PRESBYTERIAN

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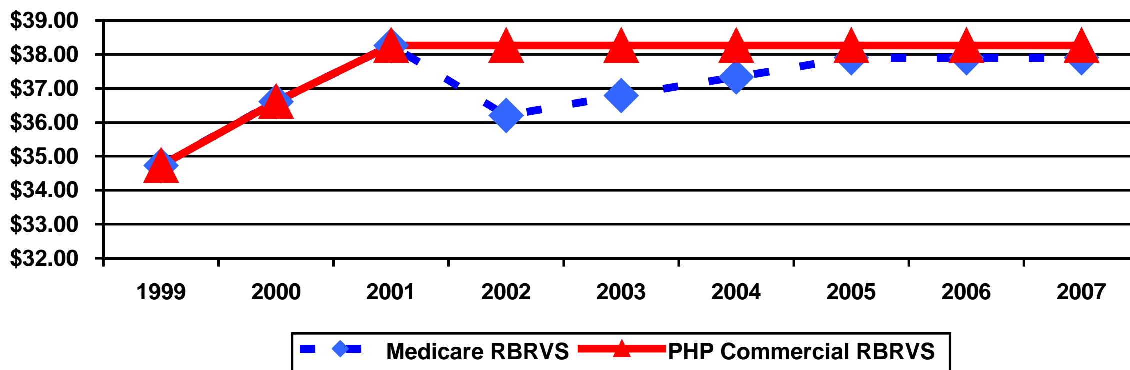
IMPORTANT UPDATES: Coding, Claims, Reimbursement, and Billing

2007 FEE SCHEDULE INFORMATION

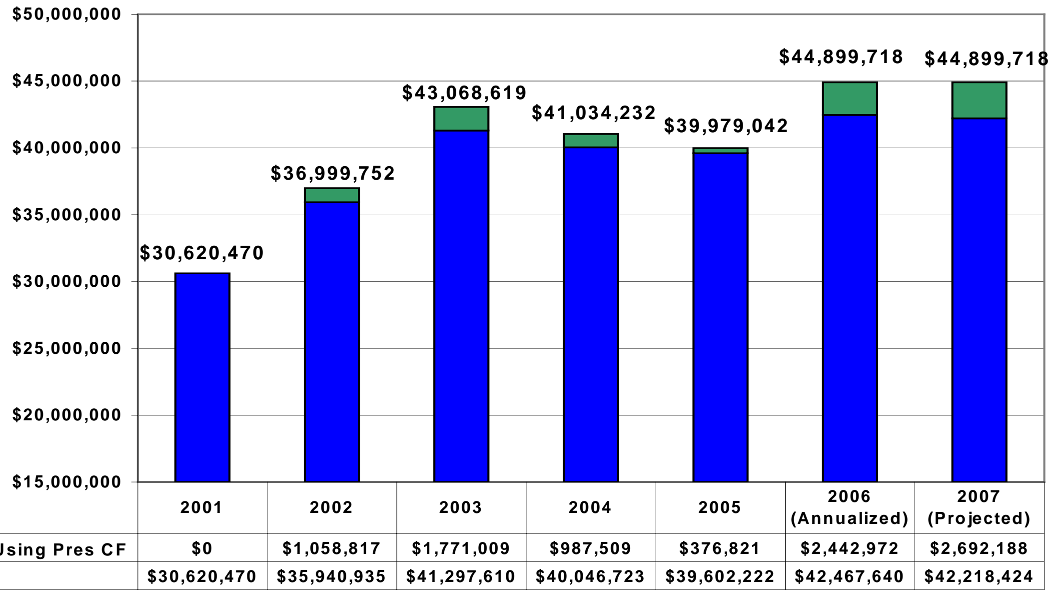
In November of 2006, the Centers for Medicare and Medicaid Services (CMS) released the 2007 Physician Fee Schedule with a conversion factor of $35.9848, which was a reduction of 5% over the 2006 conversion factor of $37.8975. Needless to say, the physician community was not very pleased with this decision and started campaigning to have Congress reconsider this reduction. In mid-December, Congress responded to the dissatisfaction from the physician community with the Tax Relief and Health Care Act of 2006. The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same conversion factor level as 2006 ($37.8975), reversing the statutorily mandated 5.0% negative update. However, leaving the conversion factor at the 2006 level does not, in any way, mean that the reimbursement amounts for 2007 will be the same as in 2006. Below is a listing of other initiatives that were implemented with the 2007 fee schedule that will affect physician payment.

