june 2014

providers' news

A publication for participating providers and their office staffs

inside

Reporting fraud, waste and abuse

If you suspect any potentially fraudulent activity by a provider, beneficiary or another entity, never confront the person suspected; instead call the FRAUD HOTLINE at 1-800-FRAUD-21 (1-800-372-8321). The Fraud Hotline is available 24 hours a day, 7 days a week. All reports are kept strictly confidential, and callers can remain anonymous.

This applies to Arkansas Blue Cross and Blue Shield and its subsidiaries and affiliate companies, including Medi-Pak® Advantage.

Resource-based relative value scale

Effective April 1, 2014, changes and updates for the Resource-based relative value scale (RBRVS) were completed.

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

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

On May 1, 2014, Arkansas Blue Cross and Blue Shield and its affiliates, USAble Corporation (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

For CMS-1500 (02/12) Form Version

Box 14 - Date of Current Illness, Injury or Pregnancy (LMP):

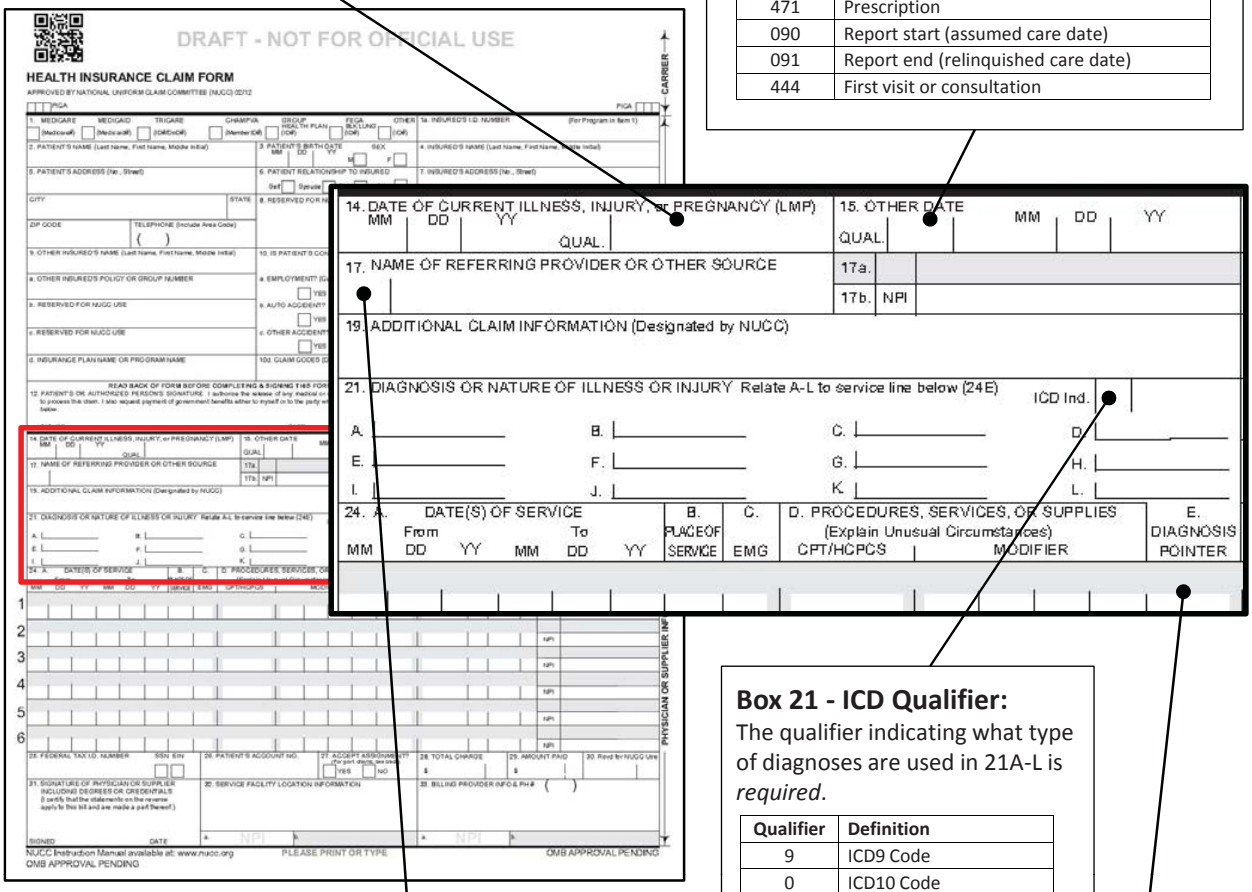
If a date is submitted in Box 14, the corresponding qualifier is *required*.

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

Box 15 - Other Date:

If a date is submitted in Box 15, the corresponding qualifier is *required*.

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 21 - ICD Qualifier:

The qualifier indicating what type of diagnoses are used in 21A-L is *required*.

