



New Hampshire Medicaid Provider Reimbursement Rate Benchmarks For Key Services

**Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services**

126-A:18-b Medicaid Reimbursement Rates

Biennial Report

October 1, 2008

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Overview

This report is prepared in response to 126-A:18-b, which requires the Department of Health and Human Services (DHHS) to review Medicaid rates, based on benchmarking rates paid by other payers for similar services.

DHHS sent a letter to the Fiscal Committee of the General Court on March 10, 2008, to address the specific service groups covered in this analysis (see page 3). DHHS originally hoped to provide payment rate benchmarks and comparative analysis of payment rates for all services totaling \$1 million or more in provider payment expenditures annually. Due to resource constraints, we limited it to eight service categories; four acute care services accounting for provider payment expenditures each totaling \$10 million or more annually and four acute care services accounting for provider payment expenditures each totaling less than \$10 million annually but selected as having rate-sensitive policy issues. In addition to the eight original categories, DHHS added Advanced Registered Nurse Practitioner and Federally Qualified Health Center/Rural Health Clinics due to their relationship to groups already included. DHHS also added Optometric Services. Only payments made in Fund Codes A, J and X were included in this analysis. The Office of Medicaid Business and Policy (OMBP) performed the analysis.

The March 10, 2008 letter included Home Health as one of the service categories DHHS was to include in the report, however this report does not include information on these services. The purpose of this report as part of the rate setting process has been superseded by Administrative Rule He-W 553, which explicitly defines an objective rate setting process for home health services. RSA 126-A:18-b became effective June 25, 2007, while He-W 553 was adopted on September 11, 2007. See He-W 553.08 for information on the new home health rate setting methodology.

OMBP selected representative procedures for each of the following service groups:

Service Group	Category of Service	Category of Service Name
Physician Services	43	Physician Services
Advanced Registered Nurse Practitioner (ARNP)	44	Advanced Registered Nurse Practitioner
Ambulance Transportation and Life Support	37	Ambulance Service
Interpreter Services	42	Audiology
Psychology (non-Community Mental Health Center (CMHC))	48	Psychology
Inpatient Hospital	1	Inpatient Hospital
Outpatient Hospital	7	Outpatient Hospital
Dental Services for Children	45	Dental Services
Optometric Services	47	Optometric Services Eyeglasses
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services	80	Rural Health Clinic

Please see **Appendix A: Selected Procedures by Service Group and Sub-Group** for the detailed list of procedures included.

The following information has been provided for each service group selected:

- Subgroups of services, including procedure codes, DRGs, or revenue codes,
- The weighted rate or sampled allowed amount currently paid by NH Medicaid,
- The total allowed amount for SFY 2007, (indicator of actual provider costs to the State for procedures paid from the NH Medicaid fee schedule),
- The total number of units paid for SFY 2007 (claims paid for inpatient hospital), and
- The following values as a percent of NH Medicaid:
 - Other State Medicaid (for the other New England states, which include Connecticut, Maine, Massachusetts, Rhode Island and Vermont),
 - Medicare, and
 - Commercial Carriers.

Please see **Appendix B: Data and Methods** for details on how we calculated these values.

Letter to Fiscal Committee of the General Court

The letter on the following eight pages was sent to the Fiscal Committee of the General Court on March 10, 2008. It describes the high level process followed for this benchmarking analysis.



Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Acting Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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March 10, 2008

The Honorable Marjorie K. Smith
Chairman
Fiscal Committee of the General Court
State House
Concord, NH 03301

INFORMATION

Pursuant to Chapter 205, Laws of 2007 (HB 43), the Department of Health and Human Services (DHHS), Office of Medicaid Business and Policy (OMBP), wishes to inform the Fiscal Committee that the payment rate benchmarking and rate analysis work required by this statute will be limited in scope to a workable number of Medicaid-covered services for at least the current biennium.

EXPLANATION

Requirements

Chapter 205 (HB 43), Laws of 2007 requires the following new section be added to RSA 126-A:

RSA 126-A:18-b Medicaid Reimbursement Rates.:

I. Every 2 years, the department of health and human services shall review Medicaid reimbursement rates based on

(a) The following benchmarks:

- (1) Medicare rates.*
- (2) Medicaid rates in other New England states.*
- (3) Reimbursement rates of managed care companies and other commercial payers.*
- (4) Actual provider costs. ...*

...II. On or before October 1 prior to each biennial legislative session and prior to submitting the department's budget request under RSA 9:4, the department of health and human services shall submit a report relative to the reimbursement rates, the methodologies underlying the establishment of such rates, and justifications for such rates to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the state library, and the health and human services oversight

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Chairman
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committee established in RSA 126-A:13. The report also shall be used to formulate the department's budget request under RSA 9:4.

Situation

The Department believes in the importance of the benchmarking and rate analysis to provide a long-needed, comprehensive review of NH Medicaid provider payment rates and a foundation for payment policy that supports rates that are fair to providers and help ensure access to healthcare services for Medicaid recipients. However, the Department does not have the resources required to fully accomplish this benchmarking task. The Department indicated previously in its fiscal impact statement that completing this work would require at least two full-time analyst positions in addition to the existing doctoral level analyst. Such positions were not provided in the budget, and the Department has since lost its doctorate level analyst due to resignation. The current state-wide freeze as well as DHHS' current staffing situation does not allow for the acquisition of additional staff with the requisite skills.

The skills required for this work include high-level analytic skills necessary to evaluate rate structures of other payers, evaluate other reimbursement models, design databases, and conduct analysis measuring differences in payment rates across the wide range of Medicaid services in comparison with Medicare, other states, the private sector, and costs. Such work requires analysts that are masters level trained or higher in health services research, health economics, or public health, and requires experience in provider payment and economic measurement methodologies.

Plan

In the absence of adequate staff with the prerequisite level of education and experience to support this particular requirement, DHHS has assessed its current analytic capacity and its current workload and has determined it can assign two analysts to the project to be overseen by the Bureau Chief of OMBP's Bureau of Data Management. Even with dedicating two staff to benchmarking activities, this approach will not provide sufficient resources to accomplish benchmarking for all the services covered by the Medicaid program nor will it allow OMBP to do more than cursory benchmarking. To bring this task within the a scope that is possible with current resources, we plan to:

- Reduce the categories of services examined to 8 of the 48 categories of service covered by Medicaid,
- Limit private sector comparison to those services for which data are available in the New Hampshire Comprehensive Health Information System, the database of insurance claims operated per RSA 420-G:11-a.
- Postpone, to future years, any examination of costs as a benchmark (except for hospital outpatient services that are paid based on costs).

The list of services included in the first year of analysis is indicated in Exhibit 1. Adjustments to this list may be needed to meet Department priorities and resources available in the coming months.

The Department had originally hoped to provide payment rate benchmarks and comparative analysis of payment rates for all services totaling \$1 Million or more in provider payment expenditures

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annually. We now plan to limit the benchmarking and comparative analysis to eight service categories, four acute care services accounting for provider payment expenditures each totaling \$10 million or more annually and four acute care services accounting for provider payment expenditures each totaling less than \$10 million annually but selected as having rate-sensitive policy issues. The services identified for the first benchmarking project are:

1. Inpatient hospital services
2. Outpatient hospital services
3. Physician services
4. Dental services
5. Home health services
6. Psychology services
7. Ambulance services
8. Medical interpreter services

Exhibit 1 shows the services to be included and those to be excluded from the initial benchmarking analysis. This plan focuses attention on acute care, where rates have tended to lag behind. However, leaving out long-term care services means the benchmarking will not address the most costly Medicaid services and will not provide a basis for judging the relative levels of payment rates across acute and long term care services. With its limited scope, the benchmarking effort will thus not provide some information the Fiscal Committee may wish to have about the relative need for payment rate increases between acute and long-term care Medicaid services.

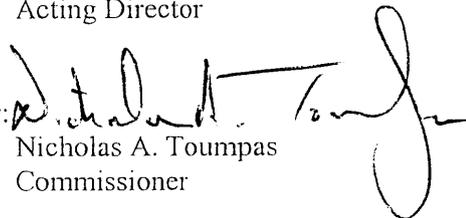
The Department continues to make every effort to meet the needs of the legislature within the staff and budgeted resources available. We believe this approach will provide very useful information for sound policy decisions and can be accomplished with currently available staff and resources.

