. The amendment specified that certain non-physician disciplines, both as initial applicants or recredentialing network applicants, would be subject to utilization standards. At the time of publication of these standards some disciplines were inadvertently omitted from the listing of "Specific Disciplines." The networks have in fact applied and have always intended to apply the utilization standards to Advanced Practice Nurses. This notice is merely to clarify that intention, due to the administrative oversight in publication of the original version of the standards.

Additionally, since the original publication of the utilization standards, participation in the networks has been extended to physician assistants.

By publication of this article the networks' terms and conditions are hereby amended to include Advanced Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists, and Physician Assistants on the listing of "Specific Disciplines" which are covered by the utilization standards. The following is a reprint of the particular section as amended:

A. **Utilization Standards Applicable to Certain Non-Physician Disciplines**

The networks have a history of contracting with physicians, and have developed over time a number of utilization programs that physicians are required to cooperate with, and may be evaluated against. With respect to certain non-physician disciplines, however, the networks generally do not have experience with direct contracting, and therefore do not have a history of developed utilization programs for such disciplines. Until such programs can be developed, the networks have determined that the following utilization standards shall be applied to initial or recredentialing network applicants or participants in the specified non-physician disciplines:

1. **Specific Disciplines:** The non-physician disciplines (hereinafter referred to collectively as "Eligible Disciplines") covered by these utilization standards are:

- Advanced Nurse Practitioners
- Audiologists
- Certified Nurse Midwives
- Certified Orthotists
- Clinical Nurse Specialists
- Licensed Certified Social Workers
- Licensed Dietitians
- Licensed Professional Counselors
- Licensed Psychological Examiners
- Occupational Therapists
- Physical Therapists
- Physician Assistants
- Prosthetists
- Psychologists
- Respiratory Therapists
- Speech Pathologists

The full text of the terms and conditions may be viewed by accessing the following website:

http://www.healthadvantage-hmo.com/doclib/documents/providers/terms%20and%20cond%20rev_03_27_07%20_4_.pdf

Arkansas Poison Center Offers Help with Poison Exposures

The Arkansas Poison Control Center (APCC) is located in the College of Pharmacy at the University of Arkansas for Medical Sciences (UAMS). APCC is the only poison center in the state and is certified by the American Association of Poison Control Centers.

The APCC hotline number can be contacted twenty four hours a day seven days a week at **1-800-222-1222** free of charge. Please share with patients the availability of the APCC hotline number in case of a poison exposure. Some poison exposures can be prevented but not all of them. The APCC hopes that every resident of Arkansas will call in case of a poison emergency.

APCC encourages providers to have their number readily available for consultation. The APCC is staffed by registered nurses and doctors from the college of pharmacy whom are Certified Specialists in Poison Information (CSPI).

The APCC helps control the ever increasing health care costs by diverting and preventing unnecessary emergency room visits. In fact in a majority of poison exposures, treatment in a health care facility is not necessary. Frequently a call to the APCC can be managed safely at home, school or place of work thereby freeing the space of already crowded emergency rooms. Often tap water irrigation of the eyes, rinsing skin with water, or simple observation for symptoms is the only care needed.

The American Association of Poison Control Centers estimates that an average call to a poison center in the United States saves approximately $560 in unnecessary medical expenses. The APCC estimates it saved Arkansans over 5 million dollars in 2006!

The Drug Information Center, another service component of the Arkansas Poison Center, can be reached by calling 1-888-228-1233. The Center provides the following services:

1. Research and answer drug information questions for health care professionals. The Drug Information Center phone number is not to be advertised to the general public, but health care professionals are welcome to provide the phone number to individual patients who have a drug information question (other than a pill identification question).

2. Identify medications for members of law enforcement, health care professionals, and school officials. If a member of the general public calls the Drug Information Center for medication identification, the Center staff member will refer the caller to their pharmacy or physician's office so that a health care professional at one of those locations can call the center.

Directive on Services Billed by Provider Type

NOTE: 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 for electronic claims, the Billing Provider is in loop 2010AA and the Pay To in loop 2010AB. The billing provider is always required and the pay to provider is required when different from the billing provider.