Qualifier	Definition
9	ICD9 Code
0	ICD10 Code

Box 17 - Name of Referring Provider or Other Source:

If a provider is named in Box 17, the corresponding qualifier is *required*.

Qualifier	Definition
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Box 24E - Diagnosis Pointer:

Diagnosis Pointers must be an alpha character (A-L), which corresponds to diagnosis code in Box 21. The first letter indicates the primary diagnosis and is *required*. A maximum of 4 pointers per service line is allowed.

AHCPII: financial settlement update

Update on Financial Settlements

Arkansas Blue Cross and Blue Shield, Health Advantage and US-Able Corporation joined the Arkansas Health Care Payment Improvement Initiative (AHCPII) program with Arkansas Medicaid and QualChoice in 2012. We are nearing our first financial settlements for the Hip and Knee Replacement, Perinatal and Congestive Heart Failure episodes. Final settlement results will be available in the spring of 2014 and will identify those principal accountable providers ("PAPs") who:

1. Met the program targets for surplus sharing and will be issued a "reward payment" or
2. Failed to meet program targets and will be required to return funds.

Once providers have received their reports, they will have **45** days to appeal. Reward payments and refund request letters will be processed in June 2014.

For PAPs who meet program targets for surplus sharing, reward payments will be issued to the "pay to" entity on record for the PAP by Arkansas Blue Cross and Blue Shield. Checks will be delivered to the PAPs with their final settlement report.

For PAPs whose final results fall into the cost sharing levels, a refund request letter will accompany the PAPs final settlement report which identifies the amount of cost share applicable to the episode and PAP. In addition to the request letter, an extra letter copy and prepaid envelope will be enclosed to facilitate the refund process. The PAP will have a maximum of sixty days to refund the applicable cost-share amount.

After sixty days, if the cost share portion has not been returned to Arkansas Blue Cross, an offset against current and future (if needed) Arkansas Blue Cross commercial claims payments will be initiated. The offset transaction will remain open until the total cost share amount has been recouped. Arkansas Blue Cross will also perform the cost share recoupment process for BlueAdvantage Administrators and Health Advantage.

Providers who have questions about the AHCPII episodic reimbursement program, its settlement process, or the appeals process, should refer to the Arkansas Blue Cross Provider Manual on the provider page at www.arkansas-bluecross.com.

Advanced imaging changes for Blue KC

In an effort to improve the quality of care for their members, both in their service area and across the country, Blue Cross and Blue Shield of Kansas City (Blue KC) began using MedSolutions to provide authorization services for all of their members receiving outpatient high tech radiology and lumbar spinal fusions. This includes Blue KC members receiving care in Arkansas. MedSolutions is a utilization management services organization specializing in the management of quality, cost-effective diagnostic services.

Effective for dates of service October 1, 2013 and after, outpatient and elective MRI, MRA, CT, CTA, PET, echocardiogram, nuclear cardiology studies and lumbar spinal fusions require prior authorization from MedSolutions for Blue KC members. Imaging performed in conjunction with an inpatient stay, 23 hour observation, or testing done in the emergency room is not subject to authorization requirements. When imaging is required in less than 48 hours due to an urgent condition, providers are to call for authorization and tell MedSolutions that the imaging is urgent and ask for an expedited review.

To request an authorization, providers may access MedSolutions' 24/7 web portal at www.medsolutionsonline.com, call 888-693-3211 or fax a MedSolutions request form (download from www.medsolutionsonline.com) to 888-693-3210. MedSolutions is ready to offer any implementation support providers may find necessary. Please contact MedSolutions at 888-693-3211 with any additional questions about the program.

Oxygen concentrators

The fee schedule amounts for oxygen concentrators are being revised. Effective May 1, 2014, the fee schedule allowances for portable oxygen concentrators, HCPCS code E1392, are being changed to $1,733.10 for purchase and $173.31 for monthly rental. Effective August 1, 2014, the fee schedule allowances for stationary oxygen concentrators, HCPCS code E1390, are being changed to $1,633.10 for purchase and $163.31 for monthly rental.

Inpatient claims financial responsibility policy revision

The Blue Cross Blue Shield Association is taking steps to ensure consistency among all Blue Plans regarding inpatient pre-service review (also known as pre-authorization or pre-certification). Beginning July 1, 2014, inpatient facilities that fail to obtain pre-authorization or precertification 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. It will become very important for facilities to check member eligibility and pre-certification requirements, whether it be via a HIPAA 270 transaction or by calling the phone number on the member's ID card.

In order to implement the Blue Cross Blue Shield Association mandate, our 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 USAble Corporation's Arkansas' FirstSource® PPO and True Blue 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, Prenotification And 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.

Electronic provider access

The Blue Cross and Blue Shield Plans are launching a new tool that will give providers the ability to access out-of-area member's Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. Electronic Provider Access (EPA) will enable providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider will have the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The availability of EPA will vary depending on the capabilities of each Home Plan. Some Home Plans will be fully implemented and have electronic pre-service review for many services, while others will not yet have implemented electronic pre-service review capabilities.

