

January 7, 2009

IMPORTANT UPDATES: Coding, Claims, Reimbursement, and Billing

2009 FEE SCHEDULE INFORMATION

In November of 2008, the Centers for Medicare and Medicaid Services (CMS) released the 2009 Physician Fee Schedule with a conversion factor of \$36.0666, a reduction of approximately 5.3% over the 2008 conversion factor of \$38.0870. With the decrease in the conversion factor for 2009, CMS also removed the Budget Neutrality Adjustor (BNA), which reduced the work Relative Value Unit (RVU) portion of the fee schedule.

It appears that the reduction of the conversion factor and the removal of the BNA for 2009 have left the Resource Based Relative Value Scale (RBRVS) fee schedule with slightly higher allowables for 2009 when compared to 2008 NM-RBRVS. When compared to the PHP-RBRVS fee schedule, which uses a conversion factor of \$38.2581 but applies BNA in the amount of 0.8994 to the work RVU value of the RBRVS fee schedule, there is little to no variance.

In light of significant payment methodology changes during the past few years, and the budget uncertainty that the new administration will be facing, **Presbyterian will be “freezing” the RBRVS fee schedule at the 2008 level for all commercial lines of business in order to bring some stability to our provider network.**

We will be using the 2008 RVUs as the base of this fee schedule but we will also apply 2009 RVUs for any new codes added as of January 1, 2009. However, we will apply the BNA of 0.8994 to the work RVU and apply the conversion factor of \$38.2581. We will continue to monitor the fee schedule to ensure that we stay neutral with our allowables.

PHP Medicare Advantage and Medicare PPO will be reimbursed using the 2009 RRBVS fee schedule as released by CMS and posted in the Federal Register, with the conversion factor of \$36.0666, for dates of services on or after January 1, 2009.

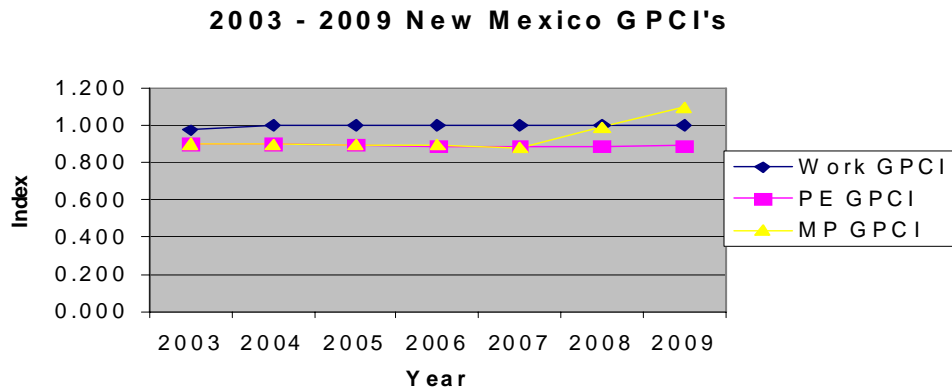
Changes in the Practice Expense RVUs

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 eliminated the non-physician work pool to calculate the practice expense RVUs. The non-physician work pool was a special method that calculated practice expense RVUs for services with non-physician work.

Changes in the Geographical Practice Cost Indices (GPCIs)

For 2009, 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 will be extended to include 2009. Practice expense (0.888 in 2008 and now 0.890 in 2009) and malpractice (0.989 in 2008 and now 1.096 in 2009) have also changed for 2009.

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



Calculation of the PHP-RBRVS Fee Schedule

2009 PHP-RBRVS Non-Facility Payment Amount =
[(2008 Work RVU * Budget Neutrality Adjustor (0.8994) (rounded to 2 decimal points) *
2008 Work GPCI) + (2008 Transitioned Non-Facility Practice Expense RVU * 2008
Practice Expense GPCI) + (2008 Malpractice RVU * 2008 Malpractice GPCI)] *
Conversion Factor

Calculation of the NM-RBRVS Fee Schedule

2009 New Mexico RBRVS Non-Facility Payment Amount =
[(2009 Work RVU * 2009 Work GPCI) (rounded to 4 decimal points) +
(2009 Transitioned Non-Facility Practice Expense RVU * 2009 Practice Expense GPCI)
+ (2009 Malpractice RVU * 2009 Malpractice GPCI)] * Conversion Factor

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

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

http://www.cms.hhs.gov/PhysicianFeeSched/01_Overview.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. Once the OPPS calculation is completed, the physician fee schedule amount and the OPPS payment are compared and the lower amount is used as the final allowable. This is effective January 1, 2009.

Changes in Reimbursement for Mental Health Codes

Effective July 1, 2008, CMS guidelines dictate that if the calculation flag on the RBRVS fee schedule is set at "2", then an adjustment of 1.05 should be applied to the fee schedule amount after all calculations are completed. The following mental health codes will be adjusted by 1.05:

90804 – 90809, 90810 – 90815, 90816 – 90822, and 90823 – 90829

Claims with the dates of service July 1, 2008 through December 31, 2008 will be adjusted by PHP and there will be no need for you to resubmit claims.

