

January 25, 2008

IMPORTANT UPDATES: Coding, Claims, Reimbursement, and Billing

2008 FEE SCHEDULE INFORMATION

In November of 2007, the Centers for Medicare and Medicaid Services (CMS) released the 2008 Physician Fee Schedule with a conversion factor of \$34.0682, which was a reduction of 10.1% over the 2007 conversion factor of \$37.8975. Needless to say, the physician community was not very pleased with this decision and started campaigning to have Congress reconsider this reduction. In late December, Congress responded to the dissatisfaction from the physician community with the Medicare, Medicaid and SCHIP Extension Act of 2007. The Medicare, Medicaid and SCHIP Extension Act of 2007 set the 2008 conversion factor for physician payment for the time period of January 1, 2008 through June 30, 2008 at a 0.5% increase over the 2007 level, which would be a conversion factor of \$38.0870. Effective for dates of service July 1, 2008 through December 31, 2008, CMS has stated that the negative 10.1% reduction will be instituted. Below is a listing of other initiatives that were implemented with the 2008 fee schedule, which will affect physician payment.

Changes in Work Relative Value Units (RVUs)

Beginning in 2007, CMS started using the revised work RVUs resulting from the mandated 5-year review of work that has led to large increases in the work RVUs. With the increase in work RVUs there is also a mandate that requires that increases in RVUs may cause the total amount of expenditures to increase by more than \$20 million from what expenditures would have been had a change not been made. Therefore, CMS established a work budget neutrality adjustor of 0.8806 for 2008 (was 0.8994 in 2007), that will reduce work RVUs accordingly.

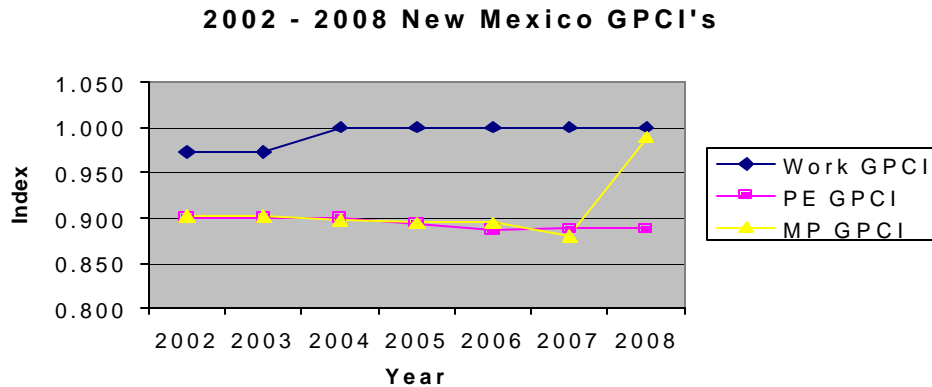
Changes in the Practice Expense RVUs

Beginning in 2007, CMS started to use a different methodology to determine practice expense RVUs. CMS used a bottom-up methodology for direct costs, they used supplementary survey data for indirect costs, and they also eliminated the non-physician workpool to calculate the practice expense RVUs. The non-physician workpool was a special method that calculated practice expense RVUs for services with no physician work.

Changes in the Geographical Practice Cost Indices (GPCIs)

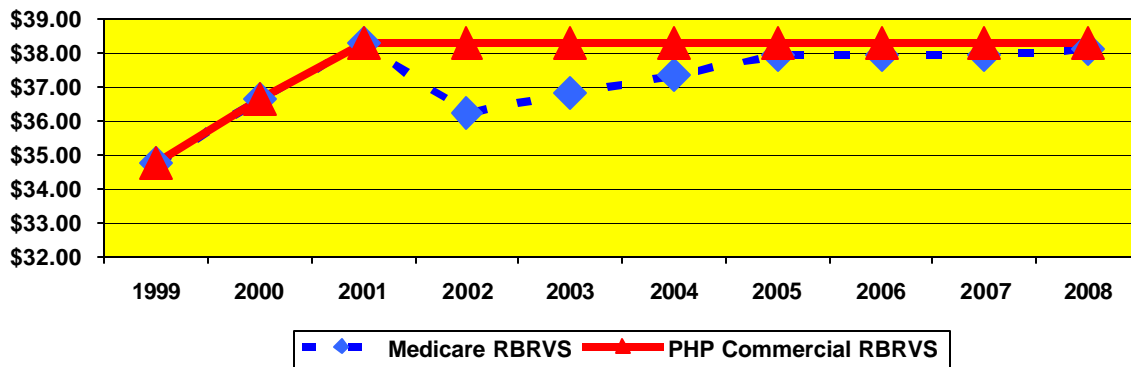
For 2008, with the introduction of the Medicare, Medicaid and SCHIP Extension Act of 2007, the application of the 1.000 floor for the work GPCI for any locality for which the index is lower than 1.000 (based on the GPCIs published in the December 1, 2007 *Federal Register*), will be extended until June 30, 2008. Practice expense and malpractice are also affected for 2008.

