

February 9, 2017

IMPORTANT UPDATES: Coding, Claims, Reimbursement, Billing

Presbyterian Health Plan Inc. and Presbyterian Insurance Company Inc. (Presbyterian) are committed to accurate and fair reimbursement for the services provided to our members. This letter contains updates on coding, reimbursement, claims and billing practices, and is intended to help providers avoid payment delays when submitting claims to Presbyterian.

Enclosed you will find the following sections:

- 2017 Resource-Based Relative Value Scale (RBRVS) Fee Schedule
- 2017 Fee Schedule Effective Dates
- Final Reductions to the Centennial Care Fee Schedule
- Oxygen Certificate of Medical Necessity (CMN) Requirements
- Quality Incentive Program for Primary Care Providers
- Presbyterian's Program Integrity Department Update
- 2017 CPT/HCPCS Code Changes
- Modifier GX, GY, and GZ
- Non-Contracted Laboratory Services

If you have any questions regarding this notification, please feel free to contact me by email at sttafoya@phs.org or by phone at (505) 923-8402, or you can contact your Provider Network Management relationship executive. Their contact information can be found at www.phs.org/ContactGuide.

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

Sincerely,



Steve Tafoya
Director of Provider Reimbursement
Presbyterian Health Plan
(505) 923-8402
sttafoya@phs.org

Enclosed: Oxygen Certificate of Medical Necessity (CMN)

2017 Resource-Based Relative Value Scale (RBRVS) Fee Schedule

CMS released the 2017 New Mexico RBRVS Fee Schedule with a conversion factor of \$35.8887, which is a 0.24 percent increase over the 2016 conversion factor of \$35.8043. The formula for the 2017 RBRVS fee schedule payment amount is as follows:

2017 Non-Facility Pricing Amount =

$$[(\text{Work Relative Value Unit (RVU)} * \text{Work Geographic Pricing Cost Index (GPCI)}) + (\text{Non-Facility Practice Expense (PE) RVU} * \text{PE GPCI}) + (\text{Malpractice (MP) RVU} * \text{MP GPCI})] * \text{Conversion Factor (CF)}$$

2017 Facility Pricing Amount =

$$[(\text{Work RVU} * \text{Work GPCI}) + (\text{Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor}$$

Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee schedule amount is compared to the OPPS payment amount and the lower amount is used in the formula below to calculate payment.

2017 OPPS Non-Facility Payment Amount =

$$[(\text{Work RVU} * \text{Work GPCI}) + (\text{OPPS Non-Facility PE RVU} * \text{PE GPCI}) + (\text{OPPS MP RVU} * \text{MP GPCI})] * \text{Conversion Factor}$$

2017 OPPS Facility Payment Amount =

$$[\text{Work RVU} * \text{Work GPCI}) + (\text{OPPS Facility PE RVU} * \text{PE GPCI}) + (\text{OPPS MP RVU} * \text{MP GPCI})] * \text{Conversion Factor}$$

For more information on the RBRVS fee schedule and the application of guidelines such as multiple surgery reductions, bi-lateral procedures, global surgery, assistant surgeon, etc., please use the following link:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU17A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>

2017 Fee Schedule Effective Dates and Distribution

The table below lists the effective dates for the updated 2017 fee schedules. The updated fee schedules are currently available upon request and can be emailed to you by contacting your Provider Network Management relationship executive. You can find his or her contact information at www.phs.org/ContactGuide. Fee schedules will also be posted to our website, www.phs.org, for easier access and a notification will be sent when the fee schedules are posted.

Fee Schedule	Effective Date
PHP-RBRVS Fee Schedule	January 1, 2017
NM-RBRVS Fee Schedule	January 1, 2017
All Ambulatory Surgical Center Fee Schedules	February 1, 2017
Medicare Durable Medical Equipment Fee Schedule	January 1, 2017

Medicare Anesthesia Conversion Factor	January 1, 2017
Medicare Average Sales Price Drug Fee Schedule	January 1, 2017
Average Wholesale Price Fee Schedule	February 1, 2017
Medicare Clinical Lab Fee	January 1, 2017

Final Reductions to the Centennial Care Fee Schedule

On Dec.13, 2016, The New Mexico Human Services Department (HSD) issued Supplement 16-12. In the supplement, HSD stated it is reducing Medicaid provider payment rates due to a serious shortfall in state revenues and a directive contained in the 2016 General Appropriations Act. These reductions will result in targeted savings while ensuring that Medicaid provider reimbursement rates are reasonable.

