PRIMARY CARE AND VACCINES FOR CHILDERN INCENTIVE PROGRAM

Policy Number: SC14P0006A2 **Effective Date:** October 13, 2014

Last Reviewed: January 1, 2016

POLICY UPDATES		
POLICY VERSION NUMBER	**DATE**	**SUMMARY OF CHANGE(S)**
Version 2	January 1, 2016	Although the Policy is no longer active and terminated12/31/2014, it will remain posted until all Settlements are completed.

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"Payment Policies assist in administering payment for UCare benefits under UCare's health benefit plans. Payment Policies are intended to serve only as a general reference resource regarding UCare's administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. In particular, when submitting claims, all providers must first identify member eligibility, federal and state legislation or regulatory guidance regarding claims submission, UCare provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and

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<u>compliant claims.</u> In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations. "*

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PAYMENT POLICY OVERVIEW

PRODUCT SUMMARY

This Policy applies to UCare's MHCP products and any UCare product where MHCP is the primary payer.

PROVIDER SUMMARY

This Policy is applicable to eligible primary care providers. Additional information is outlined in the Policy and Billing Section of this Policy.

POLICY STATEMENT

Effective for dates of service on and after January 1, 2013 – December 31, 2014 the Affordable Care Act mandates Medicaid to reimburse eligible providers for specific primary services and vaccines at the rate equal to the 2009 Medicare fee schedule. This Policy identifies the providers and services eligible for enhanced payment, as it pertains to UCare's MHCP products.

PATIENT ELIGIBILITY CRITERIA

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The individual must be enrolled in an UCare MHCP product.

DEFINITIONS	
TERM	**NARRATIVE DESCRIPTION**
Affordable Care Act (ACA)	A federal statute signed into law in March 2010 as a part of the healthcare reform agenda of the Obama administration. Signed under the title of The Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions.

POLICY AND BILLING INFORMATON

ELIGIBLE SPECIALITIES AND SUB-SPECIALTIES

DHS has indicated that they will provide UCare with a comprehensive list of providers who are eligible for the ACA increase. Outlined below is general information regarding eligible providers and eligibility requirements, etc.

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Under the Affordable Care Act (ACA) the final Rule recognizes specific specialties and subspecialties as eligible for enhanced payment. The ACA specifies increased payment for three (3) primary care specialties:

- Family Medicine
- General internal Medicine
- Pediatric Medicine

Also includes recognized subspecialties. ***See Attachment "A"***

The Final Rule interprets this language to include some subspecialties. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. The websites of these organizations currently lists subspecialty certifications within each specialty. This information is outlined in ***Attachment "A."***

PROVIDER ATTESTATION

To be paid at the enhanced rate a physician must complete an attestation. When services are performed by an Advanced Practice Provider (APP), *(e.g., Physician Assistant (PA) or Advanced Practice Nurse (APRN))*, both the APP and the physician must complete the attestation.

An eligible physician must meet one of the following requirements:

1. American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS)
2. At least 60% of Medicaid services for which the physician received payment were eligible services (See Eligible Services, that were paid during one of the periods outlined under Eligibility Period.

ELIGIBILITY PERIOD

The earliest date of service for which a provider is eligible to receive enhanced rates is determined by the date they submit their Attestation Statement to DHS.

Physicians

For physicians who submit the attestation:

- Before April 1, 2013, enhanced rates will apply to covered services effective January 1, 2013
- On or after April 1, 2013 enhanced rates will apply to covered services effective on the first day of the month in which the attestation form was received.

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Advanced Practice Providers (APPs)

For APPs (e.g., Physician Assistant (PA) or Advanced Practice Nurse (APRN)) completing the attestation on or after August 1, 2013, rates will apply to covered services effective on the first day of the month in which the attestation form was received.

NOTE: The 60% claims history criteria apply to the physician's entire scope of practice. The calculation must include all Medicaid services paid to the physician at all locations or practices where services are provided.

