

Nevada Medicaid and Nevada Check Up News



Division of Health Care Financing and Policy (DHCFP)

HP Enterprise Services (HPES)



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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$442,009,919.77 in claims during the three-month period of April, May and June 2013.

Nearly 100 percent of current claims continue to be adjudicated within 30 days. DHCFP and HPES thank you for participating in Nevada Medicaid and Nevada Check Up.

REGISTER NOW: Annual Medicaid Conference Will Focus on Impact of Health Care Reform

The Affordable Care Act will bring quite a few changes to the Nevada Medicaid program in 2014. Some of the initiatives Nevada Medicaid is taking to implement these changes may have a significant impact to providers. During the 2013 Annual Medicaid Conference, the Division of Health Care Financing and Policy (DHCFP) and HP Enterprise Services (HPES) will provide an overview of Health Care Reform and Medicaid Expansion and discuss the upcoming changes planned within the next several months.

In addition, there will be presentations on Medicaid Fraud and Abuse, Program Integrity, Provider Enrollment, Electronic Health Records, and several vendors will be onsite to provide information on specific programs and initiatives. The vendors will include Catamaran (Pharmacy benefits), Emdeon (Third Party Liability), Amerigroup Community Care and Health Plan of Nevada (Managed Care Organizations), HMS (a Recovery Audit Contractor - RAC) and Logisticare (non-emergency medical transportation). The Nevada Division of Welfare and Supportive Services (DWSS) will also have a table in the vendor area.

Save the date:

Reno	Oct. 15, 2013	Reno/Sparks Convention Center at 4590 S. Virginia St.
Las Vegas	Oct. 24, 2013	NEW LOCATION: Palace Station Hotel and Casino at 2411 W. Sahara Ave.

New for 2013: The Conference will be a full-day event this year with all of the topics offered to the entire audience. Registration is from 8 to 9 a.m. and the program is from 9 a.m. to 5 p.m. Attendees may visit the vendor booths during the 11:30 a.m. to 1:30 p.m. lunch break and from 4:30 to 5 p.m.

To attend the Conference, please register each participant online at www.seeuthere.com/hp/NV_medicaid_conf_2013. Print your Registration Confirmation and take it with you to the Conference for admittance.

Electronic Health Records (EHR) Update

There's a lot of talk right now about electronic health records and how health care professionals and hospitals are going to achieve meaningful use. Incentive payments totaling more than **\$20 million** have been distributed under the Nevada Incentive Payment Program for Electronic Health Records since August 2012.

So you probably have a lot of questions about the program as well: Am I eligible to receive incentive payments? How much are the incentive payments? What are the key dates for these programs?

It's important that you have a reliable resource to turn to for accurate information. The Centers for Medicare & Medicaid Services (CMS) is the federal agency supporting this incentive program. The CMS website is the official federal source for facts about the Medicaid EHR Incentive Programs.

Avoid reading false or misleading information. Get the facts from the federal source – the CMS Medicare and Medicaid EHR Incentive Programs website. Visit <http://www.cms.gov/EHRIncentivePrograms> today.

Additionally, the Division of Health Care Financing and Policy (DHCFP) has training materials that guide providers through the whole attestation process. Please visit <https://dhcfp.nv.gov/EHRIncentives.htm>.

To join the Health Information Technology (HIT) email distribution list or to get more information about Nevada's HIT planning efforts, please send an email to NevadaHIT@dhcfp.nv.gov.

Provider Support – CGI Business Services Center

DHCFP is contracted with a vendor, CGI, for the incentive program to assist providers through their attestation and eligibility verification. Once registered, providers can contact the CGI Business Service Center at (888) 639-3452 or send an email to them at NEIPS.us.ipod@cgi.com for questions regarding the program.

Provider assistance through the Regional Extension Center:

HealthInsight, the Regional Extension Center (REC) for Health Information Technology in Nevada, supports providers engaging in the Medicare and Medicaid EHR Incentive Programs. HealthInsight can provide direct, subsidized assistance to providers' offices to help them meet the requirements. The assistance is limited and ends in February 2014.

