State of New Mexico
Medical Assistance Program Manual
Supplement

DATE: February 19, 2013 **NUMBER:13-03**

TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

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

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

II. NEW VACCINATION REIMBURSEMENT INFORMATION

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

On January 15, 2013 the New Mexico Medicaid program issued Medical Assistance Division (MAD) policy supplement 13-01 "*Increase in Payment Rates for Primary Care Services*" which contained guidance related to section 1202 of the Affordable Care Act (ACA) that requires payment by State Medicaid agencies of at least the Medicare rates in effect in calendar years (CYs) 2013 and 2014 for primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine.

The Centers for Medicare & Medicaid Services (CMS) has recently released further guidance on this topic. Providers are encouraged to check the CMS Medicaid website for further updates on this topic at http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

This supplement serves as notice of the intent of 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. This supplement also serves as further clarification of the provider self-attestation process and on the physician extender policy as related to the primary care increase. The self-attestation form has also been revised to reflect these changes.

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 in supplement 13-01, 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.

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 ACA specifies that the increased payment applies to primary care services delivered by a physician who self-attests that he or she meets one or both of the below requirements, or by a qualified physician extender practicing under the direct supervision of a physician who accepts professional responsibility and who also meets the requirements for the primary care increase. See section E, below, for more information on the requirements related to physician extenders.

A provider may be eligible for the primary care increase in either of two ways:

- A provider board certified in family medicine, internal medicine, or pediatric medicine by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA), including any subspecialty of those designations; if the provider also attests that he or she is practicing in that board certified specialty; or

- If not board certified as indicated above, the provider can attest to practicing in the specialty areas of family medicine, general internal medicine, or pediatric medicine, and that specific primary care evaluation and management (E&M) services and vaccine administration services are at least 60 percent of the procedure codes he or she has billed the Medicaid program (fee for service and managed care programs, combined) during the most recent calendar year (2012); or, for newly eligible physicians, the prior month.

The details regarding these requirements may be found on the copy of the attached revised attestation form to be completed by the provider in order to be considered for the increased payment. Duplicates copies of the form may be made and distributed as necessary.

Whether a provider participates as a Medicaid fee for service provider, a Medicaid managed care provider, or 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 he or she practices at more than one location or for more than one practice, only one attestation form is required.

MAD will be responsible for determining if the provider qualifies for the increase and will notify the managed care organizations. Each managed care organization will be responsible for making the increased payment to qualifying providers on the services that the managed care organization paid to the provider.

C. HELP COMPLETING THE ATTESTATION FORM

If a provider does not meet the board certification requirements, and must attest to qualifying for the increased payment based on the 60% volume requirement, using the MAD website, it is possible for a provider to check to see if MAD believes the provider may meet the 60% volume requirement.

Using an individual rendering provider's National Provider Identifier (NPI), a provider can view a list of providers that MAD estimates may meet the 60% volume requirement and who also appears to practice in one of the allowed specialty areas. The provider is still responsible however, for the accuracy of the attestation form.

This list of providers is available on the MAD website at:
http://www.hsd.state.nm.us/mad/PResourcesTools.html

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.

Providers are also encouraged to check the CMS Medicaid website for further updates on this topic at http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

E. QUALIFYING PROVIDERS

In order to qualify for the primary care payment increase, the provider must be reimbursed at the fee schedule amounts. 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 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.

1. Physicians Qualifying as Board Certified

The ACA specifies increased payments for three primary care medical specialties: Family Medicine, General Internal Medicine and Pediatrics. Subspecialists that qualify for higher payment are those recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS) or American Osteopathic Association (AOA). For purposes of the rule, "General Internal Medicine" encompasses "Internal Medicine" and all recognized subspecialties. The websites of these organizations currently list the following subspecialty certifications within each specialty designation:

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 or subspecialties may still qualify for the increased primary care payment if 60% of their combined Medicaid Fee for Service and Medicaid managed care practice is for the primary care codes identified by CMS (listed below) and they practice in one of the identified primary care specialties (Family Medicine, General Internal Medicine or Pediatric.)

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 and the provider attests to practicing in one of the primary care specialties.

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

3. ***Physician Extenders***

A physician extender may qualify when they are the rendering provider on claims and are identified with their own NPI number.

It is still unclear whether a physician extender (such as a certified nurse practitioner, a certified nurse midwife, a physician assistant, or a pharmacist clinician) must practice under the direct personal supervision of a physician in order to qualify for the increased payment. We are seeking further clarification from CMS on this issue.

However, CMS has been very clear that in order to qualify for the increased payment, a physician extender must have an affiliation or association with a physician who

accepts professional responsibility and legal liability for the services provided, and who also would qualify for the increased payment is his or her own right.

The New Mexico Medicaid program will issue further guidance on the requirements related to physician extenders when we receive clarification from CMS on the issue. A physician extender who thinks that he or she may qualify for the increased payment is still encouraged to fill out the attestation form, indicating the situation under which he or she practices, including obtaining the signature of the physician who accepts professional responsibility and legal liability for the physician extender; and send the form to MAD.

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:

Outpatient and Other Visit codes (covered by Medicare)

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, calculating the increased amount owed to the provider on each claim line. This calculation will be done quarterly for all new claims processed during the quarter.

- 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. QUESTIONS

Questions 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

II. NEW VACCINATION REIMBURSEMENT INFORMATION

The New Mexico MAD policy supplement 13-01 issued on January 15, 2013 also contained information regarding vaccine reimbursement. Based on comments received from providers, MAD is revising the instructions for billing for vaccines provided through the Vaccines for Children (VFC) program, as follows:

Use of 90460:
If a provider administers one vaccine on a single day, that provider must bill code 90460 using a quantity of 1, regardless of how many components are in the vaccine. The provider must also bill the specific vaccine code with a quantity of 1, billing $0.00 as the billed amount. The provider will be reimbursed $20.80 under code 90460.

Use of 90461:
If more than one vaccine is given on a single day, the provider should bill the first vaccination as indicated using code 90460 (regardless of components) and a quantity of 1.

The additional vaccination would be billed using code 90461 for the additional "pokes"

(regardless of components of the vaccine) and the quantity billed must be the number of additional “pokes” (regardless of the components of the vaccine).

The provider will receive $20.80 for each “poke” given. Again, the provider must also bill each specific vaccine code with a quantity of 1, billing with a billed amount of $0.00.

Please note this change is NOT what was detailed in Supplement 13-01, but is a result of comments received from physicians, representatives and managed care organizations. This change is effective March 1, 2013.

MAD is working with the managed care organizations to help standardize this method for billing.

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, and practices in, a 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); 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 direction of a qualifying physician or with a physician who accepts professional responsibility and legal liability you may qualify based on that physician's qualifications. Please indicate your provider type, the physician's name and NPI number and have the physician sign and date below.

______ **305 – Physician Assistant**	_____ ***I practice under the direction of a supervising physician*** *and/or* _____ ***I practice with a physician who accepts professional responsibility and legal liability for me.***	
______ **316 – Nurse, CN Practitioner**	**Physician's name:**	
______ **320 –Pharmacist Clinician**	**Physician's NPI:**	
______ **322 – Midwife, Certified Nurse**	**Physician's Signature :**	**Date:**

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**

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

Specialty: **Pediatrics**

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