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Please Note:

Providers’ News contains information pertaining to Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company and its 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.


The BlueCard News

The BlueCard News is a publication of Arkansas Blue Cross and Blue Shield. Please send your questions or comments regarding the BlueCard News to:

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Arkansas Blue Cross and Blue Shield and its affiliates will end all HIPAA National Provider Identifier (NPI) contingencies on May 23, 2008. In accordance with CMS NPI Guidance, this is the latest day allowable to end all NPI contingency plans.

Over the course of the contingency period Arkansas Blue Cross has closely monitored the NPI compliance of all submitted claims. By late Fall 2007, nearly all institutional claims received were NPI-compliant and Arkansas Blue Cross was able to lift its contingency plan for institutional claims on January 1, 2008.

The conversion to NPI compliance for professional claims did not progress as quickly. Therefore, Arkansas Blue Cross will continue to allow professional claims to be submitted under the contingency plan up until the mandatory end date of May 23, 2008.

After May 23, 2008, all electronic HIPAA transactions must utilize the NPI for provider identification or they will be rejected for being out of compliance with HIPAA. Paper claims must also use the NPI as the provider identifier or they too will also be rejected.

Additionally, all providers must register their NPI with Arkansas Blue Cross prior to using their NPI in submitting claims. Registration of NPI may be done in writing by mail, email or fax. Providers with access to the Advanced Health Information Network (AHIN) web site may register their NPI electronically.

For specific details pertaining to registration of an NPI with Arkansas Blue Cross, please refer to the ‘Providers’ News’ article Arkansas Blue Cross Needs Your NPI! published September 2006 and September 2007.

For providers who have not obtained an NPI, please do so as soon as possible. The most expeditious way to obtain an NPI is to apply online by visiting: https://nppes.cms.hhs.gov/NPPES.

For additional assistance registering an NPI with Arkansas Blue Cross please contact your regional Network Development Representative.

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Anesthesia Update

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

Article from the November 2007 issue of the BlueCard News

The procedure for filing claims for vision services, including lenses and frames, will be as follows:

- **Billing:** All services for a single service date must be billed on the same claim form with the appropriate CPT and/or HCPCS code(s).

- **Pricing:** At this time, pricing allowances for materials or supplies (frames, lenses, etc.) are sent to the “Home Plan” as the provider’s usual charge. Deluxe frames (CPT Code V2025) are priced per the Arkansas fee schedule.

- **Payment:** The “Home Plan” will apply the member’s benefits to the entire charge for the material codes (frames, lenses, etc.). Any difference will be placed in Provider Write Off with the exception of deluxe frames.

All vision services filed with Arkansas Blue Cross and Blue Shield by providers who participate in Arkansas’ FirstSource PPO network will have the 10% PPO discount applied. Claims for materials or supplies are priced at the provider’s usual charge. The claims system then applies the appropriate discount based upon the provider’s contracting status.

Outpatient Services

Article from the December 2007 issue of the Providers’ News

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.

DME Monthly Rentals

Rentals of Durable Medical Equipment (DME) should be billed using the beginning date of rental (Not a date range), units of service of 1, and modifier RR.
Modifier Usage

Article from the March 2008 issue of the Providers’ News

When used appropriately, modifiers provide additional information that aids in the adjudication of a claim. When modifiers are used inappropriately, they will slow the process of a claim, require manual handling and usually require additional information from the provider’s office.

Modifier 50: Bilateral Surgery
Charges must be submitted on two lines. The first line should include a descriptive modifier (i.e., LT (left side) or RT (Right side)). Modifier 50 should be in the first modifier position on the second line, with the descriptive modifier in the second position.

If a provider bills bilateral surgery on one line with modifier 50, the payment will reflect one half of one side. A corrected claim must be submitted to obtain correct payment.

Modifier 51: Multiple Surgery
The Arkansas Blue Cross and Blue Shield computer systems will automatically assign Modifier 51 to the secondary surgical procedure(s) based on the Relative Value Units (RVU) assigned to the procedures. Arkansas Blue Cross will not apply multiple surgery guidelines to procedures exempt from Modifier 51 based on CPT or to add-on codes.

Modifier 51 does not apply to these groups of procedures by definition. Addition of Modifier 59 to these procedures will result in manual adjudication of the claim.

Modifier 59: Distinct Procedural Service
Modifier 59 continues to be the most misused modifier. Use of modifier 59 should be rare, should only be used when no other modifier is applicable, and should never be used if there is only one service on a claim. Inappropriate use of Modifier 59 will delay processing of the claim.

An appropriate use of Modifier 59:
• Two procedures are provided. When entered in Clear Claim Connection via AHIN, one of the procedures denies as inclusive in the other procedure billed.
• The two procedures represent distinct services that will be supported by the medical records.

Inappropriate uses of modifier 59:
• Evaluation and Management services;
• Multiple or bilateral surgery where Modifier 50 or 51 is appropriate;
• Single line claims.

Modifier 25: Significant, Separately Identifiable Evaluation & Management Service
Modifier 25 should only be used with the Evaluation and Management procedure codes, and only when you have provided an E&M service that is separate and identifiable from the other procedure(s) provided on the same day.
Medicare Crossover Information for Providers

In November 2007, new procedures were approved to allow flexibility for Plans to service Medicare Crossover inquiries. Beginning January 1, 2008, the Plan receiving a provider call is responsible for ensuring the provider receives the appropriate service.