Provider Type	Advanced Practice Nurses	Advanced Practice Nurses
Specialty	Advanced Nurse Practitioner Clinical Nurse Specialist	Certified Nurse Midwife
Collaborative Physician in Office Suite	Services provided may be billed incident to the Collaborative Physician. Collaborative Physician NPI used as line item provider on CMS 1500 and 837P.	Services provided may be billed incident to the Collaborative Physician. Collaborative Physician NPI used as line item provider on the CMS 1500 and 837P.
Collaborative Physician Not Present in Office Suite	Services should be billed by the provider of service. APN NPI used as line item provider on CMS 1500 and 837P. Medicare list of routine services may be billed "incident to" the Collaborative Physician. There should be NO corresponding 'incident to' billings by the Collaborative Physician for any services billed using the APN NPI.	Services should be billed by the provider of service. CNM NPI used as line item provider on the CMS 1500 and 837P. Medicare list of routine services may be billed "incident to" the Collaborative Physician. There should be NO corresponding 'incident to' billings by the Collaborative Physician NPI for any services billed using the APN NPI.
ER	Lower level ER visits may be billed by the provider of service. This excludes triage and services for patients transferred to an ER physician. APN NPI used as line item provider on CMS 1500 and 837P.	Lower level ER visits may be billed by the provider of service. This excludes triage and services for patients transferred to an ER physician. CNM NPI used as line item provider on the CMS 1500 and 837P.
Facility and Collaborative Physician not Present	Inpatient services are not covered. APN NPI used as line item provider on CMS 1500 and 837P. All services will be denied.	Collaborative Physician must be within 10 minutes of the facility AND have privileges at the facility to provide Cesarean sections. Services should be billed by the provider of service. CNM NPI used as line item provider on the CMS 1500 and 837P.
Home	Lower level home visits may be billed by the provider of service. APN NPI used as line item provider on CMS 1500 and 837P.	Lower level home visits may be billed by the provider of service. CNM NPI used as line item provider on the CMS 1500 and 837P
Home Health	Reimbursed at the RN level (least costly alternative). Home Health NPI should be used as provider number on the UB 04.	Reimbursed at RN level (least costly alternative). Home Health NPI should be used as provider number on the UB 04.
Outpatient Hospital	Assistant at surgery only. APN NPI used as line item provider on CMS 1500 and 837P. Modifier 'AS' should be used on all line items.	Assistant at surgery only. CNM NPI used as line item provider on CMS 1500 and 837P. Modifier 'AS' should be used on all line items.
ASC	Assistant at surgery only. APN NPI used as line item provider on CMS 1500 and 837P. Modifier 'AS' should be used on all line items.	Assistant at surgery only. CNM NPI used as line item provider on CMS 1500 and 837P. Modifier 'AS' should be used on all line items.

Provider Type	PT/OT	Psychotherapy or Psychiatric evaluation	Psychotherapy or Psychiatric evaluation
Specialty	Licensed Physical Therapist Licensed Occupational Therapist	Psychologist	Psychiatric Examiner Licensed Professional Counselor Licensed Clinical Social Worker
Collaborative Physician in Office Suite	Services must be provided by a licensed PT/OT, but may be billed either "incident to" the MD/DO/DC or directly by the PT/OT. Incident to- MD/DO/DC NPI as line item provider on the CMS 1500 and 837P. Directly- PT/OT NPI as line item provider on CMS 1500 and 837P.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.
Collaborative Physician Not Present in Office Suite	Services provided in the office of a PT/OT should be billed using the provider number of the licensed PT/OT as the line item provider on the CMS 1500 and 837P.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P. Psychotherapy services are, by definition, not incident-to services.
ER	Hospital bills for services provided by a licensed PT/OT employed by the hospital on the UB 04.	No covered services in an ER setting for this provider type.	No covered services in an ER setting for this provider type.
Facility and Collaborative Physician not Present	Hospital bills for services provided by a licensed PT/OT employed by the hospital on the UB 04.	No covered services in a facility setting for this provider type.	No covered services in a facility setting for this provider type.
Home	Services provided in the home by a PT/OT should be billed using the provider number of the licensed PT/OT as the line item provider on the CMS 1500 and 837P.	No covered services in a Home setting for this provider type.	No covered services in a Home setting for this provider type.
Home Health	Reimbursed at Home Health PT/OT rate (least costly alternative). Home Health NPI should be used as provider number on the UB 04.	No covered services in a Home Health setting for this provider type.	No covered services in a Home Health setting for this provider type.
Outpatient Hospital	Hospital bills for services provided by a licensed PT/OT employed by the hospital on the UB 04.	No covered services in an outpatient setting for this provider type.	No covered services in an outpatient setting for this provider type.
ASC	PT/OT services are not covered in an ambulatory surgery setting.	No covered services in an ASC setting for this provider type.	No covered services in an ASC setting for this provider type.

Provider Type	Advanced Practice Nurses	Speech Language Pathology
Specialty	CRNA	Speech Therapist
Collaborative Physician in Office Suite	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.
Collaborative Physician Not Present in Office Suite	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.
ER	No covered services in an ER setting for this provider type.	No covered services in an ER setting for this provider type.
Facility and Collaborative Physician not Present	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.	No covered services in a facility setting for this provider type.
Home	No covered services in a Home setting for this provider type.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.
Home Health	No covered services in a Home Health setting for this provider type.	No covered services in a Home Health setting for this provider type.
Outpatient Hospital	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.	No covered services in an outpatient setting for this provider type.
ASC	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.	No covered services in an ASC setting for this provider type.