The graph below shows the changes in the GPCIs for New Mexico for the last 6 years:



Presbyterian RBRVS Fee Schedule Updates

For the seventh year in a row, Presbyterian Health Plan (PHP) is proud to announce that for our Commercial and ASO lines of business, we will carry forward the 2001 conversion factor for the 2008 calendar year. The 2001 conversion factor of \$38.2581 will be applied to the 2008 RVUs with the application of the reimbursement changes that are detailed below. The graph below shows the PHP conversion factor since inception in 2002:



PHP will also freeze the Budget Neutrality Adjustor at the 2007 level of 0.8994 for the 2008 PHP-RBRVS Fee Schedule.

The New Mexico Medicare Fee Schedule, with the conversion factor of \$37.0870 and the budget neutrality adjustor of 0.8806, will be used for all Medicare Advantage and Medicare PPO lines of business.

Calculation of the RBRVS Fee Schedule with the Budget Neutrality Adjustor

2008 New Mexico RBRVS Non-Facility Payment Amount =
[(Work RVU * Budget Neutrality Adjustor (0.8806) (rounded to 2 decimal points) *
Work GPCI) (rounded to 4 decimal points) +
(Non-Facility Practice Expense RVU * Practice Expense GPCI) +
(Malpractice RVU * Malpractice GPCI)] * Conversion Factor

To determine the Facility allowable, use the same calculation above but apply the Facility Practice Expense RVUs.

The Presbyterian RBRVS Fee Schedule will use the same calculation above but with the budget neutrality adjustor of 0.8994 and the conversion factor of \$38.2581.

The CMS RBRVS Fee Schedule can be found at the following link:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage>

Changes in Reimbursement for Diagnostic Imaging Procedures

Section 5102(b) of the Deficit Reduction Act of 2005 requires that a payment cap be placed on the Technical Component (TC) of certain diagnostic imaging services. The cap is based on the Outpatient Prospective Payment System (OPPS). Under this provision, payment under the physician fee schedule for furnishing certain imaging procedures can not exceed the amount paid to a hospital outpatient department. Adjustment of the technical component payment under this provision will mean that the payment for the global component will also change so that the adjusted technical and the unadjusted professional components add up to the global payment amount. Below is the calculation for the implementation of this provision.

2008 OPPS Non-Facility Payment Amount =
[(Work RVU * Budget Neutrality Adjustor (0.8806) * Work GPCI) +
(OPPS Non-Facility Practice Expense RVU * Practice Expense GPCI) +
(OPPS Malpractice RVU * Malpractice GPCI)] * Conversion Factor

To determine the Facility allowable, use the same calculation above but apply the Facility Practice Expense RVUs.

Once this calculation is done, the physician fee schedule amount and the OPSS payment are compared and the lower amount is used as the final allowable.

Changes in Reimbursement for Ambulatory Surgery Centers (ASC)

For 2008, CMS published a payment system for ASCs that is effective January 1, 2008. The revised ASC payment system is based on the hospital Outpatient Prospective Payment System (OPPS). The standard ASC payment for most ASC covered surgical procedures is calculated by multiplying the ASC conversion factor (\$41.401 for calendar year 2008) by the ASC relative payment weight (set based on the OPSS relative payment weight) for each separately payable procedure.