Effective Jan. 1, 2017, HSD will reduce any professional fee schedule codes, excluding behavioral health services, that remain at or above 100 percent of the Medicare fee schedule to 94 percent of the Medicare rate. HSD will apply the same exceptions that were applied to the August 2016 rate reductions, exempting codes for maternity/obstetrics care, family planning services, and Early and Periodic Screening and Diagnostic Treatment (EPSDT) Program Well-Child Check-up from the reduction.

The Medicaid fee schedule can be found on the HSD website at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>. Impacts to the behavioral health services are listed in the below table, and any changes are noted under the “Actions” column.

Procedure Code	Action	MD/DO	PHD	PHD with prescriptive authority	Master’s Level for Independent and Non-Independent Licensure Types	Clinical Psychiatric Nurse Specialists and/or Nurse Practitioners
90792 with or without U8	Will remain at current rate	\$154.38	-	\$139.70	-	\$139.70
90834 with or without U8	Will remain at current rate	\$105.71	\$85.27	\$85.27	\$76.31	\$75.55
90837 with or without U8	Will remain at current rate	\$141.95	\$87.12	\$87.12	\$80.09	\$75.55
90847 with or without HK	Will remain rate effective 8/1/16	\$117.12	\$92.17	\$92.17	\$86.75	\$86.75
90899	To be deleted	Code 90899 is being deleted because the description is UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE. A code that specifically described the services rendered must be used.				
96101	Will remain at current rate	\$87.30	\$87.30	\$87.30		
96103	Will remain at current rate	\$72.75	\$72.75	\$72.75		
96118	Will remain at current rate	\$97.00	\$97.00	\$97.00		
96120	Will remain at current rate	\$72.75	\$72.75	\$72.75		
96150	Will remain at current rate	\$22.79	\$22.79	\$22.79		

96151	Will remain at current rate	\$22.79	\$22.79	\$22.79		
H2010	\$30.00 effective 1/1/17					

Oxygen Certificate of Medical Necessity Requirements

Presbyterian instituted a Certificate of Medical Necessity (CMN) requirement for all members starting oxygen therapy in 2017. A CMN will be required:

- When a member first starts oxygen therapy.
- In the third month of oxygen therapy to ensure it is still medically necessary.
- In 13th month of oxygen therapy to document the patient’s need for ongoing oxygen therapy, possibly for life.

The CMN is also a way for the provider to review the member’s use of oxygen therapy to ensure the member is being compliant with the provider’s order.

Should a patient only need oxygen therapy for a short period of time (e.g., discharged from the hospital with temporary oxygen therapy after a bout with pneumonia), a CMN will also be required by the ordering provider or the member’s primary care provider, indicating that oxygen therapy should be stopped.

The CMN will require the signature of the provider that is reviewing the member’s need for oxygen therapy along with the date of service that the member came into the office for the oxygen therapy evaluation. Presbyterian informed all of its contracted durable medical equipment (DME)/oxygen providers that a CMN is required for oxygen therapy, which means that requests for filling out and signing the CMN may come directly from those DME/oxygen providers.

A copy of the oxygen CMN is enclosed for your use.

Quality Incentive Program for Primary Care Providers

Presbyterian’s enhanced Provider Quality Incentive Program (PQIP) rewards primary care providers who provide quality care to our patients. The program encourages providers to ensure that their patients receive evidence-based recommended screenings and services.

When patients do not receive necessary screenings, they are considered to have a gap in care. Once a provider is enrolled in the PQIP, Presbyterian will provide a list of patients identified as having a gap in care who meet one of the following criteria:

- Missing recommended or preventive screenings.
- Need recommended interventions.
- Require medications for chronic conditions.