Provider Type	Physician Assistant (PA)	Audiologist
Specialty	Physician Assistant	Audiologist
Collaborative Physician in Office Suite	Services provided may be billed incident to the Collaborative Physician. Collaborative Physician provider number used as line item provider on CMS 1500 and 837P.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.
Collaborative Physician Not Present in Office Suite	Services should be billed by the provider of service. PA provider number used as line item provider on the CMS 1500 and 837P. Medicare list of routine services may be billed "incident to" the Collaborative Physician. Pay to NPI of collaborative physician or clinic must be provided. No payments may be made directly to the PA. There should be NO corresponding 'incident to' billings by the Collaborative Physician for any services billed using the PA NPI.	Services must be billed under the provider number of the provider of service as the line item provider on the CMS 1500 and 837P.
ER	Lower level ER visits may be billed by the provider of service. This excludes triage and services for patients transferred to an ER physician. Pay to NPI of collaborative physician or clinic must be provided. No payments may be made directly to the PA.	No covered services in an ER setting for this provider type.
Facility and Collaborative Physician not Present	No covered services in a facility setting for this provider type.	No covered services in a facility setting for this provider type.
Home	Lower level home visits may be billed by the provider of service. Pay to NPI of collaborative physician or clinic must be provided. No payments may be made directly to the PA.	No covered services in a Home setting for this provider type.
Home Health	Reimbursed at the RN level (least costly alternative). Home Health NPI should be used as provider number on the UB 04.	No covered services in a Home Health setting for this provider type.
Outpatient Hospital	Assistant at surgery only. Pay to NPI of collaborative physician or clinic must be provided. No payments may be made directly to the PA.	No covered services in an outpatient setting for this provider type.
ASC	Assistant at surgery only. Pay to NPI of collaborative physician or clinic must be provided. No payments may be made directly to the PA.	No covered services in an ASC setting for this provider type.

Access Only PPO Customers of USAble Cooperation Effective January 1, 2008

Group Name	Network
Aalf's Manufacturing Inc / Midland's Choice	Arkansas' FirstSource PPO
Anchor Packaging / Hermann Co.	True Blue PPO—Effective 1/1/06
Ark Sheet Metal Workers -Local #36-L	Arkansas' FirstSource PPO
Arkansas Pipe Trades Health & Welfare	True Blue PPO— Effective 01/01/07
Arkansas State University Athletes	Arkansas' FirstSource PPO
Arvest Bank	True Blue PPO—Effective 1/1/06
Ashley County Medical Center	Arkansas' FirstSource PPO
BEKAERT - Rogers, AR Location	Arkansas' FirstSource PPO
BEKAERT - Van Buren, AR Location	Arkansas' FirstSource PPO
Boar's Head Provisions Co	Arkansas' FirstSource PPO
Brentwood Industries, Inc	Arkansas' FirstSource PPO
Bryce Corporation	True Blue PPO—Effective 11/01/06
Columbia Forest Products	True Blue PPO—Effective 01/01/06
Diocese Of Little Rock / Christian Brothers	Arkansas' FirstSource PPO
Franklin Electric	Arkansas' FirstSource PPO
Harps Food Stores	True Blue PPO—Effective 06/01/06
Iberia Bank	True Blue PPO—Effective 03/01/07
KLA Benefits/Klipsch LLC	Arkansas' FirstSource PPO
LA Darling	True Blue PPO—Effective 01/01/06
Levi Hospital	Arkansas' FirstSource PPO
Magnolia Hospital	Arkansas' FirstSource PPO
Marshalltown Company	Arkansas' FirstSource PPO
Maverick Tube Corp	True Blue PPO—Effective 08/01/06
Motor Appliance Corporation	Arkansas' FirstSource PPO
Nestle USA	True Blue PPO—Effective 08/01/06

Group Name	Network
Odom's Tennessee Pride Sausage	Arkansas' FirstSource PPO
Peterson Manufacturing / Mission Plas	Arkansas' FirstSource PPO
Rea Magnet Wire Co	Arkansas' FirstSource PPO
Siplast Inc	Arkansas' FirstSource PPO
St. Michael Healthcare - Cobra	Arkansas' FirstSource PPO
St. Michael CH Wilkerson - Texarkana	Arkansas' FirstSource PPO
St. Michael Healthcare-Hosp	Arkansas' FirstSource PPO
St. Michael Healthcare-Rehab	Arkansas' FirstSource PPO
Stevens Media Group	True Blue PPO—Effective 01/01/06
Town & Country Grocers / Price Chopper	Arkansas' FirstSource PPO
Townsend Foods	True Blue PPO—Effective 01/01/06
UFCW (Kroger & Consumer Market)	True Blue PPO—Effective 10/01/05
Wabash National / Cloud Corp	Arkansas' FirstSource PPO

Groups Terminated Since January 1, 2006	Termination Date
Arkansas Carpenters Health & Welfare Fund	Term Effective 05/31/07
Bridgestone - Firestone	Term Effective 12/31/07
Defiance Metals	Term Effective 12/31/07 Changing to BlueCard 01/01/08
FedEx Freight East, Inc (Formerly American Freightways)	Term Effective 12/31/06
Genmar - Ranger Boats	Term Effective 12/31/06
Harding University	Term Effective 12/31/06 Changing to Blue Advantage
Southern Painters Welfare	Term Effective 05/31/06
Wallace & Owens	Moved to BlueCard 08/01/06

Coverage Policy Manual Updates

The following policies have been added to the Arkansas Blue Cross and Blue Shield Coverage Policy Manual or coverage has changed since September 2007. Other revised policies are not listed here because no change was made in coverage/non-coverage. To view the entire policy, providers can access the coverage policies at www.arkbluecross.com .

