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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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Upon filing.

Adopted on

9/25/13

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RULE CAPTION

Increase payment for certain primary care practitioners and increase the VFC administration fee

Not more than 15 words

RULEMAKING ACTION

ADOPT: 410-130-0005

AMEND: 410-120-1340,410-130-0255

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.:: ORS 413.042

Other Auth.::

Stats. Implemented:: ORS 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743

RULE SUMMARY

The Division of Medical Assistance Programs (Division) General Rules, administrative rules govern payments for services provided to certain eligible

clients. The Division proposed adoption of OAR 410-130-0005 and proposed amendment of OAR 410-130-0255, 410-120-1340 to implement changes required by the Affordable Care Act.

OAR 410-120-1340 establishes the federally required payment increase to be effective on or after Jan. 1, 2013. Rule 410-130-0005 establishes the self-attestation process required for the Division to identify providers subject to the federally required payment increase. Rule 410-130-0255 clarifies the procedure codes for the Vaccine For Children program.

Rhonda Busek	Rhonda Busek	9-24-13
Authorized Signer	Printed Name	Date

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410-130-0005 **NEW RULE**

Federally Qualified Primary Care Provider

(1) Section 1202 of the Affordable Care Act (ACA) amended sections 1902(a)(13), 1902(jj), 1905(dd) and 1932(f) of the Social Security Act to require increased Medicaid payment for primary care services to qualified providers for calendar years 2013 and 2014 as specified in these rules.

(2) Federally Qualified Primary Care Services are designated as:

(a) Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes 99201 through 99499; and

(b) Vaccine administration CPT codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes; and

(c) Administration of vaccines under Vaccines for Children Program (refer to OAR 410-130-0255).

(3) To qualify for the increased payment, the individual physician must attest that:

(a) The physician has a primary practice in family medicine, general internal medicine, or pediatric medicine; and

(b) One or both of the following are true:

(A) The physician is Board-certified in a specialty or subspecialty of family medicine, general internal medicine, or pediatric medicine by one of the following boards:

(i) The American Board of Medical Specialties (ABMS);

(ii) The American Osteopathic Association (AOA);

(iii) The American Board of Physician Specialties (ABPS);

(B) The physician can demonstrate that at least 60 percent of the procedure codes billed and paid in Medicaid claims were qualifying primary care codes described in section 2 of this rule.
(i) Over the previous calendar year, if billings exist for this time period; or

(ii) Over the previous month, if billings do not exist for the previous calendar year.

(4) To qualify for the increased payment, a Physician Assistant (PA) or Nurse Practitioner (NP) must attest that they work under the direct supervision of a Physician who:

(a) Qualifies for increased primary care payments as described in these rules; and

(b) Assumes professional responsibility for the services rendered by the PA or NP.

(5) Providers seeking the reimbursement increase from the Division of Medical Assistance Programs (Division) must self-attest with the Division. Providers, not enrolled with the Division, seeking the increase from OHP health plans (MCO or CCO), must self-attest with the applicable MCO or CCO.

(6) Reimbursement: Effective for dates of service on or after January 1, 2013, the Division shall reimburse primary care providers as follows:

(a) Federally qualified primary care providers as described in this rule at the rate specified in OAR 410-120-1340(6)(C)(ii); or

(b) Other primary care providers, including potentially qualified providers who do not self-attest to the Division as described in part (3) of this rule, at the rate specified in OAR 410-120-1340(6)(C)(iii).

(7) Annual review of qualifying providers: The Division will review a statistically valid sample of providers to determine whether they satisfy the criteria described in (3) and (4) of these rules. Providers reviewed who do not satisfy the criteria will be required to reimburse the Division for the difference between the rate they should have received according to OAR 410-120-1340(6)(C)(iii) and enhanced rate in OAR 410-120-1340(6)(C)(ii). The sample will include the following providers:

(a) Physicians who have self-attested to qualifying for the increased rate; and

(b) Providers who have self-attested that they are under the direct supervision of a qualified physician.

(8) Supplemental information on primary care reimbursement under the Affordable Care Act is available at http://www.oregon.gov/oha/healthplan/pages/tools_prov/pcp-rates.aspx.

Stat Auth.: ORS 413.042

Stats Implemented: 414.025 and 414.065

410-130-0255

Immunizations and Immune Globulins

(1) Use standard billing procedures for vaccines that are not part of the Vaccines for Children (VFC) Program.

(2) The Division of Medical Assistance Programs (Division) covers Synagis (palivizumab-rsv-igm) only for high-risk infants and children as defined by the American Academy of Pediatric guidelines.

(a) Prior authorization is required for Synagis. See Table 130-0200-1 Prior Authorization;

(b) Bill 90378 for Synagis.

(3) Providers are encouraged to administer combination vaccines when medically appropriate and cost effective.