For information on the calendar year 2008 Revised Ambulatory Surgical Center (ASC) Payment System, please use the link below:

<http://www.cms.hhs.gov/ASCPayment/downloads/ASCQAs123107.pdf>

For a complete listing of approved ASC procedure codes and their corresponding grouper assignment and payment, please use the link below:

<http://www.cms.hhs.gov/ASCPayment/>

Presbyterian will apply this reimbursement methodology to all Medicare Advantage and Medicare PPO lines of business effective January 1, 2008. In the near future, Presbyterian will also apply this reimbursement methodology to all Commercial and ASO lines of business.

Status B Codes for 2008

Effective: 02/01/2008

Procedures that have been designated by CMS as bundled services will no longer be reimbursable by PHP. CMS has designated certain CPT and HCPCS codes as Status B codes meaning these services are considered to be an integral part of another service. Even if these bundled services are billed alone, no reimbursement will be made. PHP has reviewed the CMS Status B code listing and has determined that certain codes should not be considered bundled, either through benefit definition or contractual agreements, and those codes have been removed. Also, there may be some codes that are considered non-bundled codes by the New Mexico Human Services Department (HSD), and those will remain unbundled for the Salud line of business only.

A current PHP listing of these bundled services is attached below for your review and use. A complete listing of these status B codes can be found at the CMS website at:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1192486&intNumPerPage=10>

As the status B codes are updated by CMS, PHP will also implement these codes, after review, into our claims editing system. Updates to the status B codes listing will also be included in the Presbyterian Practitioner and Provider Manual.

Code	Modifier	Description	Status Code	Code	Modifier	Description	Status Code
A4262		Temporary tear duct plug	B	94150	TC	Vital capacity test	B
A4263		Permanent tear duct plug	B	94150	26	Vital capacity test	B
A4270		Disposable endoscope sheath	B	96040		Genetic counseling, 30 min.	B
A4300		Cath impl vasc access portal	B	96902		Trichogram	B
A4550		Surgical trays	B	97010		Hot or cold packs therapy	B
G0269		Occlusive device in vein art	B	97602		Wound(s) care non-selective	B
Q3031		Collagen skin test	B	98960		Self-mgmt educ & train, 1 pt	B
R0076		Transport portable EKG	B	98961		Self-mgmt educ/train, 2-4 pt	B
15850		Removal of sutures	B	98962		Selt-mgmt educ/tran, 5-8 pt	B
20930		Spinal bone allograft	B	99000		Specimen handling	B
20936		Spinal bone autograft	B	99001		Specimen handling	B
22841		Insert spine fixation device	B	99002		Device handling	B
36416		Capillary blood draw	B	99024		Postop follow-up visit	B
38204		BI donor search management	B	99051		Med srvs eve/wkend/holiday	B
78890		Nuclear medicine data proc	B	99053		Med serv 10pm-8am 24hr fac	B
78890	TC	Nuclear medicine data proc	B	99058		Office emergency care	B
78890	26	Nuclear medicine data proc	B	99060		Out of office emerg med serv	B
78891		Nuclear med data proc	B	99070		Special supplies	B
78891	TC	Nuclear med data proc	B	99071		Patient education materials	B
78891	26	Nuclear med data proc	B	99080		Special reports or forms	B
91123		Irrigate fecal impaction	B	99090		Computer data analysis	B
92352		Special spectacles fitting	B	99091		Collect/review data from pt	B
92353		Special spectacles fitting	B	99100		Special anesthesia service	B
92354		Special spectacles fitting	B	99116		Anesthesia with hypothermia	B
92355		Special spectacles fitting	B	99135		Special anesthesia procedure	B
92358		Eye prosthesis service	B	99140		Emergency anesthesia	B
92371		Repair & adjust spectacles	B	99288		Direct advanced life support	B
92531		Spontans nystagmus study	B	99339		Domicil/r-home care supervis	B
92532		Positional nystagmus test	B	99340		Domicil/r-home care supervis	B
92533		Caloric vestibular test	B	99358		Prolonged serv, w/o contact	B
92534		Optokinetic nystagmus test	B	99359		Prolonged serv, w/o contact	B
92605		Eval for nonspeech device rx	B	99363		Anticoag mgmt, init	B
92606		Non-speech device service	B	99364		Anticoag mgmt, subsez	B
93740		Temperature gradient studies	B	99366		Team conf w/pat by hc pro	B
93740	TC	Temperature gradient studies	B	99367		Team conf w/o pat by phys	B

Code	Modifier	Description	Status Code	Code	Modifier	Description	Status Code
93740	26	Temperature gradient studies	B	99368		Team conf w/o pat by hc pro	B
93770		Measure venous pressure	B	99374		Home health care supervision	B
93770	TC	Measure venous pressure	B	99377		Hospice care supervision	B
93770	26	Measure venous pressure	B	99379		Nursing fac care supervision	B
94005		Home vent Mgmt suprvsn	B	99380		Nursing fac care supervision	B
94150		Vital capacity test	B				

NOTE: CPT codes 99100, 99116, 99135, and 99140 are payable only for the Salud lines of business.