Respectfully submitted,



Kathleen A. Dunn, MPH
Acting Director

Approved by:



Nicholas A. Toumpas
Commissioner

CC:
His Excellency, Governor John H. Lynch
The Honorable Sylvia B. Larsen, President of the Senate
The Honorable Terie Norelli, Speaker of the House

**Exhibit 1
 NH Medicaid Services for Benchmarking
 with Payments in SFY 2007**

Category of Service w Code	Total Medicaid	Acute Care Medicaid	Included in Initial Analysis	Originally Identified for Analysis
12 INTERMED CARE FAC NURSE HOME	\$192,302,606	\$8,671	No	Yes
65 HOME&COMM BASED CARE - DI	\$155,564,269	\$3,817,612	No	Yes
17 MENTAL HEALTH CENTER	\$83,151,821	\$48,735	No	Yes
30 DISPENSE PRESCRIBED DRUGS	\$69,329,665	\$66,305,384	No	Yes
7 OUTPATIENT HOSPITAL, GENERAL	\$66,863,869	\$64,086,973	Yes	Yes
1 INPATIENT HOSPITAL, GENERAL	\$57,792,732	\$54,171,864	Yes	Yes
43 PHYSICIANS SERVICES	\$42,991,525	\$41,233,611	Yes	Yes
66 HOME&COMM BASED CARE-CI & ELD	\$37,813,208	\$0	No	Yes
25 CLINIC SERVICES	\$36,330,262	\$661,610	No	Yes
78 PRIV NON-MED INST FOR CHILDREN	\$23,314,396	\$0	No	Yes
45 DENTAL SERVICE	\$15,575,670	\$15,526,100	Yes	Yes
80 RURAL HEALTH CLINIC	\$10,706,699	\$10,466,694	No	Yes
32 FURNISHED MED SUP OR DME	\$10,543,649	\$9,011,198	No	Yes
11 SKILL NURSING FAC NURSING HOME	\$9,164,695	\$4,235,676	No	Yes
60 DAY HABILITATION CENTER	\$7,630,454	\$0	No	Yes
26 HOME HEALTH SERVICES	\$7,079,910	\$7,027,332	Yes	Yes
49 PRIVATE DUTY NURSING	\$7,039,430	\$7,012,962	No	Yes
57 PERSONAL CARE	\$5,157,234	\$1,427,185	No	Yes
15 SNF NURSING HOME ATYPICAL CARE	\$4,558,607	\$164,466	No	No
16 ICF NURSING HOME ATYPICAL CARE	\$4,158,106	\$0	No	No
77 PLACEMENT SERVICES	\$4,007,326	\$0	No	No
48 PSYCHOLOGY	\$3,733,559	\$3,684,026	Yes	Yes
103 INPAT PSYCH FAC SRVS-UNDER 22	\$3,515,346	\$0	No	No
39 WHEELCHAIR VAN	\$2,910,803	\$751,536	No	Yes
102 ICF SERVICES FOR MR	\$2,459,649	\$0	No	Yes
73 INTENSIVE HOME AND COMM SERV	\$2,261,225	\$0	No	Yes
76 HOME BASED THERAPY	\$2,094,593	\$0	No	Yes
56 MEDICAL SERVICES CLINIC	\$1,870,580	\$1,852,270	No	Yes
37 AMBULANCE SERVICE	\$1,525,878	\$1,335,896	Yes	Yes
23 LABORATORY (PATHOLOGY)	\$1,370,512	\$1,343,112	No	Yes
74 CHILD HEALTH SUPPORT SERVICE	\$1,149,576	\$0	No	No
47 OPTOMETRIC SERVICES EYEGLASSES	\$1,081,188	\$1,029,239	No	Yes
51 PHYSICAL THERAPY	\$940,361	\$907,541	No	No

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 Chairman
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63 ADULT MEDICAL DAY CARE	\$898,862	\$669,621	No	No
27 FAMILY PLANNING SERVICES	\$567,974	\$567,974	No	No
44 ADVANCE REG NURSE PRACT	\$421,202	\$410,850	No	No
13 I/P HOSPITAL SWING BEDS, SNF	\$319,377	\$127,889	No	No
54 OCCUPATIONAL THERAPY	\$230,997	\$227,430	No	No
24 X-RAY SERVICES	\$218,086	\$214,373	No	No
55 PODIATRIST SERVICES	\$203,226	\$174,406	No	No
72 CRISIS INTERVENTION	\$113,140	\$0	No	No
53 SPEECH THERAPY	\$90,828	\$90,828	No	No
46 CERTIFIED MIDWIFE (NON-NURSE)	\$74,349	\$74,349	No	No
70 CHIROPRACTIC	\$61,469	\$61,217	No	No
3 INPATIENT HOSPITAL, MENTAL	\$46,116	\$46,116	No	No
14 I/P HOSPITAL SWING BEDS, ICF	\$37,791	\$3,040	No	No
42 AUDIOLOGY SERVICES	\$35,559	\$34,144	Yes*	No
8 OUTPATIENT HOSPITAL, MENTAL	\$3,019	\$3,016	No	No
99 OTHER	\$0	\$0	No	No

* Audiology services will be benchmarked for medical interpreter services only.

CHAPTER 205

HB 43 – FINAL VERSION

15Feb2007... 0005h

11Apr2007... 0745h

05/24/07 1661s

2007 SESSION

07-0145

05/10

HOUSE BILL **43**

AN ACT relative to the procedure for establishing Medicaid reimbursement rates; relative to reimbursement rates for hospital-based physician and outpatient services; and establishing a committee to study Medicaid payments for hospital-based physician and outpatient services.

SPONSORS: Rep. C. McMahon, Rock 4; Rep. Emerson, Ches 7; Rep. Donovan, Sull 4; Rep. MacKay, Merr 11; Rep. Batula, Hills 19

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill:

I. Directs the department of health and human services to review medicaid reimbursement rates every 2 years and establishes certain reporting requirements relative to such rates.

II. Establishes a committee to study Medicaid payments for hospital-based physician and outpatient services billed using the National Uniform Billing Committee Revenue Code 510 and maintains reimbursement policies, rates, and related billing instructions for physician services provided by hospital-based physicians and outpatient services in effect as of January 1, 2007 pending further action of the general court or fiscal committee.

Explanation: Matter added to current law appears in *bold italics*.

Matter removed from current law appears [~~in brackets and struckthrough~~].

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

15Feb2007... 0005h

11Apr2007... 0745h

05/24/07 1661s

07-0145

05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Seven

AN ACT relative to the procedure for establishing Medicaid reimbursement rates; relative to reimbursement rates for hospital-based physician and outpatient services; and establishing a committee to study Medicaid payments for hospital-based physician and outpatient services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

205:1 New Section; Medicaid Reimbursement Rates. Amend RSA 126-A by inserting after section 18-a the following new section:

126-A:18-b Medicaid Reimbursement Rates.

I. Every 2 years, the department of health and human services shall review Medicaid reimbursement rates based on:

(a) The following benchmarks:

(1) Medicare rates.

(2) Medicaid rates in other New England states.

(3) Reimbursement rates of managed care companies and other commercial payers.

(4) Actual provider costs.

(b) Information and testimony gathered from a public hearing, held as part of the biennial rate setting process, at which time providers, beneficiaries and their representatives, and other concerned residents shall be given a reasonable opportunity to review and comment on the rates, rate setting methodologies, and justifications.

(c) Applicable state and federal law and regulations relative to specific Medicaid services.

II. On or before October 1 prior to each biennial legislative session and prior to submitting the department's budget request under RSA 9:4, the department of health and human services shall submit a report relative to the reimbursement rates, the methodologies underlying the establishment of such rates, and justifications for such rates to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the state library, and the health and human services oversight committee established in RSA 126-A:13. The report also shall be used to formulate the department's budget request under RSA 9:4.

III. In addition to the biennial report under paragraph II, the department of health and human services shall submit an annual report relative to Medicaid reimbursement rates to the health and human services oversight committee established in RSA 126-A:13. The report shall address any questions raised by the committee and shall summarize the department's economic analysis and rate setting policy for the prior fiscal year and include any recommendations for the next fiscal year.

205:2 Committee Established. There is established a committee to study Medicaid payments for hospital-based physician and outpatient services.

205:3 Membership and Compensation.

I. The members of the committee shall be as follows:

(a) Four members of the house of representatives, appointed by the speaker of the house of representatives.

(b) Two members of the senate, appointed by the president of the senate.

II. Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee.

205:4 Duties. The committee shall study current Medicaid reimbursement policies for hospital-based physician and outpatient services billed using the National Uniform Billing Committee Revenue Code 510, including differences in billing instructions from the New Hampshire Medicaid program and the Centers for Medicare and Medicaid Services (CMS) for comparable services covered by Medicare.

