State of New Mexico
Medical Assistance Program Manual

Supplement

DATE: January 15, 2013 **NUMBER:13-01**

TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: JULIE B. WEINBERG, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECTS: I. INCREASE IN PAYMENT RATES FOR PRIMARY CARE PROVIDER SERVICES

II. VACCINATION REIMBURSEMENT

I. INCREASE IN PAYMENTS RATES FOR PRIMARY CARE SERVICES

On November 6, 2012, the Centers for Medicare & Medicaid Services (CMS) issued final rules to implement requirements for increased Medicaid payment for primary care services provided by certain practitioners for calendar years 2013 and 2014. The final rule also provided for optional changes in the reimbursement for vaccine administration under the Vaccines for Children program.

This supplement serves as notice of the intent of the Medical Assistance Division (MAD) to implement the federal requirements and to provide information and instruction to providers regarding what must be done in order to receive the increased payment.

A. EFFECTIVE DATE AND METHOD OF PAYMENT

The final rule allows Medicaid programs to distribute the increased payment amount on a quarterly basis rather than by increasing the payment made at the time the claim is processed and paid. For the reasons noted on the following page, MAD intends to make payments quarterly based on quarterly claims data.

In all cases, in calculating the payment due to a provider, the payment will be calculated based on the date of service and will not be limited by the date of the initial processing or payment of the claim. The effective date of the increased payment level is January 1, 2013.

Beginning with that date of service, claims will be subject to the re-pricing calculation for increased payment to the provider in quarterly payments. Therefore, in all cases providers will be reimbursed at the higher rate, when they qualify for the increased payment, for services with dates of service on and after January 1, 2013.

There are several reasons why making quarterly payments is the most reasonable way to implement this change:

- The federal rule requires providers to complete an "attestation" to qualify for the increased payment; but the rule was not finalized in time to have providers attest prior to January 1, 2013. Additionally, the attestation will be ongoing, with payments being made quarterly for retroactive periods.

- The federal government has yet to determine what the new payment rates will be for Medicare which provides the basis for the new Medicaid reimbursement amount.

- CMS must approve each state's plan for reimbursement and accept the method for how federal financial participation will be claimed by the state. The plan is due to CMS no later than March 31, 2013.

MAD intends to present a plan to CMS that follows the provisions stated in this notice. Prior to submitting that plan, MAD would be glad to receive your comments for consideration as stated at the end of this section of the supplement.

The increase in the primary care codes will only be effective upon the approval of the plan submitted to CMS, but will be retroactive to dates of service beginning January 1, 2013.

In the event that any Medicare rate is below the current rates for primary care codes specified in the federal rule, MAD will not lower the payment rates because of the federal rule, but will keep the current Medicaid rate. The federal rule does not require MAD to lower rates to Medicare amounts if Medicaid already has a higher rate for these services.

Note that when payment is made to providers for the increased payment, it will be made as a lump sum payment, through Xerox, the Medicaid fiscal agent, for services that were paid by Xerox. The providers will be notified when the payments will be made and the calculations will be made available to the provider upon request.

Payments will be made to the provider who was originally paid for the claim (the billing provider) even though it is always an individual provider, not a group or clinic, who must qualify for the increased payment. The payment ultimately must be given by the group or

clinic or other billing provider to the qualifying individual provider even if the individual provider is on a salary or under contract to the billing provider. This payment provision is part of the federal law.

B. ATTESTATION

The federal rule requires that the provider attest to their board certification or to the fact that 60% of the volume of their practice paid by Medicaid and Medicaid managed care organizations are for the identified primary care procedure codes and vaccination codes (listed below.)

A copy of the attestation form is attached, and may be completed by the provider in order to be considered for the increased payment. Duplicates may be made by the provider and distributed as needed.

Whether a provider participates in the Medicaid fee for service (FFS) program or in one or more Medicaid managed care programs (SALUD! or CoLTS), or in both, it is only necessary to send the attestation form to MAD, to the address indicated on the attestation form. Since it is an individual practitioner that qualifies, even if the individual practitioner practices at more than one location or for more than one practice, only one attestation form is required.

Each managed care organization will be responsible for making payment to qualifying providers for the increased payment, but MAD will be responsible for determining if the provider qualifies.