EXCLUDED PROVIDER TYPES

Providers are not eligible for enhanced rates when rendering care in the following locations:

- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Indian Health Service (IHS)

ALLOWED AMOUNT – GENERAL INFORMATION

Effective for dates of service on and after January 1, 2013 – December 31, 2014 the Affordable Care Act mandates Medicaid to reimburse qualified providers (see Eligible Providers) for specific primary care services and vaccines at the rate equal to the 2009 Medicare fee schedule.

It is UCare's intent to complete Provider Settlements within thirty (30) days of receiving all of the information needed to appropriately price and adjudicate payment (e.g., eligible provider listing, NPI numbers, and the amount due each provider) and funding from DHS. DHS will be providing UCare with a file that identifies the providers eligible for payment and the amount due each provider. This information is not developed by UCare.

ELIGIBLE SERVICES

The services listed were eligible as of July 2014. The list of services will need to be validated with each MHCP fee schedule update. To view applicable rates and eligible services reference Fact Code "V" on the DHS fee schedule.

CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
99201	Office or other outpatient visit for the evaluation and management of a *new patient*
99202	Office or other outpatient visit for the evaluation and management of a *new patient*
99203	Office or other outpatient visit for the evaluation and management of a *new patient*

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CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
99204	Office or other outpatient visit for the evaluation and management of a *new patient*
99205	Office or other outpatient visit for the evaluation and management of a *new patient*
99211	Office or other outpatient visit for the evaluation and management of an *established patient* that may not require the presence of a physician or other qualified health care professional.
99212	Office or other outpatient visit for the evaluation and management of an *established patient*
99213	Office or other outpatient visit for the evaluation and management of an *established patient*
99214	Office or other outpatient visit for the evaluation and management of an *established patient*
99215	Office or other outpatient visit for the evaluation and management of an *established patient*
99217	Observation care discharge day management
99218	*Initial* observation care, per day, for the evaluation and management of a patient
99219	*Initial* observation care, per day, for the evaluation and management of a patient
99220	*Initial* observation care, per day, for the evaluation and management of a patient
99221	*Initial* hospital care, per day
99222	Initial hospital care, per day
99223	Initial hospital care, per day
99224	*Subsequent* observation care, per day, for the evaluation and management of a patient
99225	*Subsequent* observation care, per day, for the evaluation and management of a patient
99226	*Subsequent* observation care, per day, for the evaluation and management of a patient
99231	*Subsequent* hospital care, per day
99232	*Subsequent* hospital care
99233	*Subsequent* hospital care
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including *admission and discharge on the same date*
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including *admission and discharge on the same date*
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including *admission and discharge on the same date*
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
99241	Office consultation for a *new or established patient*

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CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
99242	Office consultation for a *new or established patient*
99243	Office consultation for a *new or established patient*
99244	Office consultation for a *new or established patient*
99245	Office consultation for a *new or established patient*
99251	Inpatient consultation for a *new or established patient*
99252	Inpatient consultation for a *new or established patient*
99253	Inpatient consultation for a *new or established patient*
99254	Inpatient consultation for a *new or established patient*
99255	Inpatient consultation for a *new or established patient*
99281	Emergency department visit for the evaluation and management of a patient
99282	Emergency department visit for the evaluation and management of a patient
99283	Emergency department visit for the evaluation and management of a patient
99284	Emergency department visit for the evaluation and management of a patient
99285	Emergency department visit for the evaluation and management of a patient
99291	Critical care, evaluation and management of the critically ill or critically injured patient; *first 30-74 minutes*
99292	Critical care, evaluation and management of the critically ill or critically injured patient; *each additional 30 minutes*
99304	*Initial nursing facility care*, per day, for the evaluation and management of a patient
99305	*Initial nursing facility care*, per day, for the evaluation and management of a patient
99306	*Initial nursing facility care*, per day, for the evaluation and management of a patient
99307	*Subsequent nursing facility care*, per day, for the evaluation and management of a patient
99308	*Subsequent nursing facility care*, per day, for the evaluation and management of a patient
99309	*Subsequent nursing facility care*, per day, for the evaluation and management of a patient
99310	*Subsequent nursing facility care*, per day, for the evaluation and management of a patient
99315	*Nursing facility discharge day management*; 30 minutes or less
99316	*Nursing facility discharge day management*; more than 30 minutes
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.
99324	Domiciliary or rest home visit for the evaluation and management of a *new patient*