205:5 Chairperson; Quorum. The members of the study committee shall elect a chairperson from among the members. The first meeting of the committee shall be called by the first-named house member. The first meeting of the committee shall be held within 45 days of the effective date of this section. Four members of the committee shall constitute a quorum.

205:6 Report. The committee shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library on or before November 15, 2007.

205:7 Reimbursement Policy and Rates. Notwithstanding any provision of law, except as provided in this section, the reimbursement policies, rates, and related billing instructions, for physicians services provided by hospital-based physicians and outpatient services in effect as of January 1, 2007 shall be the policies, rates, and billing instructions used by the department of health and human services. The department of health and human services shall not submit to the Centers for Medicare and Medicaid Services any Medicaid state plan amendments related to or affecting the policies, rates, and related billing practices for hospital-based physicians and outpatient services prior to November 30, 2007. Any change to these reimbursement policies, rates and related billing instructions prior to further action by the general court shall require the prior approval of the fiscal committee.

205:8 Effective Date. This act shall take effect upon passage.

Approved: June 25, 2007

Effective: June 25, 2007

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Methodology and Origin of New Hampshire Rates

New Hampshire Medicaid pays for medical services in a variety of ways, depending on the provider and services rendered. The following provides a high-level description of these longstanding payment methodologies.

A. NH Medicaid Professional Services Fee Schedule

NH Medicaid typically pays for the following service groups on a per unit basis by CPT/HCPCS* code from the NH Medicaid fee schedule, with some procedures paid for differently depending on procedure code modifiers entered on the claim:

- Physician Services
- ARNP
- Ambulance Transportation and Life Support
- Dental Services for Children
- Interpreter Services
- Optometric Services
- Psychology Services (note, this does not include Community Mental Health Center services)

The system used by NH Medicaid for paying for these service groups is similar in most cases to the systems used by Medicare and commercial insurance carriers. Some procedures (not included in this analysis) are custom priced depending on the circumstances of the service delivered.

B. Inpatient Hospital

The NH payment method for most inpatient hospital reimbursements mimics Medicare's method based on prospectively set rates (i.e., payment rates are set ahead of time) for a bundled service group that is made up of one or more specific services delivered in the hospital. A single rate is established for a group of services expected to have similar resource use. NH and Medicare's methods differ with regard to Critical Access Hospitals. Critical Access Hospitals are very small, typically rural, hospitals that Medicare, instead of using the prospectively set rates, pays 101 percent of their allowable costs for most services.

After a claim is submitted to NH Medicaid, each inpatient discharge is categorized into a diagnosis-related group (DRG) and has a payment weight assigned to it (the weight represents the cost of the service relative to the average cost). Since it began using DRGs, NH Medicaid has implemented the system used by Medicare. The current system used since October 2007 is the Medicare Severity-DRGs, which contains over 700 DRGs. Note: because only a partial year of data is available in the MS-DRG system, the benchmarking report that follows uses data from the prior years' CMS DRG system.

Prior to the beginning of each Federal Fiscal Year, CMS publishes an updated DRG system that contains additions or changes to codes, modified grouping logic, and new relative weights for each diagnosis related group to be used for all inpatient claims with dates of discharge during the new fiscal year. In most cases for NH Medicaid, the payment is determined by multiplying the DRG

* HCPCS is the Healthcare Common Procedure Coding System adopted by Medicare, NH Medicaid, and many other payers. It is comprised of a Level I and Level II set of codes. Level I is the CPT (Current Procedural Terminology) coding system developed by the American Medical Association and used by commercial, Medicare, and Medicaid payers. HCPCS Level II is a set of codes developed by Medicare to describe products, supplies, and services not included in the CPT codes. See <http://www.cms.hhs.gov/MedHCPCSGenInfo/> for more information.

relative weight by the base rate for the average service, referred to as the Price per Point. The NH Price per Point has been \$3,147.61 for general hospitals since 2001.

Four hospitals receive additional reimbursement for Indirect Medical Education (IME) costs:

Hospital	IME Factor (%)
Mary Hitchcock Memorial Hospital	.346235
Dartmouth-Hitchcock Mental Health Center	.346235
Concord Hospital	.073510
Southern New Hampshire Regional Medical Center	.019772

Additionally, reimbursement for rehabilitation and neonatal intensive care are paid outside the relative weight and price per point system.

- Neonatal DRG 789 through 794 are reimbursed on a per diem basis of 65% of the full outlier amount.
- Rehab DRG 495 and 946 are paid at a flat reimbursement per discharge with no outliers allowed.

Outliers refer to the any days beyond the trim point (average length of stay) for each DRG.

Catastrophic Payments – Each year 5% of the total amount paid for inpatient services from the previous fiscal year is designated for catastrophic payment. This amount appears as a class line item in the annual budget. Payment is made to inpatient providers only. Since the payout is not claim or DRG specific, it is impossible to include this amount in the benchmarking process. However, it is clear that inpatient providers do receive additional payments for services beyond those received from DRGs.

C. Outpatient Hospital

Cost Based - New Hampshire Medicaid currently pays for emergency department visits, clinic visits, observation stays, ambulatory surgery and radiology procedures on the basis of costs — specifically charges reduced to cost by multiplying by a costs-to-charge ratio. Interim payments are made based on charges times the expected cost-to-charge ratio. Subsequent settlement, based on cost reports, may occur up to two years later and reflects Medicaid's share of the hospital's costs allocated to the outpatient department on cost reports. The current final payment rates are 91.27% of allowed cost for critical access and rehabilitation hospitals, and 81.24% for all other hospitals.

For SFY 07 the state recouped \$2.7 million and paid out \$525,000 to outpatient providers at the end of the cost settlement process. This settlement process is not claim or revenue code specific and therefore is not reflected in the benchmarking allowed amount per unit in the outpatient revenue code section of the Benchmarking Summary

Fee Schedule Based - Medicaid hospital outpatient payments for laboratory services are based on a fee schedule similar to the payment for professional services discussed earlier.

D. FQHC and RHC Clinic Services Encounter Rates

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are located in areas certified by the federal government as having a shortage of personal health services or primary care manpower and are established to fill these needs for primary care only. Most payments to these centers are for a standardized clinic visit encounter, which is a face-to-face encounter between a patient and a physician, a physician assistant or a nurse practitioner for primary care services.

New Hampshire Medicaid requires that RHCs and FQHCs bill their encounters using a standard CPT/HCPCS procedure code (T1015) on the professional services claim form. Hospital-based RHCs bill their services on the facility claim form. The reimbursement rate for the encounters is unique to each facility and is determined by a review by the Medicare fiscal intermediary. In New Hampshire the fiscal intermediary is National Government Services. The encounter rate for any given period is cost settled after the review of costs in the same manner as outpatient hospital. The FQHC settlement rate is the lesser of the actual cost per encounter or 133% of the Medicare rate, and the RHC settlement rate is the lesser of the actual cost per encounter or 100% of the Medicare rate.

Benchmarking Summary

The following pages provide summarized information on the procedures selected for this benchmarking study.