C. HELP COMPLETING THE ATTESTATION FORM

A provider may attest to either their board certification or to the fact that 60% of their Medicaid plus Medicaid managed care practice is for the primary service codes and vaccination codes listed below.

When a provider meets the 60% volume, the limitation to board certification or limitation to specific specialties no longer applies.

Using a rendering provider's National Provider Identifier (NPI) number, it is possible for MAD to determine if it appears that a provider meets the 60% volume requirement. A list of those providers that MAD has estimated as possibly qualifying for the increased payment based on the 60% volume requirement will be posted to the MAD website. Prior to completing the attestation form based on the 60% volume requirement, a provider may want to check the MAD website to determine if MAD estimates the provider will qualify based on volume.

It is anticipated the information will be available by February 1, 2013 under the "Provider" section of the MAD website at: http://www.hsd.state.nm.us/mad/ and on the MAD/Xerox web portal at https://nmmedicaid.acs-inc.com/nm/general/home.do

D. CONTINUED COMMUNICATION

Information and announcements regarding this activity will be place on the MAD/Xerox web portal at https://nmmedicaid.acs-inc.com/nm/general/home.do .

Check the portal often to remain informed, see when payments are going to be made, and check other updates.

E. QUALIFYING PROVIDERS

In order to qualify for the primary care payment increase, the provider must be reimbursed at the fee schedule amounts. That is, a provider whose service is billed as a Federally Qualified Health Center or a Rural Health Clinic is not subject to the increased payment because these providers are paid encounter rates rather than at a separate fee schedule amount per procedure. Practitioners whose reimbursement is included in a facility payment rather than as a separate identifiable paid service do not qualify for the increase.

Indian Health Service providers when paid at an OMB rate also do not qualify for increased payments since payments are not made at a fee schedule rate.

A qualifying provider must be a physician being paid for the specified primary care procedure codes under the CMS definition of a physician service.

A physician extender (such as a certified nurse practitioner, a certified nurse midwife, a physician assistant, and a pharmacist clinician) working under the direct supervision of a qualifying physician can qualify based on the supervising physician's qualifications.

A physician extender in his or her own private practice such as a certified nurse practitioner in independent practice does not qualify for the increased payment, even if in a collaborative arrangement, because of the way the federal law is written.

1. Physicians Qualifying as Board Certified

The federal rule and guidance supplied by CMS are very specific in stating the certifying boards and organizations as well as the specialties and subspecialties that qualify for the primary care increased payment.

American Board of Medical Specialties (ABMS)

Family Medicine, including subspecialties of Adolescent Medicine, Geriatric Medicine, Hospice and Palliative Medicine, Sleep Medicine and Sports Medicine

Internal Medicine, including subspecialties of Adolescent Medicine, Adult Congenital Heart Disease, Advanced Heart Failure and Transplant Cardiology, Cardiovascular Disease, Clinical Cardiac Electrophysiology, Critical Care Medicine, Endocrinology. Diabetes and Metabolism, Gastroenterology, Geriatric Medicine, Hematology, Hospice and Palliative Medicine, Infectious Disease, Interventional Cardiology, Medical Oncology, Nephrology, Pulmonary Disease, Rheumatology, Sleep Medicine, Sports Medicine, and Transplant Hepatology.

Pediatrics, including subspecialties of Adolescent Medicine, Child Abuse Pediatrics, Developmental-Behavioral Pediatrics, Hospice and Palliative Medicine, Medical Toxicology, Neonatal-Perinatal Medicine, Neurodevelopmental Disabilities, Pediatric Cardiology, Pediatric Critical Care Medicine, Pediatric Emergency Medicine, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Hematology-Oncology, Pediatric Infectious Diseases, Pediatric Nephrology, Pediatric Pulmonology, Pediatric Rheumatology, Pediatric Transplant Hepatology, Sleep Medicine, and Sports Medicine.

American Osteopathic Association (AOA).

Family Physicians (No subspecialties)

Internal Medicine, including subspecialties of Allergy/Immunology, Cardiology, Endocrinology, Gastroenterology, Hematology, Hematology/Oncology, Infectious Disease, Pulmonary Diseases, Nephrology, Oncology, and Rheumatology.

