IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201302 JANUARY 22, 2013

Clarification to the ACA reimbursement increase for primary care services in 2013 and 2014

In BT201247, the Office of Medicaid Policy and Planning (OMPP) informed providers of the 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, as mandated by *Section 1202* of the *Affordable Care Act* (ACA). Instructions for self-attestation were outlined in BT201255. Based on provider feedback, this provider communication will clarify some of the instructions previously published.

Determining the Increased Payment Amount

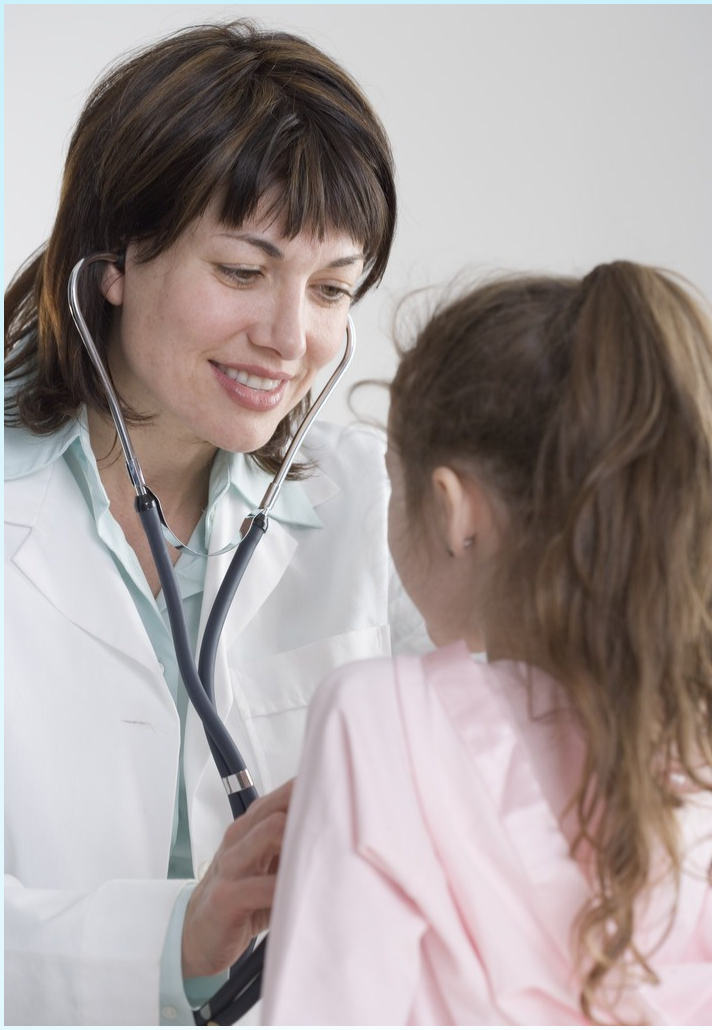
In previous bulletins, guidance indicated that for qualifying primary care services furnished by self-attested qualifying providers, the ACA implements Medicaid payments at rates not less than the Medicare rates in effect for CY 2013 and CY 2014, or, if greater, at rates that would be applicable in those CYs using the CY 2009 Medicare physician fee schedule conversion factor.

Since publication of these bulletins, the Centers for Medicare & Medicaid Services (CMS) announced a clarification to the final ACA rule. The corrected language indicates that states must pay the **lesser of** (1) the Medicare Part B fee schedule rate in effect at the beginning of CY 2013 and CY 2014 (using the 2009 conversion factor) or (2) the provider's actual billed charge for the service. The Indiana Health Coverage Programs (IHCP) will apply these parameters when determining the increased payment amounts.

At this time, there is no change to the ACA increased payment amount for vaccine administration provided under the Vaccines for Children (VFC) program. As stated in previous bulletins, the increased payment remains the lesser of (1) the regional maximum administration fee or (2) the Medicare fee schedule rate in CY 2013 and CY 2014, or if greater, the rate using the 2009 conversion factor.

