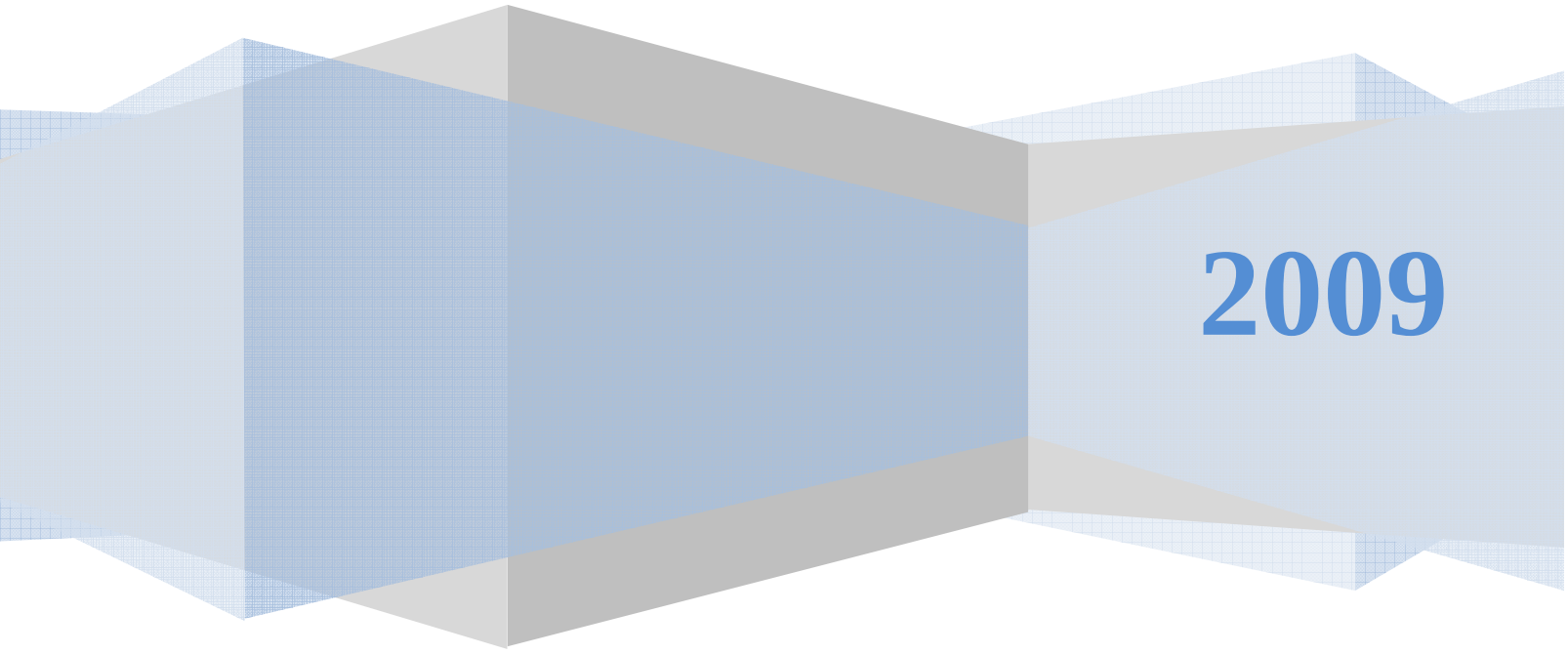
Public Employees Insurance Agency

2009 RBRVS Manual

Policies and Procedures

Effective January 1, 2009



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Keys to RVRVS RVU File

Introduction

This January 2009 Version of the RBRVS Policies and Procedures Manual replaces and supersedes all versions previously distributed by the West Virginia Public Employees Insurance

Agency (PEIA). PEIA, the Children's Health Insurance Program (CHIP) and AccessWV have adopted a modified version of Medicare's RBRVS payment system.

Generally, this document does not contain definitive coverage policies, but rather concentrates on payment policies, billing guidelines, and fee allowances.

Using This Manual

This manual includes PEIA's policies and procedures as they apply to the RBRVS reimbursement system. The relative value units (RVUs) are available on the PEIA web page at www.wvpeia.com . The fee allowances and code-specific RVUs are listed for each code.

Usually, conversion factors change at the same time as other updates to the RBRVS policies and procedures. This January 2009 update includes changes to the "Other Services" conversion factor, the anesthesia conversion factor and to the Clinical Lab Fee Schedule.

CodeReview

Wells Fargo TPA, the Third Party Administrator for PEIA previously known as Acordia National, utilizes CodeReview, a clinically based expert software application designed to detect, correct and document coding inconsistencies in claims. Claims corrected by CodeReview provide a more accurate reflection of the medical services delivered, improving the value of the data.

CodeReview provides a consistent and objective claim review by accurately applying the coding criteria for medicine, surgery, radiology, anesthesiology, laboratory, and pathology, as required by RBRVS and Medicare's Correct Coding Initiative (CCI). It identifies unbundling, fragmentation, upcoding, duplicate, obsolete and/or invalid codes.

Unique advantages to the CodeReview product include:

- clinical integrity supported by a large base of clinical knowledge determined by physician consensus panels,
- detailed reporting and messaging for the processing staff, and
- automated recording.

Incidental Procedures or Rebundling/Replacement of Procedures

An incidental procedure is one carried out at the same time as a more complex primary procedure. Incidental procedures require minimal additional physician resources and are clinically part of the primary procedure; therefore, they should not be billed separately. Unbundling or fragmentation of a procedure occurs when two or more procedure codes are used to describe a service when a single, more comprehensive, code exists that accurately describes the procedure.

CodeReview will flag the code(s) with a message when incidental procedures are billed separately or procedures are unbundled or fragmented. The following examples represent rebundling or replacement of procedure codes for incidental, unbundled, or fragmented procedures.

Incidental/Rebundling/Replacement

Example I: When submitting a claim for a diagnostic laryngoscopy in conjunction with an esophagoscopy, the diagnostic laryngoscopy is denied.

DOS	Codes Submitted	Description	Code Review Message

12/30/2001	43215	Esophagoscopy for removal of foreign body	Paid
12/30/2001	31575	Diagnostic laryngoscopy	Denied: A laryngoscopy with removal of a foreign body via esophagoscopy is not allowed

Example II: A D & C billed with a total abdominal hysterectomy is denied.

DOS	Codes Submitted	Description	Code Review Message
12/20/2001	58150	Total abdominal hysterectomy	Paid
12/20/2001	58120	Dilation & Curettage	Denied: D & C not allowed when performed with a hysterectomy

Example III: When submitting a claim for hallux valgus correction with removal of skin lesion, the skin lesion code will be denied.

DOS	Codes Submitted	Description	Code Review Message
12/29/2001	28289	Hallux rigidus correction	Paid
12/29/2001	11420	Removal of skin lesion	Denied: The skin excision is part of the global code for the hallux valgus

Example IV:

DOS	Codes Submitted	Description	Code Review Message
12/20/2001	84075	Phosphatase, alkaline	Replace with code 80053 comprehensive metabolic panel.
12/20/2001	82404	Albumin; serum	
12/20/2001	82247	Bilirubin; total	
12/20/2001	82435	Chloride; blood	
12/20/2001	82310	Calcium; total	
12/20/2001	84132	Potassium; serum	
12/20/2001	84155	Protein; total	
12/20/2001	82947	Glucose; quantitive blood	
12/20/2001	84295	Sodium; serum	
12/20/2001	84450	Transferase; AST, SGOT	
12/20/2001	84520	Urea, nitrogen (BUN)	
12/20/2001	82374	Carbon Dioxide (bicarb)	
12/20/2001	82565	Creatinine; blood	
12/20/2001	84460	Transferase; ALT, SGPT	

Supplies In Physician's Office

Prior to August 1, 2002, an additional amount was allowed for specified supplies for procedures performed in a physician's office. Effective August 1, 2002, HCPCS code A4550 is not billable for office procedures. The cost of providing these supplies is included in the RVUs for the procedure. Code 99070 continues to be a non-covered code.

Global Surgery Package

PEIA considers the reimbursement of a surgical procedure to include all normal and uncomplicated care for that procedure. As defined by CPT, a surgical procedure includes the operation per se, local infiltration, metacarpal digital block, or topical anesthesia when used, and the normal uncomplicated follow-up care. PEIA uses the RBRVS timeframes to establish the global surgical period for routine pre- and post-operative visits. Separate charges for this routine care are not covered. Preoperative visits are visits by the surgeon on the day of the surgery for minor procedures and are limited to the day before surgery for major procedures. Post-operative visits are visits by the surgeon or other provider during a specified timeframe following surgery. The pre- and post-operative timeframes, by procedure type, are:

	Pre-Operative	Post-Operative
Major	1 day	90 days
Minor	0 days	0-10 days
Endoscopic	0 days	0-10 days

PEIA's policy requires the billing of a single fee for all necessary services normally furnished by the surgeon before, during and after the procedure. Major surgery generally includes several services that occur on different days, while minor and endoscopic procedures may only include services that occur the day of, or within 10 days of the surgical procedure. With global billing, all expenses related to the surgical procedure are bundled and paid with the surgical procedure. The "Global Period" column of the RBRVS RVU file includes the correct number of pre-and post-operative surgical days for each procedure.