HealthInsight REC services include:

- Providers' needs and goals assessment;
- EHR vendor selection assistance: Needs analysis, evaluation guidance, vendor relationship management;

- Workflow analysis: Map out and improve current work processes through the use of EHR;
- Project management and implementation: Planning resources;
- Plan development: Address deficiencies and reach meaningful use requirements;
- Privacy and security best practice: Policy and procedures templates;
- Health information exchange: Connection assistance; and
- Assistance with preparation of documentation for pre-payment review and post-payment audit.

To take advantage of these services, contact HealthInsight by calling (702) 385-9933 or visit their website at: www.healthinsight.org.

Public Health Objectives and Reporting for Meaningful Use

There are three public health menu set objectives for Meaningful Use Stage 1: Electronic Laboratory Reporting (ELR), syndromic surveillance, and immunization registry reporting. The following table illustrates the requirements for public health objectives and reporting for both Stage 1 and Stage 2 Meaningful Use.

Public Health Objectives				
System	Stage 1		Stage 2	
	EP	EH	EP	EH
Syndromic Surveillance	X	X	X	X
Immunization Registry	X	X	X	X
Laboratory Reporting Registry		X		X
Cancer Reporting			X	

Important Announcement for Eligible Professionals (EPs)

The CMS deadline to register for the Nevada EHR Incentive Payment Program Year 2013 is the last day of the calendar year, December 31, 2013. EPs that register by this date with CMS will retain the option to participate in the Nevada EHR Incentive Program for 2013 and can submit their attestations through March 31, 2013.

Important Announcement for Eligible Hospitals (EHs)

Hospitals that registered with CMS by September 30, 2013, will now retain the option to participate in the Nevada EHR Incentive Payment Program for 2013 and can submit their attestations through December 29, 2013.

Tips and Reminders for Submitting Claim Forms

Please review the following reminders for submitting claim forms to HP Enterprise Services:

- **Do not** submit the new CMS-1500 (02-12) and 2012 American Dental Association (ADA) claim forms at this time. The correct forms to continue submitting until further notice are the CMS-1500 (08/05) for professional claims and the 2006 ADA. Please refer to web announcements posted at www.medicaid.nv.gov for updates on the implementation dates.
- The claim form instructions are on the [Billing Information](#) webpage of this website, along with the general Billing Manual for all provider types and the Billing Guides for each provider type.
- Be sure your billing address and phone number are entered and accurate on your claim form.

Billing Manual Archives Are Online

In response to requests from providers, the previously published versions of the Nevada Medicaid and Nevada Check Up Billing Manual have been published on the www.medicaid.nv.gov website. The Billing Manual and the Archives page are located on the [Providers Billing Information](#) webpage. Under “Billing Manual” click next to “For Archives.” Select the year from the dropdown list to view the manual(s) published for a specific year. The message “No Archives available for the above selection” indicates no new updates were made to the Billing Manual that year.

Verify Recipient Eligibility and Claims Status through Automated Response System or Electronic Verification System

Convenient tools are available to providers to verify recipient eligibility: the Automated Response System (ARS) and the online Electronic Verification System (EVS). Both of these methods are useful tools in obtaining recipient eligibility, as well as recent payment details, claim status and prior authorization information.

- To access ARS, call (800) 942-6511.
- To access EVS, visit the Nevada Medicaid website at www.medicaid.nv.gov. Select the “EVS” tab to review the User Manual and to register or login to EVS. For assistance with obtaining a secured login, contact the HP Enterprise Services Field Representatives at NevadaProviderTraining@hp.com or by calling (877) 638-3472. Select option 2 for provider, then option 0, then option 4 for Provider Training.

If ARS and EVS are not functioning, providers may contact the Customer Service Center by calling (877) 638-3472. Select option 2 for provider, then option 0, then option 2. Please have your servicing NPI or API, recipient’s Medicaid ID and date of service for the claim available.

Prevention Reminder from DHCFP: *Childhood Obesity*

The incidence of childhood obesity in the United States has more than doubled over the past 30 years. Primary care providers for children can help to motivate children and their families by encouraging them to increase exercise, get enough sleep and eat balanced meals in order to avoid childhood obesity.

