Enhanced Payments for Primary Care Physicians

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Section 1202 of the ACA

- Requires Medicaid programs to pay qualifying primary care physicians the greater of current Medicare rate or the 2009 Medicare rate for certain specified primary care services provided during calendar years 2013 and 2014
- Increases the Vaccine For Children (VFC) administration fees and requires changes to reporting vaccine administrations

Primary Care Services

- The ACA defines the primary care services eligible for enhanced payments as:
  - Evaluation and Management (E&M) services described by CPT codes 99201-99499; and
  - Vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474
- No other services qualify for enhanced payments under this section

Evaluation & Management Services

- The ACA defines all E&M services as primary care services
- This includes hospital inpatient services, critical care services, neonatal transport, and other services not usually thought of as primary care services

Qualified Providers

- To qualify for enhanced payments, physicians **must** be engaged in a primary practice as defined by the ACA
- These include the specialties of general internal medicine, family practice medicine, or pediatric medicine or any subspecialty recognized by one of three board certifying bodies

Qualified Providers

Physicians practicing any of the recognized primary care specialties or subspecialties **must** satisfy one of two requirements to receive the enhanced fees for primary care services:

- Board certification; OR
- Reporting at least 60% primary care services among all services provided to Medicaid members during 2012

Board Certification

- To qualify for enhanced payments by meeting the board certification requirement, physicians must currently be board certified in either:
  - One of the three primary care specialties designated by the ACA; OR
  - Any subspecialty recognized by the three certifying bodies named in the ACA
- Subspecialists need not be board certified in both the specialty and subspecialty

Certifying Bodies

Subspecialties recognized by any of the following three board certifying bodies are recognized as satisfying the definition of primary care:

- American Board of Medical Specialties
- American Osteopathic Association
- American Board of Physician Specialties

Percentage of Primary Care Services

- Physicians practicing one of the three qualifying primary care specialties or subspecialties may qualify for enhanced payments for primary care services if 60% of the codes reported to Medicaid during 2012 were primary care codes
- Calculations for newly registered AHCCCS providers will use codes reported the prior month

Primary Care Percentage

- CMS permits Medicaid programs to substitute codes paid for codes reported
- The percentage of primary care services is calculated by dividing the total number of codes describing primary care services paid by Medicaid during 2012 by the total number of all CPT / HCPCS codes paid by Medicaid during 2012

Calculating Primary Care Percentage

$$\frac{\text{Total \# Primary Care codes}^{1} \text{ paid by Medicaid}}{\text{Total \# of codes}^{2} \text{ paid by Medicaid}} \times 100$$

1. E&M codes 99201-99499 and vaccine administration codes 91460, 90461, 90471, 9472, 90473, and 90474
2. Includes all CPT and HCPCS codes

Primary Care Percentage

- In 2012 AHCCCS did not require vaccines to be reported with vaccine administration codes for the VFC program, utilizing the individual vaccine codes with the SL modifier to track the specific vaccines given to members
- AHCCCS will substitute vaccine codes with the SL modifier for the vaccine administration codes in primary care percentage calculations

Example 1

Office visit	99201-99499
Vaccine	90476-90749
Qualifying services	2
Total services	2
% qualifying services	2/2 = 100%

Example 2

Office visit	99201-99499
Vaccine	90476-90749
Urine dipstick	81000
Qualifying services	2
Total services	3
% qualifying services	2/3 = 66.67%

Example 3

Office visit	99201-99499
Vaccine	90476-90749
Urine dipstick	81000
EKG	93000
Qualifying services	2
Total services	4
% qualifying services	2/4 = 50.00%

Example 4

Office visit 99201-99499	
Urine dipstick	81000
EKG	93000
Antibiotic	J0290
Syringe	A4208
Qualifying services	1
Total services	5
% qualifying services	1/5 = 20.00%

Actual Calculation From Examples

- Calculations are not on a per claim basis but on the cumulative total number of codes in the numerator and denominator.
- If the examples represented all paid services:
  - Numerator is 2+2+2+1 = 7
  - Denominator is 2+3+4+5 = 14
- Percentage is 7/14 = 50.00%, which would not qualify this provider for enhanced payments

Attestation

- Physicians meeting either the board certification or 60% primary care service requirements must provide a self-attestation to receive the enhanced payments for qualifying services
- For attestations received on or before April 30, 2013 the enhanced payments will be retroactive for dates of service on or after January 1, 2013
- If received on or after May 1, 2013, the enhanced payments will be prospective from the date received

Attestation Screen Shot

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Section III: Board Certification

For purposes of receiving these increased payments, Board certified means the physician has received certification from the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties in one of the specialties of family medicine, general internal medicine, or pediatric medicine, or a subspecialty of family medicine, general internal medicine, or pediatric medicine recognized by one of those three certification authorities.

I attest that I am board certified in one of the three qualifying specialties or a sub-specialty under one of the above three specialties recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties. I hereby attest that the information submitted is in compliance with Federal and State Regulations and is current, complete and accurate to the best of my knowledge and belief. I understand that payment of claims will include monies from federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws.