Policy #	Policy Title and Information
1997026	Blepharoplasty/Blepharoptosis
1998099	Electrical Stimulation, Deep Brain (e.g. Parkinsonism, multiple sclerosis, post-traumatic dyskinesia)
1997103	Multiple Sclerosis, Immunomodulating Drugs
1997128	Leuprolide (Lupron)
2002029	Implantable Bone Conduction Hearing Aids
1997126	Low Level Laser Therapy (LLLT)
2006016	Rituximab (Rituxan), Off-label Use
2004029	Genetic Testing, Breast Cancer: Risk Recurrence to Determine Need for Adjuvant Therapy (Oncotype DX)
2007008	Genetic Testing, Breast cancer: Detection of Lymph Node Metastases (GeneSearch)
2007012	Genetic Testing, Breast Ca_Predict Need_Adjuvant Chemotherapy, Assessment of Risk of Distant Metastasis (Mammaprint)
2007011	Genetic Testing: Mod OP (KIT, CD117)(gastrointestinal stromal tumor)
2007015	Genetic Testing: Warfarin Dose/Response
2007016	Genetic Testing: Amyotrophic Lateral Sclerosis

Fee Schedule Updates

The following CPT/HCPCS codes were updated in the Arkansas Blue Cross Fee Schedule.

CPT/ HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
82274	$ 9.38	$ 0.66	$ 8.72	$ -	$ 0.66	$ -
88321	$ 145.83	$ -	$ -	$ 131.60	$ 131.60	$ -
90723	$ 70.73	$ -	$ -	$ -	$ -	$ -

CPT/ HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
90885	$ -	$ -	$ -	$ -	$ -	$ -
90885	$ -	$ -	$ -	$ -	$ -	$ -
97039	BR	$ -	$ -	$ -	$ -	$ -
0062T	$ 2,288.99	$ -	$ -	$ 511.79	$ -	$ -
0063T	$ 1,809.60	$ -	$ -	$ 242.00	$ -	$ -
0067T	BR	BR	BR	BR	BR	BR
1050F	$ -	$ -	$ -	$ -	$ -	$ -
1116F	$ -	$ -	$ -	$ -	$ -	$ -
2029F	$ -	$ -	$ -	$ -	$ -	$ -
2035F	$ -	$ -	$ -	$ -	$ -	$ -
3215F	$ -	$ -	$ -	$ -	$ -	$ -
3216F	$ -	$ -	$ -	$ -	$ -	$ -
3219F	$ -	$ -	$ -	$ -	$ -	$ -
3220F	$ -	$ -	$ -	$ -	$ -	$ -
3230F	$ -	$ -	$ -	$ -	$ -	$ -
3260F	$ -	$ -	$ -	$ -	$ -	$ -
4130F	$ -	$ -	$ -	$ -	$ -	$ -
4131F	$ -	$ -	$ -	$ -	$ -	$ -
4132F	$ -	$ -	$ -	$ -	$ -	$ -
4133F	$ -	$ -	$ -	$ -	$ -	$ -
4134F	$ -	$ -	$ -	$ -	$ -	$ -
4135F	$ -	$ -	$ -	$ -	$ -	$ -
4136F	$ -	$ -	$ -	$ -	$ -	$ -
4150F	$ -	$ -	$ -	$ -	$ -	$ -
4151F	$ -	$ -	$ -	$ -	$ -	$ -
4152F	$ -	$ -	$ -	$ -	$ -	$ -
4153F	$ -	$ -	$ -	$ -	$ -	$ -
4154F	$ -	$ -	$ -	$ -	$ -	$ -
4155F	$ -	$ -	$ -	$ -	$ -	$ -
4156F	$ -	$ -	$ -	$ -	$ -	$ -
4157F	$ -	$ -	$ -	$ -	$ -	$ -
4158F	$ -	$ -	$ -	$ -	$ -	$ -

CPT/ HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
4159F	$ -	$ -	$ -	$ -	$ -	$ -
C9236	$ -	$ -	$ -	$ -	$ -	$ -
E0619	$ 2,803.50	$ 280.35	$ 2,102.63	$ -	$ -	$ -
G0328	$ 6.81	$ 0.48	$ 6.33	$ -	$ 0.48	$ -
G8370	BR	$ -	$ -	$ -	$ -	$ -
G8371	BR	$ -	$ -	$ -	$ -	$ -
G8372	BR	$ -	$ -	$ -	$ -	$ -
G8372	BR	$ -	$ -	$ -	$ -	$ -
G8374	BR	$ -	$ -	$ -	$ -	$ -
G8375	BR	$ -	$ -	$ -	$ -	$ -
G8376	BR	$ -	$ -	$ -	$ -	$ -
G8377	BR	$ -	$ -	$ -	$ -	$ -
G8378	BR	$ -	$ -	$ -	$ -	$ -
G8379	BR	$ -	$ -	$ -	$ -	$ -
G8380	BR	$ -	$ -	$ -	$ -	$ -
G8381	BR	$ -	$ -	$ -	$ -	$ -
G8382	BR	$ -	$ -	$ -	$ -	$ -
G8383	BR	$ -	$ -	$ -	$ -	$ -
G8384	BR	$ -	$ -	$ -	$ -	$ -
G8385	BR	$ -	$ -	$ -	$ -	$ -
G8386	BR	$ -	$ -	$ -	$ -	$ -
G8387	BR	$ -	$ -	$ -	$ -	$ -
G8388	BR	$ -	$ -	$ -	$ -	$ -
G8389	BR	$ -	$ -	$ -	$ -	$ -
G8390	BR	$ -	$ -	$ -	$ -	$ -
G8391	BR	$ -	$ -	$ -	$ -	$ -
J3487	$ 206.14	$ -	$ -	$ -	$ -	$ -
L3808	BR	$ -	$ -	$ -	$ -	$ -
L3808	BR	$ -	$ -	$ -	$ -	$ -
S0180	$ 523.00	$ -	$ -	$ -	$ -	$ -
S8948	$ 23.00	$ -	$ -	$ 15.00	$ -	$ -
S8948	$ 23.00	$ -	$ -	$ 15.00	$ -	$ -