How the program works:

A list of patients with these conditions and care gaps who are seen by a provider will be posted on the reports page of the myPRES Provider Portal. Presbyterian is offering providers a pay-for-performance incentive based on the percentage of care gaps closed for listed members.

The program does not require a contract and there is no risk to the provider. Presbyterian simply wants to reward providers for ensuring our members receive evidenced-based care. Detailed information about the PQIP is available from Presbyterian's Quality Department's Program Manager, Ryan Helton, who can be reached by phone at (505) 923-5255 or by email at rhelton@phs.org.

Presbyterian's Program Integrity Department Update

At Presbyterian, we are committed to keeping administrative costs as low as possible. The detection, prevention, and reduction of fraud, waste and abuse are essential to maintain a healthcare system that is affordable for everyone. It's reported that between four and eight percent of all healthcare claims are fraudulent, adding up to nearly \$50 billion each year. Throughout Presbyterian, we have several anti-fraud measures in place. Our Program Integrity Department (PID)'s Special Investigation Unit (SIU) identifies and investigates possible fraud, waste or abuse and refers appropriate cases for criminal prosecution where any individual or company defrauds or attempts to defraud our company or our customers.

The Presbyterian PID is a recognized leader in the healthcare antifraud and abuse industry, has one of the most experienced teams of fraud investigators in the industry, and is supported by sophisticated, state-of-the-art technology and years of in-depth intelligence gathered nationwide. Presbyterian's team of fraud analysts, investigators, data consultants, and thought leaders are industry veterans. They include an onsite medical director, registered nurses, certified fraud examiners, and certified professional coders. Together, they have uncovered millions of dollars of fraudulent, wasteful, and abusive claims.

In October 2016, John Baker became Presbyterian Health Plan's new PID director. Baker brings more than 17 years of experience in healthcare with 11 years in special investigative units (SIU). When Medicare Part D was first introduced, he established the Medicare Part D program for the Regence BlueCross BlueShield SIU, he was part of a specialized team that established the SIU at Providence Health Plans, and he most recently played an integral role at Cigna in the development of their SIU.

2017 CPT/HCPCS Code Changes

Effective Jan.1, 2017, the American Medical Association (AMA) and CMS issued several CPT and HCPCS code changes, many of specifically have an impact to behavioral health providers. Below is a list of these changes and some additional information from our Presbyterian PID.

CODE	ACTION	CODE DESCRIPTION
G0477	Deleted	Drug Test, Presumptive ... capable of being read by direct optical observation only (dipsticks, cups, cards etc.) ... (Generally done in the providers office)
G0478	Deleted	Drug Test, Presumptive ... read by instrument-assisted (dipsticks, cups, cards etc.) ... (Usually considered laboratory assisted)
G0479	Deleted	Drug Test, Presumptive ... read by instrument only ... (Requires equipment usually found only in laboratories.)
G0480	Description Changed (Information	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type,

	highlighted in red was added)	single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); <u>(2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength); and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift)</u> ; qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed
G0481	Description Changed (Information highlighted in red was added)	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); <u>(2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength); and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift)</u> ; qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
G0482	Description Changed (Information highlighted in red was added)	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); <u>(2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength); and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift)</u> ; qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
G0483	Description Changed (Information highlighted in red was added)	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); <u>(2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength); and</u>

		<u>(3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift);</u> qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed
G0659	Add	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase) performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite, or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

Additions to the Health and Behavior Assessment codes include:

- 96160 – Administration of patient-focused health risk assessment instrument (e.g. Health hazard appraisal) with scoring and documentation, per standardized instrument.
- 96161 - Administration of caregiver-focused health risk assessment instrument (e.g. Depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.

Psychotherapy codes 90832 through 90838 previously stated that the therapy was done “with patient and/or family member.” This was recently changed and the phrase “and/or family member” was removed. With this change, you will need to use other appropriate codes such as 90846 or 90847, which have also changed slightly.