Vaccination Code Reimbursement Rates

Effective: January 1, 2008

For dates of service on or after January 1, 2008, some vaccine code reimbursement rates will increase to reflect the current best market price. These reimbursement rates apply to Presbyterian Health Plan Commercial, Presbyterian Senior Care and Presbyterian Salud products. **For Presbyterian Salud practitioners, vaccines that are part of the Vaccines for Children (VFC) program must be obtained through the Department of Health.** We will evaluate the vaccine reimbursement rates quarterly to ensure that they remain at a competitive market rate. We will notify you of any changes. Below you will find Presbyterian Vaccination Codes and Reimbursement Rates, a descriptive listing of immunizations and identifying codes along with the reimbursement rates for all Presbyterian network practitioners.

Code	Description	Rate
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use	\$169.10
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live for intravesical use	\$169.10
90632	Hepatitis A vaccine, adult dosage, for intramuscular use	\$69.05
90633*	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use	\$34.34
90634	Hepatitis A vaccine, pediatric/adolescent dosage – 3dose schedule for intramuscular use	\$34.34
90636	Hepatitis A hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	\$97.92
90645*	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule) for intramuscular use	\$27.32
90646	Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use	\$27.04
90647*	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use	\$27.32
90648*	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use	\$27.04
90649*	Human Papilloma Virus (HPV) Types 6, 11, 16, 18	\$144.75
90655*	Influenza virus vaccine, split virus, preservative free, 6-35 months of age, Intramuscular	\$15.38
90656	Influenza virus vaccine, split virus, preservative free, 3 years and older, Intramuscular	\$16.57
90657*	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use	\$8.10
90658*	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use	\$16.19
90669*	Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use	\$82.95
90675	Rabies vaccine, for intramuscular use	\$188.10
90680*	Rotavirus vaccine, tetravalent, live, for oral use	\$85.25

<i>Code</i>	Description	<i>Rate</i>
90690	Typhoid vaccine, live, oral	\$12.06
90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	\$53.08
90692	Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use	\$23.49
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous or jet injection use (US military)	\$48.56
90700*	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DtaP), for intramuscular use	\$25.28
90701*	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use	\$25.82
90702*	Diphtheria and tetanus toxoids (DT), absorbed for use in individuals younger than seven years, for intramuscular use	\$13.85
90703*	Tetanus toxoid absorbed, for intramuscular or jet injection use	\$19.89
90704	Mumps virus vaccine, live, for subcutaneous or jet injection use	\$25.55
90705	Measles virus vaccine, live, for subcutaneous or jet injection use	\$19.72
90706	Rubella virus vaccine, live, for subcutaneous or jet injection use	\$21.98
90707*	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use	\$53.36
90710*	Measles, mumps, rubella, and varicella (MMRV) vaccine, live, for subcutaneous use	\$155.81
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use	\$29.67
90714	Tetanus, diphtheria toxoids (Td), adsorbed, preservative free, 7 years or older, intramuscular	\$23.24
90715*	Tetanus, diphtheria, acellular pertussis, 7 years or older, intramuscular	\$23.24
90716*	Varicella virus vaccine, live, for subcutaneous use	\$89.32
90717	Yellow fever vaccine, live, for subcutaneous use	\$67.29
90718*	Tetanus and diphtheria toxoids (Td) absorbed for use in individuals seven years or older, for intramuscular or jet injection use	\$22.67
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use	\$50.86
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use	\$42.89
90723*	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and poliovirus vaccine, inactivated, (DtaP-HepB-IPV), intramuscular	\$43.75
90732*	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use	\$35.12
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injections use	\$109.24
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use	\$107.17
90735	Japanese encephalitis virus vaccine, for subcutaneous use	\$112.20
90736	Zoster (shingles) vaccine, live, for subcutaneous injection	\$183.00
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	\$134.49
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	\$25.64
90744*	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use	\$25.64
90746	Hepatitis B vaccine, adult dosage, for intramuscular use	\$59.52
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule) for intramuscular use	\$134.49
90748*	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	\$28.30

* - Denotes vaccinations included as part of the Vaccine for Children Program.

