Agenda

• Objectives
• Legislation
• Qualifying Providers
• Self Attestation
• Reimbursement
• Billing Changes
• Audit
Objectives

• Understand an overview of the program
• Know if your provider type is eligible for the program
• Learn the types of services eligible for increased rates
• Understand the billing changes for 2013 and 2014
Legislation
Legislation

• Mandated by Section 1202 of the Affordable Care Act (ACA)
• Promulgated through final rule 42 CFR 447.700
• Applies to:
  - Fee-for-service (FFS) and managed care claims paid for dates of service in calendar years (CY) 2013 and 2014 only
  - Evaluation and Management (E/M) Codes 99201 through 99499 (IHCP-covered codes only)
  - Vaccine administration codes 90460, 90461, 90471, 90472, 90473, 90474 (IHCP-covered codes only)
Qualifying Providers
Qualifying Providers

Existing providers

- To qualify to receive increased reimbursement providers must:
  - Be IHCP-enrolled as a physician with one of the following specialties: family medicine, general internal medicine, or pediatric medicine or their subspecialties
  - Self attest as board certified in family medicine, general internal medicine, or pediatric medicine or a subspecialty thereof by one of the following boards:
    • American Board of Medical Specialists (ABMS)
    • American Board of Physician Specialties (ABPS)
    • American Osteopathic Association (AOA)
  - If not board certified:
    • Self attest that at least 60% of codes billed to Medicaid during the previous calendar year are qualifying E/M codes and/or vaccine administration codes
Qualifying Providers

Newly enrolling providers

- Providers that newly enroll in the IHCP during CY2013 or CY2014 must:
  - Self attest as board certified in family medicine, general internal medicine, or pediatric medicine or a subspecialty thereof (no wait period)
- If not board certified:
  - At least 60% of codes billed to Medicaid during the prior month are qualifying E/M codes and vaccine administration codes
  - Wait at least 30 days after enrolling to self attest
Qualifying Providers

Non-physicians

• Increased rates also apply to primary care services furnished by IHCP-enrolled non-physicians, including:
  - Nurse practitioners
  - Physician assistants
  - Nurse midwives

These practitioners do not perform the self-attestation process

• These non-physician advanced practice clinicians must provide primary care services within their respective scope of practice under the professional oversight of a self-attested qualified physician
  - The self attested physician must have a professional oversight or responsibility for the services provided by the advanced practice clinician

• Participation by non-physician clinicians is based on proper CPT/modifier coding and inclusion of the rendering NPI of the supervising physician
Qualifying Providers

Ineligible practitioners

• Increased rates are **not** available for the following:
  - Federally Qualified Health Centers
  - Rural Health Clinics
  - Independently managed nurse or other practitioner directed clinics that have arms-length arrangements with physicians
  - Professional services provided in a nursing facility and reimbursed as part of the facility *per diem* rate
  - Primary care services furnished under the state Childrens Health Insurance Program (SCHIP)
Self Attestation
Self Attestation
Board-Certified Physicians

• Complete the *ACA Physician Self-Attestation Form* located on the Forms page at indianamedicaid.com, and enter:
  - The IHCP enrolled specialty
  - The Board that granted certification
  - The specialty (family, general internal, or pediatric medicine) and subspecialty under which certification is granted
  - The effective and end dates of the board certification
• Include with the form a copy of the board certification document (required)
Self Attestation
Board-Certified Physicians

- Notify HP Provider Enrollment within ten days if certification is rescinded by the Board
  - Qualification for the increased payments will end on the date board certification is lost
- When board certification expires during CY2013 or CY2014, the physician must re-attest to be eligible for the increased rates once board certification is re-established
  - Services rendered during a lapse in time between board certification and re-attestation are not eligible for the rate increase
Self Attestation

Physicians not Board-Certified

• Complete the *ACA Physician Self-Attestation Form* located on the Forms page at indianamedicaid.com

• Non-board certified physicians must self attest each calendar year the rate increase is in effect (2013 and 2014) that claims during the previous calendar year meet the 60% threshold

• For CY2013, qualification for increased rates expires on December 31, 2013

• Services rendered between January 1, 2014, and the receipt of attestation for CY2014, are not eligible for the rate increase
  - Non-board certified physicians may self attest for CY2014, at the end of CY2013, if the 60% claim volume threshold has been achieved
Self Attestation