Summary by Service Group

Service Group (COS) <i>Selected Procedures as % of Total Allowed Amount for COS</i>	Service Sub-Group	Sampled Procedures - SFY 2007			Rate as % of NH Medicaid			
		Current Rate or Sampled Allowed	Total Allowed Amount	Total Units (Claims Paid for Inpatient)	NH Medicaid	Other State Medicaid ¹⁸	Medicare	Commercial Carriers
Physician Services (43) 37.4%	<i>Primary Care Evaluation & Management</i> ¹							
	Primary Care Preventive (99381-99397)	\$59.60	\$2,533,128	42,034	100%	96%	NA ¹	209%
	Primary Care Treatment (99201-99215)	\$49.56	\$6,660,896	133,768	100%	93%	138%	187%
	<i>Obstetric Services</i> ²							
	Antepartum Care, Delivery, Postpartum Care (59400-59515; 59610-59622)	\$971.50	\$2,560,073	2,912	100%	129%	125%	193%
	Fetal Non-Stress Test (59025)	\$25.00	\$90,818	4,154	100%	151%	173%	272%
	Obstetric Ultrasound (76801-76817)	\$73.56	\$304,484	4,507	100%	123%	187%	280%
	Emergency Department services (99281-99285) ³	\$49.25	\$1,735,136	35,205	100%	111%	160%	240%
Psychiatry - Medication Mgt. (90862) ⁴	\$26.18	\$131,947	5,024	100%	122%	198%	340%	
Hospital Care (99221-99233) ⁵	\$44.26	\$1,397,935	31,235	100%	108%	168%	245%	
Consultations (99241-99255) ⁶	\$77.67	\$1,484,039	19,000	100%	118%	179%	267%	
ARNP⁷ (44) 20.3%	Primary Care Preventive (99381-99397)	\$56.94	\$27,556	485	100%	99%	NA ¹	217%
	Primary Care Treatment (99201-99215)	\$53.66	\$64,523	1,195	100%	92%	139%	192%
Ambulance Transportation and Life Support⁸ (37) 82.8%	Ground Mileage (A0425)	\$2.96	\$221,952	85,366	100%	83%	211%	555%
	Advanced Life Support (A0426, A0427, A0433)	\$174.48	\$454,875	2,607	100%	93%	230%	261%
	Basic Life Support (A0428, A0429)	\$145.00	\$589,959	4,069	100%	91%	201%	279%
Interpreter Services⁹ (Component of 42) 100%	Interpreter Services - Hearing Impaired, 15 Min (T1013, UA, U1, up to 4 units)	\$6.25	\$975	156	100%	280%	NA ¹	See Interpreter Services Section
	Interpreter Services - Language, 15 Min (T1013, UC, U1, up to 4 units)	\$3.75	\$13,759	3,649	100%	467%	NA ¹	
	Interpreter Services - Each Additional 15 Minutes (T1013, UA, U2 or T1013 UC, U2; use for 5th unit and over)	\$2.25	\$2,304	1,000	100%	778%	NA ¹	
Psychology (non CMHC)¹⁰ (48) 92.9%	Psy Dx Interview (90801)	\$87.82	\$290,875	4,372	100%	87%	168%	101%
	Psychotherapy, Office, 45-50 Min (90806)	\$65.00	\$3,067,350	45,263	100%	93%	135%	106%
	Family Psychotherapy w Patient (90847)	\$58.00	\$238,728	4,015	100%	103%	183%	121%

Summary by Service Group

Service Group (COS) <i>Selected Procedures as % of Total Allowed Amount for COS</i>	Service Sub-Group	Sampled Procedures - SFY 2007			Rate as % of NH Medicaid			
		Current Rate or Sampled Allowed	Total Allowed Amount	Total Units (Claims Paid for Inpatient)	NH Medicaid	Other State Medicaid ¹⁸	Medicare	Commercial Carriers
Inpatient Hospital¹¹ (1) <i>DRGs w/>>\$500,000 Payments 42.9%</i>	Psychoses	\$2,449.78	\$3,791,332	781	100%	NA ⁴	172%	170%
	Vaginal Delivery w/o complications	\$1,404.15	\$2,752,498	2,285	100%	NA ⁴	172%	251%
	Vaginal Delivery w/ Complications	\$1,861.50	\$686,412	391	100%	NA ⁴	172%	216%
	Cesarean Section w/o C.C.	\$2,412.33	\$1,558,122	764	100%	NA ⁴	172%	230%
	Cesarean section w C.C.	\$3,129.67	\$694,601	235	100%	NA ⁴	172%	217%
	Normal Newborn	\$497.32	\$1,591,483	3,243	100%	NA ⁴	172%	253%
	Neonate Died or Transferred (daily rate)	\$1,527.98	\$2,387,023	157	100%	NA ⁴	172%	66%
	Extreme Immaturity or Resp Distress (daily rate)	\$730.01	\$2,473,308	79	100%	NA ⁴	172%	257%
	Prematurity w/ Major Problems (daily rate)	\$581.44	\$878,333	82	100%	NA ⁴	172%	288%
	Prematurity w/o Major problems (daily rate)	\$506.68	\$915,487	222	100%	NA ⁴	172%	199%
	Full Term Neonate w Major Problems (daily rate)	\$465.74	\$649,887	203	100%	NA ⁴	172%	496%
	Neonates w/ other significant problems (daily rate)	\$434.60	\$612,083	525	100%	NA ⁴	172%	296%
	Rehabilitation	\$3,463.94	\$1,102,643	104	100%	NA ⁴	172%	445%
	ECMO or Trach w MFV 96+ hrs or PDX exc face, mouth & neck w/ maj O.R	\$59,082.84	\$1,144,757	18	100%	NA ⁴	172%	234%
	TRACH W MV 96+ hrs or PDX exc face, mouth & Neck w/o maj O.R.	\$35,951.69	\$742,616	19	100%	NA ⁴	172%	363%
	Craniotomy Age 0-17	\$7,321.03	\$725,353	27	100%	NA ⁴	172%	227%
	Chronic Obstructive Pulmonary Disease	\$3,505.81	\$546,780	200	100%	NA ⁴	172%	228%
Outpatient Hospital¹² (7) <i>34.8%</i>	<i>Revenue Codes with Allowed Amounts greater than \$500K</i>							
	Emergency (Rev Cd 450)	\$95.47	\$7,618,079	79,792	100%	NA ⁴	NA ⁶	192%
	Operating Room Services (Rev Cd 360)	\$182.91	\$6,449,908	35,263	100%	NA ⁴	NA ⁶	566%
	Recovery Room (Rev Cd 710)	\$7.13	\$1,265,223	177,381	100%	NA ⁴	NA ⁶	309%
	Hospital-based Rural Health Clinic (Rev Cd 521)	\$96.91	\$1,536,088	15,820	100%	NA ⁴	NA ⁷	NA ⁵
	Physical Therapy (Rev Cd 420)	\$28.92	\$1,117,732	38,647	100%	NA ⁴	NA ⁶	183%
	Radiation Therapy (Rev Cd 333)	\$252.12	\$1,093,214	4,336	100%	NA ⁴	NA ⁶	187%
Cardiology (Rev Cd 480)	\$239.59	\$599,703	2,503	100%	NA ⁴	NA ⁶	221%	

Summary by Service Group

Service Group (COS) <i>Selected Procedures as % of Total Allowed Amount for COS</i>	Service Sub-Group	Sampled Procedures - SFY 2007			Rate as % of NH Medicaid				
		Current Rate or Sampled Allowed	Total Allowed Amount	Total Units (Claims Paid for Inpatient)	NH Medicaid	Other State Medicaid ¹⁸	Medicare	Commercial Carriers	
	EEG (Rev Cd 740)	\$508.90	\$571,493	1,123	100%	NA ⁴	NA ⁶	299%	
	Occupation Therapy (Rev Cd 430)	\$32.52	\$515,206	15,845	100%	NA ⁴	NA ⁶	163%	
	<i>Most frequently used CPT codes available for Outpatient Services</i>								
	Chest X-Ray (2 Views) (71020)	\$64.03	\$360,987	5,638	100%	NA ⁴	NA ⁶	199%	
	X-Ray Exam of Ankle (73610)	\$71.65	\$144,582	2,018	100%	NA ⁴	NA ⁶	155%	
	MRI Brain wo Dye (70551)	\$911.79	\$397,543	436	100%	NA ⁴	NA ⁶	141%	
	MRI Brain wo&w Dye (70553)	\$1,058.55	\$456,237	431	100%	NA ⁴	NA ⁶	202%	
	MRI Lumbar Spine wo Dye (72148)	\$716.07	\$330,106	461	100%	NA ⁴	NA ⁶	206%	
	MRI Neck Spine wo Dye (72141)	\$806.78	\$202,501	251	100%	NA ⁴	NA ⁶	175%	
	Drug Screen , Single (80101)	\$15.13	\$229,807	15,189	100%	NA ⁴	NA ⁶	264%	
	Complete CBC w Auto Diff WBC (85025)	\$8.62	\$189,553	21,996	100%	NA ⁴	NA ⁶	418%	
	Comprehen Metabolic Panel (80053)	\$11.75	\$122,322	10,414	100%	NA ⁴	NA ⁶	468%	
	Assay Thyroid Stim Hormone (84443)	\$19.58	\$110,748	5,657	100%	NA ⁴	NA ⁶	337%	
Dental Services for Children ¹³ (45) 66.1%	Diagnostic (D0120, D0150, D0140)	\$37.23	\$1,826,345	50,784	100%	118%	NA ¹	131%	
	Diagnostic Imaging (D0272, D0274, D0210)	\$27.84	\$629,176	22,600	100%	131%	NA ¹	155%	
	Preventive (D1120, D1203, D1351)	\$29.18	\$2,295,022	78,653	100%	133%	NA ¹	153%	
	Restorative (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2391, D2392, D2393, D2394, D2940)	\$103.93	\$4,108,821	41,358	100%	129%	NA ¹	155%	
	Endodontics (D3220, D3310, D3320, D3330)	\$150.21	\$443,370	3,119	100%	153%	NA ¹	161%	
	Oral Surgery (D7140, D7210, D7240)	\$120.94	\$1,219,182	10,081	100%	155%	NA ¹	183%	
Optometric Services (Medical Services Only) ¹⁴ (47) 88.7%	Refraction (92015)	\$20.70	\$119,545	7,971	100%	143%	NA ¹	149%	
	Fitting of Spectacles (92340, 92341)	\$11.43	\$172,742	9,666	100%	226%	NA ¹	259%	
	Eye Exams (92002, 92004, 92012, 92014)	\$52.47	\$271,593.00	9,197	100%	87%	177%	157%	
FQHC and RHC Clinic Service Encounter Rates ¹⁵ (80) 75.1%	Federally Qualified Health Center (T1015)	\$132.64	\$7,461,107	56,250	100%	NA ⁴	76%	103%	
	Rural Health Clinic (T1015)	\$72.46	\$637,179	8,794	100%	NA ⁴	104%	189%	