Pediatrics, including subspecialties of Adolescent and Young Adult Medicine, Neonatology, Pediatric Allergy/immunology, Pediatric Endocrinology, and Pediatric Pulmonology.

American Board of Physician Specialties (ABPS)

The ABPS does not certify subspecialists. Therefore, eligible certifications are:

American Board of Family Medicine Obstetrics;
Board of Certification in Family Practice; and
Board of Certification in Internal Medicine.

2. Physicians Who Are Not Board Certified in the Specifically Identified Specialties May Qualify Based on Volume

Physicians who are not board certified in the specifically identified specialties may still qualify for the increased primary care payment if 60% of their combined Medicaid and Medicaid managed care practice is for the primary care codes identified by CMS (listed below).

This qualification is determined to be met when the number of the procedure codes and vaccination codes described below is at least 60% of all paid procedure codes for that physician.

The rendering provider NPI in the rendering provider field on a claim is used to identify the physician.

3. Physician Extenders

A physician extender (Certified Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist, Physician Assistant, or Pharmacist Clinician) may qualify when they are the rendering provider on claims and are identified with their own NPI number.

In order to qualify, they must be under the direct supervision of a physician who qualifies, either on the basis of the board certification or by meeting the volume requirement.

F. APPLICABLE PRIMARY CARE PROCEDURE CODES

The federal rule is very specific about the CPT procedure codes that are considered "primary care" codes and would therefore be used in the 60% calculation. They are:

<u>Outpatient and Other Visit codes (covered by Medicare)</u>

New patient: 99201, 99202, 99203, 99204, and 99205
Established patient: 99211, 99212, 99213, 99214, and 99215
Facility Observation Visits: 99217, 99218, 99219, 99220, 99224, 99225, and 99226
Inpatient Hospital Visits: 99221, 99222, 99223, 99231, 99232, and 99233
Observation/Inpatient Visits: 99234, 99235, 99236, 99238, 99239
Consultations: 99241, 99242, 99243, 99244, and 99245

The federal rule also extends to codes that are not covered by Medicare, for which CMS will calculate Medicare-like rates for states to use. Medicaid programs are not required to cover codes on the list that are not already benefits of the Medicaid program. They are:

Preventative Medicine Visits

New Patient Preventative Medicine Visits (covered only as EPSDT screenings): 99381, 99382, 99383, 99384, and 99385 (covered only through age 20). Codes 99386 and 99387 are not covered by Medicaid.

Established Patient Preventative Medicine Visits (covered only as EPSDT screenings): 99391, 99392, 99393, 99394, and 99395 (covered only through age 20). Codes 99396 and 99397 are not covered by Medicaid.

Counseling Factor Risk Reduction and Behavior Change Intervention

Codes 99401 through 99412 and code 99429 are not covered by the Medicaid program.
Code 99420 is covered by the Medicaid program.

E&M Non Face to Face

Codes 99441 through 99442 are not covered by the Medicaid program.

G. PAYMENT PROCESS

The following steps lead to increased payment to the provider:

- The eligible individual provider or his or her representative completes the attestation form and mails the form to the MAD address indicated on the form.

- MAD sends a form letter to the provider acknowledging receipt of the form and stating if the provider is deemed qualified for the payment increase.

- MAD maintains a list of qualifying providers and shares that list with managed care organizations.

- When CMS finalizes the new rates for the preventative codes, the rates will be posted on the MAD website. MAD will use the higher of either the existing Medicaid rate or

the 2013 Medicare or CMS determined rate to calculate the increased payments; no additional payment will be due for codes for which the Medicaid rate is higher than the Medicare rate. The additional reimbursement the provider receives will be the difference between the Medicaid rate for a procedure code and the 2013 Medicare rate, or the CMS determined rate for services not covered by Medicare.

- Following approval of the Medicaid plan by CMS, for FFS claims, MAD will accumulate all the paid claims for the qualifying providers for dates of service January 1 through March 31, 2013, and will calculate the increased amount owed to the provider on each claim line.

- The payment is not limited to the amount billed by the provider. The provide is due the increased amount even if the billed amount on the claim is less than the Medicare or CMS determined amount.

- When Medicaid payment is for a co-insurance, deductible, or copayment, rather than payment for the specific procedure code at the fee schedule payment rate, the increased payment is not made.