Presbyterian RBRVS Fee Schedule Updates

For the sixth 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 2007 calendar year. The 2001 conversion factor of $38.2581 will be applied to the 2007 RVUs with the application of the reimbursement changes that are detailed below. The graph below shows the PHP conversion factor since inception in 2002:



The New Mexico Medicare Fee Schedule, with the conversion factor of $37.8975, will be used for all Medicare Advantage and Medicare PPO lines of business. The graph below shows the benefit to our provider network by using the PHP-RBRVS for all commercial and ASO lines of business:



	2001	2002	2003	2004	2005	2006 (Annualized)	2007 (Projected)
Amt Benefit to Network Using Pres CF	$0	$1,058,817	$1,771,009	$987,509	$376,821	$2,442,972	$2,692,188
Amt Paid Using CMS CF	$30,620,470	$35,940,935	$41,297,610	$40,046,723	$39,602,222	$42,467,640	$42,218,424

Changes in Work Relative Values Units (RVUs)

For 2007, CMS is 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 0.8994 that will reduce work RVUs accordingly.

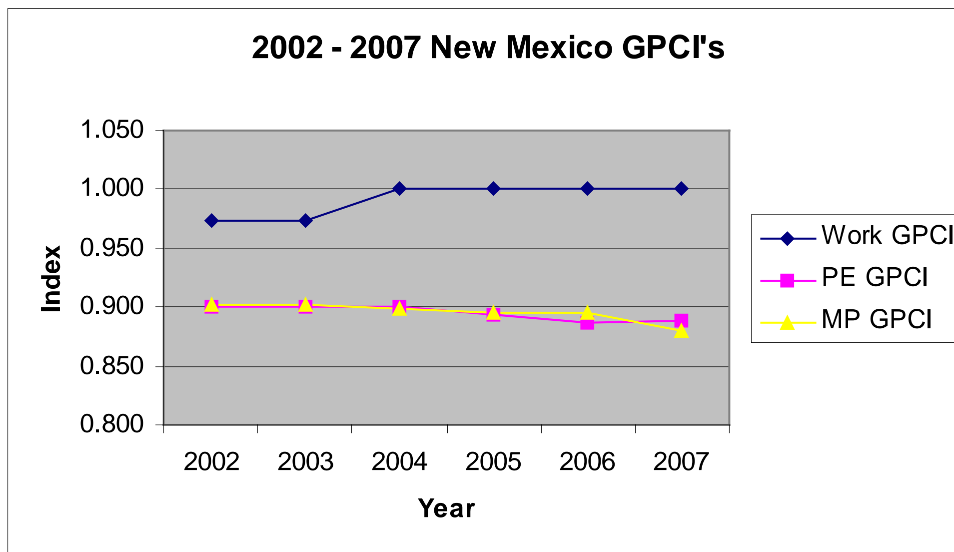
Changes in the Practice Expense RVUs

For 2007, CMS used 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 2007, as mandated by the Tax Relief and Health Care Act of 2006, the application of the 1.00 floor for the work GPCI for any locality for which the index is lower than 1.00 (based on the GPCIs published in the December 1, 2006 *Federal Register*), will be extended until December 31, 2007. Practice expense and malpractice will not be affected by this provision.

The graph below shows the changes in the GPCIs for New Mexico for the last 5 years:



Calculation of the RBRVS Fee Schedule with the Budget Neutrality Adjustor

2007 RBRVS Non-Facility Payment Amount =
[(Work RVU * Budget Neutrality Adjustor (0.8994) (rounded to 2 decimal points) * Work GPCI) +
(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.

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 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.

2007 OPPS Non-Facility Payment Amount =
[(Work RVU * Budget Neutrality Adjustor (0.8994) * 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 OPPS payment are compared and the lower amount is used as the final allowable.

Changes in Reimbursement for Certain Multiple Imaging Procedures

Per CMS guidelines, we will apply a 25% payment reduction on the Technical Component (TC) of selected multiple diagnostic imaging procedures for 2007. CMS has created 11 Radiology Families grouped by contiguous body parts in which the highest paying procedure from a family will pay at 100% and any other procedures from the same family will reduce by 25% when procedures are performed during the same session on the same day. This applies only to contiguous body areas, i.e., within a family of codes, not across families that are provided in one session. For example, if one procedure from family group 2 and 1 procedure from family group 4 is performed at the same session on the same day, then there is no reduction. If two procedures from family group 5 are performed at the same session on the same day, then the highest paying procedure will pay at 100% and the other procedure will reduce by 25%. Below is a link for more information and a listing of the 11 Radiology Families for your review.

http://www.cms.hhs.gov/MLNMattersArticles/2005MMA/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=7&sortOrder=ascending&itemID=CMS053457&intNumPerPage=10

Presbyterian will apply this reduction for all lines of business effective January 1, 2007.