PT, OT, ST Modifiers for 2008

Effective: 01/01/2008

Below is a listing of CPT and HCPCS codes that CMS has defined as therapy services which may require the addition of the following modifiers when billing for these services.

- ? **GN** - Outpatient Speech Language Services
- ? **GO** - Outpatient Occupational Therapy Services
- ? **GP** - Outpatient Physical Therapy Services

Covered therapy services are to be delivered by licensed healthcare practitioners including physicians, DOM, chiropractors, or an appropriately licensed therapist in direct patient contact.

64550	90901	<u>92506</u>	<u>92507</u>	<u>92508</u>	<u>92526</u>
<u>92597</u>	<u>92605****</u>	<u>92606****</u>	<u>92607</u>	<u>92608</u>	<u>92609</u>
92610	92611	92612	92614	92616	95831
95832	95833	95834	95851	95852	96105
96110	96111	<u>96125</u>	<u>97001</u>	<u>97002</u>	<u>97003</u>
<u>97004</u>	<u>97010****</u>	<u>97012</u>	<u>97016</u>	<u>97018</u>	<u>97022</u>
<u>97024</u>	<u>97026</u>	<u>97028</u>	<u>97032</u>	<u>97033</u>	<u>97034</u>
<u>97035</u>	<u>97036</u>	<u>97039*</u>	<u>97110</u>	<u>97112</u>	<u>97113</u>
<u>97116**</u>	<u>97124</u>	<u>97139*</u>	<u>97140</u>	<u>97150</u>	<u>97530</u>
97532	<u>97533</u>	<u>97535</u>	<u>97537</u>	<u>97542</u>	97597
97598	97602****	97605	97606	<u>97750</u>	<u>97755</u>
<u>97760**</u>	<u>97761</u>	<u>97762</u>	<u>97799*</u>	<u>G0281</u>	<u>G0283</u>
G0329	0019T***	0029T***			

CMS provides the following guidelines for the codes listed above:

Underlined codes are always therapy services, regardless of the circumstances or who performs them. These codes *always* require therapy modifiers whenever they are billed. If no modifier is submitted on the claim form, the service will be denied.

* Codes are active codes on the physician fee schedule but do not have established allowables (codes 97039, 97139 and 97799). Since code 97799 is a miscellaneous code, it will require a description of the service you are performing and/or medical records to determine medical necessity.

** Code 97760 should not be reported with code 97116. However, if code 97760 was performed on an upper extremity and code 96116 (gait training) was also performed; both codes may be billed with modifier 59 to denote a separate anatomic site.

*** Codes do not have established allowables and should not be used unless there is no other CPT or HCPCS code available that describes the service(s) you are performing.

**** Codes are bundled. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, separate payment will not be issued.

Evaluation and Management (E&M) Services with Minor Surgeries

Per CMS, Evaluation and Management services are generally not separately reportable when billed with minor surgical procedures for an established patient. A minor surgical procedure would be a procedure that has a global period of 000 (Zero) days. The E&M is part of the global service and there is an inherent E&M service component included in all surgical procedures. The same is true when billing a substantial diagnostic or therapeutic procedure. In order to bill an E&M with these services, there must be some other sign, symptom or complaint that needs attention above and beyond the service provided, and for which the services can stand alone as a billable E&M service. If a significant, separately identifiable E&M service is appropriately performed and documented in the member's medical record, the E&M must be reported by adding the modifier "25" to the appropriate level of service.

Presbyterian wants to ensure that you have the information needed to submit claims that can be paid without delays. If you have any questions at all, please contact your Provider Services Coordinator or myself and we will be happy to assist you. We are available Monday through Friday from 8 a.m. to 5 p.m.

We appreciate your commitment to providing excellent care and services to our members. Thank you for partnering with us to improve the health of individuals, families, and communities.

Sincerely,



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