- The billing providers will be notified of the date the payment will be made. The payment will appear as a single line payment on the billing provider's remittance advice from Xerox.

- The provider may request a report showing how the payment amount was calculated and may dispute the calculation. If the dispute cannot be resolved the provider does have the right to an administrative hearing. See NMAC 8.353.2 *Provider Hearings*.

H. OPPORTUNITY TO COMMENT

Questions and comments on this process may be directed to Ellen Maestas-Waller in the Program Policy and Integrity Bureau at:

Ellen Maestas-Waller
Medical Assistance Division - Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348
Phone: (505) 827-1305
Email: Ellen.Maestas-Waller@state.nm.us

Comments will be taken through February 21, 2013. Providers will be informed of any changes made based on the comments received. The comments received will be made available to interested parties upon request.

II. VACCINE ADMINISTRATION FEES

A. Vaccine Administration Fees in the Vaccines for Children Program

The federal rule regarding vaccines differs from the federal rule for primary care codes, item I, in a number of ways. The main difference is that a Medicaid program is not required to increase the payment for 2013 and 2014.

However, MAD is proposing to increase the vaccine administration rates on a per-vaccine basis (not a per-antigen or per-component basis) to the regional limit cap rate which at this time appears to be $20.80. This change would be effective March 1, 2013 and will apply to the first or only component of each vaccine represented by the following codes:

90460 (formerly $10.97)
90471 (formerly $10.97)
90472 (formerly $10.97)
90473 (formerly $10.97)
90474 (formerly $10.97)

90460 and all the other above listed codes will be paid for each administration of a vaccine even if given on the same day as other vaccines. The provider may bill the appropriate code above for each administration of a vaccine.

Because the $20.80 is a maximum per injection (or oral administration), the code 90461 will be paid at $0.00 since it should represent the additional components in a single injection that was included in the billing of code 90460.

If a provider administers more than one injection on the same day, the provider may bill the appropriate code 90460 or 90471 through 90474 for each injection and thus be assured of a payment of $20.80 (or up to the billed amount) for each administration.

It is anticipated that the financial impact of this change will result in an additional $90,000 paid to providers annually.

B. Vaccine Administration for other than the Vaccines for Children Program

In order to equalize the vaccine administration fee schedule for all vaccine administrations, MAD is proposing to raise the payment rate for the following codes from $10.97 to $20.80 effective March 1, 2013.

90460
90471
90472
90473
90474

Because the $20.80 is a maximum per injection (or oral administration), the code 90461 will be paid at $0.00 since it should represent the additional components in a single injection that is included in the billing of code 90460.

MAD would also allow pharmacies to be paid for vaccine administration at $20.80 when administration is by a qualified pharmacist for recipients 18 years of age and above.

Questions and comments on changes associated with vaccination reimbursement may be directed to Freddie Gatewood in the Program Policy and Integrity Bureau at:

Freddie Gatewood
Medical Assistance Division - Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348
Phone: (505) 827-7797
Email: Freddie.Gatewood@state.nm.us

Comments will be taken through February 21, 2013. Providers will be informed of any changes made based on the comments received. Any claims affected by a change will be reprocessed by Xerox with no action required on the part of the provider. The comments received will be made available to interested parties upon request.

It is anticipated that the financial impact of this change will result in an additional $20,000 paid to providers annually

If you have questions regarding the above information, you may contact the Medicaid Program Policy and Integrity Bureau at (505) 827-3171.

We appreciate your participation in the Medicaid program.

Effective January 1, 2013, the CMS rule "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration under the Vaccines for Children Program" implements higher Medicaid payments for primary care services by certain physicians in calendar years (CYs) 2013 and 2014.

In order to receive the increased payment, a physician may self-attest that he / she:

(1) Is Board certified with specialty designation of family medicine, general internal medicine or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA); and / or,

(2) Practices in a primary care specialty and has furnished evaluation and management services and vaccine administration services that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed CY or, for newly eligible physicians, the prior month.

In order to be considered for the increased payment, providers must fill out the following form.

Provider Name	**Provider NPI**
Billing Provider Name(s) (group, clinic, corporation, etc.)	**Provider Group NPI number(s)**

NOTE: If you are a physician extender working under the direct supervision of a qualifying physician who accepts professional responsibility and legal liability you may qualify based on the supervising physician's qualifications. Please indicate below your provider type and your supervising physician's name and NPI number.

