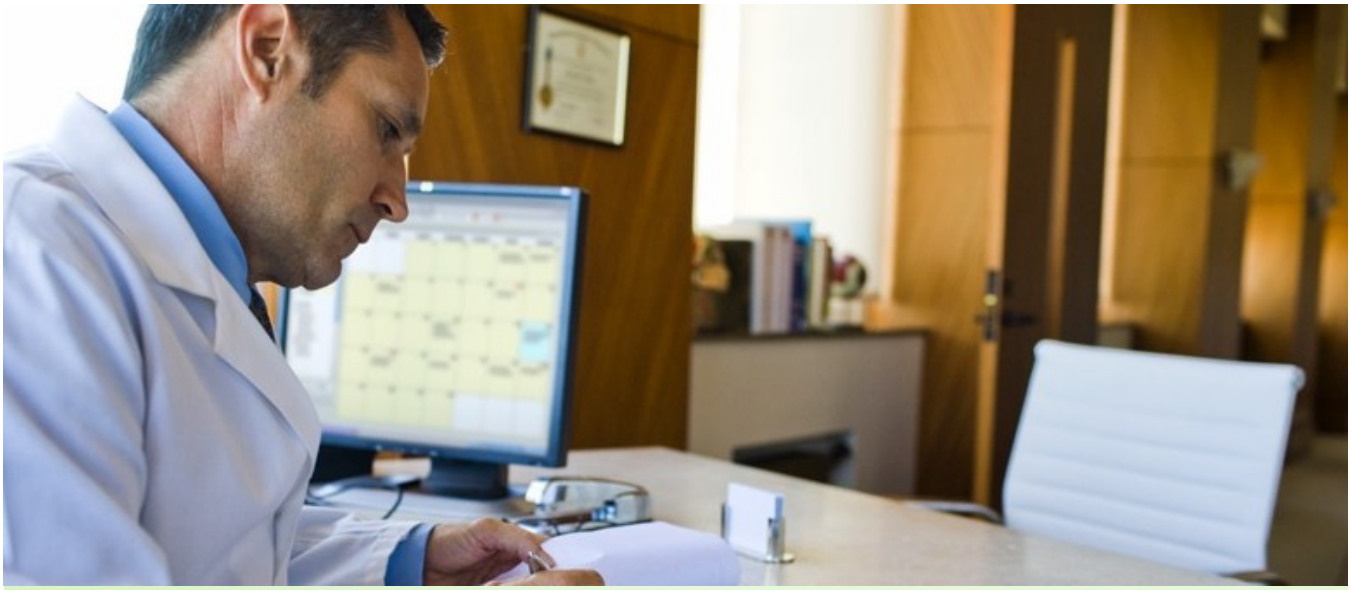
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201247 NOVEMBER 27, 2012



ACA increases reimbursement for primary care services in 2013 and 2014

Section 1202 of the *Affordable Care Act* (ACA) requires a temporary increase in Medicaid payments for qualifying primary care services provided by qualifying physicians for dates of service in calendar years (CYs) 2013 and 2014. The federally funded, temporary rate increase is authorized only for these two calendar years, after which the rate structure will return to its existing level, pending no further federal action. Qualified services paid on a fee-for-service (FFS) basis, as well as those paid by managed care entities (MCEs) may be eligible for the temporary rate increase. The Indiana Health Coverage Programs (IHCP) will make quarterly supplemental payments to self-attested qualifying physicians for qualifying primary care services provided to FFS members. The payment methodology for services provided to managed care members is pending, and physicians will be notified at a later date how the temporary payment increases will be paid.

Increased payment

For qualifying primary care services furnished by self-attested qualifying providers, the ACA implements Medicaid payments at rates not less than the Medicare rates in effect for CY 2013 and CY 2014, or, if greater, the rates that would be applicable in those CYs using the CY 2009 Medicare physician fee schedule conversion factor. Under the Vaccines for Children (VFC) program, the ACA implements vaccine administration rates at the lesser of the CY 2013 or CY 2014 Medicare rate or the maximum regional VFC rate in those years. The rate differential between the ACA-implemented rate and the current Indiana Medicaid State Plan rate will be distributed to self-attested qualifying providers for qualifying services provided to FFS members, including those dually eligible for both Medicare and Medicaid, in a quarterly supplemental payment. Primary care services provided to State Children's Health Insurance Program (SCHIP) members are not eligible for the increased payment.

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The temporary increase in payments is for dates of service in CY 2013 and CY 2014 only. Quarterly payments for qualifying primary care services provided to FFS members cannot be made until a State Plan amendment has been approved by the Centers for Medicare & Medicaid Services (CMS). More information regarding the supplemental payments will be forthcoming. The payment increase is only for qualifying services provided from January 1, 2013, through December 31, 2014; however, payments for dates of service in CY 2013 and CY 2014 may be made to providers after this time period.