Local access to the EPA is found on the Advanced Health Information Network (AHIN) under the "Members" menu option.

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.

Arkansas Blue Cross does not pay for supervision. Claims for supervision, documented appropriately with Modifier QK, will be denied. In these situations, Arkansas Blue Cross will only pay the CRNA who provided the anesthesia service.

New codes for applied behavior analysis for autism

New CPT codes for applied behavior analysis (ABA) will be effective July 1, 2014. After July 1, 2014, providers should begin using the new CPT codes listed below for ABA services. The current HCPCS codes (H0031, H0032, H0046, H2012, H2019 and H2020) may be used through September 30, 2014 allowing providers time to change their billing systems. Providers should not use codes from both the CPT and HCPCS code sets on the same claim for the same date of service.

All ABA services will continue to require prior authorization. Please note the times on the new codes are all based on 30 minutes of face-to-face time, except for 0373T. The previous HCPCS codes were based on either one hour or 15 minutes of face-to-face time. The new CPT codes are as follows:

CPT Codes	Description
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report
No more than once every 6 months. (Previously billed using H0032)	
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient
0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient

CPT Codes	Description
0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)
0360T-0363T combined total of no more than 3 hours every 3 months. (Previously billed using H0031)	
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time. (List separately in addition to code for primary procedure)
0364T-0365T combined total of up to 40 hours per week for 50 weeks. (Previously billed using H0046)	
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time. (Not covered. See Arkansas Blue Cross and Blue Shield's Coverage Policy manual.)
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure) (Not covered. See Arkansas Blue Cross and Blue Shield's Coverage Policy manual.)
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time
0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)
0368T-0369T - combined total of 6 hours per week for 50 weeks. (Previously billed using a combination of H2012 and H2019)	
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) (Non-covered. Patient is not present.)
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) (Not covered. See Coverage Policy.)
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients (Not covered. See Arkansas Blue Cross and Blue Shield's Coverage Policy manual.)
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient (By Report; records required.)
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure) (By Report; records required.)

Billing for services to family members prohibited

Arkansas Blue Cross and Blue Shield wishes to remind all providers of a long-standing policy of billing for services to family members. Arkansas Blue Cross, Health Advantage and USAble Corporation have published claims filing policies and procedures which 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 to immediate relatives. Any claim intentionally or mistakenly filed and that is subsequently paid for such services, requires the offending provider to immediately refund all such payments upon request.

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 USAble Corporation. Moreover, filing claims for services to immediate relatives, and receiving payment on such claims, is an abusive claims filing practice that may also constitute fraud, leading 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 performed by another, including any pharmacy charges resulting from prescriptions written by the provider.*

Previous articles regarding billing for services rendered to family members are located in the June 2002, September 2003, March 2011, and September 2013 issues of *Providers' News.*

Home sleep studies

Based on Arkansas Blue Cross and Blue Shield Coverage Policy 2009019, Sleep Apnea - Testing, the only covered unattended sleep study is represented by HCPCS code G0398. If a provider's machine has less than seven channels, it will not be covered and should be billed using the most appropriate code other than HCPCS code G0398. Below are the codes for home sleep studies:

CPT/HCPCS Codes	Description
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)
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

Coverage policy manual updates

Since March 2014, the following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. To view entire policies, access the coverage policies located our website at www.arkansasbluecross.com.

New / Updated Policies:

Policy #	Policy Name
1998070	Cochlear Implant
1998118	Surgery for Morbid Obesity
1998154	Electrical Stimulation, Transcutaneous Electrical Nerve Stimulator
2003037	Assisted Reproductive Technologies - Archived (See Coverage Policy #2014008)
2004003	Ablation Therapy, Radiofrequency and Cryoablation of Pulmonary Tumors
2006033	Angioplasty/Stenting, Intracranial Arteries and/or Extracranial Vertebral Artery Stenosis - Archived (See Coverage Policy #2014009)
2008010	Certified Nurse Practitioners
2009042	Embolectomy-Thrombectomy, Mechanical, Endovascular, for Treatment of Acute Stroke - Archived (See Coverage Policy #2014009)
2010014	Genetic Test: Chromosomal Microarray (CMA) Analysis for the Genetic Evaluation of Patients with Developmental Delay/Intellectual Disability or Autism Spectrum Disorder
2011004	Genetic Test: Non-Small Cell Lung Cancer, EGFR Mutation Analysis to Predict Sensitivity to Erlotinib
2012004	Cerebral Aneurysm, Embolization Device and Stenting-ARCHIVED (See Coverage Policy #2014009)
2014002	Genetic Test: Dilated Cardiomyopathy
2014004	Clinical Trials - PPACA Requirements, Non-grandfathered Plans
2014005	Antigen Leukocyte Antibody Test (ALCAT)
2014006	Sofosbuvir (Sovaldi)
2014007	Simeprevir
2014008	Infertility Services
2014009	Endovascular Procedures for Intracranial Arterial Disease and Extracranial Vertebral Artery Disease
2014010	Biomarker, Serum Tests for Multiple Sclerosis

Medicare Advantage and risk adjustment

What is risk adjustment?