Fee Schedule: Injection Codes

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

CPT / HCPCS Code	Current Fee	Update Fee
90371	$ 126.11	$ 128.11
90375	$ 71.28	$ 71.62
90376	$ 74.56	$ 75.27
90378	$ 708.32	$ 728.94
90385	$ 6.89	$ 9.95
90585	$ 125.47	$ 124.92
90586	$ 120.61	$ 119.43
90632	$ 47.38	$ 45.46
90633	$ 25.66	$ 27.30
90636	$ 81.33	$ 82.83
90645	$ 22.08	$ 22.28
90647	$ 22.08	$ 22.28
90649	$ 120.75	$ 120.50
90655	$ 15.99	$ 15.99
90656	$ 17.24	$ 18.61
90657	$ 6.56	$ 15.99
90658	$ 13.13	$ 15.99
90669	$ 77.69	$ 81.96
90691	$ 57.96	$ 58.96
90700	$ 32.97	$ 32.33
90702	$ 22.40	$ 21.10
90703	$ 20.68	$ 21.05
90706	$ 18.38	$ 18.67
90707	$ 44.24	$ 44.95
90713	$ 27.30	$ 27.17
90714	$ 19.79	$ 20.21
90715	$ 35.18	$ 36.58

CPT / HCPCS Code	Current Fee	Update Fee
90716	$ 75.66	$ 78.33
90718	$ 15.02	$ 13.75
90732	$ 28.11	$ 30.92
90740	$ 117.62	$ 119.09
90746	$ 58.81	$ 59.55
90747	$ 117.62	$ 119.10
J0130	$ 444.03	$ 441.13
J0132	$ 2.17	$ 2.20
J0135	$ 336.15	$ 346.03
J0150	$ 25.08	$ 26.35
J0152	$ 71.80	$ 71.28
J0170	$ 0.97	$ 1.01
J0180	$ 18.32	$ 132.29
J0210	$ 10.50	$ 13.70
J0215	$ 27.20	$ 27.79
J0256	$ 3.52	$ 3.45
J0270	$ 2.04	$ 1.91
J0275	$ 17.80	$ 24.73
J0278	$ 1.23	$ 1.13
J0282	$ 0.31	$ 0.20
J0287	$ 10.89	$ 10.92
J0289	$ 17.91	$ 17.02
J0290	$ 2.50	$ 2.46
J0295	$ 6.33	$ 5.20
J0300	$ 2.71	$ 2.26
J0360	$ 7.42	$ 8.20
J0364	$ 3.13	$ 3.35

CPT / HCPCS Code	Current Fee	Update Fee
J0365	$ 2.78	$ 2.79
J0380	$ 1.07	$ 1.36
J0460	$ 0.19	$ 0.69
J0475	$ 204.93	$ 202.94
J0476	$ 72.58	$ 73.21
J0500	$ 14.30	$ 16.47
J0515	$ 3.29	$ 4.05
J0530	$ 14.35	$ 14.37
J0540	$ 29.76	$ 30.90
J0550	$ 29.76	$ 36.37
J0580	$ 49.44	$ 47.58
J0587	$ 7.40	$ 9.06
J0594	$ 9.51	$ 9.63
J0595	$ 0.71	$ 0.57
J0600	$ 52.19	$ 52.12
J0636	$ 0.61	$ 0.40
J0637	$ 28.74	$ 25.25
J0640	$ 1.09	$ 1.16
J0670	$ 1.40	$ 1.44
J0690	$ 1.47	$ 1.52
J0694	$ 7.98	$ 8.51
J0706	$ 3.21	$ 2.40
J0713	$ 4.02	$ 3.95
J0715	$ 4.75	$ 5.02
J0720	$ 4.27	$ 16.78
J0725	$ 3.82	$ 3.78
J0735	$ 59.75	$ 65.91
J0743	$ 14.11	$ 13.99
J0744	$ 2.84	$ 2.54
J0745	$ 1.19	$ 1.27
J0760	$ 4.81	$ 5.08