Qualifying services

The final rule implementing this ACA provision (*42 CFR 447.700*) provides for increased payment for qualifying primary care services. Specifically, Healthcare Common Procedure Coding System (HCPCS) codes 99201 through 99499 (evaluation and management, or E/M, services) and vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474 may be eligible for the increased payment. The IHCP's current coverage policy of E/M codes will not change. Therefore, any currently noncovered E/M codes in the range 99201 through 99499 will remain noncovered and will not be eligible for the increased payment. The vaccine administration codes 90460 and 90461 will also remain noncovered. As detailed in the *Changes in Billing Instructions* section on page 3 of this bulletin, the vaccine administration codes 90471 through 90474 will be covered for dates of service from January 1, 2013, through December 31, 2014, to allow physicians to be considered for the increased payment.

"… Any currently noncovered E/M codes in the range 99201 through 99499 will remain noncovered and will not be eligible for the increased payment."

Qualifying providers

The ACA establishes increased payments to physicians with a specialty designation of family medicine, general internal medicine, and pediatric medicine, as well as their subspecialties. Current IHCP-enrolled physicians may qualify as primary care physicians in these specialties in two ways:

1) The physician is board certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA) in family medicine, general internal medicine, or pediatric medicine or a subspecialty thereof; or

2) At least 60% of Medicaid codes billed by the physician to Medicaid for all of CY 2012 are qualifying E/M codes and vaccine administration codes.

Physicians who enroll in the IHCP during CY 2013 or CY 2014 who self-attest as eligible within one of the specialties (family medicine, general internal medicine, and pediatric medicine) but who are not board certified, may qualify if 60% of codes billed to Medicaid in the prior month are qualifying E/M and vaccine administration codes.

Primary care services provided by advanced practice clinicians, including nurse practitioners, physician assistants, and nurse midwives, within their scope of practice under the professional oversight of a self-attested qualifying physician, will also be eligible for the higher payment. The self-attested physician must have professional oversight or responsibility for the services provided by the advanced practice clinicians; thus, arrangements under which independent nurse-managed

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clinics or other practitioners enter into arm's-length arrangements with physicians are not eligible. For dates of service in CY 2013 and CY 2014, the Office of Medicaid Policy and Planning (OMPP) has changed the billing instructions for independently enrolled nurse practitioners who are employed by a physician in a physician-directed group to allow primary care service provided by these providers to be eligible for the payment increase. See *Changes in Billing Instructions* for these changes.

"Self-attestations received after January 31, 2013, will be effective the date received. More information regarding self-attesting will be provided in a future provider communication."

To be eligible for the increased payment, physicians must self-attest as qualifying either by board certification or 60% of billed codes. Generally, the effective date for the increased payment cannot be earlier than the date the self-attestation is received. However, CMS is allowing states to permit self-attestations received by the state any time in January of 2013 to be retroactively effective to January 1, 2013. Therefore, self-attestations received from January 1, 2013, through January 31, 2013, may be backdated to January 1, 2013. Self-attestations received after January 31, 2013, will be effective the date received. More information regarding self-attesting will be provided in a future provider communication.

Increased payment is not available for services provided by a physician delivering services under any other benefit authorized by section 1905(a) of the ACA. This includes services provided in Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs), because payment for these services is made on an encounter-rate basis and is not specific to the physician services. Additionally, professional services provided in a nursing facility and reimbursed as part of a *per diem* rate are not eligible for the increased payment.

As required by the ACA rule, at the end of CY 2013 and the end of CY 2014, the OMPP will review a statistically valid sample of physicians who have received the increased payments to verify they are either board certified in an eligible specialty or that 60% of claims billed are for eligible codes. Physicians identified as not meeting these requirements will be removed from the program and any increased payments will be recouped.

Changes in billing instructions

The following billing instructions are temporary and valid for the two years the ACA physician rate increase is in effect, for dates of service from January 1, 2013, through December 31, 2014. Although only physicians who have self-attested, or advanced practice clinicians who work under a physician who has self-attested, may be eligible for the payment increase, all providers should follow these temporary billing instructions.

Individually enrolled nurse practitioners

Currently, nurse practitioners who are individually enrolled in the IHCP and employed by physicians in a physician-directed group or clinic bill using their own rendering National Provider Identifier (NPI) in field 24J of the *CMS-1500* and the billing physician's NPI in field 33a.