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans, such as Arkansas Blue Cross and Blue Shield, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures for members by adjusting payments based upon demographics (age and gender) as well as health status. Diagnoses documented, coded and submitted to CMS this year will impact revenue and resources required for the following year.

History of risk adjustment

As part of risk adjustment implementation, CMS initially collected hospital inpatient diagnoses for determining payment to Medicare Advantage Plans. In 2000, Congress mandated a change to include ambulatory data. This change took place gradually, with full implementation in 2007. CMS selected a payment model that included diagnosis data reported from physician office, hospital inpatient and hospital outpatient settings, the CMS-Hierarchical Condition Category (CMS-HCC) payment model.

What is your role as a physician?

Physician data is critical for accurate risk adjustment. Outpatient providers and physicians are the largest source of ambulatory data for risk adjustment. CMS-HCC model relies on ICD 9/10-CM coding specificity.

How does risk adjustment impact physicians and members?

It's important to keep in mind that the risk adjustment process benefits you and your patients. How? Increased coding accuracy helps Arkansas Blue Cross identify patients who may benefit from disease and medical management programs. More accurate health status information can be used to match health care needs with the appropriate level of care. In addition to coding accuracy, a review of this type also helps ensure that health plans are reimbursed appropriately by CMS for how sick their members actually are.

In doing so, risk adjustment enables Arkansas Blue Cross to maintain member copayments and coinsurance at affordable levels and reduce the amount providers collect at the time of service.

Risk adjustment helps providers meet CMS provider responsibilities regarding reporting ICD-9-CM codes, including:

- Bring all acute and chronic conditions forward from face-to-face visits annually in your medical record with supportive documentation.
- Document ALL conditions that you monitor, evaluate, assess/address, or treat.
- Code all diagnoses to the highest level of specificity.
- Maintain accurate and complete medical records (ICD-9-CM codes must be submitted with supportive documentation).
- Report all diagnoses on claims and encounter data in a timely manner.
- Provide protection should a provider find themselves participating in CMS or plan audits.

With your help in providing accurate and timely coding for risk adjustment, your commitment will assist in improving the overall patient health care evaluation process, as well as improve office practice patterns, communication and provide your patients and our members with superior service.

Why is medical record documentation important for risk adjustment?

- Accurate risk adjusted payment relies upon complete medical record documentation and annual diagnosis coding.
- CMS conducts risk adjustment data validation (RADV) of all ongoing medical conditions through medical record review.
- Specificity of the ICD-9-CM diagnosis coding must be substantiated by the medical record.

What is the importance of ICD-9-CM diagnosis coding?

- ICD-CM is the official diagnosis code set for Medicare, and is used for risk adjustment payment.
- Medical record documentation dictates which code is assigned.
- Appropriate ICD-9 coding requires complete and accurate documentation as well as the use of the most specific code available.

As of October 1, 2015, all providers and health plans will

be required to use ICD-10-CM, a more robust code set with greater specificity than ICD-9-CM. Now is the best time to improve documentation to accurately reflect the health status of your patients and to prepare for the level of documentation required for ICD-10-CM.

Medical Record Documentation

Complete and accurate medical documentation by physicians, other providers and their staff is vital to accurate risk adjustment. The following tips can help you meet the requirements of the Risk Adjustment program.

- Documentation should be clear, concise, consistent, complete and legible.
- Document all acute and chronic conditions thoroughly along with MEAT (monitor, evaluation, assess/address, or treat) at least annually.
- Document and code to the highest level of specificity, including acute, chronic, laterality, episode of care, and anatomic location.
- Omit the word "chronic" from a condition and it can have a negative impact on resources or validation of the codes submitted. (i.e. chronic hepatitis, chronic bronchitis)
- Avoid statements such as "history of" if condition is chronic or ongoing.
- Don't miss documenting and coding status codes at least once a year. (e.g., amputations and artificial openings, status of dialysis)
- If you document possible, probable or rule out conditions then you can only code the signs and symptoms until a definitive diagnosis is made.
- Use standard abbreviations.
- Utilize problem list (ensuring they are comprehensive, show evaluation and treatment for each condition related to an ICD-9-CM code on the date of service, and are signed and dated by the physician or physician extender). Or better yet bring all conditions forward into the progress note assessment linking medication/labs to the specific problem or diagnosis and list the treatment plan.
- Identify patient and date on each page of the record.
- Authenticate the records with signature and credentials.

The major points

Federal regulations require Medicare and its agents to review and validate medical records in order to avoid overpayments or underpayments.

It is important for the physician's office to completely code each encounter; the claims should report the ICD-9-CM code for every diagnosis that was documented and impacted the episode of care. Only report codes of diagnoses that were actively addressed and documented.