Changes in Reimbursement for Ambulatory Surgery Centers (ASC)

For 2007, CMS published a fee schedule for ASCs that is effective January 1, 2007, changing the grouping of CMS approved ASC codes from groupers 1 through 9, to groupers 1 through 56. The fee schedule can be reviewed by going to the Pinnacle Business Solutions, Inc., Medicare Services Web site at:

http://www.oknmmedicare.com/provider/viewarticle.aspx?articleid=4002

For a complete listing of approved ASC procedure codes and their corresponding grouper assignment, 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, 2007. In the near future, Presbyterian will also apply this reimbursement methodology to all Commercial and ASO lines of business.

Payment of Moderate (Conscious) Sedation

CPT codes 99143, 99144, 99145, 99148, 99149, and 99150

Effective 02/01/2007

Moderate (conscious) sedation is a drug induced depression of consciousness during which patients responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate.

When providing moderate sedation, the following services are included and should NOT be reported separately:

- Assessment of the patient;
- Establishment of IV access and fluids to maintain patency, when performed;
- Administration of agent(s);
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure, and
- Recovery (not included in intra-service time)

The above is taken directly from the *2007 AMA Current Procedural Terminology (CPT) Professional Edition*.

PHP has created coding edits that will **not** pay for moderate sedation when billed with codes listed in Appendix G of the 2007 CPT book. There is also a listing of certain

radiology oncology procedure codes that are not reimbursable when billed with moderate sedation CPT codes. This information can be found by reviewing the National Correct Coding Policy Manual, Version 12.3, Chapter 9, Radiology Services, section F, at the following link:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/

Once you are in this website, you will need to select "NCCI Policy Manual for Part B Medicare Carriers", and then search for Chapter 9 in the listing.

Reimbursement Guidelines for the Administration of Gardasil for Human Papilloma Virus (HPV)

Effective 01/01/2007

Gardasil is a vaccine indicated in girls and women 9 to 26 years of age for the prevention of cervical cancer and genital warts caused by human papilloma virus (HPV) Types 6, 11, 16, and 18. Gardasil is also indicated in girls and women 9 to 26 years of age for the prevention of the following pre-cancerous or dysplastic lesions caused by HPV Types 6, 11, 16, and 18: cervical adenocarcinoma *in situ,* cervical intraepithelial neoplasia (CIN) grade 2 and 3; vulvar intraepithelial neoplasia (VIN) grade 2 and 3; vaginal intraepithelial neoplasia (VaIN) grade 2 and 3; and CIN grade 1.

Gardasil should be administered in three separate intramuscular injections in the upper arm over a 6-month period with the first dose at an elected date, the second dose 2 months after the first dose, and the third dose 6 months after the first dose. At this time, due to vaccine availability the target population is for females, 11-12 years of age.

PHP will limit coverage of the immunization for HPV to females ages 9 through 26.

The vaccine is billed with CPT code 90649 - Human Papilloma Virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), and 3-dose schedule for intramuscular use.

Effective 01/01/2007 for all lines of business, PHP will pay CPT code 90649 with any of the diagnosis codes listed below for females ages 9 through 26 (up until their 27th birthday):

- V05.8 – Need for other prophylactic vaccination and inoculation against single diseases, other specified disease
- V04.89 - Need for other prophylactic vaccination and inoculation against other viral diseases
- 054.0 - 054.9 - Herpes simplex
- 078.11 - Condyloma acuminatum (cluster of mucosa or epidermal lesions on external; viral infection is sexually transmitted)
- 079.4 - Human papillomavirus
- 180.0 - 180.9 - Malignant neoplasm of cervix uteri

- 184.0 - 184.4 - Malignant neoplasm of other female genital organs
- 233.1 - Carcinoma in situ of cervix uteri
- 622.10 - 622.12 Dysplasia of cervix (uteri)
- 795.05 - Cervical high-risk human papillomavirus (HPV) DNA test positive
- 795.09 - Other abnormal Papanicolaou smear of cervix and cervical HPV
- V01.6 - Contact with or exposure to venereal diseases
- V02.8 - Carrier or suspected carrier of other venereal diseases
- V69.2 - High-risk sexual behavior

If CPT code 90649 is billed for ages under 9 or over 26, the charge for the administration and the charge for the HPV vaccine will also be denied by the PHP claims payment system. The member will not be responsible for these denied services and cannot be balance billed.