Interpreter Services

Sample Commercial Rates for Interpretation Services are:

Interpreter	Language	Typical Rate	Unit	Hourly Rate		Comments
Lutheran Social Services LanguageBank	Foreign	\$ 45.00	Hour	\$ 90.00	Minimum	Minimum of 2 hours, helps account for travel time. Only done in-person
Granite State Independent Living	Foreign		Hour	\$35 - \$45	Hour	Time is charged portal to portal, which accounts for travel time, mileage paid at \$0.58 per mile. Have not done foreign language interpretation yet, but may be able to in the future.
AT&T Language Line - Pay As You Go	Foreign	\$ 3.96	Minute	\$ 237.60	Hour	Pay as you go, no minimums
AT&T Language Line - Contract Basis	Foreign	\$ 3.94	Minute	\$ 236.10	Hour	Average rate, based on range of \$2.90 - \$4.97 per minute. Cost depends on language and time of day. Minimum of \$100/month, \$275 set up fee
	Sign	Negotiated	Negotiated			They provide video interpreting for the hearing impaired, under a much different pricing structure negotiated by their sales team.
DT Interpreting	Foreign	\$ 1.59	Minute	\$ 95.40	Hour	Use of their dual set phones, \$450 equipment charge
	Sign	\$ 3.00	Minute	\$ 180.00	Hour	Video translation, \$450 per month equipment charge for video equipment (Wentworth Douglass uses 60 - 70 minutes per month, used most in areas with Deaf schools)

Northeast Deaf and Hard of Hearing Services is a referral agency for freelance interpreters. According to them, most freelance interpreters use the fee schedule published the Department of Education for Vocational Rehab. This results in fees between \$30 - \$45 dollars per hour, for a minimum of two hours, and includes reimbursement for travel time and mileage (currently \$0.585 per mile).

The Office of Minority Health has a contract with Language Line, paying a rate of \$1.89 per minute.

NH Department of Ed - Voc Rehab Rates (*Please Note: These rates only apply to sign language interpreters, not to foreign language interpreters*):

The following rates are excerpts from the Interpreter fee schedule for the NH Department of Education published on the NHRID website. The rates included reflect non-legal scenarios and represent the various certification levels recognized by the State. It is standard for interpreters to bill a two-hour minimum for any assignment which is under two hours long. These two hours do include driving time (interpreters are also reimbursed for travel time, mileage and tolls)

Interpreter Categories	Base Rate	Experiential Increase (Per Hour)				
		* Add \$1 for each additional 2 years of experience				
		2 years	4 years	6 years	8 years	10 years
NATIONALLY CERTIFIED						
Level V (Master) - (CSC, RSC, CI&CT, ACCI-V, NIC-M,SC-L)	\$33.00	\$34.00	\$35.00	\$36.00	\$37.00	\$38.00
Level IV (Advanced) - (IC&TC, CI or CT, ACCI-IV, NIC-A, OIC&OTC)	\$30.00	\$31.00	\$32.00	\$33.00	\$34.00	\$35.00
Level III (Generalist) - (IC or TC, ACCI-III, NIC-C)	\$28.00	\$29.00	\$30.00	\$31.00	\$32.00	\$33.00
STATE SCREENED						
(NHICS, MCDHH)	\$23.00	\$24.00	\$25.00	\$26.00		
Non-licensed interpreters with waiver	\$20.00					

Source:

NHRID Interpreter Fee Schedule. 2006. New Hampshire Registry of Interpreters for the Deaf. 8 Jul. 2008 < http://www.nhrid.org/Interpreter_Fee_Schedule_effective_July_1_2006.swf>.

Footnotes

Footnotes:

- ¹ Primary Care Evaluation & Management: Preventive and Treatment visits with physicians belonging to the specialties of General Practice, Family Practice, Internal Medicine, and Pediatrics. Preventive procedure codes: 99381-99397. Treatment procedure codes: 99201-99215.
- ² Obstetric Services: Maternity services provided by Ob-Gyns, including antepartum care, delivery, postpartum care, fetal non-stress tests, and obstetric ultrasounds.
- ³ Emergency Department services: Physicians billing emergency procedure codes 99281-99285.
- ⁴ Psychiatry - Medication Mgt. Includes procedure 90862 Medication Management.
- ⁵ Hospital Care: Evaluation and Management services provided by physicians during an inpatient admission. Procedure codes 99221-99233.
- ⁶ Consultations: Physician visits, either outpatient or inpatient, performed at the request of another physician, typically a PCP referring to a specialist. Procedure codes 99241-99255.
- ⁷ ARNP: Preventive and Treatment visits with nurse practitioners. Preventive procedure codes: 99381-99397. Treatment procedure codes: 99201-99215. Please see Appendix B: Data and Methods for explanation as to why ARNP average rate is higher than physician average rate for same service categories.
- ⁸ Ambulance Transportation and Life Support includes Ground Mileage, Advanced Life Support and Basic Life Support procedure codes.
- ⁹ Interpreter Services: For T1013 UA U1 and T1013 UC U1: These rates are for 15 minute units. Providers can bill up to four of these units, which would result in 1 hour. Providers should bill T1013 UA U2 or T1013 UC U2 for any additional units over the first 4. For T1013 UA U2 and T1013 UC U2: The majority of these claims are for language interpretation (210), not hearing impaired (11). Other State Medicaid totals based on Maine and Vermont only, which pay one rate rather than our three. Connecticut does not currently cover this service. It will be part of their MCO contracts once they retain a vendor to provide this service. We were unable to get information for Massachusetts or Rhode Island.
- ¹⁰ Psychology (non CMHC): Rates benchmarked are TOS 1 or 9 with no modifiers.
- ¹¹ Inpatient Hospital: These are the standard rates without consideration of outlier days, indirect medical costs (IME), Disproportionate Share Hospitals (DSH) or capital as these parameters are not constant values. IME and DSH vary for each provider and outlier days vary for each incident of care. DRG for Rehabilitation is a flat reimbursement per discharge with no outliers allowed. Inpatient will need to be updated when MHIC runs the MS-DRG. Current values are old-DRG 1:1 equivalents where available.
- ¹² Outpatient Hospital: Average allowed Amt per unit. Rates vary widely by provider. See Outpatient Hospital Services Worksheet.
- ¹³ Dental Services for Children: Commercial rates based on Northeast Delta Dental data provided by Dental Unit. Other State Medicaid Values based on Connecticut rates provided by the Dental Unit.
- ¹⁴ Optometric Services includes Refraction, two codes for Fitting of Spectacles, and four codes for Eye Exams. These services all fall under type of service Medical Care. HCPCS V-series codes and CPT code 92390 have been excluded from this analysis because they are currently under contract to NH Optical Laboratory LLC, paid using Level I Pricing.
- ¹⁵ FQHC and RHC Clinic Service Encounter Rates: RHC and FQHC Medicare % of Medicaid is based on upper payment limits, not actual payments. RHC = \$74.29 to \$75.63. FQHC = \$99.17 to \$100.96.
- ¹⁶ Payment as % of NH Medicaid: There will be gaps. Not all rows will have benchmarks in all columns.
- ¹⁷ For Massachusetts and Medicare itself, we calculated adjusted rates for procedures where they use both facility and non-facility rates. These calculations use the adjusted rates.