Contributory (co-morbid) conditions should be reported if they impact the care and, therefore, are addressed at the visit, but not if the condition is inactive or immaterial. It should be obvious from the medical record entry associated with the claims that all reported diagnoses were addressed and that all diagnosis were reported.

Request for medical records

Arkansas Blue Cross continually conducts medical record reviews to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding.

We may also contract with a third-party vendor to conduct on-site reviews of identified medical records.

Under CFR 164.502 (Health Insurance Privacy and Accountability Act [HIPPA] implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained a "general consent" of the member. A general consent form should be an integral part of your medical record file.

CMS data validation

RADV ensures the integrity and accuracy of risk-adjusted payment. It is the process of verifying that diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for a member.

In addition, if CMS conducts an annual RADV on the Medicare Advantage health plan, Arkansas Blue Cross will request from you medical record documentation for members included in the audit.

If this occurs medical records can be mailed or faxed to:

Arkansas Blue Cross
Revenue Management Dept.
320 West Capitol, Suite 400
Little Rock, AR 72201

For more information related to risk adjustment, visit the Centers for Medicare & Medicaid Services website at www.csscoperations.com.

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 full-time 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.

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.

FEP

Claims payment schedule

During the fourth quarter of 2014, the Federal Employees Program claim payments will change from a daily schedule to twice weekly. The payments will be processed on Wednesday and Friday, adjusting for holidays as needed. Updates providing the exact timing of the conversion will be posted on AHIN.

ASE/PSE

Changes for 2014

Employee Benefits Division (EBD), the plan administrator for Arkansas State Employees and Public School Employees (ASE/PSE), has requested that Health Advantage inform providers of reference priced drugs covered by the ASE/PSE plans to assist in educating members on cost sharing.

The ASE/PSE 2014 Gold and Bronze plans have incorporated reference pricing in the coverage of prescription drugs. This information has been communicated to ASE/PSE members and information is located on AHIN for reference to assist in provider/patient discussions concerning these drugs.

- Effective April 7, 2014, EBD closed enrollment for the Bariatric Surgery Pilot Program. Members enrolled as of April 4, 2014, will continue to be covered under current criteria.
- Effective for June 1, 2014 dates of service and after, ASE/PSE coverage policies will default to the Health Advantage coverage policy. Please refer to www.healthadvantage-hmo.com, under doctors and hospitals for coverage policy information.
- Beginning for dates of service June 1, 2014 and after, the health plan for ASE/PSE will no longer cover general anesthesia for EGDs and colonoscopies on a routine basis. General anesthesia services will be denied. Previously upon receipt of the claim, medical records were requested for review to determine coverage. If a provider believes their patient has special needs that require general anesthesia, supporting documentation along with the claim may be submitted to Health Advantage for re-review.
- Effective July 1, 2014, ARBenefits for ASE/PSE will begin requesting pre-notification of all newly diagnosed malignancies. Providers confirming the diagnosis of malignancy for members are asked to call 877-815-1017, opt. 2 and follow the pre-certification prompts. Providers will be asked for member demographics, diagnosis, pertinent clinical information, as well as, treatment plan.
- Effective September 1, 2014, prior authorization will be required for specialty drugs covered under medical.
- Effective January 1, 2015, ARBenefits for ASE/PSE will begin requiring pre-certification of all outpatient oncology related treatments. Providers initiating new treatment regimens will be required to call 877-815-1017, opt. 2 and follow the pre-certification prompts. Providers will be asked for the information, as noted above, in order for medical necessity and experimental/investigational status to be determined. Effective January 1, 2015, if a pre-certification is not obtained for a service, the service will be denied without member responsibility.

Medi-Pak Advantage

Out-of-network exception process

Medi-Pak Advantage has implemented the pre-service out-of-network exception process to allow in-network providers an opportunity to submit a request for services provided at an out-of-network facility, or by an out-of-network provider, to be paid at the in-network benefit level. This process should be used when no in-network provider is available for the requested service. These requests must be submitted prior to services being rendered.

The request must come from an in-network physician who wishes to refer the Medi-Pak Advantage member for out-of-network care. The request must be provided in writing to Medicare Operations, and will be reviewed internally for coverage determination.

For more information regarding the out-of-network exception process, please contact Medi-Pak Advantage Customer Service at 1-877-233-7022, Monday through Friday, 8 a.m. to 5 p.m.

Fee Schedule

Fee schedule additions and updates

The following CPT and HCPCS codes were added or updated on the Arkansas Blue Cross fee schedule.