Diagnosis Codes

- CodeReview will rely on your use of accurate and current CPT-4, HCPCS, and ICD-9 codes.
- Enter the diagnosis code that best corresponds with the procedure.
- If more than one applies, list the primary diagnosis code first.
- Each procedure is evaluated against a diagnosis. If the diagnosis and procedure do not correspond, the procedure may be rejected.
- When billing a "not otherwise classified" code, please provide a description of the service and/or appropriate documentation such as an operative report for review.
- Use of obsolete codes will result in delayed payment or denial of the service.

Example: Submitted on Claim

Date of Service	Codes Submitted	Description	Result
12/01/2004	99203	New patient office or OP visit, detailed	99203 Denied
12/02/2004	33510	Coronary artery bypass, vein only; single	33510 Paid
12/03/2004	99231	Subsequent hospital care	99231 Denied
12/28/2004	99212	Office visit; established patient	99212 Denied

Note: For the example above 414.01 Coronary artherosclerosis would be an appropriate diagnosis.

Date Span

Do not bill date spans. Claims billed in this manner will be returned to the provider. Each date of service must be listed separately as shown in the example below.

Date of Service		Place of Service	Procedure		Diagnosis	Charge	Days or Units
From	To		CPT/HCPCS	Modifier			

M	D	Y	M	D	Y						
05	17	04	05	17	04	11	99212		1	$40.00	1
05	18	04	05	18	04	11	99212		1	$40.00	1
05	19	04	05	19	04	11	99212		1	$40.00	1

Scope Procedures

The CPT code descriptions list the primary code with all minor related procedures performed simultaneously. Because multiple procedures can be performed through the same scope, separate reimbursement may not be allowed for subsequent procedures.

Based on the RBRVS Endoscopic guidelines, the following claim would be processed as follows:

Example I

DOS	Code	Description	Results
12/01/2004	43200	Esophagus, diagnostic	Deny part of global code 43202
12/01/2004	43202	Esophagus, biopsy	Paid

Example II

DOS	Code	Description	Results
12/04/2004	44388	Colonoscopy, endoscopy	Deny part of global code 44392
12/04/2004	44392	Colonoscopy, polypectomy	Paid

Multiple non-diagnostic scopes performed on the same date of service are reviewed on a case-by-case basis to determine if additional payment is warranted.

Example III

DOS	Code	Description	CodeReview Message
12/08/2004	29880	Arthroscopy with meniscectomy	Paid
12/08/2004	29877	Arthroscopy debridement/shaving of cartilage	Operative report required to determine the extent of the procedure. Shaving the articular cartilage in the same area as the primary procedure is considered part of the global service.

RBRVS Policy Issues

All services, therapies, equipment and supplies are subject to medical necessity guidelines and specific plan coverage as per the plan administrator.

1. CODING CONVENTION

The Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System is used along with plan guidelines, including the following:

A. American Medical Association (AMA) Common Procedure Terminology (CPT-4) codes (level I codes);
B. Alpha-numeric codes (level II) HCPCS; and
C. American Medical Association Anesthesia Coding System

2. TYPES OF PROVIDERS INCLUDED UNDER RBRVS

A. The following provider types are reimbursed with the RBRVS fee schedule:

- Acupuncturists licensed in accordance with the minimum standards of practice for acupuncture as established by the WV Board of Acupuncture;
- Certified registered nurse anesthetist (CRNA);
- Clinical psychologists;
- Clinical social workers;
- Hospital-based laboratories providing outpatient services;
- Independent laboratories performing anatomic pathology services;
- Independently practicing occupational therapists conducting outpatient services;
- Independently practicing physical therapists providing outpatient services;
- Licensed professional counselors;
- Limited license practitioners (including doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, oral and maxillofacial surgeons, and chiropractors);
- Nurse midwives;
- Nurse practitioners;
- Physician assistants; and
- Physicians (including doctors of medicine and osteopathy).

B. Parity - Non-physician providers and limited license practitioners are paid at parity with physicians.

C. Institutional Providers - Services rendered by hospital employees, such as physical therapists and occupational therapists, are paid under the hospital payment methodology for inpatient services. Allowances for outpatient services are based on PEIA's Outpatient Perspective Payment System (OPPS) and other PEIA fee schedules.

3. SERVICES COVERED UNDER RBRVS

A. The following services, subject to benefit limitations, are reimbursed using RBRVS:

- Diagnostic tests other than clinical laboratory tests;
- Outpatient therapy services;
- Professional services of physicians and limited license practitioners;

- Radiology services; and
- Supplies and services provided "incident to" physicians' professional services.

NOTE: Outpatient therapies are subject to a combined plan maximum of 20 visits per plan year per patient.

B. Unlisted Procedure Codes - Payment for unlisted procedure codes (those typically ending in -99) are determined on a case-by-case basis. **Office notes or an operative report is required.**

C. Other Services - Fee schedules are used for reimbursement of the following non-RBRVS services:
- clinical laboratory services;
- casts, splints and supplies;
- some immunization services;
- durable medical equipment;
- enteral and parental supplies;
- medical and surgical supplies;
- orthotics and prosthetics; and
- drugs, (including chemotherapy), biologicals, immunosuppressives, radiopharmaceuticals, blood and blood products.

D. Outpatient Hospital Services – PEIA's Outpatient Prospective Payment System (OPPS) is used to reimburse outpatient hospital services. Passthrough services are priced using the payment methodologies listed in item C above. The OPPS manual is on the PEIA web page at www.wvpeia.com .

4. ANESTHESIA SERVICES

Generally, Medicare's payment methodology is used with a separate conversion factor for anesthesia services. The following policies apply for anesthesia services:

A. American Society of Anesthesiologists' (ASA) Uniform Relative Value Guide;

B. CPT anesthesia codes;

C. ASA's definition of anesthesia time;

D. Multiple procedure policy whereby payment is calculated using the base units of the procedure with the highest base value and the actual anesthesia time of the multiple procedures;

E. CMS' attending physician relationship policy whereby this relationship is only recognized when the anesthesiologist is involved in a single procedure with an intern or resident.

The following payment methodologies differ from those used by Medicare:

A. Parity in Payment - Non-medically directed CRNAs are paid at parity with anesthesiologists, when personally providing anesthesia or other medical services within the scope of a CRNA's license.

B. Time Units - Whole time units are used. If total minutes exceed a 15-minute interval, one additional unit is paid. Note: Report the total number of minutes on the claim.

C. Emergency Anesthesia – An additional payment of 2 base units is made to anesthesiologists and CRNAs if the anesthesia for surgery is done on an emergency basis. Other patient status codes are not recognized.

D. CPR - Anesthesiologists and non-medically directed CRNAs (within the scope of their license) may bill for cardiopulmonary resuscitation performed in conjunction with the anesthesia procedure or outside the operating suite.

E. Other Services - Anesthesiologists and non-medically directed CRNAs (within the scope of their license) may bill for the following additional services:
   - placement of a Swan-Ganz catheter or other central venous pressure line;
   - critical care visits;
   - emergency intubations; spinal puncture;
   - blood patch; and
   - epidural pain management.

   Payment for these services is based on the RBRVS payment system. They must be billed with the appropriate CPT codes, and will be subject to medical necessity and benefit limitations.

F. Anesthesia Teams - An anesthesia team includes one anesthesiologist and one CRNA per patient. Anesthesiologists may supervise up to 4 CRNAs. The total payment level for the anesthesia team is 100 percent of the payment level for an anesthesiologist performing individually. The payment is split to allow 60 percent to the anesthesiologist and 40 percent to the medically directed CRNA.

G. Procedure code 01995 - "Regional IV administration of local anesthetic agent (upper or lower extremity)" is only used in cases that involve the application of a tourniquet to a limb and injection of an agent for regional anesthesia. There are only base units for these codes. No time units are allowed.

H. Procedure code 01996 - "Daily management of epidural or subarachnoid drug administration" is not allowed on the same day as the insertion of the epidural catheter or a general anesthesia service. Again, these are base unit codes only. No time units are allowed.

I. Maternity-related Anesthesia - Labor/delivery anesthesia is paid in the following manner:
   - 01960 – anesthesia for vaginal delivery only;
   - 01961 – anesthesia for cesarean delivery only;
   - 01962 – urgent hysterectomy following delivery;
   - 01963 – cesarean hysterectomy without any labor analgesia/anesthesia care;
   - 1965 – incomplete or missed abortion procedure;
   - 1966 – induced abortion procedure;
   - 01967 – neuraxial labor analgesia/anesthesia for planned vaginal delivery;
   - 01968 – cesarean delivery following neuraxial labor analgesia/anesthesia
   - 01969 – cesarean hysterectomy following neuraxial labor analgesia/anesthesia;
   - team billing is not allowed prior to January 1, 1998, with the exception of cesarean delivery under general anesthesia;

- time will be capped at 2 hours (8 units) for all labor/delivery anesthesia; and
- 2 additional base units are allowed for emergency cesarean section when billed with CPT 99140.