Providers are also encouraged to obtain Body Mass Index (BMI) measurements at each well-child visit and to talk with the child and parent about the BMI and what it means.

We Can® (Ways to Enhance Children’s Activity & Nutrition) was launched by the National Institutes of Health in 2005. They provide material and suggestions for parents, caregivers and communities in the form of tools, fun activities and more to help encourage healthy lifestyles.

If you would like more information on We Can®, go to their website at <http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/about-wecan/index.htm>

Care Management for Fee-For-Service Medicaid Recipients with Qualifying Chronic Health Conditions

Nevada's Division of Health Care Financing and Policy (DHCFP) is excited to introduce care management services to recipients with chronic health conditions currently not having their care managed. The chronically ill fee-for-service Medicaid recipients of Nevada have been identified as a group in need of care management. In collaboration with the Centers for Medicare & Medicaid Services (CMS), who approved the implementation of an 1115 Research and Demonstration Waiver called the Nevada Comprehensive Care Waiver (NCCW), a new Care Management Organization (CMO) will provide care managers to fee-for-service Medicaid recipients with qualifying chronic health conditions. The DHCFP is using this opportunity to look for new and innovative ways to provide medical services to Medicaid recipients with high needs.

The CMO will assign a care manager to each enrolled recipient. These care managers will coordinate care with the recipient's health care team, such as physicians, specialists, nurse practitioners, nutritionists, pharmacists and behavioral health specialists, with the goal of improving health outcomes.

This holistic approach to care will focus on the medical, behavioral and social health care needs of recipients requiring complex care plans. Consistency of care increases and duplication of services should be reduced through better health management.

The CMO will serve as the focal point of an enrolled recipient's care. What does care management include? A variety of services will be provided to the recipients by the CMO and its care managers.

- Health assessments will be conducted to identify gaps in care or health issues that require medical attention.
- Those enrolled recipients without providers will

be assisted in finding the appropriate medical professionals to participate in their care.

- Care managers will coordinate services among various providers. They will participate in a number of activities with the recipient, such as providing health information, participating in medical appointments, or following up after a medical visit.
- The level of care management will be directed by the recipient's level of need.

Once the DHCFP has received approval for the next phase of the NCCW, the CMO will begin providing the infrastructure needed to create medical/health homes. By developing links between community resources and providers and using electronic health information (EHI) and other data sharing tools, coordination of care between providers will improve, thus maximizing health outcomes for those enrolled. After the CMO is operational and a few medical/health homes have been established, the goal is to expand the program to all Medicaid recipients who might benefit from care management.

As the DHCFP strives to meet the needs of those most in need and align itself with the pending Patient Protection and Affordable Care Act (ACA), it continues to evaluate and adjust to Nevada's changing Medicaid needs and population.

Medicaid providers will have a crucial role in the success of the CMO program, which is why the DHCFP and the contracted CMO will soon embark on a statewide outreach plan to educate providers on the program. The CMO will serve as a resource for providers by monitoring recipient's treatment plans and helping to ensure recipients follow up with their care plans. Nevada Medicaid looks forward to the ever-changing, ever-growing partnerships with Nevada's medical provider community.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact HPES by calling (877) 638-3472, press option 2 for providers, then option 0, then option 2 for claim status.

If you have a question about Medicaid Service Policy or Rates, you can go to the DHCFP website at <http://dhcfp.nv.gov>. Under the "DHCFP Index" box, move your cursor over "Contact Us" and select "[Main Phone Numbers](#)." Call the Administration Office of the area you would like to contact.

Business Associate Addendum: *Written Assurance PHI Will Be Safeguarded*

On January 25, 2013, the U.S. Department of Health and Human Services published a final Omnibus Rule modifying the privacy, security, enforcement and breach notification rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Businesses defined as “covered entities” under HIPAA are obliged to follow its rules. Covered entities are health plans (like Medicaid), health care clearinghouses, and health care providers. Personal Health Information (PHI) can be shared among covered entities for the purposes of treatment, payment and health care operations. If we share information for those purposes with a business which is not a covered entity, we need written assurance that the business will safeguard PHI. That written assurance is called a Business Associate Addendum (BAA).