Note: Nurse Practitioners (NP) and Physician Assistants (PA) who practice under supervision of a physician in one the specialties or sub specialties described above are eligible for enhanced reimbursement. Physicians must complete Form B (hyperlink) in order for the Nurse Practitioner or Physician Assistant to receive enhanced reimbursement for the designated services.

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Section IV: 60% Attestation (Current Provider)

"Meet the 60% requirements" means that 60% of Medicaid codes billed during calendar year 2012 were the applicable codes noted below. The applicable codes are: Current Procedural Terminology (CPT) Evaluation and Management (E&M) Codes 99201 through 99499, and CPT vaccine administration codes 90460, 90461, 90471, 90472, 90473, 90474 or their successor codes.

I attest that I am a primary care physician or subspecialist who works in one or more of the specialty designations noted in Section I, but I do not have a certification recognized by American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties but I have billed at least 60% of the services provided to Medicaid members during calendar year 2012 using the designated E&M or vaccine administration services codes.

I hereby attest that the information submitted is in compliance with Federal and State Regulations and is current, complete and accurate to the best of my knowledge and belief. I understand that payment of claims will include monies from federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws.

Note: Nurse Practitioners (NP) and Physician Assistants (PA) who practice under supervision of a physician described above are eligible for enhanced reimbursement. Physicians must complete Form B (hyperlink) in order for the Physician Assistant and Nurse practitioner to receive enhanced reimbursement for the designated services.

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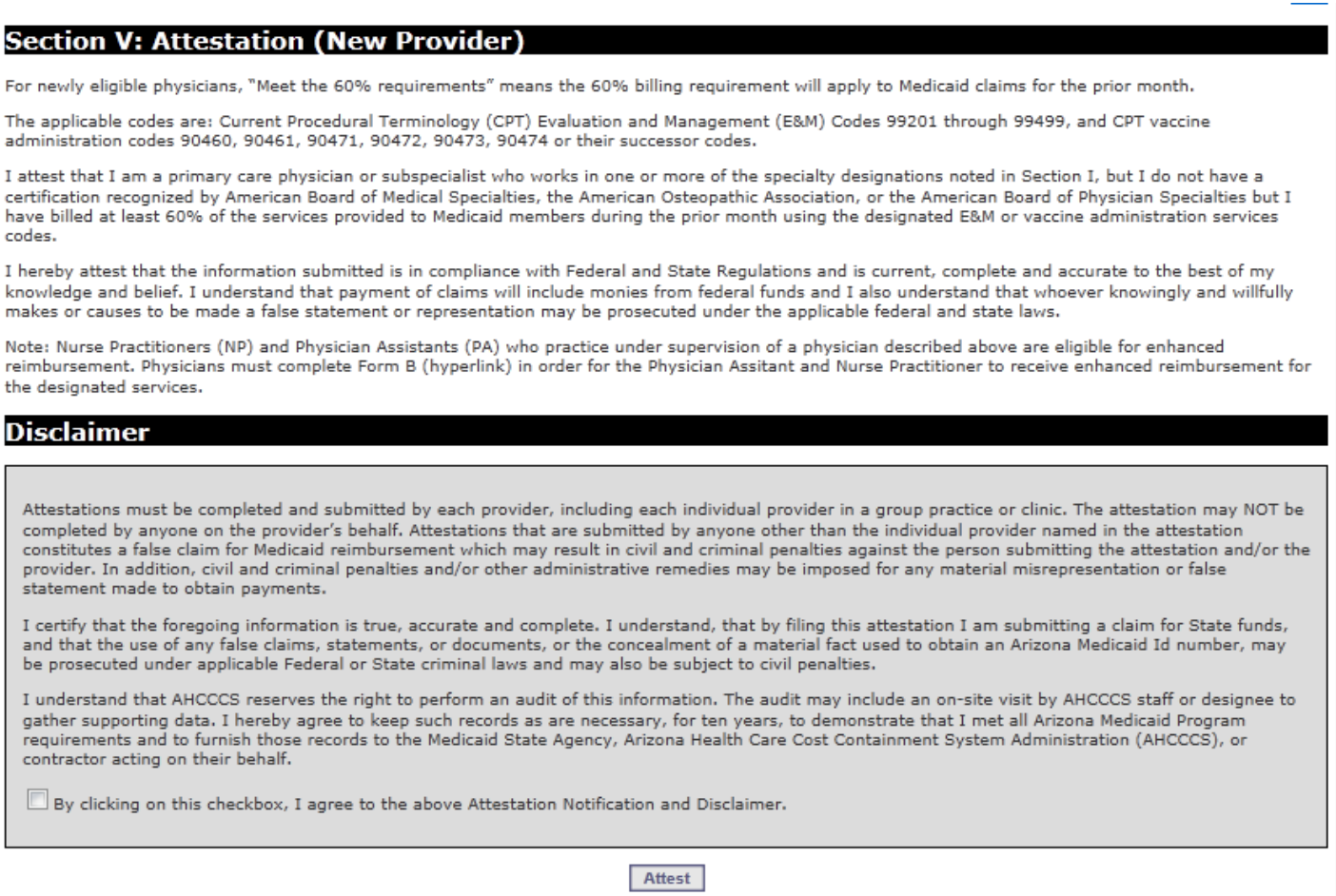

Section V: Attestation (New Provider)

For newly eligible physicians, "Meet the 60% requirements" means the 60% billing requirement will apply to Medicaid claims for the prior month.