5. CLINICAL LABORATORY AND PATHOLOGY SERVICES

Medicare's policies for clinical lab interpretation services and consultative pathology services are used. Payment for non-physician clinical lab and pathology services is based on Medicare's National Lab Fee Schedule and is available on PEIA's web site at www.wvpeia.com . Only the professional components of physician pathology services are paid if they are performed in the hospital; the professional and technical components are paid if performed by an independent lab. For inpatient services, the technical component is paid under the inpatient reimbursement methodology. Modifiers 26 (or PC) and TC will auto-process in the CodeReview system.

A. Clinical Lab - Payment for collection of specimens through venipuncture or catherization are included in the payment for the lab procedure when collected by the lab that processes the specimen**. The lab that performs the clinical lab service, must also bill for the service.**

B. Laboratory Certification - To bill PEIA, a lab must have a certificate of registration through the Clinical Laboratory Improvement Act of 1988 (CLIA).

C. Hospital Outpatient Facility Laboratory Payment - Payment for diagnostic and laboratory services when provided in an outpatient hospital facility is based on one of the following fee schedules:
   - the RBRVS fee schedule for diagnostic x-rays and clinical pathology services, or
   - the outpatient perspective payment system, or
   - the Clinical Laboratory fee schedule.

D. The following CPT codes are used to bill clinical consultations:
   - 80500 Clinical pathology consultation; limited, without review of patient's history and medical records, and
   - 80502 Clinical pathology consultation; comprehensive for a complex diagnostic problem, with review of patient's history and medical records.

   The attending physician must individually request these clinical pathology consultations. Standing orders are not accepted.

E. Code Q0091 is covered. If Q0091 is billed with an evaluation and management (E&M) code, then modifier 25 must be added to the E&M code. The patient's medical records must document a separately identifiable service to support the billing of an E&M service. If Q0091 is billed with a "Preventive Medicine Services" CPT code, then Q0091 is bundled with the preventive medicine service. As of July 1, 2004, office notes are not required when modifier 25 is billed with the E&M code.

6. MODIFIERS

The most common modifiers are listed below and are generally in accordance with the Current Procedure Terminology manual (standard edition) and HCPCS Manual. Specific policies pertaining to modifiers are listed below.

Modifiers 22 and 52 - Unusual or Reduced Services

Increases or decreases in payment are allowed for unusual circumstances. An operative report and written description of the reason for using one of the two modifiers is required. The claim will be priced manually.

Modifier 23 - Unusual Anesthesia

When anesthesia is used for a procedure that usually requires no anesthesia or local anesthesia, Modifier 23 is used. Written documentation is required to document the reason for the anesthesia. This service is manually priced. This modifier is not used for emergency anesthesia.

Modifier 24 - Unrelated E & M Service, same physician/same day

Bill modifier 24 for unrelated E & M services provided during the post-op period by the same physician who performed the surgical procedure. Full payment is allowed.

Modifier 25 - Significant, Separately Identifiable E & M Service, same physician/same day

Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable E & M service that was unrelated to the other services billed for that same date of service. **E&M services billed with Modifier 25 and CPT codes 98940-98943 require office notes.** Otherwise, office notes are not required.

Modifier 26 and TC - Professional & Technical Components

Modifier 26 is used to indicate that only the professional component of a service or procedure was performed and modifier TC is used to indicate that only the technical component was performed. Modifiers 26 and TC are used for three types of services:

- Diagnostic and therapeutic radiology services;
- Certain diagnostic tests that involve a physician's interpretation;
- Physician pathology services; and
- Facility-based E & M services billed with the revenue code for clinic services (require modifier TC).

Modifier 32 – Mandated services

Modifier 32 is used to bill services related to mandated consultation and/or related services (e.g., PRO, third party payer, governmental, legislative or regulatory requirement). This services will be denied unless it is a service that would be covered absent the mandate.

Modifier 47 - Anesthesia by Surgeon

Modifier 47 is used to bill regional or general anesthesia provided by the surgeon. This does not include local anesthesia. Reimbursement is based on the anesthesia payment schedule.

Modifier 50 - Bilateral Procedures

Modifier 50 is used when performing a procedure on both sides of the body that is normally done on only one side of the body. The payment level will be 150 % of the base procedure.

Modifier 51 - Multiple Procedures Modifier 51 is used to bill multiple surgical procedures. The procedure with the highest RVUs or fee allowance is processed at 100%, and the second through fourth are processed at 50% of their respective values. Additional procedures require an operative report and are processed on a "by report" basis. For certain dermatologic services, separate CPT codes (and RVUs) are used to represent multiple surgical procedures. For these services, multiple procedure rules will not apply.

Modifier 52 – Reduced Services

Prior to July 2003, modifier PS has been used to indicate instances when the pre-operative and surgical care was provided by the surgeon, but not the post-operative care. Due to HIPAA regulations, local codes and modifiers are not permitted. To bill a surgical service with pre-operative care, excluding post-operative care, you must now bill modifier 52 with the surgical CPT code and indicate the reason for the reduced service. This modifier may be used to indicate reduced services for any code, but an explanation of the reduced service is required.

Modifier 53 – Discontinued Procedure (Physician)

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure when extenuating circumstances threaten the well-being of the patient. In this situation, report the procedure by adding modifier 53 to the CPT code reported. Do not use this modifier to report the elective cancellation of a procedure prior to induction of anesthesia and/or surgical preparation in the operating suite.

Modifier 54 - Surgical Care Only

There may be circumstances in rural areas in which a family practitioner provides the pre-operative care in anticipation of the arrival of an itinerant surgeon. The surgeon performing the intra-operative surgical care only should submit a bill with modifier 54 and will receive payment based on the intra-operative percentage of the global surgery allowance.

Modifier 55 - Post-Operative Care Only

The AMA's CPT post-op care modifier 55 is used to bill for post-operative care only. Payment will represent only the post-operative portion of the global surgical fee.

Modifier 56 - Pre-Operative Care Only

Providers responsible for the pre-operative care only must use modifier 56. Payment will represent only the pre-operative portion of the global surgical fee. All claims with modifier 56 are subject to manual review.

Modifier PS – Prior to July 2003, modifier PS has been used to indicate instances when the pre-operative and surgical care was provided by the surgeon, but not the post-operative care. Due to HIPAA regulations, local codes and modifiers are not permitted. To bill a surgical service with pre-operative care, excluding post-operative care, you must now bill modifier 52 with the surgical CPT code and indicate the reason for the reduced service.

Modifier 57 - Initial Decision for Surgery

U se Modifier 57 is to identify an evaluation and management service that resulted in the initial decision to perform surgery when surgery is performed within the global surgery pre-operative period. As of July 1, 2004, office notes are not required when billing this modifier. Full payment is made for the E & M service that resulted in the decision for surgery.

Modifier 58 - Staged or Related Procedure by the Same Physician in the Post-Op Period

Modifier 58 is used to identify a procedure during the post-operative period that was (a) planned before the time of the original (staged) procedure; (b) more extensive than the original surgical procedure; or (c) for therapy following a diagnostic surgical procedure. Full payment will be made for these procedures, except in the case of more than one surgery being performed, and then multiple surgery guidelines will apply.

Modifier 62 - Co-Surgeons

When two surgeons work together to perform the same procedure (same CPT code) and provide separate services during the same procedure, each physician is considered a co-surgeon. Medicare's requirement that the surgeons be from different specialties does not apply. Each physician must submit a claim with modifier 62 added to the procedure code. Each surgeon will be paid 62.5% of the global surgery fee allowance. Billing of an assistant-at-surgery is not allowed when co-surgeons perform the surgery.

Modifier 66 - Team Surgery

When more than two surgeons from different specialties work together to perform the same procedure (same CPT code) and provide separate services during the same procedure, each physician is considered to be a member of a surgical team. Each physician must submit a claim with modifier 66 added to the procedure code. Billing for an assistant-at-surgery is not allowed when team surgery is performed. An operative report must be submitted when modifier 66 is used. Each of these cases will be reviewed manually and priced on a case-by-case basis.

Modifier 76 - Repeat Procedure by Same Physician

Modifier 76 is used when a repeat procedure is performed by the same physician during the global fee period. Full payment will be made for the procedure.

Modifier 77 - Repeat Procedure by Another Physician

Modifier 77 is used when a repeat procedure is performed by another physician during the global fee period. Full payment will be made for the procedure.

Modifier 78 - Return Trip to the Operating Room

Modifier 78 is used when a return trip to the operating room for another procedure is necessary within the global surgical period. All claims with modifier 78 are subject to manual review prior to payment.

Modifier 79 - Procedures Unrelated to Original Procedure Performed by Same Physician

Use modifier 79 when necessary procedures, unrelated to the original procedure, are performed by the same physician and within the global post-operative period. All claims with modifier 79 will be subject to manual review.

Modifiers 80, 81, and 82 - Assistant-at-Surgery

The primary surgeon receives 100% of the global surgery fee allowance and the assistant-at-surgery receives 16% of the global surgery fee allowance. The three modifiers, as defined below, are used to indicate the teaching status of the hospital in which the procedure is performed:

- Modifier 80 is used when the procedure is performed in a non-teaching hospital;
- Modifier 81 is used when the procedure is performed in a non-teaching hospital by a mid-level provider;
- Modifier 82 is used when the procedure is performed in a teaching hospital and a qualified resident is not available to act as an assistant surgeon.

Modifier 90 – Reference (Outside) Laboratory

Modifier 90 is used to report laboratory procedures performed by a party other than the treating or reporting physician. PEIA requires that the provider who processes the laboratory services must also bill for the services. For more details, see Policy #5, Clinical Laboratory and Pathology Services.

Modifier 91 – Repeat Clinical Diagnostic Laboratory Test

Modifier 91 is used to report repeat laboratory tests performed on the same day to obtain subsequent (multiple) test results. This modifier is not used when tests are rerun to confirm initial results due to testing problems.

Modifier 94 (is no longer valid) the valid HCPCS modifier is Modifier QX

Modifier 94/QX - Nurse Anesthetist

Modifier 94 is used to submit claims for services of a nurse anesthetist acting as part of an anesthesia team.

Modifier 95 (is no longer valid) the valid HCPCS modifier is Modifier QY

Modifier 95/QY - Supervisory Anesthesia

Modifier 95 is used to identify claims that are submitted by anesthesiologists acting as part of an anesthesia team.

Modifier 99 - Multiple Modifiers

Under certain circumstances, two or more modifiers may be necessary to delineate a service. In such situations, modifier 99 is added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service. Any bill with modifier 99 will be subject to mandatory manual review. A written report explaining the multiple modifiers will be required.

Modifier AT – Acute Treatments

This modifier is used to report codes 98940, 98941, 98942, and 98943 when the service billed is for acute treatment. The provider's documentation must support the level of service billed. Since PEIA does not cover chiropractic manipulative treatment for non-acute conditions, services billed without the modifier will be denied.

DME Modifiers Per HCPCS

LL – lease rental
NU – new
RR – rental
UE – used

If HCPCS DME codes are not billed with a modifier, the code will be denied.

7. SITE-OF-SERVICE ADJUSTMENT

For services provided August 1994 through March 2000, the practice expense component of a fee is reduced by 50% if a service typically performed in a physician's office is performed elsewhere, e.g., as an inpatient hospital service, in an outpatient department of a hospital, or in an ambulatory surgical center.

Effective April 1, 2000, PEIA adopted the facility and non-facility based RVUs as designed by CMS. To determine the correct allowance for a specific procedure, the place of service (facility

or non-facility) must be considered. If the procedure is performed in a provider's office, the non-facility RVUs will be used to calculate the fee allowance. If the procedure is performed in a facility setting (outpatient or inpatient at a hospital, ambulatory surgical facility, skilled nursing facility, dialysis facility, etc.) the facility-based RVUs will be used to calculate the fee allowance.

Effective April 1, 2006, for Evaluation and Management (E&M) services rendered by providers who practice within a hospital, a TC modifier is required on the hospital bill. The RBRVS non-facility allowance is processed for the physician's E & M service and the difference of the facility and non-facility allowance is processed to the hospital. The member copayment is applied to the professional service, and the facility allowance is covered at 100% of the allowed amount.

8. RADIOLOGY SERVICES

Medicare's policy for portable x-rays, transportation, and low osmolar contrast media is used. To report radiation treatment management refer to the Radiation Treatment management instructions in the CPT manual.

9. CRITICAL CARE CODES

Critical care codes 99291 (critical care, first hour) and 99292 (additional 30 minutes) are used. With this policy, physicians are instructed to use these codes regardless of whether the visit is initial or subsequent. In addition, physicians are precluded from billing procedures and services that the CPT manual defines as attendant to critical care management. Examples of these types of services include the insertion of arterial lines and central venous pressure monitoring lines. Some CPT codes not billable with 99291 and 99292 are 36000, 36410, 36600, 71010, 71015, 71020, 91055, 91105, 92953, 93040, 93041, 93561, 93562, 94656, 94657, 94660, 94662, 94760, 94761, and 94762. Payments for these codes are included into payments for 99291 and 99292.

10. CHEMOTHERAPY ADMINISTRATION

Physicians may bill for an office visit on the day chemotherapy is administered as long as the visit is separately identifiable and documented. Separate payment is allowed for each chemotherapeutic agent furnished on the same day. If the chemotherapy is provided by several routes, then payment is allowed for each route of administration. For example, if on the same day, adriamyacin is given by a "push" technique and cisplatinum is given by an "infusion" technique, then both the "infusion" and "push" techniques may be billed. Billing for each of the chemotherapeutic agents should be made using the appropriate alphanumeric code (HCPCS).

11. NURSING HOME VISITS

Payment for treating acute conditions at a nursing home, to the extent they are covered by the Plan, is made based on the appropriate visit code level and is not adjusted for number of patients seen at the facility.

12. CHIROPRACTIC SERVICES

Chiropractors are considered as physicians under the RBRVS fee schedule. Services they provide must be within the scope of their license and the coverage policies of PEIA. There are benefit limitations related to the maximum visits covered and type of care covered. Chiropractic services are only covered for active/corrective therapy. Maintenance therapy is not covered. Acute treatment must be billed with modifier AT. Otherwise, the service will be denied.

13. REBUNDLING PAYMENT POLICY

The RBRVS fee schedule uses the American Medical Association's Current Procedural Terminology, Standard Edition (CPT) codes. Relative value units for the physician work associated with the service were developed, in general, using the definitions provided in the CPT manual, and reflect the relative resources required to produce a particular service.

For example, work RVUs for a comprehensive surgical procedure such as a complete transurethral resection of the prostate (TURP) reflect the relative level of complexity and time required to perform the surgery. The CPT manual definition of the services normally performed during a complete TURP procedure also includes component procedures such as a vasectomy and a cystourethroscopy. The resources required to perform these component services are included in the work RVUs for the comprehensive procedure. Under PEIA's payment rules, payment is made for the comprehensive service only. Additional payment is not made for any of the component procedures, e.g., vasectomy, if performed by the same physician on the same day. Nor are physicians allowed to bill for the components separately.

To reduce unbundling or fragmentation of billing, PEIA has generally adopted Medicare's list of services subject to rebundling edits, including, but not limited to CCI edits. Exceptions to services that are considered "bundled" into payment for other services are:

A. **Prolonged MD Attendance** — For prolonged MD attendance, PEIA allows physicians to submit bills for this category of services using CPT codes 99354 - 99357. This service is reported in addition to the designated evaluation and management services at any level and any other physician services provided at the same session as evaluation and management services. Choose the appropriate codes for supplies provided and procedures performed in the care of the patient during this period. Prepayment review is required.

B. **Maternity Services** — PEIA continues to pay for maternity services under a global package.

C. **Generation and Interpretation of Automated Data** — Payment for procedure codes associated with the generation and interpretation of automated data, 78890, for a service that requires up to 30 minutes, and 78891, for a service that exceeds 30 minutes, are now bundled into payment for the primary procedure, e.g., myocardial imaging. These RVUs were distributed across all other nuclear medicine procedure codes in the nuclear medicine section of the CPT manual, 78000 - 78999.

D. **Evaluation of Psychiatric Records and Reports and Family Counseling** — Separate billing for two types of psychiatric services: psychiatric evaluation of hospital records or other psychiatric reports (CPT code 90885); and interpretation of psychiatric testing results and examinations to family or other responsible persons (CPT code 90887) is not allowed. Services described in these codes are generally performed during the pre- and post-work phase of other psychiatric services). As such, the work associated with reviewing records and counseling family members has been incorporated in the work RVUs of other psychiatric services. Paying for both services would be duplicative. Separate billing is not allowed for review of reports or family counseling for non-psychiatric evaluation.

E. Fitting of Spectacles — Separate billing for fitting of spectacles (if covered) and low vision aids (CPT 92340 - 92371) is not allowed. The work involved is equivalent to fitting of prosthetic devices and payment is included in the payment for the devices. The PEIA allows separate billing for repair (CPT codes 92370 and 92371) to the extent that it is a covered service.

F. Hot or Cold Packs (97010) — As recommended by CMS, effective June 1, 1997, PEIA no longer allows separate payment for CPT 97010. Payment for this code has been bundled into payment for other services (such as office visits and physical therapy codes). CMS justified bundling of this code for three reasons: (1) hot and cold packs are easily self-administered, (2) less professional judgment is required for this modality than for other modalities, and (3) the application is usually a precursor to other interventions and, as such, is appropriately used in combination with other procedures.

G. Skin Lesion Destruction & Repair Codes – Several codes describe the incision, drainage, excision, debridement, and removal of benign or premalignant skin lesions. Billing should be submitted reflective of the CPT billing guidelines. Codes 10040 – 11471 will all be subject to review of medical necessity, possible cosmetic reasons for removal, biopsy results, pathology reports and possible re-coding related to actual lesion sizes as indicated by the CPT coding guidelines.

I. Fracture Care and Supplies – splints, slings and cast supplies applied after the initial care of the injury are covered in the office setting, in addition to the allowance for the surgical CPT code, when billed with the correct HCPCS codes as follows:

- A4565 for slings, and/or
- Q4001 – Q4049 for cast supplies.

The allowance for the initial fracture, dislocation, or injury care includes the application of a splint, sling, or cast. Charges for these items will be bundled with the surgical CPT code if billed with the initial service. However, subsequent replacement of casts/splints (29000 – 29799) performed after the initial service (follow-up care) is covered when medically necessary. The fee allowances for slings and cast supplies are on PEIA's web page at www.wvpeia.com.

14. CARE PLAN OVERSIGHT

Payment for physician "care plan oversight" services is allowed as follows:

A. allowed only for patients receiving home health, or hospice services or for patients admitted to a skilled nursing facility for approved medically necessary inpatient care;
B. only one care plan oversight payment may be made per calendar month per patient;
C. a face-to-face encounter between the physician and patient must have occurred within 6 months prior to the commencement of billing for this service;
D. payment will not be made to physicians who have a significant ownership interest in or financial relationship with a home health or hospice agency;
E. only the attending physician is allowed to receive payment;
F. medical directors and physicians employed by or who have a contractual relationship with a home health or hospice agency are not allowed to receive payment;
G. physicians may not bill during the post-operative period of a global surgical period unless the oversight service is unrelated to the procedure;

H. CPT code 99375 is used to bill this service for a patient of a home health agency;
I. CPT 99378 is used to bill this service for a hospice patient; and
J. CPT 99380 is used to bill this service for a patient in a skilled nursing facility.

PEIA will relax Medicare's requirement for 30 minutes of constant physician attendance time to allow for multiple encounters that may occur on multiple days, but that add up to a total of 30 or more minutes. Physicians are to bill CPT code 99375, 99378 and 99380 only. CPT codes 99374, 99377, and 99379 are bundled services and are not allowed separately.

15. MULTIPLE NUCLEAR MEDICINE DIAGNOSTIC PROCEDURES

The multiple surgery rules apply to the following combination of codes for services of the same provider (or group practice) on the same day:

A. 78306, bone imaging; whole body, and 78320, bone imaging; SPECT;
B. 78802, radionuclide localization of tumor; whole body, and 78803 tumor localization; SPECT; and
C. 78806, radionuclide localization of abscess; whole body, and 78807, radionuclide localization of abscess; SPECT.

16. END-STAGE RENAL DISEASE

PEIA will pay for either an E&M code (99231 - 99233 and 99261-99263) or an inpatient dialysis code (90935, 90937, 90945, & 90947), but not both codes and not more than one of either code on the same day. An initial inpatient hospital visit or initial consultation with an inpatient dialysis service is allowed.

Monthly payments for ESRD monitoring and assessment of dialysis services, are based on the number of face-to-face (physician and patient) visits performed during the month. Payment allowances follow RBRVS reimbursement methodology and coding as in the chart below.

HCPCS Code	CPT Code	Description
G0308	90951	ESRD related svc 4+mo<2yrs
G0309	90952	ESRD related svc 2-3mo<2yrs
G0310	90953	ESRD related svc 1 visit<2yrs
G0311	90954	ESRD related svs 4+mo 2-11yrs
G0312	90955	ESRD relate svs 2-3 mo 2-11yrs
G0313	90956	ESRD related svs 1 mo 2-11yrs
G0314	90957	ESRD related svs 4+ mo 12-19 yrs
G0315	90958	ESRD related svs 2-3 mo 12-19 yrs
G0316	90959	ESRD relate svs 1 visit 12-19 yrs
G0317	90960	ESRD related svs 4+mo 20+yrs
G0318	90961	ESRD related svs 2-3 mo 20+yrs
G0319	90962	ESRD related svs 1 visit 20+ yrs
G0320	90963	ESRD related svs home under 2 yrs
G0321	90964	ESRD related svs home mo<2yrs
G0322	90965	ESRD relate svs home mo12-19 yrs
G0323	90966	ESRD related svs home mo 20+ yrs
G0324	90967	ESRD related svs home/dy<2yrs
G0325	90968	ESRD relate home/dy 2-11 yrs
G0326	90969	ESRD relate home/dy 12-19yrs
G0327	90970	ESRD relate home/dy 20+yrs

17. THERAPEUTIC APHERESIS

Follow-up E&M services are bundled into payment for therapeutic apheresis, CPT codes 36511, 36512, 36513, 26514, 36515, and 36516. Therefore, the following E&M CPT codes cannot be billed on the same day as therapeutic apheresis:

A. 99211 through 99215; (office, E&M)
B. 99231 through 99233; and (inpatient hospital care)
C. 99261 through 99263. (follow-up inpatient consult)

The establishment of vascular access and/or an initial E&M service (99221 - 99223, 99241 - 99245, 99251 - 99255, and 99238) are paid, if billed on the same date as therapeutic apheresis.

18. ALLERGY SERVICES

Under this policy, allergists are to bill two codes when preparing and administering antigens.

A. Injections must be billed using CPT codes:
   - 95115 (single injection); or
   - 95117 (two or more injections on the same day).
B. Antigen extracts and the physician's professional service for preparing the extract are to be billed using one of the following CPT codes:
   - 95144 professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens, single dose vials, specify number of doses;
   - 95145 professional services for supervision and provision of antigens for allergen immunotherapy; single stinging insect venom, multiple dose vials, specify number of doses;
   - 95146 two stinging insect venoms;
   - 95147 three stinging insect venoms;
   - 95148 four stinging insect venoms;
   - 95149 five stinging insect venoms;
   - 95165 professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens, multiple dose vials, specify number of doses (use this code when billing for treatment boards); and
   - 95170 whole body extract of biting insect or other arthropod, specify number of doses.
C. CPT codes 95120 through 95134 and "J" codes are NOT VALID for payment purposes under this policy:
D. Allergists are instructed to produce multiple dose vials, rather than the more expensive single dose vials, unless the antigen is to be injected by another physician. CPT code 95144, single dose vial, when billing the injection codes 95115 or 95117 is not allowed.
E. Bill CPT code 95165, in addition to the appropriate injection code, when administering treatment boards. Physicians who administer treatment boards do not create vials, but rather draw multiple antigens directly into a syringe just prior to administration. Allergists who administer treatment boards must bill the appropriate injection code and 95165, professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens, multiple dose.
F. The following Medicare definitions, policy, and coverage applies:

- PEIA's reimbursement allowance for antigens is based on RBRVS and that methodology's definition of "dose." For purposes of reimbursement under this policy, **a dose is one (1) cc.**
- CPT codes 95115 and 95117 are injection codes only. The correct quantity (number of units) is always one (1) for both codes. The same provider should not bill codes 95115 and 95117 on the same date of service.
- Physicians who administer treatment boards use CPT 95165. As such, it does not include the injection/administration allowance and CPT 95115 or 95117 is billed in addition to 95165.
- Fee allowances are based on a maximum of ten (10) doses or 10 cc per multi-dose vial. PEIA should be billed for a maximum of ten (10) doses per vial, even if more than ten (10) doses are obtained from the vial (for example, the physician administers 0.5 cc of antigen rather than 1 cc of antigen).
- You may not bill an additional amount for diluted doses for CPT 95165, for example: by mixing one (1) cc aliquot from a multi-dose vial with nine (9) cc's of diluents in a new multi-dose vial.
- E&M services billed on the same day as allergen immunotherapy services are only covered if a separately identifiable service is provided. If the service is separately identifiable, add modifier 25 to the E&M code.
- Only the following will be paid for antigens:
  a) Board certified pediatric and internal medicine physicians who have completed an allergy fellowship, and who are board certified in allergy and clinical immunology,
  b) Otolaryngologists who are board certified,
  c) Exceptions are considered in rural areas when written documentation is provided to PEIA.

19. X-RAYS AND ELECTROCARDIOGRAMS TAKEN IN THE EMERGENCY ROOM

PEIA adopted CMS's policy of paying for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. The professional component of the service must include an interpretation and written report for inclusion in the patient's medical record. Reviewing an x-ray or EKG, without providing a written report, does not meet the criterion that CMS established for separate payment. If multiple claims are submitted for the same emergency room visit:

A. PEIA will pay the interpretation and report that directly led to the diagnosis/treatment.

B. PEIA will pay the interpretation of the x-ray or EKG by a radiologist or cardiologist if the interpretation is performed at the same time as the diagnosis and treatment.

   a. PEIA may allow for two interpretations and written reports in unusual circumstances.

20. SERVICES OF TEACHING PHYSICIANS

In 1996, CMS clarified its payment policy for services provided by teaching physicians and residents in qualified teaching programs under the RBRVS payment system. In general, the provisions are similar to those previously established by CMS and currently used by PEIA. There was some relaxation of the attending physician requirement. Rather than requiring that only one physician be designated as the attending physician for the entire hospitalization, CMS will allow hospitals to determine the responsible teaching physician in each individual case. Since PEIA has adopted Medicare's graduate medical education (GME) payment policies in its

inpatient prospective payment system and makes direct and indirect medical education payments to hospitals, it seemed reasonable to adopt Medicare's GME policies with respect to billing under the RBRVS payment system. An exception is made for services provided in rural health centers and Federally Qualified Health Centers to which PEIA does not make payments that reflect the cost of the residents' services. For that reason, PEIA will allow separate billing under RBRVS for services provided by residents in these centers.

A. The following conditions are necessary to allow for billing of services by teaching physicians under PEIA's RBRVS payment system:
    - the teaching physician must be present for a key portion of the time during the performance of the service;
    - the teaching physician must be present during the critical portion of a surgical or complex or dangerous procedure, and be immediately available to furnish services during the entire service or procedure;
    - the billing of E&M services must represent the level of complexity that the case presents to the teaching physician and not to the inexperienced resident; and
    - the presence of the teaching physician during the service or procedure must be documented in the medical record.
B. A special exception is made for mid-level E&M services furnished in settings outside of the inpatient hospital setting for family practice types of residency programs. CMS believes that the nature of these residency programs is fundamentally incompatible with the physical presence requirements. In 1997, CMS further clarified that the exception to the physician presence requirement is for certain evaluation and management services (CPT codes 99201, 99202, 99203, 99212, and 99213) furnished in ambulatory care centers within the context of specific types of residency training programs. All of the following criteria must be met:
    - Residents providing services without a teaching physician present must have completed more than 6 months of an approved residency program.
    - The teaching physician may not supervise more than four residents at any given time and must be immediately available.
    - The patients must be an identifiable group of individuals who use the outpatient setting for their usual and continuing source of care.
    - The range of services furnished by the residents includes acute care for undifferentiated problems or chronic care for ongoing conditions; coordination of care furnished by other physicians and providers; or comprehensive care not limited by organ system or diagnosis.
    - The center must be located in a setting in which the resident's time is included in the full-time equivalency count used for direct GME.
C. Residents may directly bill the Medicare program for services provided to beneficiaries under a limited number of circumstances. Generally, when services of residents in approved GME programs are provided to Medicare beneficiaries in the affiliated hospital, these services are payable as hospital, rather than physician services. The costs of providing the medical services are paid through the direct GME payments to hospitals. This provision holds when teaching hospitals enter into written agreements with other types of facilities for the residents to provide medical services, if the time spent in these

other facilities is counted toward the hospitals' full-time equivalency count of residents for GME payment purposes.

D. Residents in non-approved programs are able to bill Medicare for services that they provide in hospital settings, within the scope of their license. All residents may bill Medicare for physician services provided to beneficiaries in freestanding skilled nursing facilities and home health agencies. Under this rule, CMS will also allow residents to bill for physician services provided in non-institutional settings, such as freestanding clinics that are not part of the hospital.
E. CMS's policy regarding approved GME programs for residents, interns and fellows states that fellows cannot bill separately for services when acting as part of the teaching program, even when they are supervising interns and residents. Thus, fellows will continue to be treated the same as other residents.
F. "Moonlighting" residents may receive payment for physician services provided in the outpatient or emergency department of the teaching hospital, if there is a contract between the resident and the hospital indicating that the following criteria have been met:
    - The resident is fully licensed to practice medicine in the State where the services are being provided;
    - The services are identifiable physician services; and
    - The services can be separately identifiable from those services that are required as part of the approved GME program.

21. RULES FOR DIAGNOSTIC TESTS and DIAGNOSTIC RADIOLOGIC PROCEDURES

Effective June 1, 1998, PEIA adopted CMS's policy requiring that diagnostic tests, including diagnostic radiological procedures and diagnostic laboratory tests, be ordered by the physician who treats the patient. The physician who treats the patient is the physician responsible for the treatment of the patient and the physician who orders the diagnostic test will be the one who uses the results in the management of the patient's specific medical problems. Diagnostic tests ordered by a physician who is not the patient's treating physician, (e.g. medical director of a nursing home, mobile center) will not be covered. The following guidelines apply:

A. X-rays used by chiropractors to demonstrate subluxation of the spine are covered and may be ordered or performed by a chiropractor. The services performed by the chiropractor must be within the scope of their license and PEIA coverage guidelines.
B. A diagnostic mammogram may be ordered by the interpreting physician (who meets the qualification requirements for an interpreting physician) when ordered based upon the findings of a screening mammogram, even if that physician does not treat the patient.
C. Procedure codes 95860, 95861, 95863, 95864, and 95870 must be personally performed by a physician or a physical therapist certified by the American Board of Physical Therapy as a qualified electrophysiological clinical specialist and they must be permitted to provide the service under State law. Surface EMG's are non-covered.
D. Procedure codes 95900, 95903, 95904, 95933, 95934, 95936, and 95937 must be personally performed by a physical therapist that is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiological clinical specialist, or it may be performed under the direct supervision of a physician.
E. If a physician performing diagnostic tests (ordered by the treating physician) determines the patient needs additional testing, based on the findings of the test performed, the

testing physician must receive authorization from the ordering physician in order to proceed with the additional tests.

F. In an emergency, the testing physician may order the necessary tests. The emergency must be documented.

G. Non-physician practitioners (i.e. midwives, family nurse practitioners, podiatrists, etc.), who are eligible providers for PEIA may also order diagnostic tests if they are acting within the scope of their license where the service is provided.

H. A patient may have more than one treating physician (a primary care physician and a specialist or more than one specialist), depending upon the patient's medical problems.

I. Effective January 1, 2009, PEIA will implement CMS' policies of (a) capped payments on the technical component of designated diagnostic imaging procedures and (b) multiple procedure reductions when performed in the same imaging family.

   a. Capped Payments – CMS requires a payment cap on the RBRVS technical component (TC) of certain diagnostic imaging procedures at the amount paid for the same services when performed in outpatient hospital departments. The cap applies to the RBRVS technical component of the service regardless of whether it is billed alone (i.e. CPT code +TC modifier) or as a part of a complete "global" procedure. The cap is based on the Outpatient Prospective Payment System (OPPS) payment. The payment allowance is the lower of the RBRVS and the OPPS payment amount. For the affected procedures, the TC RBRVS and OPPS and payment allowances are both included in the RBRVS Fee Schedule.

   b. Multiple Procedure Reductions for Diagnostic Imaging – CMS reduces the fee allowances for multiple imaging services performed on the same day for imaging services in the same imaging family. The RBRVS Fee Schedule includes an indicator (see column AH) for applicable codes to designate imaging families. The indicators are:

Diagnostic Imaging Family Indicators	
01	Ultrasound (Chest/Abdomen/Pelvis-Non-Obstetrical)
02	CT and CTA (Chest/Thorax/Abd/Pelvis)
03	CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)
04	MRI and MRA (Chest/Abd/Pelvis)
05	MRI and MRA (Head/Brain/Neck)
06	MRI and MRA (Spine)
07	CT (Spine)
08	MRI and MRA (Lower Extremities)
09	CT and CTA (Lower Extremities)
10	MR and MRI (Upper Extremities and Joints)
11	CT and CTA (Upper Extremities)
Blank	Not Applicable

PEIA will allow 100% for the procedure with the highest RVUs or fee allowance. For the second through fourth procedures, PEIA will allow 75% of their respective values.

22. INDEPENDENT DIAGNOSTIC TESTING FACILITY

As of June 1, 1998, diagnostic tests must be provided by an independent diagnostic testing facility (IDTF). In an IDTF, diagnostic tests are performed by licensed, certified non-physician personnel under appropriate physician supervision. An IDTF is defined as a fixed location, a

mobile entity, or an individual non-physician practitioner. A physician's office is also appropriate when requirements are met.

A. The following diagnostic tests are not required to be furnished in accordance with the IDTF criteria:
    - Diagnostic mammogram (coverage for this test is regulated by the Food and Drug Administration;
    - Diagnostic psychological testing services personally performed by a clinical psychologist;
    - Diagnostic tests personally furnished by an audiologist; and
    - Clinical lab (CLIA certification is required).

23. COLORECTAL CANCER SCREENING

Colorectal cancer screenings are covered at 100% if billed with the correct "G" codes:

Screening Procedure Code	Description	Frequency
G0104	flexible sigmoidoscopy	every 48 months/age 50 and over
G0105	Colonoscopy (high risk)	every 24 months for high risk patients*
G0106	x-ray, barium enema	every 4 years/age 50 and over
G0107	fecal-occult blood test	every 12 months/age 50 and over
G0120	x-ray, barium enema	every 2 years/high risk patients*
G0121	Colonoscopy (not high risk)	patient age 50 and over not meeting criteria for high risk

*High risk is defined as a patient who faces a high risk for colorectal cancer due to:

- family history;
- prior experience of cancer or precursor neo-plastic polyps;
- history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's disease, or ulcerative colitis); and
- presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.

NOTE: If in the course of a routine screening, a medical problem is diagnosed and treated, the screening ICD-9 code must be billed in addition to the diagnostic ICD-9. In this case, only the screening allowance is processed at 100%. The remaining expenses are processed at the regular benefit level.

24. CUSTOM DME ITEMS

Custom-made durable medical equipment (DME) and supply items, to the extent that they are covered by this Plan, will be reimbursed based on the manufacturer's cost of the item and time involved in the measuring/preparation of the order. To determine the appropriate allowance for custom-made items, you must submit the manufacturer's invoice with the CMS-1500 claim form. These items will be evaluated on an individual basis.