Each Plan has a designated line set up to handle Medicare crossover claims only. When providers call Arkansas Blue Cross and Blue Shield Customer Service on a Medicare crossover claim, the CSR will transfer providers to the member’s Plan or contact the other Plan on the providers’ behalf.

Frequently Asked Questions

Below are some common questions BlueCard Customer Service receives from providers.

Q1 A provider receives a denial 0514. What does the provider need to do?
A1 Denial 0514 means that the claim is closed until requested information is received from the provider. Providers may receive a bar-coded request letter. If so, providers need to submit the requested information to allow the claim to continue processing. If a provider does not receive a request for information letter, the BlueCard Customer Service can contact the patient’s Home Plan to inquire about what information is needed. If a provider does not know if a request for information letter has been received, they should check AHIN by using the claim status search function. If a bar-coded request letter has been sent out, it will be located on AHIN. Providers will have access to all letters Arkansas Blue Cross sends on claims; providers will see letters sent to them, letters sent to the member, and letters sent to a different provider (i.e. referring provider).

Q2 A provider receives a denial 1083. What does the provider need to do?
A2 No action is required from a provider to expedite the processing of the claim when this denial is received on a remittance advice. Denial 1083 could be caused by a change in the patient’s alpha prefix. BlueCard’s system will fix this error and resubmit the claim to the patient’s home plan for processing. However, a provider should contact the member and correct their files so that future claims are not delayed.

Q3 A provider only needs to check claim status. Can providers do this without calling BlueCard Customer Service?
A3 Yes, providers can check the current status of a claim by going to the Advanced Health Information Network (AHIN) and completing a claim status search. AHIN has the most recent claim status information available.

Timely Claims Filing Reminder

Please wait until a claim is actually denied by the Home Plan as being past the timely filing deadline before submitting proof of timely filing. Delays in processing can occur when information is submitted unnecessarily.
Where and How do Providers Submit BlueCard Claims?

Article from the November 2007 issue of the BlueCard News

Providers should submit BlueCard claims electronically through the Advanced Health Information Network (AHIN) which is Arkansas Blue Cross and Blue Shield’s preferred method of submitting claims.

If a provider contracts with the member’s home Plan (for example: contiguous counties or overlapping service areas), then the provider should file the claim directly to the member’s Plan. Be sure to include the member’s complete identification number when submitting the claim. The complete member identification number includes the three-character alpha prefix. **Do not make up alpha prefixes.** Incorrect or missing alpha prefixes and member identification numbers only delay claims processing.

Once Arkansas Blue Cross receives a claim, it will electronically route the claim to the member’s Blue Cross and Blue Shield Plan. The member’s home Plan then processes the claim and approves payment and Arkansas Blue Cross will pay the provider.

If a provider is a non-PPO (traditional) provider and is presented with an identification card with the “PPO in a suitcase” logo on it, the provider should still accept the card and file the claim with their local Blue Cross and Blue Shield Plan. Providers will still be given the appropriate traditional pricing.

The claim submission process for international Blue Cross and Blue Shield members is the same as for domestic Blue Cross and Blue Shield members.

Remittance Advice Available Online via AHIN

Article from the December 2005 issue of the Providers’ News

Over 8,000 providers in the state of Arkansas now have access to the Advanced Health Information Network (AHIN), Arkansas Blue Cross and Blue Shield’s internet portal for providers.

Providers are able to search for and retrieve entire remittances (Adobe Acrobat (PDF) format) identical in all respects to the paper remittances currently mailed. The online remittances can be printed, saved to a local machine, and replicated for use by multiple billers.

Remittances are available approximately two days sooner on AHIN as compared to receipt by mail. Remittances will be maintained online for a period of six months.

For more information, please consult the bulletin board section of AHIN. Complete instructions on how to use this function are listed.
AHIN Training for Providers

The Advanced Health Information Network (AHIN) training sessions are offered once a month in each region. Providers must be a current AHIN user to attend a class. To enroll in the next class, contact the AHIN customer service at (501) 378-2336.

New to BlueCard?

Article from the November 2007 issue of the BlueCard News

Providers who are new to BlueCard can call 1(800)676-BLUE (2583) for benefits and eligibility information on BlueCard patients. A representative will ask for the alpha prefix on the member’s ID card and will connect you to the appropriate membership and coverage unit at the member’s Blue Cross and Blue Shield Plan. The 3-character alpha prefix at the beginning of the member’s identification number is the key element used to identify and correctly route out-of-area BlueCard claims. The alpha prefix identifies the Blue Cross and Blue Shield Plan or national account to which the member belongs.

Claim Status Emails

Article from the November 2007 issue of the BlueCard News

For claim status emails sent to customer service, please ensure that the provider number field is filled in with the Pay To provider’s NPI and/or legacy number. The SCCF claim number is now a required field when emailing customer service and must be included.

When filling out the initial email, make certain that the provider button is selected on the email screen and not the member button. If the member button is selected, all of the pertinent information will not be collected in order for the representative to assist with the inquiry.

Also, in the Total Amount Billed field, please remember to give the total amount billed on that claim and not the amount of the charge in question.

Finally, if the email states at the bottom that “this inquiry is now closed”, please create a new email because the previous inquiry is now closed. Providers may include the confirmation number from the previous related email to expedite a request.