CPT / HCPCS Code	Current Fee	Update Fee
J0770	$ 22.11	$ 20.76
J0780	$ 1.90	$ 1.54
J0800	$ 164.15	$ 178.24
J0835	$ 66.69	$ 67.20
J0850	$ 901.25	$ 913.98
J0881	$ 3.17	$ 3.03
J0882	$ 3.22	$ 3.03
J0885	$ 9.47	$ 9.42
J0886	$ 9.47	$ 9.42
J0894	$ 27.54	$ 27.99
J0895	$ 14.47	$ 14.03
J0970	$ 31.66	$ 38.42
J1000	$ 1.40	$ 6.06
J1020	$ 2.25	$ 2.34
J1051	$ 6.12	$ 6.19
J1055	$ 42.40	$ 36.00
J1080	$ 12.51	$ 12.84
J1100	$ 0.12	$ 0.13
J1110	$ 24.46	$ 523.37
J1120	$ 17.47	$ 18.13
J1160	$ 1.20	$ 1.02
J1165	$ 0.61	$ 0.34
J1170	$ 2.23	$ 0.97
J1190	$ 175.24	$ 170.20
J1205	$ 136.49	$ 143.94
J1212	$ 44.69	$ 52.90
J1240	$ 3.19	$ 3.53
J1245	$ 1.54	$ 1.39
J1250	$ 5.17	$ 5.12
J1260	$ 5.61	$ 4.90
J1265	$ 0.84	$ 0.88

CPT / HCPCS Code	Current Fee	Update Fee
J1270	$ 2.66	$ 2.60
J1325	$ 15.08	$ 15.10
J1327	$ 14.00	$ 18.55
J1335	$ 24.99	$ 25.20
J1364	$ 6.61	$ 6.78
J1390	$ 1.40	$ 19.09
J1440	$ 198.10	$ 202.10
J1441	$ 312.50	$ 313.28
J1450	$ 10.98	$ 10.22
J1451	$ 13.45	$ 13.44
J1455	$ 10.61	$ 10.77
J1457	$ 1.56	$ 1.69
J1460	$ 10.79	$ 11.65
J1470	$ 21.58	$ 23.30
J1480	$ 32.37	$ 34.95
J1490	$ 43.16	$ 46.25
J1500	$ 53.95	$ 57.90
J1510	$ 64.74	$ 69.55
J1520	$ 75.53	$ 81.20
J1530	$ 86.32	$ 92.85
J1540	$ 97.11	$ 104.50
J1550	$ 107.90	$ 116.50
J1566	$ 34.88	$ 28.24
J1567	$ 39.58	$ 42.45
J1570	$ 43.34	$ 45.06
J1580	$ 1.15	$ 0.72
J1595	$ 53.75	$ 54.64
J1600	$ 8.09	$ 8.10
J1610	$ 65.11	$ 70.00
J1626	$ 6.65	$ 6.02
J1630	$ 2.05	$ 1.98

CPT / HCPCS Code	Current Fee	Update Fee
J1631	$ 5.04	$ 5.10
J1640	$ 7.36	$ 7.04
J1645	$ 11.61	$ 11.73
J1650	$ 6.01	$ 5.97
J1652	$ 6.32	$ 6.22
J1655	$ 2.51	$ 2.42
J1670	$ 105.00	$ 108.62
J1720	$ 2.03	$ 2.04
J1730	$ 116.33	$ 107.85
J1740	$ 144.43	$ 144.52
J1742	$ 283.20	$ 301.48
J1745	$ 55.77	$ 57.13
J1752	$ 10.81	$ 10.82
J1756	$ 0.39	$ 0.38
J1785	$ 4.08	$ 3.70
J1790	$ 1.13	$ 1.06
J1800	$ 4.36	$ 4.01
J1817	$ 2.61	$ 2.62
J1825	$ 267.47	$ 208.43
J1830	$ 69.90	$ 111.89
J1835	$ 41.20	$ 41.66
J1840	$ 1.85	$ 4.22
J1885	$ 0.49	$ 0.45
J1940	$ 0.28	$ 0.26
J1950	$ 480.57	$ 475.17
J1955	$ 8.54	$ 6.19
J1956	$ 7.21	$ 6.32
J1980	$ 9.38	$ 9.28
J2010	$ 3.69	$ 4.06
J2020	$ 26.42	$ 26.43
J2060	$ 1.20	$ 1.06

CPT / HCPCS Code	Current Fee	Update Fee
J2150	$ 1.07	$ 1.00
J2175	$ 2.02	$ 1.21
J2180	$ 3.94	$ 4.72
J2185	$ 3.83	$ 3.84
J2210	$ 5.22	$ 5.24
J2248	$ 1.63	$ 1.49
J2250	$ 0.25	$ 0.24
J2270	$ 2.71	$ 2.78
J2271	$ 3.87	$ 4.00
J2275	$ 6.64	$ 7.09
J2278	$ 6.72	$ 6.78
J2280	$ 3.31	$ 3.25
J2300	$ 1.18	$ 1.42
J2310	$ 2.09	$ 2.50
J2320	$ 3.12	$ 3.61
J2321	$ 6.35	$ 5.93
J2322	$ 12.44	$ 13.46
J2325	$ 32.97	$ 33.32
J2353	$ 102.66	$ 103.98
J2354	$ 2.57	$ 2.41
J2355	$ 259.74	$ 259.35
J2357	$ 17.80	$ 17.98
J2360	$ 12.39	$ 11.06
J2370	$ 0.68	$ 0.61
J2400	$ 15.76	$ 15.04
J2405	$ 0.40	$ 0.27
J2410	$ 2.54	$ 2.57
J2425	$ 11.81	$ 11.80
J2430	$ 31.04	$ 29.72
J2440	$ 0.58	$ 0.56
J2469	$ 17.27	$ 17.28