Footnotes

¹⁸ The states included in Other State Medicaid values vary by procedure:
59412 Antepartum Manipulation - CT and VT do not pay for
59414 Deliver Placenta - CT does not pay for
59610 VBAC Delivery - CT does not pay for
59612 VBAC Delivery Only - CT does not pay for
59614 VBAC Care After Delivery - CT does not pay for
59618 Attempted VBAC Delivery - CT does not pay for
59620 Attempted VBAC Delivery Only - CT does not pay for
59622 Attempted VBAC After Care - CT does not pay for
76805 Ob US >= 14 Wks, Sngl Fetus - ME pays by report, no published rates
76810 Ob US >= 14 Wks, Addl Fetus - ME pays by report, no published rates
76815 Ob US, Limited, Fetus(s) - ME pays by report, no published rates
76816 Ob US, Follow-Up, Per Fetus - ME pays by report, no published rates
90862 Medication Management - ME does not pay for
A0426 ALS 1 - ME pays negotiated rate
A0427 ALS1-Emergency - ME pays negotiated rate
A0433 ALS 2 - ME pays negotiated rate, CT and RI do not pay for
A0428 BLS - ME pays negotiated rate
A0429 BLS-Emergency - ME pays negotiated rate
T1013 Sign Lang/Oral Interpreter - CT, MA and RI do not pay for Medicaid, ME doesn't publish their rate
All Dental Procedures - included only CT rates per OMBP Management
92015 Refraction - VT does not pay for
92341 Fitting of Spectacles - VT does not pay for

NA Explanations:

NA¹ Not Paid by Medicare.

NA² Not Paid by Commercial Carriers used for this analysis.

NA³ We cannot compare our CPT code rates to Revenue Code rates.

NA⁴ We cannot compare our rates to values from other states, as payment methodologies are not the same.

NA⁵ NH Bills these using Revenue codes, not CPT codes.

NA⁶ We cannot compare our rates to Medicare values, as payment methodologies are not the same.

NA⁷ Although the rate setting methodology for clinic services is similar between NH Medicaid and Medicare, the actual rates vary for each provider making comparison impossible.

Previous Year Rate Changes

Following are five documents relative to rate changes that occurred in SFY 2008. The first four documents are a series of letters sent to the Fiscal Committee of the General Court between July 10, 2007 and October 1, 2007, which provide an explanation of the rate changes requested. The fifth document is a spreadsheet providing estimated cost of provider rate increases SFY08-09, dated July 7, 2007.



State of New Hampshire

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JUN 26 2007

JOHN A. STEPHEN
COMMISSIONER

July 10, 2007

The Honorable Marjorie K. Smith
Chairman
Fiscal Committee of the General Court
State House
Concord, NH 03301

APPROVED BY _____
DATE 7/24/07
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ITEM # FIS-07-235

Information

Pursuant to the provisions of Chapter 263:109, Laws of 2007 (HB2), Rate Setting, this letter contains information about the implementation of rate increases for SFY 2008.

Explanation

Chapter 263:109, Laws of 2007 (HB2), Rate Setting, includes the following section:

109 Department of Health and Human Services; Rate Setting. For the biennium ending June 30, 2009, the commissioner of the department of health and human services shall set rates paid to providers consistent with the operating budget appropriations allotted to pay providers in each program including any rate increases provided in the operating budget. Such rates shall reflect legislative decisions to provide specific rate increases as footnoted in the operating budget. The commissioner shall report quarterly to the fiscal committee of the general court, the governor, the speaker of the house of representatives, and the president of the senate concerning the status of appropriations for payments to providers and the rates established by the department.

In addition, Chapter 262:1, Laws of 2007 (HB1), the operating budget, contains the following footnotes about the appropriations for rate increases in each division. Rate increase implementation status is included below.

Bureau of Behavioral Health, Community Mental Health Services, PAU 05-01-09-04-01

From the amounts appropriated herein, the Department shall provide a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective January 1, 2009 for community mental health centers, and increase the daily rate for services provided within a mental health certified community residence to \$94 in FY08 effective July 1, 2007, and to \$107 in FY09 effective July 1, 2008.

Implementation status:

On June 26, 2007, the Bureau of Behavioral Health submitted a Control Memo to EDS (the Medicaid fiscal agent) requesting 2% rate increases for Medicaid-covered services

provided by community mental health centers. The memo also requested an increase in the daily rate from \$81 to \$94 for services provided within a community residence. The rate increases were effective as of July 1, 2007.

Bureau of Developmental Services, Developmental Services, PAU 05-01-10-01

From the amounts appropriated herein, the Department shall provide a 2% rate increase in FY08 Effective July 1, 2007, and a 2% rate increase in FY09 effective January 1, 2009 for direct care providers for persons with developmental and acquired disabilities.

Implementation status:

On June 27, 2007, the Bureau of Developmental Services submitted a Control Memo to EDS requesting 2% rate increases for Medicaid-covered services provided by area agencies. The rate increases were effective as of July 1, 2007. These rate increases are consistent with the requirements of SB 138, which as of July 9, 2007 is in enrolled status.

Bureau of Elderly and Adult Services, Nursing Services, PAU 05-01-08-04-01

From the amounts appropriated herein, the Department shall provide a 2% rate increase in FY08 Effective July 1, 2007, and a 2% rate increase In FY09 effective January 1, 2009 for skilled nursing facilities, ambulance services, wheelchair van, physicians services, dental services personal care, adult medical day care, rural health clinic, nursing homes, home health services, home nursing services, HCBC-ECI independent case management, HCBC, mid-level care, and other nursing homes. The amounts appropriated also contain funding for a 4.6% rate increase in FY08 effective July 1, 2007 for Crotched Mountain.

Prior to implementing the rate increases appropriated in class 87, the Commissioner shall solicit input from the providers. The Commissioner may establish rate increases for such Services in consultation with home health services providers, and may target such rate increases to specific home health services.

Implementation status:

On July 2, 2007, the Bureau of Elderly and Adult Services submitted a Control Memo to EDS (the Medicaid fiscal agent) requesting a 2% rate increase for SFY08 effective July 1, 2007 in Home Nursing Services (HCBC-ECI) for the following services. Adult in Home care, personal care, adult medical day care; home delivered meals, transportation and independent case management. Excluded from an increase were personal emergency response system (PERS) and home modifications.

Home Health Services (class 87) rate increases will be finalized after the July 10, 2007 meeting with the Home Health agencies. Services include; nursing, home health aide, homemaker and respite.

Mid-Level Residential Care rate has been increased 2% for SFY08 effective July 1, 2007.

Nursing Services (Nursing Homes) rates were adjusted for August 1, 2007. Costs used for the rate calculation were based using SFY05 Medicaid Cost Reports. Rates were calculated to include the increased appropriation to the Nursing Service line in the budget and a utilization factor of 4,512 residents. The budget neutrality factor is 19.11%. As required by law, rates have also been adjusted for changes in acuity for each facility. The net result of these changes is that 40 of 77 nursing homes in the acuity-based system have seen increases in their rates over their February 1, 2007 rates and 74 of 77 nursing homes have seen increases in their rates over their average SFY07 rates.

The nursing home rates have been sent to members of the Nursing Home Technical Advisory Committee (TAC). Also, the new rates will be presented at a public meeting held on July 16, 2007.

Division for Children, Youth and Families, Child and Family Services, PAU 05-01-06-07-01

From the amounts appropriated herein the Department shall provide a 5% rate increase in FY08 effective July 1, 2007, and a 5% rate increase in FY09 effective July 1, 2008 for childcare providers, a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective July 1, 2008 for residential providers, and a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective January 1, 2009 for ancillary service providers.

Implementation status:

The Division for Children, Youth and Families (DCYF) has increased residential service providers' rates for SFY08 by 2% above the rates that these providers were paid in SFY07. The base rates that the Division used for the calculation of the 2% rate increase were the rates, effective July 1, 2006, that were paid to these providers in SFY07. The effective date of the SFY08 rates is July 1, 2007. The rates have been changed in NH Bridges and in the Medicaid Management Information System (MMIS), and letters have been mailed to providers informing them of the new rates.

DCYF has also increased the ancillary service providers' rates for SFY08 by 2% above the rates that these providers were paid in SFY07. The base rates that the Department used for the calculation of the 2% rate increase were the rates, effective July 1, 2006, that were paid to these providers in SFY07. The effective date of the SFY08 rates is July 1, 2007. The rates have been changed in NH Bridges and, when appropriate, in the Medicaid Management Information System (MMIS), and letters have been mailed to providers

informing them of the new rates. Exceptions to the 2% rate increase are: Guardian ad Litem and Legal Counsel because these rates are determined by the Administrative Office of the Court; and mileage reimbursement, because DCYF reimburses mileage at the rate established by the IRS, and that rate change usually occurs on January 1 of each year.