The Omnibus Rule makes a significant change to the definition of “business associate” to include any entity that “creates, receives, maintains or transmits” PHI. The Final Rule also extends direct liability for disclosures of PHI by business associates.

The Division of Health Care Financing and Policy (DHCFP) has identified several provider types which receive PHI from DHCFP or HP Enterprise Services (HPES) (fiscal agent), but may not be defined as “covered entities” under HIPAA. Under the new definition, these providers would become business associates. These provider types are 30, 38, 48, 57, 58, 59 and 83.

When these provider types enroll or re-enroll in Nevada

Medicaid, or when they are requested by DHCFP or HPES, they must print, sign and return the Business Associate Addendum (MNH-3820). The BAA is online on the Provider Enrollment webpage at www.medicaid.nv.gov under “Required Enrollment Documents.”



Recovery Audit Contractor (RAC) Program

Providers who bill the fiscal agent for services provided to Nevada Medicaid or Nevada Check Up recipients are subject to audits and/or reviews of their claims and the documentation supporting these claims. Providers are selected for audits and/or review for various reasons, including random selection, complaints received, data mining, schemes taking place in other states and many other reasons.

All providers are subject to audits and/or reviews. It is extremely important to provide all information requested by any of these entities so everything pertinent can be considered in the audit/review. The Division of Health Care Financing and Policy (DHCFP) has taken considerable steps in coordinating the reviews to ensure that providers are not contacted by multiple auditing entities regarding the same issue(s).

The Patient Protection and Affordable Care Act (PPACA) calls for expansion of the Recovery Audit

Contractor (RAC) Program to the Medicaid program. The contractor is tasked with identification of underpayments and the identification and recovery of overpayments.

Nevada has contracted with Health Management Systems (HMS) to perform this service and their reviews are in progress now (as of September 2012). Claims with underpayments will be reprocessed in order to reimburse the provider properly for their services.

The Medicaid RAC program will not replace the State’s other Program Integrity initiatives. In accordance with the statute, states must coordinate the RAC’s efforts with those of existing state entities and law enforcement authorities, as well as with federal authorities. This will ensure that cases of fraud, waste and abuse are processed through the appropriate channels. HMS will be communicating with provider associations and provider education will be offered as this project continues.

Nevada Medicaid Fee for Service Frequently Asked Questions (FAQs) Regarding the Primary Care Physician Rate Increase for 2013 and 2014

As part of the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) has implemented a rate increase for certain Primary Care Physicians (PCPs) and their associated subspecialties. This increased rate is effective for calendar years 2013 and 2014. The increased rate only applies to services rendered to Medicaid recipients. Per CMS, stand-alone Children's Health Insurance Program (CHIP) programs are not eligible. Nevada Check Up is a stand-alone CHIP program.

The following frequently asked questions will assist providers with concerns regarding this program.

Reimbursement

1. The attestation form was submitted for the provider, why was payment not received?

Reimbursement may not have been received for several reasons:

- The provider only treated Medicaid Managed Care recipients and therefore would only receive reimbursement from the Managed Care Organizations.
- Attestation form was submitted with the incorrect National Provider Identifier (NPI).
- Provider joined/left a medical practice and the information was not updated with the Division of Health Care Financing and Policy (DHCFP) Provider Support Unit.
- Provider did not meet the self attestation criteria regarding specialty designation.
- Provider did not provide current Board Certification in one of the eligible categories.
- Provider did not submit the requested information to the DHCFP within the allowed time frame.
- Spelling of provider name does not match what is on file with the DHCFP.

2. How frequently will the provider receive the enhanced reimbursement?

The supplemental payments will be issued on a quarterly basis. The first two quarters of 2013 were delayed due to the need for final approval from the CMS prior to issuing payments.

3. Why does the Remittance Advice (RA) not match the reimbursement amount listed in the letter from the DHCFP? (i.e., the letter detailing the reimbursement was received but the payment was not, or the payment was received but a letter detailing the reimbursement was not.)

- The provider works for multiple practices.
- The provider's practice information has not been updated with the DHCFP Provider Support Unit.
- Spelling of provider name does not match what is on file with the DHCFP.