Preventive Chest X-Rays

Effective: February 1, 2009

In the past, PHP has paid for chest x-rays when performed with routine preventive diagnoses. This issue has been researched and PHP has determined that this should not be a covered service. Therefore, effective January 1, 2009, PHP will no longer reimburse for chest x-rays when billed with a preventive diagnosis code. However, chest x-rays will continue to be covered when performed in conjunction with a medically necessary symptom/diagnosis. This decision was based on research from the following websites:

<http://www.ahrq.gov/clinic/uspstf/uspstf/uspstf.htm>
<http://www.ahrq.gov/clinic/3rduspstf/lungcancer/lungcanrs.htm>
<http://www.arkmedicare.com/provider/medpolb/ac01005.asp>

Extracorporeal Photopheresis

Effective: February 1, 2009

CMS guidelines have been changed regarding the diagnosis requirements for Extracorporeal Photopheresis (EP). According to CMS, the services for EP should be coded using CPT-4 code 36522 or ICD-9-CM Procedure code 99.88. For some time, CMS allowed EP only when rendered for Mycosis Fungoides (ICD-9-CM codes 202.10 through 202.18). CMS has added two diagnosis codes to the list of diagnosis codes considered reasonable and necessary, and the additional diagnoses are complications of transplanted heart (ICD-9-CM codes 996.83), and complications of transplanted bone marrow (ICD-9-CM codes 996.85). PHP will follow this CMS policy for all lines of business, unless the individual benefit plan specifies otherwise. More information on the subject can be found online at the following website:

<http://www.cms.hhs.gov/Transmittals/downloads/R1206CP.pdf>

Status B Codes for 2009

Effective: February 1, 2009

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 codes 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 codes 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. You can find a complete listing of these Status B codes on 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*, which is available online at www.phs.org.

Code	Modifier	Description	Status Code
A4262		Temporary tear duct plug	B
A4263		Permanent tear duct plug	B
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
R0076		Transport portable EKG	B
15850		Removal of sutures	B
20930		Sp bone agrft morsel add-on	B
20936		Sp bone agrft local add-on	B
22841		Insert spine fixation device	B
36416		Capillary blood draw	B
38204		Bl donor search management	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		Measure venous pressure	B
93770	TC	Measure venous pressure	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
95992		Canalith repositioning proc	B
96040		Genetic counseling, 30 min	B

Code	Modifier	Description	Status Code
96902		Trichogram	B
97010		Hot or cold packs therapy	B
97602		Wound(s) care non-selective	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
99056		Med service out of office	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 supervis	B
99340		Domicil/r-home care supervis	B
99358		Prolonged serv, w/o contact	B
99359		Prolonged serv, w/o contact	B
99363		Anticoag mgmt, init	B
99364		Anticoag mgmt, subseq	B
99366		Team conf w/pat by hc pro	B
99367		Team conf w/o pat by phys	B
99368		Team conf w/o pat by hc pro	B
99374		Home health care supervision	B
99377		Hospice care supervision	B
99379		Nursing fac care supervision	B
99380		Nursing fac care supervision	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, 2009

For dates of service on or after January 1, 2009, 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.

<i>Code</i>	Description	<i>Rate</i>
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	\$103.42
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	\$150.51
90655*	Influenza virus vaccine, split virus, preservative free, 6-35 months of age, Intramuscular	\$17.40
90656	Influenza virus vaccine, split virus, preservative free, 3 years and older, Intramuscular	\$17.40
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	\$17.40
90669*	Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use	\$100.51
90675	Rabies vaccine, for intramuscular use	\$193.75
90680*	Rotavirus vaccine, tetravalent, live, for oral use	\$83.35
90690	Typhoid vaccine, live, oral	\$12.06
90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	\$54.66
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	\$26.00
90701*	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use	\$27.96
90702*	Diphtheria and tetanus toxoids (DT), absorbed for use in individuals younger than seven years, for intramuscular use	\$13.98
<i>Code</i>	Description	<i>Rate</i>
90703*	Tetanus toxoid absorbed, for intramuscular or jet injection use	\$27.96
90704	Mumps virus vaccine, live, for subcutaneous or jet injection use	\$26.54
90705	Measles virus vaccine, live, for subcutaneous or jet injection use	\$20.48
90706	Rubella virus vaccine, live, for subcutaneous or jet injection use	\$22.83

90707*	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use	\$55.40
90710*	Measles, mumps, rubella, and varicella (MMRV) vaccine, live, for subcutaneous use	\$149.24
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use	\$31.46
90714	Tetanus, diphtheria toxoids (Td), adsorbed, preservative free, 7 years or older, intramuscular	\$23.55
90715*	Tetanus, diphtheria, acellular pertussis, 7 years or older, intramuscular	\$23.55
90716*	Varicella virus vaccine, live, for subcutaneous use	\$92.86
90717	Yellow fever vaccine, live, for subcutaneous use	\$34.65
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	\$48.75
90732*	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use	\$38.64
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injections use	\$112.49
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use	\$114.67
90735	Japanese encephalitis virus vaccine, for subcutaneous use	\$115.56
90736	Zoster (shingles) vaccine, live, for subcutaneous injection	\$184.72
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	\$119.42
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	\$27.84
90744*	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use	\$25.29
90746	Hepatitis B vaccine, adult dosage, for intramuscular use	\$62.85
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule) for intramuscular use	\$119.42
90748*	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	\$27.04

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

PT, OT, ST Modifiers for 2009

Effective: January 1, 2009

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	<u>95992***</u>
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>
G0283	G0329	0019T***	0029T***	<u>0183T***</u>	

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.

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 8:00 a.m. to 5:00 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,

A handwritten signature in black ink, appearing to read 'S Tafoya', with a stylized flourish at the end.

Steve Tafoya
Director of Provider Reimbursement
Provider Services
(505) 923-8782
sttafoya@phs.org