The applicable codes are: Current Procedural Terminology (CPT) Evaluation and Management (E&M) Codes 99201 through 99499, and CPT vaccine administration codes 90460, 90461, 90471, 90472, 90473, 90474 or their successor codes.

I attest that I am a primary care physician or subspecialist who works in one or more of the specialty designations noted in Section I, but I do not have a certification recognized by American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties but I have billed at least 60% of the services provided to Medicaid members during the prior month using the designated E&M or vaccine administration services codes.

I hereby attest that the information submitted is in compliance with Federal and State Regulations and is current, complete and accurate to the best of my knowledge and belief. I understand that payment of claims will include monies from federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws.

Note: Nurse Practitioners (NP) and Physician Assistants (PA) who practice under supervision of a physician described above are eligible for enhanced reimbursement. Physicians must complete Form B (hyperlink) in order for the Physician Assitant and Nurse Practitioner to receive enhanced reimbursement for the designated services.

Disclaimer

Attestations must be completed and submitted by each provider, including each individual provider in a group practice or clinic. The attestation may NOT be completed by anyone on the provider's behalf. Attestations that are submitted by anyone other than the individual provider named in the attestation constitutes a false claim for Medicaid reimbursement which may result in civil and criminal penalties against the person submitting the attestation and/or the provider. In addition, civil and criminal penalties and/or other administrative remedies may be imposed for any material misrepresentation or false statement made to obtain payments.

I certify that the foregoing information is true, accurate and complete. I understand, that by filing this attestation I am submitting a claim for State funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain an Arizona Medicaid Id number, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I understand that AHCCCS reserves the right to perform an audit of this information. The audit may include an on-site visit by AHCCCS staff or designee to gather supporting data. I hereby agree to keep such records as are necessary, for ten years, to demonstrate that I met all Arizona Medicaid Program requirements and to furnish those records to the Medicaid State Agency, Arizona Health Care Cost Containment System Administration (AHCCCS), or contractor acting on their behalf.

☐ By clicking on this checkbox, I agree to the above Attestation Notification and Disclaimer.

Attest

Payment of the Enhanced Fees

- CMS must approve the AHCCCS enhanced payment methodology
- The earliest CMS can review and approve that methodology is July 1, 2013, or possibly later
- After CMS approval, enhanced payments will be made retroactive to the date the physician is eligible for those enhanced payments

Vaccine Administration

- The enhanced fee section of the ACA increased the Regional Maximum fee for vaccines administered under the Vaccines For Children program (VFC)
- CMS rules implementing this change requires reporting of vaccine administration services with the vaccine administration codes (90460 90461, 90471, 90472, 90473, and 90474)

Reporting Changes

- Prior to 2013 AHCCCS required vaccine administrations to be reported with the specific vaccine codes, not the administration codes
- Vaccines administered under the VFC program had the SL modifier added to the vaccine code, indicating it had been given to the provider at no charge

Reporting Changes

- To comply with the new CMS rules, vaccine administrations must now be reported with the vaccine administration codes
- To allow AHCCCS to track the individual vaccines administered, the specific vaccine codes must also be reported

Reporting Changes

- If provided under the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code
- Do not add the SL modifier to either the vaccine code or administration code for vaccines administered to members 19 years of age or older or if the vaccine is not provided under VFC, regardless of the patient's age

Multiple Administrations

- AHCCCS will pay a separate administration fee when additional vaccines/toxoids are administered with a separate injection
- Additional administration fees are not paid when additional vaccines/toxoids are mixed in the same syringe
- Vaccines typically administered together can not be separated to result in additional fees

Charges for Vaccine Administration

- The charges for vaccine administrations should now be reported with the vaccine administration codes, not the vaccine codes
- For non-VFC vaccines, charges for the vaccine/toxoid may also be reported
- Charges vary by whether the physician is eligible for enhanced fees and whether the vaccine is provided under the VFC program

Vaccine Administration Fees

	Physician eligible for enhanced fees	Physician not eligible for enhanced fees
Vaccine provided through VFC	$21.33 / each separate injection	$15.43 / each separate injection
Vaccine not provided through VFC	$26.81 / each separate injection plus fee for vaccine/toxoid	$20.64 / each separate injection plus fee for vaccine/toxoid

Questions?

http://www.azahcccs.gov/commercial/ProviderBilling/rates/PCSrates.aspx

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