CPT / HCPCS Code	Current Fee	Update Fee
J2501	$ 3.92	$ 4.02
J2503	$ 1,089.39	$ 1,087.37
J2504	$ 184.95	$ 190.00
J2505	$ 2,270.91	$ 2,252.17
J2513	$ 13.20	$ 12.72
J2515	$ 5.44	$ 6.26
J2540	$ 0.84	$ 0.87
J2543	$ 5.25	$ 5.29
J2545	$ 47.97	$ 51.39
J2550	$ 1.96	$ 1.70
J2560	$ 3.27	$ 3.43
J2590	$ 2.09	$ 2.26
J2597	$ 2.52	$ 2.18
J2675	$ 1.57	$ 1.70
J2680	$ 2.68	$ 2.00
J2690	$ 2.49	$ 2.78
J2700	$ 1.56	$ 1.52
J2710	$ 0.11	$ 0.34
J2720	$ 0.47	$ 0.51
J2730	$ 70.59	$ 36.96
J2760	$ 24.71	$ 24.48
J2765	$ 0.49	$ 0.42
J2780	$ 0.65	$ 0.63
J2783	$ 148.55	$ 144.70
J2788	$ 27.16	$ 27.73
J2790	$ 83.26	$ 84.82
J2792	$ 16.84	$ 16.40
J2794	$ 5.08	$ 4.77
J2800	$ 11.35	$ 10.71
J2805	$ 54.53	$ 54.88
J2820	$ 25.56	$ 26.10

CPT / HCPCS Code	Current Fee	Update Fee
J2916	$ 4.90	$ 5.02
J2930	$ 3.15	$ 3.36
J2941	$ 50.44	$ 50.94
J2993	$ 897.76	$ 883.27
J2997	$ 34.90	$ 35.06
J3010	$ 0.37	$ 0.36
J3030	$ 64.47	$ 64.33
J3070	$ 5.34	$ 5.12
J3100	$ 2,128.78	$ 2,136.19
J3105	$ 2.13	$ 3.08
J3110	$ 8.11	$ 8.52
J3120	$ 5.33	$ 5.39
J3130	$ 10.66	$ 10.79
J3230	$ 2.89	$ 3.63
J3246	$ 7.59	$ 7.94
J3250	$ 4.69	$ 4.51
J3260	$ 2.27	$ 1.74
J3301	$ 1.58	$ 1.55
J3303	$ 2.19	$ 1.57
J3315	$ 175.00	$ 167.34
J3355	$ 53.21	$ 52.72
J3360	$ 0.82	$ 0.81
J3370	$ 3.15	$ 3.55
J3396	$ 9.30	$ 9.43
J3410	$ 0.20	$ 0.19
J3411	$ 2.27	$ 2.38
J3415	$ 3.85	$ 3.93
J3420	$ 0.32	$ 0.28
J3430	$ 0.61	$ 3.41
J3465	$ 5.24	$ 5.07
J3470	$ 16.91	$ 16.97

CPT / HCPCS Code	Current Fee	Update Fee
J3473	$ 0.41	$ 0.42
J3480	$ 0.02	$ 0.04
J3485	$ 1.08	$ 1.13
J3486	$ 5.30	$ 5.29
J7030	$ 1.12	$ 1.17
J7040	$ 0.56	$ 0.58
J7042	$ 0.40	$ 0.42
J7050	$ 0.28	$ 0.29
J7060	$ 1.43	$ 1.41
J7070	$ 2.85	$ 2.83
J7100	$ 15.34	$ 15.80
J7110	$ 8.99	$ 12.99
J7120	$ 0.92	$ 0.96
J7187	$ 0.93	$ 0.93
J7189	$ 1.19	$ 1.20
J7197	$ 1.72	$ 1.91
J7198	$ 1.48	$ 1.49
J7302	$ 412.23	$ 468.71
J7306	$ 412.23	$ 468.71
J7308	$ 115.88	$ 115.41
J7310	$ 4,500.00	$ 4,942.84
J7340	$ 29.92	$ 29.87
J7341	$ 1.88	$ 2.00
J7343	$ 20.24	$ 21.23
J7344	$ 99.49	$ 99.25
J7345	$ 65.26	$ 61.92
J7346	$ 809.73	$ 813.11
J7500	$ 0.20	$ 0.15
J7501	$ 52.41	$ 50.27
J7502	$ 3.68	$ 3.69
J7504	$ 357.08	$ 352.87

CPT / HCPCS Code	Current Fee	Update Fee
J7505	$ 980.03	$ 952.20
J7506	$ 0.17	$ 0.18
J7509	$ 0.09	$ 0.08
J7511	$ 349.45	$ 354.68
J7513	$ 329.35	$ 338.36
J7515	$ 0.95	$ 0.94
J7516	$ 20.96	$ 20.07
J7518	$ 2.36	$ 2.45
J7614	$ 0.83	$ 0.91
J7620	$ 0.14	$ 1.12
J7626	$ 4.93	$ 4.54
J7682	$ 63.17	$ 57.55
J8501	$ 5.26	$ 5.24
J8515	$ 15.15	$ 17.96
J8520	$ 3.15	$ 4.50
J8521	$ 14.36	$ 14.90
J8530	$ 1.02	$ 1.00
J8560	$ 30.82	$ 30.93
J8610	$ 0.26	$ 0.24
J9000	$ 6.37	$ 6.58
J9001	$ 414.18	$ 410.50
J9017	$ 32.32	$ 33.63
J9025	$ 4.48	$ 4.21
J9031	$ 120.61	$ 119.43
J9035	$ 59.83	$ 59.77
J9040	$ 40.92	$ 35.00
J9045	$ 9.23	$ 7.81
J9055	$ 51.83	$ 51.89
J9060	$ 2.58	$ 2.56
J9062	$ 12.89	$ 12.79
J9065	$ 36.34	$ 33.64