Qualifying Providers

As previously communicated in BT201247, the ACA establishes increased payments to physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine, and subspecialties thereof. Current IHCP-enrolled physicians in family medicine, general internal medicine, or pediatric medicine, or a subspecialty thereof, may qualify in one of two ways:



- 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**
- At least 60% of codes billed by the physician to Medicaid for the previous calendar year are qualifying evaluation and management (E/M) codes (IHCP-covered codes in the range 99201 through 99499) and/or vaccine administration codes (90471 through 90474).

More specifically, a physician must first be enrolled with the IHCP in family medicine (provider specialty 316), general internal medicine (provider specialties 322 and 344), or general pediatric medicine (provider specialties 335 and 345), or a board-certified subspecialty thereof (such as cardiology, nephrology, immunology, and so forth). If so enrolled, the physician may qualify for the increased payments if (1) the physician is board certified in one of the three specialty designations or a subspecialty thereof, or (2) at least 60% of codes billed are qualifying codes. The CMS has determined the ACA rule does not extend the increased payments to other categories of physicians, such as OB/GYNs, who are not considered one of the three specialty designations (family, general internal, or pediatric medicine), or subspecialties thereof, as defined by the three certifying boards.

The following scenarios illustrate the rule's application.

Example 1

A provider is a practicing cardiologist who is enrolled with the IHCP as *312 – Cardiologist* and is board certified by the ABMS in Cardiovascular Disease.

Cardiology is a subspecialty of general internal medicine according to the ABMS. Because this provider is both enrolled through IHCP in a subspecialty of general internal medicine and is board certified in a general internal medicine subspecialty, this provider ***is eligible*** for the rate increase. This provider does not have to meet the 60% threshold of claims, because the provider is board certified by ABMS in Cardiovascular Disease.

Example 2

A provider is a practicing obstetrician who is enrolled with the IHCP as *328 – Obstetrician/Gynecologist* and had qualifying E/M and vaccine administration codes accounting for 65% of billed codes to Medicaid in CY 2012.

Because obstetrician/gynecologist is not considered a subspecialty of family medicine, general internal medicine, or pediatric medicine by the three aforementioned certifying boards, this provider is ***not eligible*** for the rate increase, regardless of the codes billed in CY 2012.

Example 3

A provider is a practicing pediatrician who is enrolled with the IHCP as *335 – Pediatrician* and had qualifying E/M and vaccine administration codes accounting for 55% of billed codes to Medicaid in CY 2012.

Although this provider is enrolled in an eligible specialty, the provider is not board certified and does not meet the 60% rule for qualifying codes. Therefore, this provider is ***not eligible*** for the rate increase.

Self Attestation

As previously stated in BT201255, qualifying board-certified physicians enrolled with the IHCP in family medicine, general internal medicine, or pediatric medicine or a subspecialty thereof, may self-attest by completing the *ACA Physician Self-Attestation Form* found on the Forms page at indianamedicaid.com. Although primary care services provided by advanced practice clinicians under the professional oversight of a self-attested qualifying physician are eligible for the higher payment, advanced practice clinicians should *not* self-attest. Therefore, nurse practitioners, physician assistants, and nurse midwives should *not* complete the self-attestation form.

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

Claims for Vaccines for Children (VFC) Vaccines

As previously stated in BT201247, "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." Additionally, "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) code for the vaccine and a billed amount of $0.00."

Claims for VFC vaccines with a billed amount of $0.00 will receive a denial with *EOB 268 – Billed amount missing*. Although providers will receive this denial, providers should continue to bill these claims as instructed and not rebill the IHCP with a different billed amount.

Currently, claims cannot be submitted on Web interChange with a billed amount of $0.00. A system modification is being made to allow a $0.00 billed amount for all claims billed through Web interChange. Providers will be notified as soon as the system change is complete. In the meantime, Web interChange users may choose to submit these claims on paper claim forms.

QUESTIONS?

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