Division for Children, Youth and Families, Child Care, PAU 05-01-06-07-01

From the amounts appropriated herein the Department shall provide a 5% rate increase in FY08 effective July 1, 2007, and a 5% rate increase in FY09 effective July 1, 2008 for childcare providers, a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective July 1, 2008 for residential providers, and a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective January 1, 2009 for ancillary service providers.

Implementation status:

The Division for Children, Youth and Families (DCYF) calculated a 5% rate increase for childcare providers above the rates that these providers were paid in SFY07. The base rates for SFY07 were the rates paid to these providers effective July 1, 2006. The effective date of the SFY08 rates was July 1, 2007. The rates were changed in NH Bridges and were posted on the Department's website. Additionally, an updated rate sheet was mailed to all childcare providers who have billed the Division since January 2007.

Office of Medicaid Business and Policy, Provider Payments, PAU 05-01-02-01-03

From amounts appropriated herein, the Department shall provide a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective January 1, 2009 for skilled nursing facilities, intermediary care facilities, ambulance services, home health services, wheelchair van, physicians services, dental services, personal care, adult medical day care, and rural health clinic.

Implementation status:

July 1, 2007 rate increases have been fully implemented for the following providers:

- wheelchair van,
- physicians,
- personal care, and
- adult medical day care services.

Implementation of the July 1, 2007 rate increases for the remaining providers requires additional research and collaboration with provider associations. Collaboration with provider associations and analysis of federal Medicare and Medicaid policy are ongoing

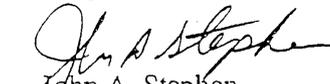
The Honorable Marjorie K. Smith
Chairman
July 10, 2007
Page 5

and require a delay in rate change implementation. It is anticipated that these rates will be finalized within the next couple weeks. These rate changes include:

- Rate increases for skilled nursing facilities and intermediary care facilities are being coordinated with the Bureau of Elderly and Adult Services Ratesetting Unit.
- The ambulance rate increase is being worked on as a collaborative effort with the New Hampshire Ambulance Association.
- The home health services rate, increase will be finalized after the July 10, 2007 meeting with the Home Health agencies.
- The rate increase for dental services is being analyzed by the New Hampshire Medicaid Dental Director to determine the appropriate dental service codes to increase.
- The rate increase for rural health centers will be implemented upon completion of analysis of federal Upper Payment Limit policy.

A further update will be provided once the open issues are resolved. Quarterly reports will be submitted to Fiscal Committee, reporting on expenditures by services and clients. Another report on rate increases will be submitted at the beginning of SFY 2009.

Respectfully submitted,


John A. Stephen
Commissioner

CC: The Honorable Sylvia B. Larsen, President, NH Senate
The Honorable Terie Norelli, Speaker, NH House of Representatives
The Honorable Marjorie K. Smith, Chairman, House Finance Committee
The Honorable Lou D'Allesandro, Chairman, Senate Finance Committee



State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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JOHN A. STEPHEN
COMMISSIONER

July 10, 2007

The Honorable Marjorie K. Smith
Chairman
Fiscal Committee of the General Court
State House
Concord, NH 03301

APPROVED BY _____

DATE 7/24/07

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Information

ITEM # FIS-07-236

Pursuant to the provisions of Chapter 263:54, Laws of 2007, Nursing Facility Rates, attached is a report on assumptions used by the Department of Health and Human Services to calculate the acuity-based rates paid to nursing facilities in SFY 2008.

Explanation

Chapter 263:54, Laws of 2007, (HB 2) contains the following reporting requirement regarding acuity-based rates paid to nursing facilities.

Chapter 263:54, Laws of 2007, Nursing Facility Rates; Report by Department of Health and Human Services. For the biennium ending June 30, 2009, the department of health and human services shall provide a report to the fiscal committee of the general court detailing assumptions used by the department to calculate acuity-based rates paid to nursing facilities. The department also shall provide copies of the report to the chairs of the house and senate health and human services committees and the finance committees. Said report shall be filed with the committees prior to the effective date of any rate change, and shall include, but not be limited to, the average monthly nursing facility bed days used to calculate rates, the projected surplus or deficit in current operating budget appropriations for nursing services, and the budget neutrality factor that will be applied to the rates, if any.

The Bureau of Elderly and Adult Services, per Medicaid state plan and administrative rule, adjusts nursing facility rates each August 1 and February 1. The attached worksheet lists each nursing facility, its anticipated patient days and the rates for each time period. The product of the patient days and rates for all homes produces an aggregate total, which is then reduced by the anticipated patient resources, to arrive at a projected spending amount of \$188.7 million. The spending amount is the appropriation in the class 090, nursing services, contained in the approved SFY 2008 operating budget.

The following are the assumptions for the rate periods:

July 1-31, 2007: Payments for dates of service through July 31, 2007 will be paid at the February 1, 2007 rates which used a higher utilization level than is presently being experienced, so the anticipated surplus resulting from this lower utilization has been added into the August 1, 2007 rates.

The Honorable Marjorie K. Smith
Chairman
July 10, 2007
Page 2

August 1, 2007 to January 31, 2008: Rates for this six-month time period assume that 50.27% of the nursing home budget will be expended on these rates (184 days divided by 366) as well as the surplus value resulting from the February 1, 2007 rates as described above, in order to fully spend the proportionate amount of the budget through January 31, 2008.

February 1, 2008 to June 30, 2008: The assumption is that the remainder of the budget will be expended on these rates. If there appear to be any budget surplus or deficits from the August 1, 2007 rates at the time that the February rates are calculated in December those amounts will be added into the rate calculations.

The patient days for each facility are based on a total of 4,512 residents as per the SFY 2008 caseload value from House Bill 1 (operating budget) page 403. The allocations for each nursing facility are based on the most recent twelve-month period. The atypical patient days and estimated spending is based on a total of 75 residents. The average number of atypical residents has remained relatively constant over time.

The patient resources percentage of 19.8% was derived from a review of patient resource payments compared to Medicaid payments for the 12-month period ending May 31, 2007.

The budget neutrality factor resulting from the August 1, 2007 rate calculations was 19.11%.

The Bureau intends to report information quarterly to the Fiscal Committee, the Finance Committees and the Health and Human Services Committees to show the correlation between estimated payments contained on this worksheet and the actual experience as the state fiscal year progresses.

Respectfully submitted,

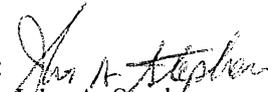


Kathleen Otte
Director
Bureau of Elderly and
Adult Services



Nancy L. Rollins
Director
Division of Community Based
Care Services

Approved by:



John A. Stephen
Commissioner

The Honorable Marjorie K. Smith
Chairman
July 10, 2007
Page 3

CC: The Honorable Marjorie K. Smith, Chairman, House Finance Committee
The Honorable Lou D'Allesandro, Chairman, Senate Finance Committee
The Honorable Cindy Rosenwald, Chairman, House Health and Human Services Committee
The Honorable Iris W. Estabrook, Chairman, Senate Health and Human Services Committee
His Excellency, Governor John H. Lynch
The Honorable Raymond S. Burton
The Honorable John D. Shea
The Honorable Beverly A. Hollingworth
The Honorable Raymond J. Wieczorek
The Honorable Debora B. Pignatelli