CPT / HCPCS Code	Current Fee	Update Fee
J9070	$ 2.04	$ 2.01
J9080	$ 4.08	$ 4.01
J9090	$ 18.26	$ 17.56
J9091	$ 20.41	$ 20.05
J9092	$ 40.82	$ 40.11
J9093	$ 2.05	$ 1.99
J9094	$ 4.10	$ 3.99
J9095	$ 10.25	$ 9.97
J9096	$ 20.51	$ 19.94
J9097	$ 40.96	$ 39.88
J9100	$ 1.82	$ 1.90
J9110	$ 9.07	$ 9.50
J9120	$ 513.17	$ 475.00
J9130	$ 5.07	$ 5.49
J9140	$ 10.14	$ 10.98
J9150	$ 20.73	$ 20.30
J9151	$ 58.20	$ 57.99
J9170	$ 322.01	$ 326.36
J9178	$ 20.45	$ 20.38
J9181	$ 0.52	$ 0.48
J9182	$ 5.24	$ 4.84
J9185	$ 248.55	$ 237.98
J9190	$ 1.61	$ 1.84
J9200	$ 49.61	$ 57.35
J9201	$ 124.33	$ 127.70
J9202	$ 204.90	$ 201.88
J9208	$ 42.83	$ 40.03
J9209	$ 9.00	$ 8.37
J9211	$ 324.75	$ 317.52
J9214	$ 14.46	$ 14.61
J9218	$ 9.09	$ 8.38

CPT / HCPCS Code	Current Fee	Update Fee
J9219	$ 1,770.21	$ 1,730.67
J9225	$ 1,472.23	$ 1,482.95
J9250	$ 0.26	$ 0.28
J9260	$ 2.71	$ 2.91
J9261	$ 89.08	$ 90.32
J9263	$ 9.56	$ 9.60
J9264	$ 9.08	$ 9.23
J9265	$ 15.72	$ 15.30
J9266	$ 1,751.22	$ 2,000.00
J9268	$ 2,056.91	$ 1,900.00
J9280	$ 16.53	$ 15.11
J9290	$ 66.12	$ 60.43
J9291	$ 132.25	$ 120.86
J9293	$ 158.07	$ 113.34
J9300	$ 2,482.27	$ 2,532.34
J9305	$ 46.58	$ 44.70
J9310	$ 516.40	$ 486.90
J9320	$ 149.00	$ 154.26
J9340	$ 43.50	$ 43.17
J9355	$ 60.25	$ 56.51
J9360	$ 1.05	$ 1.09
J9370	$ 7.66	$ 7.50
J9375	$ 15.32	$ 15.00
J9380	$ 38.31	$ 37.51
J9390	$ 28.21	$ 22.48
Q0164	$ 0.04	$ 0.03
Q0166	$ 50.60	$ 52.45
Q0167	$ 5.30	$ 5.63
Q0168	$ 11.26	$ 11.44
Q0170	$ 0.30	$ 0.27
Q0172	$ 0.06	$ 0.04

CPT / HCPCS Code	Current Fee	Update Fee
Q0175	$ 0.21	$ 0.20
Q0176	$ 0.21	$ 0.20
Q0179	$ 26.03	$ 19.28
Q0180	$ 48.99	$ 45.96
Q2009	$ 6.03	$ 6.05
Q2017	$ 294.46	$ 294.24
Q3025	$ 121.62	$ 124.77
Q4080	$ 39.51	$ 42.41
Q4081	$ 0.95	$ 0.94
Q4083	$ 106.19	$ 106.90
Q4084	$ 185.81	$ 187.00
Q4085	$ 115.94	$ 116.49
Q4086	$ 185.89	$ 183.21
Q4087	$ 43.53	$ 34.84
Q4088	$ 39.00	$ 32.61
Q4089	$ 1.04	$ 5.55
Q4090	$ 84.16	$ 66.68
Q4091	$ 42.40	$ 33.88
Q4092	$ 41.41	$ 33.66
Q4094	$ 0.55	$ 0.44
Q9945	$ 0.31	$ 1.92
Q9946	$ 1.85	$ 1.92
Q9947	$ 1.33	$ 1.50
Q9948	$ 0.37	$ 0.32
Q9949	$ 0.40	$ 0.38
Q9950	$ 0.24	$ 0.20
Q9952	$ 2.87	$ 2.69
Q9954	$ 9.66	$ 9.93
Q9957	$ 63.52	$ 64.93
Q9958	$ 0.07	$ 0.08
Q9964	$ 0.20	$ 0.22

Providers' News

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