Attestation

4. Does the provider need to submit a new self attestation every quarter?

No. The original attestation form will be accepted for the duration of the program. It is expected that a provider will notify the DHCFP if their eligibility changes.

5. Will the attestation be retroactive to the January 1, 2013, effective date?

The only providers who are eligible retroactively to the January 1, 2013, effective date are providers who submitted their form prior to the March 15, 2013, cutoff date. Providers who submitted their forms after March 15 are eligible going forward starting the month of form submission.

Board Certification

6. Will the provider still receive payment if their board certification expires during the quarter?

Yes. The certification will be accepted for that quarter. However, if the provider does not provide the new certification they will not be eligible going forward and will be removed from the list.

7. How long does the provider have to submit a corrected attestation form, statement of responsibility form or current board certification before they are removed from the eligible list?

Providers have 30 days from the date of the request from DHCFP to submit the information. If the information is not received within the time frame, the provider will be removed from the list and will not be eligible until the information is received. Once the requested information is received, the provider will be eligible on a go forward basis. Only providers who submit the requested information within the 30 days will be eligible retroactively to the date of attestation form submission. CMS will not authorize DHCFP to reimburse a provider without the necessary information on file.

Questions and answers from the Centers for Medicare & Medicaid Services (CMS)

Which Medicaid providers qualify for payment?

8. Can physicians qualify solely on the basis of meeting the 60 percent claims threshold, irrespective of specialty designation? Would a board certified “general surgeon” qualify for higher payment if he or she actually practices as a general practitioner?

The statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine or pediatric medicine. 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. Under the regulation, “general internal medicine” encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA.

In order to be eligible for higher payment:

- a. Physicians must first self-attest to a covered specialty or subspecialty designation.
- b. As part of that attestation they must specify that they either are board certified in an eligible specialty or subspecialty and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes specified in the regulation. It is quite possible that physicians could qualify on the basis of both board certification and claims history.

Only physicians who can legitimately self-attest to a specialty designation of (general) internal medicine, family medicine or pediatric medicine or a subspecialty within those specialties recognized by the ABMS, AOA or ABPS qualify.

It is possible that a physician might maintain a particular qualifying board certification, but might actually practice in a different field. A physician who maintains one of the eligible certificates, but actually practices in a non-eligible specialty, should not self-attest to eligibility for higher payment. Similarly, a physician board certified in a non-eligible specialty (for example, surgery or dermatology) who practices within the community as, for example, a family practitioner could self-attest to a specialty designation of family medicine, internal medicine or pediatric medicine and a supporting 60 percent claims history. In either case, should the validity of that physician’s self-attestation be reviewed by the state as part of the annual statistical sample, the physician’s payments would be at risk if the agency finds that the attestation was not accurate.

9. The Affordable Care Act specifies increased payments for three primary care medical specialties: Family Medicine, General Internal Medicine and Pediatrics. The Final Rule interprets this language to include some subspecialties with a relation to the original three, but does not list the subspecialties. What are the subspecialists that are eligible for higher payment?

Subspecialists that qualify for higher payment are those recognized by the ABMS, ABPS or 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:

ABMS:

- **Family Medicine** – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine.
- **Internal Medicine** – 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.

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- **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; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology; Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

AOA:

- **Family Physicians** – No subspecialties.
- **Internal Medicine** – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Diseases; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.
- **Pediatrics** – Adolescent and Young Adult Medicine; Neonatology; Pediatric Allergy/Immunology; Pediatric Endocrinology; Pediatric Pulmonology.

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. There is no board certification specific to Pediatrics.

10. **The American Board of Physician Specialties does not certify subspecialists. Which board certifications would qualify a physician for higher payment?**

Physicians who are board certified by the ABPS in Internal Medicine, Family Practice or Family Medicine Obstetrics would qualify for higher payment. Physicians with a certification in Family Medicine Obstetrics are all certified first in family medicine with additional certification in obstetrics. They practice as family practitioners and are therefore able to self-attest to a qualified specialty. This is not true of individuals certified in obstetrics by either the ABMS or AOA who do not qualify for higher payment.