B Status Codes for 2006

Effective: 02/01/2007

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 that mean 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 and a complete listing of these status B codes can be found at the CMS Web site at:

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

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

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

Code	Mod	Description	Status Code		Code	Mod	Description	Status Code
A4262		Temporary tear duct plug	B		93770		Measure venous pressure	B
A4263		Permanent tear duct plug	B		93770	TC	Measure venous pressure	B

Code	Mod	Description	Status Code
A4270		Disposable endoscope sheath	B
A4300		Cath impl vasc access portal	B
A4550		Surgical trays	B
G0269		Occlusive device in vein art	B
Q3031		Collagen skin test	B
Q9958		HOCM <=149 mg/ml iodine, 1ml	B
Q9959		HOCM 150-199mg/ml iodine,1ml	B
Q9960		HOCM 200-249mg/ml iodine,1ml	B
Q9961		HOCM 250-299mg/ml iodine,1ml	B
Q9962		HOCM 300-349mg/ml iodine,1ml	B
Q9963		HOCM 350-399mg/ml iodine,1ml	B
Q9964		HOCM>= 400mg/ml iodine, 1ml	B
R0076		Transport portable EKG	B
15850		Removal of sutures	B
20930		Spinal bone allograft	B
20936		Spinal bone autograft	B
22841		Insert spine fixation device	B
36416		Capillary blood draw	B
36540		Collect blood venous device	B
38204		Bl donor search management	B
78890		Nuclear medicine data proc	B
78890	TC	Nuclear medicine data proc	B
78890	26	Nuclear medicine data proc	B
78891		Nuclear med data proc	B
78891	TC	Nuclear med data proc	B
78891	26	Nuclear med data proc	B
90885		Psy evaluation of records	B
90887		Consultation with family	B
90889		Preparation of report	B
91123		Irrigate fecal impaction	B
92352		Special spectacles fitting	B
92353		Special spectacles fitting	B
92354		Special spectacles fitting	B
92355		Special spectacles fitting	B
92358		Eye prosthesis service	B
92371		Repair & adjust spectacles	B
92531		Spontaneous nystagmus study	B
92532		Positional nystagmus test	B
92533		Caloric vestibular test	B
92534		Optokinetic nystagmus test	B
92605		Eval for nonspeech device rx	B
92606		Non-speech device service	B
93740		Temperature gradient studies	B
93740	TC	Temperature gradient studies	B
93740	26	Temperature gradient studies	B
93770	26	Measure venous pressure	B
94005		Home vent mgmt supervision	B
94150		Vital capacity test	B
94150	TC	Vital capacity test	B
94150	26	Vital capacity test	B
96040		Genetic counseling, 30 min	B
96902		Trichogram	B
97010		Hot or cold packs therapy	B
98960		Self-mgmt educ & train, 1 pt	B
98961		Self-mgmt educ/train, 2-4 pt	B
98962		Self-mgmt educ/train, 5-8 pt	B
99000		Specimen handling	B
99001		Specimen handling	B
99002		Device handling	B
99024		Postop follow-up visit	B
99051		Med serv, eve/wkend/holiday	B
99053		Med serv 10pm-8am, 24 hr fac	B
99058		Office emergency care	B
99060		Out of office emerg med serv	B
99070		Special supplies	B
99071		Patient education materials	B
99080		Special reports or forms	B
99090		Computer data analysis	B
99091		Collect/review data from pt	B
99100		Special anesthesia service	B
99116		Anesthesia with hypothermia	B
99135		Special anesthesia procedure	B
99140		Emergency anesthesia	B
99288		Direct advanced life support	B
99339		Domicil/r-home care supervision	B
99340		Domicil/r-home care supervision	B
99358		Prolonged serv, w/o contact	B
99359		Prolonged serv, w/o contact	B
99361		Physician/team conference	B
99362		Physician/team conference	B
99363		Anticoag mgmt, init	B
99364		Anticoag mgmt, subseq	B
99371		Physician phone consultation	B
99372		Physician phone consultation	B
99373		Physician phone consultation	B
99374		Home health care supervision	B
99377		Hospice care supervision	B
99379		Nursing fac care supervision	B
99380		Nursing fac care supervision	B

Salud Ambulance Update

Effective 01/01/2007

In a notification from the Medical Assistance Division of the State of New Mexico Human Services Department, Number 06-09, dated December 28, 2006, there is direction that in order to be HIPAA compliant, the use of the modifiers 92 and 93 will be discontinued as of January 31, 2007. In their places, modifiers U2 and U3 must be used on claims beginning with dates of services on or after February 1, 2007.

Also, PHP has noticed an increase in claim submissions for ambulance services for the commercial and ASO lines of business where the uses of the modifiers U1 through U9 and UA through UD have been submitted. Please be advised that the use of these modifiers for any lines of business besides Salud and SCI is incorrect and can result in denial of your services. These modifiers have the description of "Medicaid Care Level" and should only be used for Salud and SCI lines of business.

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 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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