_____ **305 – Physician Assistant**

_____ **316 – Nurse, CN Practitioner**

_____ **320 –Pharmacist Clinician**

_____ **322 – Midwife, Certified Nurse**

Supervising physician's name:
Supervising Physician's NPI:

I attest that I meet one of the following criteria: *please check either (1) or (2)*

(1) _____ I am certified in the following specialty by one of the boards below that is designated by CMS as eligible to receive the increased payment **AND** I practice in that specialty (*please circle both the appropriate specialty and subspecialty).*

Please attach a copy of the certification document.

This certification is in effect from: _____ ***to*** _____
(Begin Date) *(Expiration Date)*

American Board of Medical Specialties (ABMS)

Specialty: **Family Medicine**

Subspecialties:

Adolescent Medicine	Geriatric Medicine	Hospice and Palliative Medicine
Sleep Medicine	Sports Medicine	

Specialty: **Internal Medicine**

Subspecialties:

Adolescent Medicine	Advanced Heart Failure and Transplant Cardiology	Cardiovascular Disease
Clinical Cardiac Electrophysiology	Critical Care Medicine	Endocrinology
Diabetes and Metabolism	Gastroenterology	Geriatric Medicine
Hematology	Hospice and Palliative Medicine	Infectious Disease
Interventional Cardiology	Medical Oncology	Nephrology
Pulmonary Disease	Rheumatology	Sleep Medicine
Sports Medicine	Transplant Hepatology	Adult Congenital Heart Disease

Specialty: **Pediatrics**

Adolescent Medicine	Child Abuse Pediatrics	Developmental-Behavioral Pediatrics
Hospice and Palliative Medicine	Medical Toxicology	Neonatal-Perinatal Medicine
Neurodevelopmental Disabilities	Pediatric Cardiology	Pediatric Critical Care Medicine

	Pediatric Emergency Medicine	Pediatric Endocrinology	Pediatric Gastroenterology
Subspecialties:	Pediatric Hematology - Oncology	Pediatric Infectious Diseases	Pediatric Nephrology
	Pediatric Pulmonology	Pediatric Rheumatology	Pediatric Transplant Hepatology
	Sleep Medicine	Sports Medicine	

American Osteopathic Association (AOA).

Specialty: **Family Physicians**
(No subspecialties)

Specialty: **Internal Medicine**

	Allergy/Immunology	Cardiology	Endocrinology
Subspecialties:	Gastroenterology	Hematology	Hematology/Oncology
	Infectious Disease	Pulmonary Diseases	Nephrology
	Oncology	Rheumatology	

Specialty: **Pediatrics**

	Adolescent and Young Adult Medicine	Neonatology	Pediatric Allergy/immunology
Subspecialties:	Pediatric Endocrinology	Pediatric Pulmonology	

American Board of Physician Specialties (ABPS)

The ABPS does not certify subspecialists. Therefore, eligible certifications are (*please circle one)*:

American Board of Family Medicine Obstetrics | Board of Certification in Family Practice | Board of Certification in Internal Medicine

(2) _____ I have furnished the specified E&M services and vaccine administration services that equal at least 60% of the Medicaid codes I have billed during the most recently completed CY or, for newly eligible physicians, the prior month **AND** I practice in one of the CMS designated primary care specialties: (*circle one of the following)*

General / Internal Medicine **Family Medicine** **Pediatric Medicine**

The following are considered by CMS to be "primary care" codes:
99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99224, 99225, and 99226 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395 and 99420. The following codes are the allowed vaccine codes: 90460, 90461, 90471, 90472, 90473, 90474.

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws.

Original signature required.

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name	**Signature**	**Date**

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact details.

Contact Person	**Telephone Number**	**E-Mail Address**

**Please note that MAD will annually be required to review a statistically valid sample of providers who received higher payment to verify that they either were appropriately Board certified or that 60 percent of their claims during that period were for the identified E&M codes. If this review does not support the self attestation, the increased payments will be subject to recoupment.*

Return completed application to:

Ellen Maestas-Waller
Medical Assistance Division - Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348