11. **Can mid-level/non-physician practitioners, such as nurse practitioners, receive the higher payment?**

The Final Rule specifies that services must be delivered under the Medicaid physician services benefit. This means that higher payment also will be made for primary care services rendered by practitioners working under the personal supervision of a qualifying physician. The Final Rule makes clear that, while deferring to state requirements regarding supervision, the expectation is that the physician assumes professional responsibility for the services provided under his or her supervision. This normally means that the physician is legally liable for the quality of the services provided by individuals he is supervising. If this is not the case, the practitioner would be viewed as practicing independently and would not be eligible for higher payment.

12. **While sports medicine is a subspecialty of internal medicine, it is also a subspecialty of non-primary care specialties. Is it correct that CMS would only qualify a physician for the board certification for the sports medicine subspecialty when it is a subspecialty of internal medicine?**

Yes, that is correct.

13. **Are the services of “physician extenders” (defined as physicians who provide services in support of eligible physicians) eligible for higher payment when an eligible primary care specialist bills for their services? Examples of “physician extenders” include neurologists, OB/GYNs, pathologists, anesthesiologists and surgeons who provide services to the patients of eligible physicians.**

No. The only services that qualify are those provided directly by physicians (or by non-physician practitioners that they supervise) who self-attest to an eligible primary care designation and whose attestation is supported by evidence of board certification or claims history. Physicians who do not qualify on their own merits cannot receive higher payment by having an eligible physician bill on their behalf. As previously noted, physicians must accept professional responsibility/liability for the services provided by non-physician practitioners under their supervision.

14. **Do allergists qualify for higher Medicaid payment under this regulation?**

CMS recently received information from the American Board of Medical Specialties attesting that the American Board of Allergy and Immunology (ABAI) is an ABMS-recognized sub-discipline of the American Board of Pediatrics and the American Board of Internal Medicine.

Specifically, the ABAI is a conjoint board of the American Board of Pediatrics (ABP) and the American Board of Internal Medicine (ABIM). All physicians certified by the Board of Allergy and Immunology must

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first be board certified by either ABP or ABAI. Medical specialists certified by the Allergy and Immunology Board remain subspecialists of Internal Medicine and Pediatrics. However, it is possible that some holders of a certificate from ABAI will not have a current certificate in Internal Medicine or Pediatrics because some diplomats of the ABP and ABIM who hold subspecialty certificates are not required to maintain their primary certificates. The ABMS was concerned that these diplomats might be excluded from eligibility for higher payment under a strict interpretation of the rule even though they do act as their patients' primary care provider in many cases and urged that CMS formally recognize that diplomats of ABAI are, in fact, subspecialists in Internal Medicine and Pediatrics and eligible for higher payment up to the Medicare rate.

Based on this information, CMS agrees that allergists are eligible for higher payment under the rule.

Attestation

15. Is self-attestation required or may a state rely solely on information about board certification gathered upon provider enrollment or data on a physician's MMIS claims history to determine eligibility for this payment?

The Final Rule requires that physicians first self-attest to an eligible specialty or subspecialty and then attest to either board certification or an appropriate claims history. States cannot pay a physician without evidence of self-attestation.

16. Does the 60 percent threshold include both E&M codes and vaccine administration codes?

Yes. The 60 percent threshold can be met by any combination of eligible E&M and vaccine administration codes.

17. Can a physician self-attest to board certification or a supporting claims history after January 1, 2013, when the primary care payment increase begins but expect higher payment back to the beginning of the year?

States must have the appropriate self-attestations in hand before they can pay physicians at the higher rate. States can impose reasonable requirements regarding "retroactive" self-attestations to facilitate program administration. For example, a state could limit retroactive payments to the beginning of the month or quarter in which the attestation is submitted. However, physicians must be made aware of the payment provision and of the requirements concerning self-attestation before January 1, 2013, through state provider bulletin or manual systems or other mechanisms.

18. With respect to the use of board certification to confirm a physician's self-attestation, must the physician's board status be current or is initial board certification sufficient?