Mailing address

• Mail the *ACA Physician Self-Attestation Form* to

HP Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263
Self Attestation
Verify Status - Approved
### Self Attestation

**Verify Status - Rejected**

<table>
<thead>
<tr>
<th>Enrollment Information</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Status</th>
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<td>Medicaid / Package C</td>
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**ACA/PCP Provider Attestation Information**

Status: Rejected - Copy of Board Certification Not Submitted

Board certification document not submitted
Self Attestation

Verify Status – Not Received
Reimbursement
Reimbursement

• Increased rates for FFS claims are paid as a supplemental payment on a quarterly basis
  – Supplemental payments can not begin until CMS has approved the State Plan Amendment
• The rate increase is effective January 1, 2013, for all providers that self attest any day during January 2013
• Providers that self attest on or after February 1, 2013, become eligible for the rate increase on the date HP Provider Enrollment receives their attestation
  – Back-dating the effective date is not permissible
• Reimbursement rates for qualifying procedure codes return to existing levels beginning January 1, 2015
Reimbursement

E/M Services

• At a minimum, the increased rates will be the lesser of the provider’s billed amount or the Medicare Part B rates in effect during CY2013 and CY2014 (using the 2009 conversion factor)
Reimbursement

Vaccine administration codes

• Supplemental payments for vaccine administration codes under the Vaccines for Childrens Program (VFC) is the lesser of the CY2013 or CY2014 Medicare rate or the maximum regional VFC rate in those years
Billing Changes
Billing Changes

Nurse Practitioners

• Applicable to IHCP-enrolled nurse practitioners employed at a physician-directed group or clinic with direct oversight by a physician
• Append the SA modifier to each procedure code on all claims
  – SA modifier indicates service provided by a nurse practitioner
• Do not report the individual NPI of the nurse practitioner on claims
• Report the individual NPI of the supervising physician in the rendering provider field locator
• Claims for CY2013 and CY2014, that do not follow these billing guidelines do not qualify for the supplemental payments
Billing Changes

VFC administration codes

• Applies to vaccines administered under the VFC program
• Report V20.2 as the primary diagnosis code on claims
• Report the CPT code for the vaccine that was administered with a billed amount of $0.00
  – NOTE: Web interChange cannot accept a billed amount of $0.00
  – Claims for VFC vaccines with a billed amount of $0.00 will receive a denial with EOB 0268 - *Billed Amount Missing*. Providers should not rebill with a different amount
Billing Changes

VFC administration codes

- Append the SL modifier to the appropriate administration procedure code
- VFC claims that follow these guidelines qualify for increased reimbursement and ensure the vaccine is included in the CHIRP registry
- The claim reimbursement amount remains $8.00
  - The increased rate is included in the quarterly supplemental payment (for FFS members)
Billing Changes

VFC administration codes

• 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*
Billing Changes
Non-VFC administration codes

• Increased reimbursement is also available for administration codes not furnished through the VFC program

• Reminder: Vaccine administration codes are not separately reimbursable when an E/M service is billed on the same date of service

• When the vaccine administration is the only service rendered:
  - Report the CPT code for the vaccine that was administered
  - Report the appropriate vaccine administration procedure code for each vaccine administered
  - Do not append the SL modifier to the administration procedure code(s)
  - Report the appropriate diagnosis code
Billing Changes

Non-VFC 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)
Audit
Audit

• As required by the ACA, the Office of Medicaid Policy and Planning (OMPP) will conduct an audit of a statistically valid sample of physicians who received the increased payments to verify:
  - Board certification in an eligible specialty, or
  - 60% of claims billed in the previous CY (or month) included eligible procedure codes
• Physicians who do not meet requirements will be removed from the program
  - Any increased reimbursements received will be recouped
Find Help
Helpful Tools

• IHCP website at indianamedicaid.com
• Provider Bulletin BT201247, BT201255, BT201302
• HP Provider Enrollment
  - 1-877-707-5750 toll free
• Provider field consultant
  - indianamedicaid.com > Contact Us > Provider Relations Field Consultants link
Q&A