(4) Vaccines For Children (VFC) Program:

(a) Under this federal program, vaccine serums are free for clients ages 0 through 18. The Division will not reimburse for the purchase or administration of privately purchased vaccines that are provided through the VFC Program. ;

(b) Only providers enrolled in the VFC Program can receive free vaccine serums. To enroll as a VFC provider, contact the Public Health Immunization Program. For contact information, see the Oregon VFC program website at http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx

(c) The Division will reimburse all enrolled VFC Program providers for the administration of any vaccine provided by the VFC Program at the Regional Maximum amount of $21.96. Whenever a new vaccine becomes available through the VFC Program, administration of that vaccine is also covered by the Division;

(d) Refer to Table 130-0255-1 for immunization codes provided through the VFC Program;

(e) Providers shall follow the current Advisory Committee on Immunization Practices (ACIP) guidelines for immunization schedules. Exceptions include:

(A) On a case-by-case basis, provider may use clinical judgment in accordance with accepted medical practice to provide immunizations on a modified schedule;

(B) On a case-by-case basis, provider may modify immunization schedule in compliance with the laws of the State of Oregon, including laws relating to exemptions for immunizations due to religious beliefs or other requests.

(f) Use the following procedures when billing the Division for the administration of a VFC vaccine:

(A) When the sole purpose of the visit is to administer a VFC vaccine, the provider should bill the appropriate vaccine specific procedure code (90632-90748) with modifier -SL or -26 for each injection. Do not bill the immunization administration Current Procedural Terminology (CPT) code 90460-90474 or 99211;

(B) When the vaccine is administered as part of an Evaluation and Management service (e.g., well-child visit) the provider should bill the appropriate vaccine specific procedure code with modifier -SL, or -26 for each injection in addition to the Evaluation and Management code.

(g) For clients with private insurance, bill the Division or the client's managed care plan directly for the administration of VFC vaccines. Medicaid is not considered the "payer of last resort" for administration of VFC vaccines.

(h) For VFC providers who qualify for the federal primary care rate increase as specified under 42 CFR 447 Subpart G, CCOs and MCOs are required to reimburse for the administration of any vaccine provided by the VFC Program at the Regional Maximum amount of $21.96. See OAR 410-130-0005 for information about how to qualify for the federal primary care rate increase. Plans have the option to apply the Regional Maximum amount to non- primary care VFC providers.

(i) The Division is applying the VFC rate increase to all VFC fee for service providers, regardless of whether they have attested for the primary care rate increase.

(5) Table 130-0255-1

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-120-1340

Payment

(1) The Division of Medical Assistance Programs (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.

(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.

(4) The Division uses FFS payment rates in effect on the date of service that are the lesser of:

(a) The amount billed;

(b) The Division maximum allowable amount or;

(c) Reimbursement specified in the individual program provider rules:

(5) Amount billed may not exceed the provider's "usual charge" (see definitions);

(6) The Division's maximum allowable rate setting process uses the following methodology for:

(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the 2013 Total RVU weights published in the Federal Register, Vol. 77, November 16, 2012 with technical corrections published Dec. 14, 2012, to be effective for dates of services on or after January 1, 2013.

(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight;

(B) For professional services typically performed in a facility, the Facility Total RVU weight;

(C) The Division applies the following conversion factors:

(i) $40.79 for labor and delivery codes (59400-59622);

(ii) $36.0666 for Federally Qualified primary care codes billed by providers meeting the criteria in OAR 410-130-0005;

(iii) $27.82 for other Oregon primary care providers and services not specified in (ii). A current list of primary care CPT, HCPCs and provider specialty codes is available at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml

(iv) $25.48 for all remaining RVU weight based CPT/HCPCS codes.

(D) Rate calculation: Effective January 1, 2013, The Division will calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) Work RVU) X (Work GPCI of 1.0) + (Practice Expense RVU) X (Practice GPCI of 0.969) + (Malpractice RVU) X (Malpractice GPCI of 0.625);

(ii) Sum in (D)(i) multiplied by the applicable conversion factor in section C.

(b) Non RVU based rates:

(A) $20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;

(B) Clinical lab codes are priced at 70% of the 2013 Medicare clinical lab fee schedule;

(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of the 2012 Medicare fee schedule;

(D) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25%. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;

(E) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling.

(F) Individual provider rules may specify reimbursement rates for particular services or items.

(7) The rates in (6) are updated periodically and posted on the Authority web site at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(8) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Division's Hospital Services Program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, shall not exceed any upper limits established by federal regulation.

(9) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(10) Payment rates for in-home services provided through Department of Human Services (Department) Aged and Physically Disabled Division (APD) will not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met. .

(11) The Division sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by APD for out-of-state nursing facilities.

(12) The Division shall not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(13) The Division shall not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules, (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules, (chapter 410, division 129 and 131);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program administrative rules, (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Program administrative rules, (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Program administrative rules, (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services Program rules, (chapter 410, division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program administrative rules, (chapter 410, division 122).

(14) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment will not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(15) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment cannot exceed the co-insurance and deductible amounts due;

(b) The Division pays the Division allowable rate for Division covered services that are not covered by Medicare.

(16) For clients with third-party resources (TPR), the Division pays the Division allowed rate less the TPR payment but not to exceed the billed amount.

(17) The Division payments, including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(18) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with

applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743