The certification must be current. If it has lapsed but the physician still practices as an eligible specialist, the self-attestation would need to be supported with a 60 percent claims history.

19. In our state, advanced practice nurses must have a collaborative practice agreement with a physician within 50 miles of their office. Under the collaborative practice agreement, a physician must review a certain percentage of the nurse's patient charts every two weeks. Such nurses bill independently using their own Medicaid number. Is the collaborative practice agreement enough documentation for an advanced practice nurse, with at least 60 percent of services billed by the nurse for calendar year (CY) 2012 for the designated codes, to be eligible for increased payments for those codes in CY 2013?

Increased payment is available for services provided by eligible physicians or for services provided under their personal supervision. This means that the physician accepts professional responsibility (and legal liability) for the services provided. It does not appear that the collaborative arrangement requires that the physician accept professional responsibility for each of the services provided by the nurses. Therefore, increased payment would not be available.

However, if the physician *is required to accept professional responsibility* for the services provided by the advanced practice nurses *and* the *physician* is eligible based on self-attestation to a specified primary care specialty designation supported by either appropriate board certification or a 60 percent claims history, then increased payment would be available.

20. If the supervising physician does not self-attest to the physician specialty or subspecialty qualification, can the physician supervise a mid-level provider? If the supervising physician self-attests to the 60 percent threshold, but not one of the defined specialty or subspecialty qualifications, can the physician supervise a mid-level?

The eligibility of services provided by mid-level/non-physician practitioners is dependent on 1) the eligibility of the physician and 2) whether or not the physician accepts professional responsibility for the services pro-

vided by the mid-level. As previously noted, the physician is eligible only if he **first self-attests** to a specified specialty designation and **also** to either being appropriately board certified or having a 60 percent claims history.

- 21. With respect to self-attestation, if a provider only meets the 60 percent threshold or only meets the board certification, would the provider only have to attest to that one component to be eligible or is it necessary to meet both components?**

The physician must first self-attest to a primary care designation of internal medicine, family medicine or pediatrics. This attestation signifies that the physician considers himself or herself to be an eligible specialty practitioner. The self-attestation must then indicate whether the physician considers himself or herself to be qualified because of appropriate board certification or practice history as represented by a 60 percent claims history. Some physicians may be appropriately board certified and have a 60 percent claims history.

There may be physicians with board certification in a specialty not recognized for higher payment under the rule who actually practice as pediatricians, family practitioners or internists who would be eligible for higher payment. For example, an OB/GYN who no longer practices in that specialty but practices as a family practitioner could appropriately self-attest to being a primary care provider. Such a provider would need to qualify based on the 60 percent threshold and not board certification. If a physician supports his or her initial self-attestation with an attestation of appropriate board certification, s/he can qualify only if s/he actually has the appropriate board certification. Practice habits would not be applicable.

As discussed in response to an earlier question, there may also be physicians with board certification in one of the three eligible specialty areas who do not actually practice in those areas. They should not self-attest to being a primary care provider.

- 22. How should a physician who is certified in internal medicine, family practice or pediatrics by a board other than the ABMS, the AOA or the ABPS self-attest?**

Such a physician would self-attest to a primary specialty designation of family medicine, pediatric medicine or internal medicine and would then attest to, and qualify based on, a 60 percent claims history.

Verification of Eligible Providers

- 23. How will CMS ensure that only eligible providers receive the higher rate?**

The Final Rule requires physicians to self-attest to an eligible specialty designation and to further indicate whether they are board certified in an eligible specialty or subspecialty or 60 percent of the services for which they bill are for eligible E&M or vaccine administration codes. Annually, states must conduct a review of a statistically valid sample of physicians that have self-attested to either board certification or a supporting claims/service history. Physicians and State Medicaid agencies must keep all information necessary to support an audit trail for services reimbursed at the higher rate.

- 24. If the sampled data indicates the inclusion of non-qualified providers, should repayment be based upon data for all physicians who received higher payment or only the sampled providers?**

CMS will require that the state repay erroneous payments found through the sampled pool of providers, and will not extrapolate data from the sample to the entire universe of physicians who received the higher primary care payment. States with high error rates should submit a plan for corrective action to reduce errors.