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
43775	BR	$0.00	$0.00	BR	$0.00	$0.00
54500	$121.64	$0.00	$0.00	$121.64	$0.00	$0.00
59025	$74.67	$48.39	$26.28	$0.00	$48.39	$0.00
70010	$96.00	$96.00	$0.00	$0.00	$96.00	$0.00
81201	$749.92	$52.49	$697.43	$0.00	$52.49	$0.00
81202	$93.34	$6.53	$86.81	$0.00	$6.53	$0.00
81203	$570.05	$39.90	$530.15	$0.00	$39.90	$0.00
81220	$900.00	$63.00	$837.00	$0.00	$63.00	$0.00
81322	$58.40	$4.09	$54.31	$0.00	$4.09	$0.00
81507	$1,325.00	$92.75	$1,232.25	$0.00	$92.75	$0.00
86386	$21.79	$1.53	$20.26	$0.00	$1.53	$0.00
87153	$157.38	$11.02	$146.36	$0.00	$11.02	$0.00
88363	$34.67	$30.88	$0.00	$30.88	$30.88	$0.00
90632	$63.72	$0.00	$0.00	$0.00	$0.00	$0.00
90633	$28.46	$0.00	$0.00	$0.00	$0.00	$0.00
90681	$105.51	$0.00	$0.00	$0.00	$0.00	$0.00
90698	$80.43	$0.00	$0.00	$0.00	$0.00	$0.00
90710	$157.64	$0.00	$0.00	$0.00	$0.00	$0.00
90717	$103.44	$0.00	$0.00	$0.00	$0.00	$0.00
99100	$51.00	$0.00	$0.00	$51.00	$0.00	$0.00
99116	$255.00	$0.00	$0.00	$255.00	$0.00	$0.00
99135	$255.00	$0.00	$0.00	$255.00	$0.00	$0.00
99140	$102.00	$0.00	$0.00	$102.00	$0.00	$0.00
0262T	BR	$0.00	$0.00	BR	$0.00	$0.00
0359T	$360.00	$0.00	$0.00	$360.00	$0.00	$0.00
0360T	$60.00	$0.00	$0.00	$60.00	$0.00	$0.00
0361T	$60.00	$0.00	$0.00	$60.00	$0.00	$0.00
0362T	$60.00	$0.00	$0.00	$60.00	$0.00	$0.00
0363T	$60.00	$0.00	$0.00	$60.00	$0.00	$0.00
0364T	$12.00	$0.00	$0.00	$12.00	$0.00	$0.00
0365T	$12.00	$0.00	$0.00	$12.00	$0.00	$0.00
0366T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0367T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0368T	$60.00	$0.00	$0.00	$60.00	$0.00	$0.00

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
0369T	$60.00	$0.00	$0.00	$60.00	$0.00	$0.00
0370T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0371T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0372T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0373T	BR	BR	BR	BR	BR	BR
0374T	BR	BR	BR	BR	BR	BR
C9021	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9739	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9740	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
E1392	$1,733.10	$173.31	$1,299.83	$0.00	$0.00	$0.00
G0202	$179.48	$50.31	$129.17	$0.00	$50.31	$0.00
G0204	$219.12	$62.96	$156.15	$0.00	$62.96	$0.00
G0206	$172.49	$50.31	$122.19	$0.00	$50.31	$0.00
G9197	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
G9200	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
H0031	$120.00	$0.00	$0.00	$120.00	$0.00	$0.00
H0032	$360.00	$0.00	$0.00	$360.00	$0.00	$0.00
H0046	$24.00	$0.00	$0.00	$24.00	$0.00	$0.00
H2012	$120.00	$0.00	$0.00	$120.00	$0.00	$0.00
H2019	$30.00	$0.00	$0.00	$30.00	$0.00	$0.00
H2020	BR	$0.00	$0.00	BR	$0.00	$0.00
J0834	$86.67	$0.00	$0.00	$0.00	$0.00	$0.00
J0878	$0.67	$0.00	$0.00	$0.00	$0.00	$0.00
J1745	$88.52	$0.00	$0.00	$0.00	$0.00	$0.00
J2020	$43.68	$0.00	$0.00	$0.00	$0.00	$0.00
Q2038	$16.15	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule

Injection code updates

The following injection codes were updated on Arkansas Blue Cross and Blue Shield fee schedule.

CPT Code	Allowed
90371	$115.91
90375	$228.96
90376	$221.56
90385	$26.06
90585	$127.26

CPT Code	Allowed
90586	$127.26
90632	$53.10
90670	$160.12
90675	$241.04
90686	$20.19

CPT Code	Allowed
90691	$73.39
90703	$40.59
90714	$22.00
90732	$80.96

(continued on page 16)

Injection code updates (continued from page 15)