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CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
99325	Domiciliary or rest home visit for the evaluation and management of a *new patient*
99326	Domiciliary or rest home visit for the evaluation and management of a *new patient*
99327	Domiciliary or rest home visit for the evaluation and management of a *new patient*
99328	Domiciliary or rest home visit for the evaluation and management of a *new patient*
99334	Domiciliary or rest home visit for the evaluation and management of an *established patient*
99335	Domiciliary or rest home visit for the evaluation and management of an established patient
99336	Domiciliary or rest home visit for the evaluation and management of an established patient
99337	Domiciliary or rest home visit for the evaluation and management of an established patient
99341	Home visit for the evaluation and management of a *new patient*
99342	Home visit for the evaluation and management of a *new patient*
99343	Home visit for the evaluation and management of a *new patient*
99344	Home visit for the evaluation and management of a *new patient*
99345	Home visit for the evaluation and management of a *new patient*
99347	Home visit for the evaluation and management of an *established patient*
99348	Home visit for the evaluation and management of an *established patient*
99349	Home visit for the evaluation and management of an *established patient*
99350	Home visit for the evaluation and management of an *established patient*
99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)
99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99360	Standby service, requiring prolonged attendance, each 30 minutes (e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)

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CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
99364	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)
99374	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility)
99377	Supervision of a hospice patient (patient not present)
99378	Supervision of a hospice patient (patient not present)
99379	Supervision of a nursing facility patient (patient not present)
99380	Supervision of a nursing facility patient (patient not present)
99381	Initial comprehensive preventive medicine evaluation and management of an individual, *new patient*; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual, *new patient*; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual, *new patient*; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual, *new patient*; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual, *new patient*; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual, *new patient*; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual, *new patient*; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual, *established patient*; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual, *established patient*; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual, *established patient*; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual, *established patient*; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual, *established patient*; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an

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CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
	individual, *established patient*; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual, *established patient*; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minute
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99460	*Initial hospital or birthing center* care, per day, for evaluation and management of normal newborn infant
99461	*Initial care*, per day, for evaluation and management of normal newborn infant seen in *other than hospital or birthing center*
99462	*Subsequent hospital care*, per day, for evaluation and management of normal newborn
99463	*Initial hospital or birthing center care*, per day, for evaluation and management of normal newborn infant *admitted and discharged on the same date*
99464	Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn
99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
99466	Critical care face-to-face services, during an inter-facility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care

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CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
	during transport
99467	Critical care face-to-face services, during an inter-facility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; each additional 30 minutes
99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

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CPT® or HCPCS CODE	NARRATIVE DESCRIPTION
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

PRIOR AUTHORIZATION OR THRESHOLD LIMITS

There is no prior authorization, authorization or threshold limits associated with the Primary Care and Vaccines for Children Incentive Program.

RELATED PAYMENT POLICY DOCUMENTATION

REFERENCES TO OTHER PAYMENT POLICY DOCUMENTATION THAT MAY BE RELEVANT TO THIS POLICY.

POLICY NUMBER	POLICY DESCRIPTION AND LINK

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REFERENCE AND SOURCE DOCUMENTS

LINKS TO CMS, MHP, MINNESOTA STATUTE AND OTHER RELEVANT DOCUMENTS USED TO CREATE THIS POLICY.

Applicable State & Federal Law

Minnesota Laws, 2013, Regular Session, ch, to be codified MS 256B.76
Social Security Act sections 1902(a)(13), 1902(jj), 1932(f), 1905(dd)
42 CFR 447.000 c)(1) and (2)
Section 1202 of the Health Care and Education Reconciliation Act of 2010

Source Documents

http://www.abms.org/who_we_help/physicians/specialties.aspx
http://www.osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/specialty-subspecialty-certification.aspx
http://www.abpsus.org/abps-medical-board-certifications
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177322#

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