Codes 90846 and 90847 now state that they are for “50 minutes.” This means that to use these codes, your visit must be at least 26 minutes long. Visits that last 25 minutes or less cannot be billed using these codes.

If you notice anything that you think seems like fraud or abuse, please send us an email or call our confidential 24-hour fraud and abuse hotline.

- Local: (505) 923-5959
- Toll-free: 1-800-239-3147
- Email: PHPFrau@phs.org

You can also contact the New Mexico Office of the Superintendent of Insurance’s Insurance Fraud Bureau at:

- Local: (505) 476-0560
- Toll-free: 1-877-807-4010
- Email: stopfraud@state.nm.us

Modifier GX, GY, and GZ

Presbyterian’s claim payment system will deny claim lines when billed with the following noted modifiers.

Modifier	Description	Use
GX	Notice of liability issued, voluntary under payor policy.	Must be used when a provider wants to indicate that a notice of liability issued, voluntary under payor policy, which should be used to report when a voluntary ABN was issued for a service.
GY	Item or service statutorily excluded; does not meet the definition of any Medicare benefit; or for non-Medicare insurers, it is not a contract benefit.	Must be used when providers want to indicate that the item or supply is statutorily non-covered, or is not a Presbyterian or Medicare benefit.
GZ	Item or service expected to be denied as not reasonable and necessary.	Must be used when providers want to indicate that they expect Presbyterian will deny an item or supply as not reasonable and necessary, and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary. EX code "OA" will be located on the explanation of payment (EOP), which will allow provider to bill the member if an ABN is on file.

EX code "OA" will be located on the EOP, which will allow providers to bill the member if the member was advised prior to services being rendered that the services may not be a covered service and an ABN is on file, signed by the member.

Non-Contracted Laboratory Services

Throughout 2016, Presbyterian continued to witness a significant increase in the amount of genetic, genomic, quantitative and qualitative testing that is being referred to non-contracted labs. Presbyterian would like to remind our provider network that we have an arrangement with TriCore Reference Laboratory (TriCore) to provide our laboratory services for all lines of business. If you feel that there are lab procedures TriCore does not perform, please contact TriCore directly as TriCore is contracted with most major laboratories.

When you send your labs to non-contracted lab providers, it is usually the member that is most impacted. If the lab provider is not contracted directly with Presbyterian or TriCore, the claim for these services will be denied, which leads to your patient being billed for the full-billed charges. Most often, members are not aware that you are sending these to a non-contracted lab and are even more surprised when they receive a bill for services they thought were completely covered under their visit to your office.

Per your Presbyterian Services Agreement between your practice and Presbyterian, all contracted providers are required to send lab specimens and refer Presbyterian members to TriCore for testing and results. As a reminder, all genetic and genomic testing requires a prior authorization before being sent to a laboratory, including TriCore. Typically, TriCore coordinates the referral of lab testing to out-of-network facilities. If you are unable to coordinate through TriCore, separate prior authorization is required by calling (505) 923-5757 or 1 (888) 923-5757 (option four).

Presbyterian is taking a harder stance on this issue. Should providers continue to refer services to non-contracted labs, corrective action up to and including termination of their agreement with Presbyterian may be taken.

Certificate of Medical Necessity
Oxygen Therapy

Date: _____

Patient Name: _____

Date of Birth: _____

Member Number: _____

Type of Services: (Please check the appropriate box)

New Services <input type="checkbox"/>	90 day Recertification <input type="checkbox"/>	13 month Recertification <input type="checkbox"/>	Stop Service <input type="checkbox"/>
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Service Start Date: _____

Service Stop Date: _____

Diagnosis: _____

Date of re-evaluation: _____

Clinical Improvement: (Please check appropriate box)

- The patient is using the device for an average 4 hours per 24-hour period and is benefiting from its use.
- The patient is using the device for an average of 4 hours per 24-hour period and is not benefiting from its use.
- The patient is not using this device.

Physician Signature:

Date:
