Physicians Medical Group of San Jose, Inc.

AB 1455 REGULATIONS FOR CLAIMS SUBMISSIONS, CLAIMS SETTLEMENT, CLAIMS DISPUTES, AND FEE SCHEDULES

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care.

In order to comply with AB 1455, the following information is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices, fee schedule information, and claim disputes for commercial HMO and POS products where Physicians Medical Group of San Jose (PMGSJ) is delegated to perform claims payment and provider dispute resolution processes. All administrative services are provided by EXCEL MSO, LLC which is PMGSJ's contracted management service organization.

I Claims submission instructions.

Providers must submit a completed claim form to PMGSJ that provides reasonably relevant information so that liability may be determined as soon as it is received. Reasonably relevant information means the minimum amount of itemized, accurate, and material information generated by or in the possession of the provider of service that allows a claims adjuster to adjudicate the claim. For physicians and other professional providers, a completed CMS 1500 is required for claim payment. Institutional providers are required to submit a completed current form. These forms may be submitted on paper or in an electronic format. In order to determine liability, additional information such as an operative report, co-ordination of benefits information, third party liability information, etc. may be required and may be submitted by mail, personal delivery or by fax to (408) 937-3634.

A. Sending Claims to Physicians Medical Group of San Jose

Claims for services provided to members assigned to Physicians Medical Group of San Jose must be sent to the following address:

Via Mail or Physical Delivery:
Physicians Medical Group of San Jose
Claims Department
1565 Mabury Road, Suite D
San Jose, CA 95133

Via Electronic Submission:
Physicians may submit claims electronically to PMGSJ through vendors such as Office Ally, ENS, Zirmed, and Proxymed. Additional electronic claim submission media options may be arranged through PMGSJ.

B. Calling Physicians Medical Group of San Jose Regarding Claims. For claim filing requirements or status inquiries, you may contact PMGSJ Claims Department by calling: (408) 937-3620.

For additional questions, Provider Service Representatives are available to assist you. Please call (408) 937-3612 or (408) 937-3604.

C. Claim Submission Data

1. Claim data must include the correct Name of the Patient and/or the Member's name, Correct Insurance ID number, Date of Birth, Diagnosis Codes, CPT Codes, Place of Service, Name of Rendering Provider, Providers Tax ID#, Provider's NPI number, Billed amount, and if the Place of Service is different than box 33, box 32 needs to have the place of service.

   Claims shall:

   a) Include office notes, if billing a high level CPT code

   b) Include the surgical notes, if billing multiple procedure codes

   c) Have the primary insurance's EOB attached (These claims are to be received within 90 days of the primary insurance's payment.)

2. Third Party Liability claims require primary insurance information attached to the claim.

3. Claims will not be accepted with WHITE OUT.
   Each claim is a legal document and may not be corrected with white out. Please just draw a line through any incorrect information and initial it.

D. Claim Receipt Verification.
For verification of claim receipt by PMGSJ, please do the following:

1. Verify receipt of claim by using our web-based PMGSJ application or phone:

   Website: http://www.pmgmd.com (User name and password are required)

   Telephone (408) 937-3620

2. Paper claims will be identified and acknowledged within 15 working days of the date of receipt by PMGSJ. Electronic claims will be identified and acknowledged within two working days of receipt by PMGSJ.

3. Claims received from a provider's clearinghouse will be acknowledged directly to the clearinghouse within two days of receipt.

E. Claim submission time guidelines

Claims are to be submitted in a timely manner. Except as required by any state or Federal law or regulation, or a contract exception, PMGSJ's submission requirements are as follows:

1. Contracted Providers
   The original or initial claim must be received by PMGSJ within 90 days from the date of service. If PMGSJ is not the primary payer under the co-ordination of benefits (COB) rules, PMGSJ will allow an additional 90 days from the date of contest, denial or notice from a primary payer with supporting documentation.

   Claims that are not received within the timely filing period will be denied.

2. Non-Contracted Providers
   a) The original, or initial, Commercial/Senior claim must be received by PMGSJ within 180 days from the date of service. In the case of co-ordination of benefits, and with supporting documentation, PMGSJ will allow an additional 90 days from the date of contest, denial or notice from a primary payer.

   Claims that are not received within the timely filing period will be denied.

   b) For Medi-Cal claims, the original, or initial, Medi-Cal claim must be received by PMGSJ within six months following the month in which services were rendered rendered. This requirement is referred to as the six-month billing limit. Claims that are not received by Excel within the six-month billing limit will be reimbursed at a reduced rate or will be denied as follows:

   i) Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.

   ii) Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.

   iii) Claims received after the twelfth month following the month of service will be denied.

F. Misdirected claims

If a claim is received by PMGSJ and the health plan is responsible for adjudication, PMGSJ will forward the claim to the HMO within 10 working days of receipt. If PMGSJ is aware of the correct payer, another IPA or Medical Group, the claim will be forwarded within 10 working days of receipt. Any other misdirected claim will be returned to the provider.

II Fee schedules

A. PMGSJ's contracted providers

1. Primary Care Physicians (PCPs) are paid a capitation amount as established by PMGSJ's Board of Directors. This capitation amount covers all of the capitated services provided by the PCPs. Each month, PCPs receive a capitation report with the dollar amount paid for each of their members. In addition, PCPs may be paid fee for service for immunizations, EKGs, hospital visits, inhalation therapy, authorized procedures, etc.

2. Capitation is paid for certain contracted sub-specialists such as laboratory and pathology. The negotiated amount is paid per month. Sub-capitated providers receive a monthly report with the capitation amount paid.

3. PMGSJ has established a fee for service schedule for certain services that are not fully addressed by standard coding and payment schedules such as immunizations, and payment for well woman exams. This fee for service schedule is available for review at EXCEL MSO.

4. PMGSJ participating physicians are paid a percent of the Medicare fee schedule, locality 9, for eligible fee for service claims. This amount is determined by the Board of Directors and is incorporated into the contract of the participating physician.

5. Some contracted physicians and ancillary providers have individual contracted rates. For example, radiology, anesthesia, emergency room physicians, etc. These rates are in the provider's prevailing contract.

6. If reimbursement rates are not available, claims will be paid at the lesser of the 70% percentile of reasonable and customary (R&C) rates for Santa Clara County, or 70% of billed charges.

7. All fee for service claims are paid according to PMGSJ's adjudication guidelines, which include Medicare's payment guidelines. (SEE ATTACHMENT A)

8. Correct co-pays are taken at the time of patient's visit to the office or facility and are deducted from the fee for service payment.

B. Fees for non-contracted providers

1. Medi-Cal rates are paid for Medi-Cal services.

2. Medicare rates are paid for senior claims.

3. Healthy Families and Healthy Kids are paid at Medi-Cal rates with a "Plus Factor" of 10.25%.

4. Commercial, claims are paid as follows:

   a) Letter of Agreement

   b) Fiftieth percentile of the prevailing reasonable and customary rates for PMGSJ's geographic area using the "Physicians Fee Reference".

   c) Billed charges only when necessary.

C. Claims adjudication timeframes

PMGSJ will adjudicate each complete HMO claim according to the agreed upon contact rate no later than 45 business days after the date of receipt of the complete claim unless contested or denied.

POS claims and ERISA claims will be adjudicated according to the agreed upon contact rate no later than 30 business days after the date of receipt of the complete claim unless contested or denied.

D. Denied, contested or adjusted claims

PMGSJ will notify the provider of service in writing of a denied, contested or adjusted claim no later than 45 business days after receipt of the claim for HMO claims and no later than 30 days after receipt of a POS or ERISA claim.

Information regarding denied claims will appear on the provider's explanation of benefits (EOB). The reason for the denial will be in writing.

A contested claim is one that PMGSJ cannot adjudicate or accurately determine liability because more information is needed from either the claimant, the member, or a third party. Incomplete claims and claims for which information has been requested in order to determine payer liability, including third party liability, will be contested or denied in writing within the above timeframes. Contested claims will appear on the provider's EOB and will have the reason in writing for the contest and the additional information that is required to adjudicate the claim.

Adjusted claims will appear on the provider's EOB and will have the reason in writing for the adjustment.

The EOB will also contain instructions on where and how to file a provider dispute.

E. Interest on late payment of claims

1) AB 1455

PMGSJ is required by AB1455 to automatically make a late payment on a complete claim for emergency services and care, which is neither contested nor denied, of the greater of $15.00 for each 12 month period, or portion thereof, on a non-prorated basis, or interest at the rate of 15% per annum for the period of time that the payment is late.

Late payments on all other complete claims will automatically include interest at the rate of 15% per annum for the period of time that the payment is late.

If PMGSJ fails to automatically include the interest due on a late claim, they will make a payment of $10.00 plus the above interest.

"Automatically" is defined as interest which is included with the original payment or is due within five working days of the payment of the claim without the need for any reminder or request by the provider. If interest on a claim is less than $2.00, the interest for that claim may be paid, along with interest on other such claims, within 10 calendar days of the close of the calendar month in which the original claim was paid.

2) Interest Requirements for Common Adjustment Situations

In addition to late payments on complete claims, AB 1455 also requires interest in other adjustment situations. The following are the required guidelines:

Situation	*Pay interest?*
The payer made a mistake in determining the amount of the original claim payment. Denials that are made in error and overturned are included in this situation.	Yes
The payer receives new/additional information from an outside source (e.g., retroactive enrollment form an employer) that was not available to the payer at the time of the original claim payment or denial.	No
A contract negotiation for an expired contract is concluded and the payer must make retroactive adjustments to previously paid claims.	Yes, only for claims with DOS after the contract expiration date

Situation	*Pay interest?*
A contract negotiation is concluded and the payer must make retroactive adjustments to previously paid claims; however the original contract was an "evergreen" contract and the settlement and the contract do not call for interest on the adjustments.	No
"Gesture of good will" payment. [Payment Advice/EOB should make this clear]	No
A claim that was provider-denied due to untimely filing is paid because evidence of timely prior filing to the correct payer is submitted.	Yes
A claim that was provider-denied due to untimely filing is paid because evidence is submitted of timely prior filing to an entity that was not financially responsible.	No
A claim that was provider-denied due to untimely filing is paid because information about a good cause for the delay is accepted by the payer.	No

F. Overpayment of claims

1) If PMGSJ determines that an overpayment has occurred, it will notify the provider of service in writing within 365 days of the date of payment on the overpaid claim through a separate notice that will include the following:

a) Member name,
b) Claim ID number,
c) Date of service,
d) Clear explanation of why the overpayment occurred, and
e) The amount of the overpayment.

The provider of service has 30 business days to submit a written dispute to PMGSJ if the provider does not believe an overpayment has occurred. In this case, PMGSJ will treat the claims overpayment issue as a provider dispute.

If the provider does not dispute the overpayment, the provider of service must reimburse PMGSJ within 90 days of the first request. PMGSJ may recoup uncontested overpayment amounts by offsetting overpayments from payments from a current payment. The EOB will identify the specific overpayment and the claim ID number.

2) Authorized services provided after termination

PMGSJ will not deduct payments for authorized and rendered services when new eligibility information becomes available and the information advises that the member has terminated coverage with PMGSJ. PMGSJ will:

a. Request that the providers check eligibility with the health plans before rendering services especially high dollar services such as surgeries.

b. When an HMO notifies PMGSJ that a member is not eligible and authorized services have been rendered, the provider will be notified to bill the new insurance company or the member. The provider will be asked to refund the money if they are paid by the new insurance company or the member.

c. Request that the providers bill the patient twice, obtain and forward the documentation to EXCEL MSO. Excel will then attempt to recover the money from the health plans.

III Provider Disputes

A. Dispute Resolution Process for Contracted Providers

1. Definition of Contracted Provider Dispute.
A contracted provider dispute is a provider's written notice to PMGSJ and/or the member's applicable health plan challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or is seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum, the following information:

a) Provider's name, provider's identification number, provider's contact information.

b) If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from PMGSJ to a contracted provider, the following must be provided:

(i) clear identification of the disputed item,
(ii) the date of service, and
(iii) a clear explanation of the basis upon which the provider believes the payment amount may be incorrect, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

c) If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue must contain;

(i) the contracted provider's name,
(ii) what the dispute involves,
(ii) if it is an enrollee or group of enrollees,
(iv) the name and identification number(s) of the enrollee or enrollees,
(v) a clear explanation of the disputed item, including the date of service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

2. Sending a Contracted Provider Dispute to Physicians Medical Group of San Jose
Contracted provider disputes submitted to PMGSJ must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of Provider Appeals Department at:

Physicians Medical Group of San Jose
1565 Mabury Road, Suite D
San Jose, CA 95133
Attention: Provider Appeals Department
Fax: (408) 937-3637

3. Time Period for Submission of Provider Disputes
Contracted provider disputes, for Date of Service after January 1, 2004, must be received by PMGSJ within *365* days from PMGSJ action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or in the case of PMGSJ inaction, contracted provider disputes must be received by PMGSJ within *365* days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Contracted provider disputes that do not include all required information as set forth above in Section II;.A;b may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to PMGSJ within thirty (30) working days of your receipt of a returned contracted provider dispute.

4. Acknowledgment of Contracted Provider Disputes
Paper contracted provider disputes will be acknowledged by PMGSJ within fifteen (15) working days of the date of receipt by PMGSJ.

5. Contact PMGSJ Regarding Contracted Provider Disputes.
All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to PMGSJ's Provider Appeals Department at: (408) 937-3642.

6. Instructions for Filing Substantially Similar Contracted Provider Disputes
   Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

   a) Sort provider disputes by similar issue,
   b) Provide cover sheet for each batch,
   c) Number each cover sheet, and
   d) Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets.

7. Time Period for Resolution and Written Determination of Contracted Provider Dispute
   PMGSJ will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

8. Past Due Payments
   If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, PMGSJ will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

B. Dispute Resolution Process for Non-Contracted Providers

1. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to PMGSJ challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information:

   a) The provider's name,
   b) The provider's identification number, contact information, and
   c) if the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from PMGSJ, the following must be provided:

      i. a clear identification of the disputed item,
      ii. the date of service, and
      iii. a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect

   d) If the non-contracted provider dispute involves an enrollee or group of enrollees, the following must be provided:

i. name and identification number(s) of the enrollee or enrollees,
ii. a clear explanation of the disputed item, including the date of service, the provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

2. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in section III, A, 2 through 8.

ATTACHMENT A

Claims Adjudication Guidelines

Once a completed claim form and supporting documentation is received within the timely submission guidelines, EXCEL MSO will adjudicate PMGSJ's claims taking the following into consideration:

1. Member eligibility as provided by the health plan

2. Services are health plan benefits

3. PMGSJ is responsible for the payment of the services

4. Services have been authorized according to PMGSJ's guidelines

5. CPT coding is correct for the services provided

6. Medicare, Medi-Cal and AMA billing guidelines have been met

7. Unbundled claims are re-bundled according to PMGSJ's code review software

8. Co-ordination of benefits and third party liability guidelines have been met

9. High level billing codes are down coded per PMGSJ's guidelines. Claims billed at their highest level of care (e.g.: 99215, 99245, etc.) will be automatically down coded to a four (4) level of care (e.g.: 99214, 99244, etc.) unless the claim has office chart notes attached for review. All claims with notes attached will be sent to the U.M. Department for medical review and level of billing appropriateness. 10/01/02

10. Office visits for pre- and post-operative services related to a surgery and billed during the follow-up period of the surgery, are not separately reimbursable if billed by the primary surgeon or assistant surgeon. PMGSJ uses the RBRVS (AMA) guidelines.

11. Medical review by an MD may determine when services are not medically indicated or when services are to be down coded.

12. OB payments and global services are as follows:

Commercial members:

PMGSJ has established a fee for service schedule for global obstetrical care. The reimbursement amount is incorporated into the Provider's Agreement. Periodically, the fees may be updated by the Board of Directors. The fees are available for review at the IPA office.

Two OB ultrasounds during pregnancy may be performed in the office without authorization, and will be reimbursed. All other ultrasounds performed in the office require authorization or they will be included in the global reimbursement.

Services included in the global reimbursement rate include:

1. Routine OB care including ante partum care, delivery, inpatient care, and postpartum care.
2. Interpretation of stress and non-stress tests, fetal monitoring, etc.,
3. Handling fees for pathology and lab procedures,
4. Member co-payments, and
5. Postpartum visit and pap smear (pap smear & contraceptive management must be done at the first follow up visit after delivery).

For members who receive part of their maternity care prior to joining PMGSJ, the following will apply:

1. One hundred percent of the global rate for care from the first trimester through postpartum care,
2. Ninety percent of the global rate for care from (20 to 30weeks), and
3. Seventy percent of the global rate for care from (30 weeks to term).

Medi-Cal, Healthy Families and Healthy Kids members:

PMGSJ has established a fee for service schedule for obstetrical care. Each service is to be billed individually - no global fee. The reimbursement amount is incorporated into the Provider's Agreement. Periodically, the fees may be updated by the Board of Directors. The fees are available for review at the IPA office.

Reimbursement for initial history and physical will be paid only one time per pregnancy. If the patient transfers care, the new physician will need to request notes from the physician who performed the initial history and physical. Effective for dates of service after June 1, 1998, the first evaluation of the member which establishes the pregnancy will be reimbursed at IPA rates.

Ultrasounds:

1. Two OB ultrasounds during pregnancy may be performed in the office without authorization. All other ultrasounds performed in the office require authorization. (3/20/98).

2. First and second trimester ultrasounds are paid according to level of completeness.

3. Gynecological Ultrasounds: All gynecological ultrasounds done in the office require pre-authorization. In case of emergency (i.e. ectopic pregnancy, incomplete abortion, etc.) office ultrasound can be performed before authorization is obtained.

Retroactive authorization should be obtained within 24 to 72 hours after the fact. (Otherwise it will be denied).

Services included in routine OB care:

1. Interpretation of stress and non- stress tests, fetal monitoring, etc.
2. Urine pregnancy test and dip stick
3. Handling fees for pathology and lab procedures
4. PPD (for high risk)

Incidental tubal ligations performed at the time of a C-section are considered a second procedure and will be paid at 50% of the IPA rates.

Physician standby for C-section is eligible for payment. (6/12/98)

CPT modifiers are recognized. PMGSJ's reimbursement rules for CPT modifiers are as follows:

1. Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed during the same operative session should be identified by adding modifier '50' to the appropriate five digit code. PMGSJ will reimburse the second or subsequent procedure at 50% of the contracted compensation schedule.

   This applies to both surgeons and assistant surgeons.

2. Multiple Procedures: When multiple procedures, other than Evaluation and Management Services, are performed at the same session by the same provider, the primary procedure or service must be reported as listed. The additional procedure(s) or services(s) may be identified by appending modifier '51' to the additional procedure or service codes(s). **Note**: This modifier should not be appended to designated "add-on" codes.

   Effective for multiple procedures on or after June 1, 2006:

Surgeon		Assistant Surgeon	
1st Procedure	100% of the contracted fee for service amount	1st Procedure	20% of contracted fee
2nd through 5th procedure	50% of the contracted fee for service amount	2nd through 5th Procedure	10% of contracted fees
6th Procedure	25% of the contracted fee for service amount	6th Procedure	5% of contracted fees
7th and any additional	10% of the contracted fee for service amount	7th and additional	2.5% of contracted fees

An example of multiple bilateral procedures allowances:

31255	First Procedure	@	100% of the allowed
31255-50	Second billing is for the bi-lateral	@	50% of the allowed
31267-51	Third billing is for the second procedure	@	50% of the allowed
31267-51-50	Fourth billing is second bi-lateral proc.	@	25% of the allowed
30140-51 left	Fifth billing is a third procedure	@	25% of the allowed
30140-51-50	Sixth billing is the third bi-lateral proc.	@	12.5% of the allowed
30140-51 right	Seventh billing is a fourth procedure	@	10% of the allowed
30140-50-51	Eighth is the fourth bi-lateral procedure	@	5% of the allowed

Procedures following the third bi-lateral procedure or the sixth billing are to be paid at 10% of the allowed charges.

3. Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service, that is a partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers '73' and '74' (see modifiers approved for ASC hospital outpatient use). PMGSJ will reimburse eligible reduced services at 80 percent of the contracted compensation schedule.

4. Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier '53' to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers '73' and '74' (see modifiers approved for ASC hospital outpatient use). PMGSJ will reimburse eligible services at 70 percent of the contracted compensation schedule.

5. Surgical Care Only. When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier '54' to the usual procedure number. PMGSJ will reimburse eligible services at 50 percent of the contracted compensation schedule.

6. Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding modifier '55' to the usual procedure number. PMGSJ will reimburse eligible services at 30 percent of the contracted compensation schedule.

7. Preoperative Management Only: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding modifier '56' to the usual procedure number. PMGSJ will reimburse eligible services at 20 percent of the contracted compensation schedule.

8. Co-Surgeons: When two surgeons work together as primary surgeons perform- ing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier '62' to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with the modifier '62' added. **Note**: If a co-surgeon acts as an assistant in the performance of an additional procedure(s) during the same surgical session, the service(s) may be reported using a separate procedure code(s) with modifier '80' or modifier '82' added, as appropriate. Co-surgeons are reimbursed as follows:

    a) The procedure code is calculated at 125% of the allowed amount and then divided by 2. e.g., and
    b) $1000.00 is the contracted reimbursement, X 125% = $1250.00 divided by 2 gives each surgeon $625.00.

9. Assistant Surgeon: Surgical assistant services may be identified by adding modifier '80' to the usual procedure number(s). PMGSJ will reimburse eligible services at 20% of the contracted compensation schedule.
Exception: Assistant surgeons for cardiovascular procedures will be paid at 25% of the primary surgeon's reimbursement rates.