CPT Code	Allowed
A9576	$1.85
A9577	$2.31
A9578	$1.63
A9579	$2.03
A9581	$14.52
A9583	$12.00
A9585	$0.42
J0129	$24.83
J0130	$771.57
J0132	$2.58
J0133	$0.07
J0135	$590.39
J0150	$6.32
J0151	$3.23
J0171	$0.16
J0180	$152.04
J0207	$324.23
J0221	$159.77
J0256	$4.27
J0257	$4.12
J0278	$1.33
J0280	$1.61
J0285	$15.98
J0287	$10.85
J0290	$1.62
J0295	$1.83
J0348	$0.76
J0360	$3.31
J0364	$34.00
J0401	$3.73
J0456	$3.57
J0461	$0.05
J0470	$29.78
J0475	$167.77
J0476	$78.52
J0480	$2,664.24
J0485	$3.94
J0490	$40.38
J0500	$39.41
J0515	$20.82
J0558	$4.29
J0561	$5.40
J0585	$5.64
J0586	$7.63
J0587	$11.58
J0588	$4.66
J0592	$3.41
J0594	$30.09
J0595	$1.84
J0597	$37.80
J0598	$51.18
J0610	$1.67
J0630	$71.78
J0636	$0.36
J0637	$13.61
J0640	$4.12
J0641	$1.77
J0670	$3.10
J0690	$0.82
J0692	$2.68
J0694	$5.26
J0697	$3.24
J0698	$2.03
J0702	$5.97
J0706	$0.58
J0712	$1.07
J0713	$2.24
J0717	$6.17
J0720	$31.15
J0725	$15.33
J0735	$21.31
J0740	$638.61
J0744	$1.14
J0770	$12.22
J0775	$39.97
J0780	$4.19
J0795	$8.06
J0800	$3,162.60
J0834	$65.45
J0840	$2,516.80
J0881	$3.88
J0882	$3.88
J0885	$11.91
J0886	$11.91
J0894	$31.05
J0897	$14.90
J1000	$9.19
J1020	$3.31
J1030	$2.97
J1040	$5.68
J1070	$4.93
J1080	$4.33
J1100	$0.12
J1110	$42.62
J1120	$25.98
J1160	$4.60
J1162	$1,355.84
J1165	$0.59
J1170	$2.53
J1200	$0.60
J1205	$147.61
J1212	$77.98
J1230	$7.66
J1240	$5.56
J1245	$0.85
J1250	$6.24
J1260	$6.49
J1265	$0.45
J1270	$1.81
J1290	$368.86
J1300	$214.38

CPT Code	Allowed
J1325	$16.22
J1327	$28.68
J1335	$35.02
J1364	$28.82
J1380	$9.45
J1410	$170.29
J1430	$149.75
J1438	$277.61
J1450	$4.20
J1451	$6.97
J1453	$1.79
J1458	$374.21
J1459	$38.22
J1460	$25.77
J1556	$39.75
J1557	$38.29
J1559	$7.99
J1560	$257.74
J1561	$41.08
J1566	$31.24
J1568	$31.72
J1569	$40.73
J1570	$76.93
J1571	$52.36
J1572	$37.78
J1580	$1.44
J1602	$24.85
J1610	$137.17
J1630	$1.42
J1631	$19.97
J1640	$17.25
J1645	$14.69
J1650	$1.83
J1652	$4.15
J1670	$310.35
J1720	$5.34
J1740	$164.52
J1742	$76.45

CPT Code	Allowed
J1743	$501.51
J1745	$84.18
J1750	$12.40
J1756	$0.27
J1786	$43.69
J1800	$1.93
J1815	$0.66
J1817	$6.59
J1930	$40.49
J1931	$29.45
J1940	$5.88
J1950	$790.43
J1955	$8.02
J1956	$10.66
J1980	$18.30
J2010	$8.63
J2020	$43.62
J2060	$0.71
J2150	$1.72
J2175	$2.94
J2210	$4.90
J2270	$6.02
J2271	$0.91
J2275	$10.55
J2278	$6.86
J2280	$4.57
J2300	$1.63
J2310	$21.21
J2315	$2.87
J2323	$14.53
J2325	$62.65
J2353	$206.06
J2354	$1.27
J2355	$287.28
J2357	$27.55
J2360	$5.65
J2370	$4.13
J2400	$22.07

CPT Code	Allowed
J2405	$0.12
J2410	$2.49
J2425	$14.98
J2426	$7.99
J2430	$14.45
J2469	$20.37
J2501	$1.71
J2503	$1,069.10
J2505	$3,439.84
J2507	$588.67
J2510	$15.42
J2515	$34.43
J2540	$0.81
J2543	$1.65
J2545	$89.25
J2550	$1.64
J2560	$18.88
J2562	$311.83
J2590	$0.55
J2597	$5.36
J2675	$1.17
J2680	$20.40
J2690	$25.84
J2700	$2.08
J2720	$1.12
J2724	$14.85
J2730	$92.08
J2760	$105.36
J2765	$0.85
J2770	$206.64
J2778	$412.89
J2780	$1.19
J2783	$223.19
J2785	$55.19
J2788	$8.62
J2790	$86.97
J2791	$4.94

(continued on page 18)

Injection code updates (continued from page 17)