25. IMMUNIZATIONS

As of August 1, 2002, charges for vaccines and toxoids and their administration are covered as separate services. Bill both the immunization CPT code (90476 – 90749) **and** the administration CPT code (90465 – 90474). Prior to August 1, 2002, PEIA requested that you bill only the immunization CPT code, which included the allowances for the vaccine and the administration. Reimbursement rates are as follows:

A. vaccines and toxoids – Medicare rates; and
B. administration for immunizations/vaccines – $12 is allowed for the administration codes of 90465 through 90475 .

If an E&M service is billed on the same day as the administration of a vaccine, then the office notes must document a separately identifiable E&M service. Add modifier 25 to the E&M code. Otherwise, the services will be bundled.

26. MAMMOGRAM - SCREENINGS

PEIA covers 100% of an annual routine mammogram for screening purposes. The related office visit is subject to the applicable copayment. If the mammogram is billed with a medical diagnosis, rather than as a screening, it is considered a diagnostic test and is subject to the deductible and coinsurance.

As of July 1, 2003, PEIA will also cover the computer aided detection "add-on" code with the screening mammogram.

27. UPDATING THE CONVERSION FACTORS

Annually, Medicare updates its conversion factor to reflect the change in the cost of operating a medical practice. It uses the Medicare's economic index (MEI) to measure this change. PEIA considers these factors and makes changes to the conversion factors in accordance with the budget for that fiscal year. PEIA conversion factors are listed below.

28. PEIA CONVERSION FACTORS

	August 1994	August 1995	August 1996	June 1997	January 1998	July 1999	April 2000	July 2001	October 2001
Anesthesia	$47.25	$48.86	$49.84	$49.84	$43.38	$43.80	$43.80	$43.80	$42.25
All Other	$43.28	$44.76	$45.66	$45.66	$43.38	$46.00	$42.00	$42.00	$42.25

	August 2002	July 2003	July 2004	July 2005	Jan. 2006	January 2007	February 2008	January 2009
Anesthesia	$38.00	$38.25	$38.80	$38.80	$38.80	$38.80	$38.80	$38.15
All Other	$42.25	$42.27	$41.39	$42.15	$42.30	$42.72	$43.46	$39.95

Conversion factors from October 2001 to date also apply to WVCHIP. Conversion Factors from July 2005 to date also apply to AccessWV.

29. CLINICAL LAB FEE SCHEDULE UPDATE

Clinical lab reimbursement is based on Medicare's clinical lab fee schedule and policies Effective January 1, 2009, PEIA's Clinical Lab Fee Schedule is 100% of Medicare's 2009 allowances. PEIA's Clinical Lab Fee Schedule is on PEIA's web page at www.wvpeia.com .

PEIA PROCEDURES

1. BILLING INSTRUCTIONS

Reimbursement depends on the proper filing of claims and meeting the conditions of reimbursement. PEIA has developed this Billing Manual to facilitate the proper filing of claims.

2. BILLING PROCEDURE

The provider must file claims for services rendered to PEIA members on the CMS-1500 claim form. The UB04 claim form is acceptable for hospitals that bill for outpatient RBRVS and clinical lab services. The provider or his or her authorized representative must accurately complete and sign (signature stamp is acceptable) the claim form. Electronic billing is preferred and strongly encouraged. If you need assistance with implementation of electronic submission of claims, contact Wells Fargo TPA at 1-888-440-7342.

Providers must file a separate claim for each patient within 6 months from the date of service or 6 months from date of the primary insurer's Explanation of Benefits. If the claim is not submitted timely, the provider will be responsible for the charges. The denied expenses may not be billed to the patient. If the claim is for an illness or injury wrongfully or negligently caused by a third party (subrogation) and reimbursement from another party or insurance is expected, you are still required to file the claim within 6 months or the service will not be covered.

Examine the PEIA Medical ID card to determine the correct ID number for claim submission. Carefully check the insured's identification number for accuracy. Errors in completing the claim form may delay processing and payment. Mail the original claim form to:

Wells Fargo TPA
P. O. Box 2451
Charleston, WV 25329-2451

Wells Fargo TPA also processes claims for PEIA through an electronic claims submission system with two national vendors. This system facilitates prompt and accurate payment of claims.

3. PRE-AUTHORIZATION

Pre-authorization of some services is highly recommended. For pre-authorization of a procedure or service, please submit your written pre-authorization request to Wells Fargo TPA with all necessary medical documentation, such as clinical notes, lab results, biopsy results, pictures if applicable, etc. The Medical Management Department at Wells Fargo TPA will review the pre-authorization for PEIA plan coverage eligibility and medical necessity. This is not the precertification required for inpatient admissions and certain outpatient procedures. Normally, requests for pre-authorization by Wells Fargo TPA are for procedures covered only under certain documented circumstances, such as chelation, potentially cosmetic procedures, vision or massage therapy and accident-related dental care.

The provider should request pre-authorization in sufficient time to complete the review prior to the scheduled date for the service.

4. MEDICARE/PEIA BENEFICIARIES

In situations where Medicare is the primary payer and PEIA is the secondary payer, the provider must submit the original claims and the associated Medicare Explanation of Benefits (EOMB) to proper insurer.

Medicare Crossover – If the Medicare EOMB indicates that the claim was sent electronically to WELLS FARGO TPA, submission by the health care provider is not necessary. Remark code of MA18 on the Medicare EOMB indicates that the claim was submitted electronically.

5. COMMERCIAL PRIVATE INSURANCE

PEIA coordinates with other commercial insurance policies. In some cases, even the member may have coverage that is primary to PEIA due to early retirement status, COBRA, or other extenuating circumstances. PEIA may coordinate with individual plans and automobile policies with medical payments coverage, as appropriate. PEIA determines primary coverage for dependent children using the Birthday Rule. Please send all appropriate information regarding other insurance or payments along with the claim at the time of submission to assure prompt and accurate payment.

6. THIRD-PARTY LIABILITY (TPL)

The PEIA has a Subrogation Recovery policy. Benefits paid due to an accident involving third party liability are subject to this policy. Beacon Recovery Group, PEIA's subrogation vendor, will pursue recovery of any payments made by the PEIA that are the responsibility of a third party. Claims submitted beyond the 6-month timely filing period will be denied and are not billable to the member.

7. COMPLETION OF THE CMS-1500 CLAIM FORM

Listed below is a description of the data fields on the CMS-1500 claim form that the provider must complete when billing PEIA:

CMS-1500 Billing Instructions		
Item	**Field Name**	**Description**
1A	Insured's ID Number	Enter the policyholder's 10-digit identification number (the ID No. on the PEIA Group Benefits Card.
2	Patient's Name	Enter the last name, first name and middle initial of the patient.
3	Patient's DOB and Sex	Enter the patient's date of birth (mm/dd/yy)
4	Insured's Name	Enter the policyholder's name as listed on the PEIA Group Benefits Card.
5	Patient's Address	Enter the patient's correct address in full.
6	Patient's Relationship to the Insured	Indicate whether the patient is self, spouse, child or other.
7	Insured's Address	Enter the current address of the PEIA policyholder in full.
8	Patient Status	Enter the current patient status.
9	Other Insured's Name	Enter policyholder's name if insurance other than PEIA covers this patient. If no other, coverage go to box 10.
9A	Other Insured's Policy or Group Number	Enter policy or group number of the insurance policy.
9B	Other Insured's DOB	Enter policyholder's date of birth and sex.
9C	Employer's Name or School Name	Enter the name of the employer through which the policy is held.
9D	Insurance Plan Name or Program Name	Enter the name of the insurance plan or program.
10	Is Patient's Condition Related To	If treatment was due to accidental injury or was employment-related, mark the appropriate block.

CMS-1500 Billing Instructions		
Item	**Field Name**	**Description**
11	Insured's Group Number	Number Enter the PEIA number as shown on the PEIA Group Benefits Card.
12	Patient's Signature	Patient's signature or signature on file is accepted.
13	Insured's Signature	PEIA Benefit Plan has an automatic assignment policy. Payment will be made to the provider unless proof of payment or zero balance due is indicated.
14	Date of Current	Indicate date of onset of current illness, injury or pregnancy.
15	Previous Date of Same or Similar Illness	Indicate date of initial treatment of the same or similar condition, if known.
16	Dates Patient Unable to Work	Desired, but not required.
17	Name of Referring Physician or Other Source	Enter the referring physician's name.
17A	ID Number of Referring Physician	Enter the referring physician's nine-digit identification number, if known.
18	Hospitalization Dates	Admission and discharge dates, if known.
19	Reserved for Local Use	Leave Blank
20	Outside Lab	Indicate Yes or No
21	Diagnosis, Illness, or Injury	Enter the ICD-9 code(s).
22	Medicaid Resubmission Code	Leave Blank
23	Prior Authorization Number	Enter the prior authorization case number, if pre-certified.
24A	Date(s) of Service	Enter the date(s) of service covered by this claim. Enter it in month, day, year format mm/dd/yy, such as 8/21/95.
24B	Place of Service (use current CMS)	Enter the appropriate place of service code: 11 Office 12 Home 21 Hospital — Inpatient 22 Hospital — Outpatient 23 Hospital — Emergency Department 24 Ambulatory Surgical Center (ASC) 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance — Land 42 Ambulance — Air/Water 51 Psychiatric Facility — Inpatient 52 Psychiatric Facility — Outpatient