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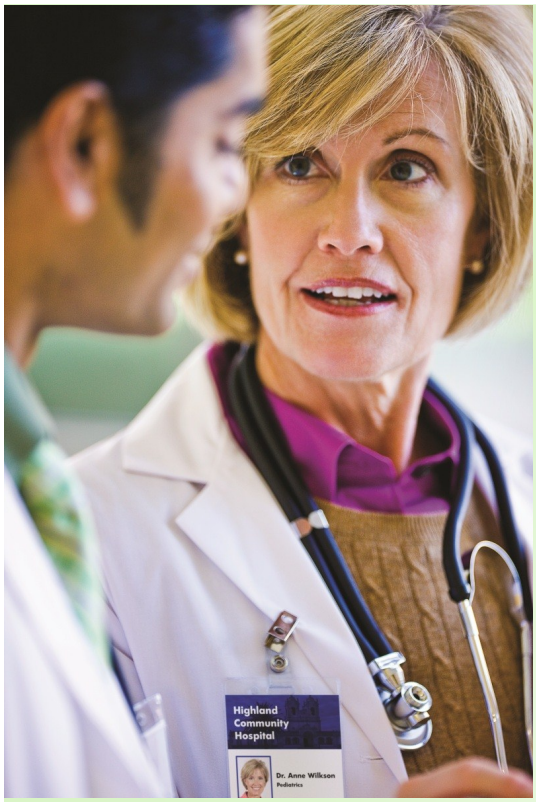

For dates of service from January 1, 2013, through December 31, 2014, individually enrolled nurse practitioners must bill using the SA modifier and the rendering (supervising) physician's NPI in field 24J of the *CMS-1500*. The nurse practitioner's own NPI will no longer be included on the claim, and the SA modifier will identify the service is provided by a nurse practitioner. Claims that do not follow these billing instructions will not qualify for the ACA physician rate increase.

Claims for Vaccines for Children (VFC) vaccines

Currently, providers using VFC-provided vaccines bill the IHCP for the vaccine administration fee by billing V20.2 as the primary diagnosis code, along with the procedure code for the specific vaccine administered, with a maximum of $8.00 for the vaccine administration fee. A separate vaccine administration code is not billed.

For dates of service from January 1, 2013, through December 31, 2014, providers using VFC-provided vaccines should bill the IHCP for the VFC vaccine administration fee by billing V20.2 as the primary diagnosis, the procedure code of the specific vaccine administered with a billed amount of $0.00, and the appropriate vaccine administration code with the SL modifier (see the following list of procedure codes). The allowed amount per claim for the administration of a VFC vaccine will remain at $8.00; any increase in reimbursement will be paid in a supplemental payment. Providers are reminded that reimbursement for a VFC vaccine is not appropriate, because providers receive VFC vaccines at no charge. However, to ensure that the vaccine is appropriately included in the Children and Hoosier Immunization Registry Program (CHIRP), the provider must bill the appropriate Current Procedural Terminology (CPT®[1]) code for the vaccine and a billed amount of $0.00.

- 90471 SL – *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
- 90472 SL – *Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
- 90473 SL – *Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
- 90474 SL – *Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration*

When a VFC vaccine is administered by a nurse practitioner employed by physicians in a physician-directed group or clinic, the previous codes should be billed followed by the SA modifier (for example, 90471 SL SA) to identify the service is performed by a nurse practitioner.

[1] *CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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Claims that do not follow these billing instructions will not qualify for the ACA physician rate increase.

Claims for non-VFC vaccines

Currently, for vaccines that are not part of the VFC program, providers may bill for both the vaccine and its administration (using CPT codes 96372, 96373, or 96374). However, if an E/M service code is billed with the same date of service as an office-administered immunization, providers should not bill the vaccine administration code separately. Reimbursement for the administration is included in the E/M code-allowed amount. Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one vaccine is administered on the same date of service and no E/M code is billed, providers may bill an administration fee for each injection.

For dates of service from January 1, 2013, through December 31, 2014, providers should bill the most appropriate vaccine administration code in the following list. The maximum reimbursement rate for vaccine administration remains the same as the maximum reimbursement rate for CPT code 96372, which is $12.94. This rate was cross walked to the following vaccine administration codes:

- 90471 – *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*
- 90472 – *Each additional vaccine (single or combination vaccine/toxoid)*
- 90473 – *Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)*
- 90474 – *Each additional vaccine (single or combination vaccine/toxoid)*

Reimbursement for the administration continues to be included in the E/M code-allowed amount. Therefore, if an E/M service code is billed with the same date of service as an office-administered immunization, providers should not bill the vaccine administration code separately. Separate reimbursement is still allowed when the administration of the drug is the only service billed by the practitioner. Additionally, if more than one vaccine is administered on the same date of service and no E/M code is billed, providers may bill an administration fee for each injection using the appropriate CPT code.

Claims that do not follow these billing instructions will not qualify for the ACA physician rate increase.

QUESTIONS?

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