CPT Code	Allowed
J2792	$19.49
J2794	$6.22
J2795	$0.12
J2796	$53.89
J2800	$42.45
J2805	$87.23
J2820	$33.75
J2916	$2.67
J2920	$1.86
J2930	$2.71
J2997	$62.73
J3000	$10.89
J3010	$0.51
J3070	$166.30
J3095	$4.31
J3101	$82.21
J3105	$2.69
J3130	$10.76
J3230	$22.53
J3240	$1,259.69
J3243	$1.85
J3246	$9.68
J3250	$10.87
J3301	$1.84
J3303	$1.50
J3315	$192.12
J3355	$65.96
J3357	$157.53
J3360	$4.12
J3370	$2.09
J3385	$369.44
J3396	$11.50
J3410	$0.34
J3411	$3.65
J3415	$8.74
J3420	$2.63
J3430	$1.06

CPT Code	Allowed
J3465	$3.93
J3475	$0.21
J3480	$0.01
J3486	$10.82
J3489	$84.69
J7030	$1.42
J7040	$0.71
J7042	$0.58
J7050	$0.36
J7060	$1.29
J7070	$2.53
J7100	$24.04
J7120	$1.21
J7187	$0.99
J7189	$1.77
J7190	$0.96
J7193	$1.02
J7195	$1.37
J7197	$3.27
J7198	$1.71
J7309	$87.03
J7312	$205.15
J7316	$1,088.57
J7321	$93.21
J7323	$160.80
J7324	$192.52
J7325	$12.82
J7326	$605.84
J7330	$33,181.76
J7335	$24.73
J7500	$0.28
J7502	$3.23
J7504	$772.61
J7506	$0.08
J7507	$1.55
J7508	$0.42
J7509	$0.55

CPT Code	Allowed
J7511	$562.81
J7515	$0.86
J7516	$40.23
J7517	$1.17
J7518	$4.30
J7520	$15.12
J7525	$141.73
J7527	$7.12
J7605	$6.39
J7606	$7.19
J7608	$2.02
J7611	$0.10
J7612	$0.19
J7614	$0.10
J7620	$0.20
J7626	$5.31
J7631	$0.45
J7639	$34.11
J7682	$113.32
J8501	$7.74
J8510	$11.24
J8520	$10.47
J8521	$34.90
J8540	$0.17
J8560	$60.48
J8610	$1.08
J8700	$7.67
J8705	$95.61
J9000	$3.22
J9015	$1,811.79
J9017	$51.19
J9025	$5.13
J9027	$134.82
J9031	$127.26
J9035	$68.20
J9040	$21.80
J9041	$47.39

CPT Code	Allowed
J9042	$110.95
J9043	$147.76
J9045	$3.65
J9050	$1,471.21
J9055	$54.63
J9060	$2.37
J9065	$24.21
J9070	$54.55
J9098	$566.29
J9100	$1.05
J9130	$4.15
J9150	$26.47
J9155	$3.22
J9171	$3.98
J9178	$1.33
J9179	$102.22
J9181	$0.67
J9185	$88.04
J9190	$1.97
J9200	$81.39
J9201	$7.55
J9202	$225.53
J9206	$5.35
J9207	$71.36
J9208	$35.54
J9209	$2.96
J9211	$30.55
J9214	$21.49
J9217	$215.06
J9218	$8.22
J9225	$3,099.94
J9226	$16,320.74
J9228	$136.10
J9245	$1,277.85
J9260	$2.56
J9261	$140.09
J9263	$0.59
J9264	$9.85

CPT Code	Allowed
J9265	$4.91
J9268	$1,509.08
J9280	$23.94
J9293	$35.46
J9302	$49.09
J9303	$97.93
J9305	$62.36
J9307	$197.31
J9310	$721.65
J9315	$270.38
J9320	$349.23
J9330	$59.37
J9351	$2.28
J9354	$30.30
J9355	$83.86
J9357	$1,114.35
J9360	$1.98
J9370	$5.06
J9371	$2,149.68
J9390	$11.04
J9395	$94.52
J9400	$8.39
P9041	$10.47
P9043	$9.95
P9045	$52.36
P9046	$21.59
P9047	$53.98
P9048	$49.78
Q0138	$0.75
Q0139	$0.75
Q0162	$0.06
Q0163	$0.21
Q0164	$0.03
Q0166	$1.84
Q0167	$3.69
Q0169	$0.02
Q0180	$72.99
Q2009	$1.47

CPT Code	Allowed
Q2043	$33,417.04
Q2050	$507.47
Q3027	$35.29
Q4074	$84.88
Q4081	$1.19
Q4101	$42.38
Q4102	$9.22
Q4104	$28.78
Q4105	$12.61
Q4106	$46.18
Q4107	$103.31
Q4108	$29.72
Q4110	$40.84
Q4111	$7.34
Q4112	$457.31
Q4113	$457.31
Q4114	$1,297.26
Q4115	$12.75
Q4116	$34.16
Q4121	$24.10
Q4123	$17.87
Q9956	$38.44
Q9957	$57.66
Q9961	$0.20
Q9963	$0.20
Q9965	$1.10
Q9966	$0.23

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providers' news staff

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Please Note

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

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