CMS-1500 Billing Instructions		
Item	**Field Name**	**Description**
		53 Community Mental Health Center 54 Intermediate Care Facility 55 Residential Substance Abuse Facility 56 Psychiatric Residential Treatment Ctr. 61 Comprehensive Inpatient Rehab Facility 62 Comprehensive Outpatient Rehab Facility 65 End Stage Renal Treatment Facility 71 State or Local Public Health Facility 72 Rural Health Clinic (RHC) 81 Independent Lab 99 Unlisted Other Facility
24C	Type of Service	Leave Blank
24D	Procedure Code	Enter the five-digit procedure applicable to the date of service that describes the procedure performed. If applicable, enter one of the modifiers described earlier in this manual.
24E	Diagnosis Code	Enter the ICD-9 CM code that describes the reason for treatment, or the corresponding dx number from box 21.
24F	Charges	Enter the total charge(s) for the procedure(s) performed (not reductions due to Medicare).
24G	Days or Units	Enter the number of units for the procedure you are billing as per CPT/HCPCS instructions. For anesthesia, show the elapsed time in **minutes** in item 24G. (Convert hours into minutes and enter the total minutes for this procedure.)
24J	COB	Leave Blank
24K	Reserved for Local Use	Leave Blank
25	Federal Tax ID Number	Enter the provider's 9-digit tax identification number.
26	Patient's Account Number	Enter the patient account number. It may be alpha/numeric characters, but must not exceed 15 characters. It appears on the provider remittance advice. Last name, first name and middle initial may be used.
27	Accept Assignment	For Medicare patients, indicate whether Medicare assignment for this claim is accepted. Otherwise, this field is not required.
28	Total Charge	Indicate the total for all charges (not Medicare allowances) billed on this claim.
29	Amount Paid	Indicate amounts paid toward these charges by other insurance or patient. If other insurance, attach explanation of benefits.
30	Balance Due	Enter balance due. If the patient has made full or partial payment, the appropriate portion will be sent to the member.
31	Signature of Physician or Supplier	The provider, or an authorized representative, must sign the claim form. If a billing clerk signs the provider's name, the clerk must write his or her initials beside the signature. Enter the date you sign the claim. A signature stamp may be used.
32	Name/Address of	If the patient was in an institutional setting (i.e. hospital, nursing

CMS-1500 Billing Instructions		
Item	**Field Name**	**Description**
	Facility	home, etc.) enter the name and address of the facility (see note below).
33	Physician's/Supplier's Billing Name	Enter the name, address, zip code, and telephone number of the provider who rendered the services. If the billing address does nc match the service address, complete both areas 32 and 33 regardless of where services are rendered. This is a plan requirement.

8. PROVIDER REMITTANCE ADVICE

The Remittance Advice provides detailed information regarding the payment and/or denial of claims. The Remark Code (RMK CODE) explains why a line item on a claim or the entire claim was rejected or why the full charge was not paid. Remark Codes and explanations are printed on the Remittance Advice form.

9. TIMELY PAYMENT

Wells Fargo TPA's target turnaround time for a "clean" claim is 12 working days from receipt date. A "clean" claim is a claim for which no additional information or review is required for adjudication.

10. ADJUSTMENT OF DENIED/PAID CLAIMS

Several situations may necessitate the adjustment of a claim:

- receipt of additional information;
- reconsideration of payment due to medical necessity;
- identification of an adjudicator error; and
- corrected billings.

In situations where a provider feels processing was in error, call Wells Fargo TPA. If a written explanation is necessary, mail it to Wells Fargo TPA's customer service department for reconsideration.

In situations where there is no payment due to missing information such as "other carriers" payments or billing information, please resubmit the claim with the requested information for reprocessing of the claim.

Please mail this correspondence to:

Wells Fargo TPA
P. O. Box 2451
Charleston, WV 25329-2451

11. REQUEST FOR ADDITIONAL INFORMATION

Certain circumstances require that Wells Fargo TPA send a request for additional information from the provider or member. Upon receipt of the requested information, the pended claim will be processed. If the requested information is not received within 30 days from the date the letter was sent, the claim will be closed. Once the requested information is returned to Wells Fargo TPA, the closed claims will be reconsidered. If the claim is closed due to non-receipt of requested information from the provider, the "no balance billing" applies. If the additional information was requested from the member, then the member may be billed.

RELATIVE VALUE UNITS

The relative value units (RVUs) for January 1, 2009, are on the provider tab of PEIA's web page. The address is www.wvpeia.com. These RVUs also apply to WVCHIP and AccessWV. For your convenience, in addition to the RVUs, the PEIA fee allowances are included.

The keys to the status codes, global surgery indicators, and payment policy indicators for the RBRVS file are listed below.

Key to Status Codes

Status	Description
A	Active Code: Payment is made using PEIA's physician fee schedule for these services. Services with RVUs are covered by PEIA if they are not otherwise excluded (e.g. cosmetic and dental services are only covered as specified by PEIA).
B	Bundled code: Payment for covered services is bundled into payment for other unspecified services. There is no separate payment for of these services.
C	Carrier-priced code: PEIA will establish allowances for unlisted procedures codes (codes that typically end in "99") and for services which CMS has not established RVUs.
I	Immunization code: "I" to indicates immunization services. PEIA's allowance is based on Medicare's average wholesale price (AWP) for the vaccine. As of August 1, 2002, the administration fee is billed separately. For flu and pneumonia vaccines, the administration fee is bundled with any other services billed on the same day as the vaccine administration.
M	Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. PEIA may also choose to use these codes to report performance.
N	Non-covered service: This code represents a service, which is not covered by PEIA. There are also CPT codes with a status of "A" or "C" which may or may not be covered based on PEIA's benefit plan and coverage guidelines.
T	Injections: There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule on the same date by the same provider. If any other services are payable on the same date by the same provider, these services are bundled into the service(s) for which payment is made.
X	Not a valid code for PEIA services. PEIA uses another code for reporting this service, or uses a different fee schedule to determine the fee allowance, or it is not covered.

Key to Global Surgery Indicator Variable

PEIA adopted Medicare's pre- and post-operative global surgical package windows for surgeries. During these global periods, payment for office visits associated with the surgical procedure is not made. The Global Indicator Variable indicates the post-operative period.

Code	**Explanation**
MMM	Global surgical concept does not apply; maternity code
XXX	Global concept does not apply
YYY	Global period determined by carrier

ZZZ	Code falls within global period for another service. These are add-on codes and can only be billed with another service
090	90 days (These are considered major procedures)
010	10 days
000	0 days

Key for Payment Policy Indicator Variables

Indicator variables for multiple surgery, bilateral surgery, co-surgery, and team surgery procedures are indicated with a "Y" in the RBRVS RVU file.

Multiple Surgery	"Y" indicates that these services may be billed as multiple procedures.
Bilateral Surgery	"Y" indicates that the services may be billed as bilateral procedures.
Assistant Surgery	"Y" indicates that payment may be made for assistant at surgery, if medically necessary.
Co-Surgery	"Y" indicates that physicians may bill as co-surgeons for the service.
Team Surgery	"Y" indicates that physicians may bill as team surgeons for this service. Supporting documentation is required.

Key for PC/TC Status Indicator Variables

The key to the column labeled "PC/TC Ind" in the RBRVS RVU file is in the table below.

0	Physician service codes
1	Diagnostic test for radiology services
2	Professional Component only codes
3	Technical Component only codes
4	Global Test only codes
5	Incident to codes
6	Laboratory Physician interpretation codes
7	Physical therapy service
8	Physician interpretation codes
9	Not applicable

Key to Indicators for Diagnostic Imaging Families

The key to the column labeled "Diagnostic Imaging family Indicators" is in the RBRVS RVU file is in the table below.

01	Ultrasound (Chest/Abdomen/Pelvis-Non-Obsetrical)
02	CT and CTA (Chest/Thorax/Abd/Pelvis)
03	CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)
04	MRI and MRA (Chest/Abd/Pelvis)
05	MRI and MRA (Head/Brain/Neck)

06	MRI and MRA (Spine)
07	CT (Spine)
08	MRI and MRA (Lower Extremities)
09	CT and CTA (Lower Extremities)
10	MR and MRI (Upper Extremities and Joints)
11	CT and CTA (Upper Extremities)
Blank	Not Applicable

Who to Call With Questions

Questions	Company	Phone Numbers	Web Site
Health claims, benefits, preauthorizations, prior approvals for Out- of- state services	Wells Fargo TPA	1-204-353-7820 1-888-440-7342	www.wellsfargo.com/tpa
Prescription Drug Benefits	Express Scripts	1-877-256-4680	www.express-scripts.com
Subrogation and Recovery	Beacon Recovery Group	1-800-874-0500	
Prescription Drug: • prior authorizations • step therapy • quantity limits	Rational Drug Therapy (RDT)	1-800-847-3859 Fax: 1-800-531-7787	
Eligibility, life insurance and 3rd level appeals	PEIA	1-304-558-7850 1-888-680-7342	www.wvpeia.com

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