Attachment

Count	Number	SFY2008 Estimated Nursing Home Gross Payments	Total Medicaid		July 1 to July 31, 2007		August 1, 2007 to January 31, 2008		February 1 to June 30, 2008		Total Medicaid Expenditure
			Days	Rate	Days	Rate	Days	Rate	Days	Rate	
1	80305033	Alice Peck Day Memorial Hospital	7443	148.65	630	\$93,650	3742	\$588,579	3071	\$430,134	\$1,112,363
2	594	Bel-Air Nursing Home	5427	149.27	460	\$68,664	2728	\$400,634	2239	\$292,806	\$762,105
3	30102335	Belknap County Nursing Home	26074	151.65	2208	\$334,843	13108	\$2,033,837	10757	\$1,486,257	\$3,854,937
4	30009862	Colonial Poplin Nursing Home	4991	146.53	423	\$61,982	2509	\$362,877	2059	\$265,178	\$690,037
5	80547244	Coos County Nursing Home - Berlin	28845	146.16	2443	\$357,069	14501	\$2,108,735	11901	\$1,541,099	\$4,006,903
6	80877168	Coos County Nursing Hosp. - W. S.	21993	141.15	1863	\$262,962	11057	\$1,577,944	9074	\$1,153,124	\$2,994,031
7	30008947	Courville at Manchester	10471	136.65	887	\$121,209	5264	\$696,427	4320	\$508,940	\$1,326,576
8	80305037	Courville at Nashua	16341	133.87	1384	\$185,276	13966	\$1,147,307	6742	\$838,463	\$2,171,046
9	30011352	Dover Rehab & Living Center	17751	146.46	1504	\$220,276	15039	\$1,342,080	7324	\$980,822	\$2,543,178
10	30001121	Edgewood Manor	31846	149.26	2697	\$402,554	16010	\$2,401,020	13354	\$1,754,647	\$4,558,220
11	30101898	Epsom Manor	25261	153.02	2140	\$327,463	14494	\$1,840,738	10422	\$1,345,124	\$3,513,325
12	99750096	Eventide Home Inc.	2367	134.22	200	\$26,844	13686	\$162,863	977	\$119,068	\$308,775
13	80305019	Exeter Healthcare, Inc	2054	216.93	174	\$37,746	20793	\$214,792	847	\$156,828	\$409,365
14	99750021	Fairview Nursing Home	25226	143.84	2137	\$307,386	14068	\$1,784,104	12527	\$1,303,710	\$3,395,199
15	80848162	Genesis - Country Village Center	20938	149.48	1773	\$265,028	15452	\$1,626,478	13760	\$1,188,559	\$3,080,065
16	80305007	Genesis - Harris Hill Center	12709	148.89	1076	\$160,206	6389	\$991,509	5243	\$724,547	\$1,876,262
17	40848160	Genesis - Keene Center	24160	137.03	2046	\$280,363	13996	\$1,699,954	12463	\$1,242,324	\$3,222,642
18	80305015	Genesis - Laconia Center	26968	155.34	2284	\$354,797	15825	\$2,145,554	14092	\$1,567,854	\$4,068,204
19	49750172	Genesis - Lafayette Center	15287	155.53	1295	\$201,411	7685	\$1,166,660	13518	\$852,602	\$2,220,673
20	44001427	Genesis - Laurel Center	26696	131.10	2261	\$296,417	13147	\$1,764,459	11707	\$1,289,421	\$3,350,297
21	30002722	Genesis - Lebanon Center	23026	150.89	1950	\$294,236	15246	\$1,764,877	13576	\$1,289,741	\$3,348,853
22	49750171	Genesis - Mountain Ridge Center	22246	160.13	1884	\$301,685	16414	\$1,835,742	14616	\$1,341,484	\$3,478,910
23	30006431	Genesis - Pleasant View Center	37114	156.03	3144	\$490,558	15497	\$2,891,430	13800	\$2,113,015	\$5,495,003
24	40305034	Genesis - Ridgewood Center	37555	153.56	3181	\$488,474	15646	\$2,953,965	13932	\$2,158,688	\$5,601,127
25	30102357	Goldenvew	20493	141.96	1736	\$246,443	14119	\$1,454,539	12573	\$1,063,018	\$2,764,000
26	30003252	Good Shepherd Nursing Home	17822	150.06	1510	\$226,591	15143	\$1,356,813	13485	\$991,515	\$2,574,919
27	99750025	Grafton County Nursing Home	31313	154.75	2652	\$410,397	15191	\$2,391,367	13527	\$1,747,585	\$4,549,349
28	30011351	Greenbriar Terrace Healthcare	61202	137.04	5184	\$710,415	30768	\$4,217,062	12205	\$3,081,733	\$8,009,211
29	80005038	Hackett Hill Healthcare	10913	157.27	924	\$145,317	5486	\$828,715	13452	\$605,589	\$1,579,622
30	80305009	Hanover Hill Health Care Center	27832	152.23	2357	\$358,806	15643	\$2,188,769	13930	\$1,599,552	\$4,147,127
31	30011350	Hanover Terrace Healthcare	18169	136.75	1539	\$210,458	13931	\$1,272,458	12405	\$929,897	\$2,412,813
32	30009030	Harborside - Applewood	16988	158.64	1439	\$228,283	15540	\$1,327,116	13838	\$969,907	\$2,525,306
33	30009031	Harborside - Crestwood	18803	161.37	1593	\$257,062	15898	\$1,502,838	14157	\$1,098,285	\$2,858,186
34	30009032	Harborside - Milford	13153	148.36	1114	\$165,273	14792	\$978,047	13172	\$714,841	\$1,858,161
35	30009033	Harborside - Northwood	37830	163.02	3204	\$522,316	16366	\$3,112,486	14574	\$2,274,495	\$5,909,297
36	30009034	Harborside - Pheasantwood	26011	152.80	2203	\$336,618	15423	\$2,016,866	13734	\$1,473,778	\$3,827,262
37	30009035	Harborside - Westwood	18201	173.23	1542	\$267,121	18013	\$1,648,190	16040	\$1,204,456	\$3,119,767
38	30102995	Haven Health at Seacost	20712	136.40	1754	\$239,246	13779	\$1,434,807	12270	\$1,048,462	\$2,722,515
39	30102102	Haven Health of Claremont	15342	139.23	1299	\$180,860	13991	\$1,079,126	12459	\$788,634	\$2,048,619
40	99750142	Haven Health of Derry	15503	141.34	1313	\$185,579	7794	\$1,070,428	12230	\$782,219	\$2,038,227
41	80305016	Havenwood	10803	139.54	915	\$127,679	14786	\$803,028	13167	\$586,835	\$1,515,542
42	99750029	Hillsboro House Nursing Home	4390	130.91	372	\$48,699	13457	\$296,996	11983	\$217,015	\$562,709
43	83016930	Hillsborough County Nursing Home	76578	142.32	6486	\$923,088	15637	\$6,019,932	13924	\$4,399,274	\$11,342,294

Count	Number	July 1 to July 31, 2007			August 1, 2007 to January 31, 2008			February 1 to June 30, 2008			Total Medicaid Expenditure		
		Total Medicaid Days	Rate	Days	Total	Rate	Days	Total	Rate	Days		Total	
44	30009262	11734	140.52	994	\$139,677	142.64	5899	\$841,433	127.02	4841	\$614,893	\$1,596,003	
45	80305023	2370	144.22	201	\$28,988	162.91	1191	\$194,026	145.07	978	\$141,876	\$364,890	
46	30100460	2859	157.05	242	\$38,006	151.64	1437	\$217,907	135.03	1180	\$159,338	\$415,251	
47	30100462	874	120.68	74	\$8,930	147.03	439	\$64,546	130.93	361	\$47,265	\$120,741	
48	30101907	31071	141.55	2632	\$372,560	145.28	15620	\$2,269,274	129.37	12819	\$1,658,376	\$4,300,209	
49	80848085	35753	143.88	3028	\$435,669	142.75	17974	\$2,565,789	127.12	14751	\$1,875,083	\$4,876,540	
50	30003658	6497	146.17	550	\$80,394	139.68	3266	\$456,195	124.38	2680	\$333,343	\$869,932	
51	82016882	72898	150.17	6174	\$927,150	149.53	36648	\$5,479,975	133.15	30075	\$4,004,579	\$10,411,704	
52	99750153	10589	147.81	897	\$132,586	144.39	5323	\$768,588	128.58	4369	\$561,749	\$1,462,922	
53	80848045	13308	154.17	1127	\$173,750	152.44	6690	\$1,019,824	135.74	5490	\$745,237	\$1,938,810	
54	99006643	29536	153.53	2502	\$384,132	148.30	14849	\$2,202,107	132.06	12186	\$1,609,256	\$4,195,495	
55	99750012	21989	141.76	1862	\$263,957	140.50	11055	\$1,553,228	125.11	9072	\$1,135,017	\$2,952,201	
56	80305021	9082	160.07	769	\$123,094	158.69	4566	\$724,579	141.31	3747	\$529,488	\$1,377,160	
57	30102629	22914	146.57	1941	\$284,492	146.39	11520	\$1,686,413	130.36	9454	\$1,232,395	\$3,203,300	
58	99750047	12897	155.66	1092	\$169,981	156.85	6484	\$1,017,015	139.67	5321	\$743,191	\$3,030,188	
59	99750059	57408	140.65	4862	\$683,840	139.30	28861	\$4,020,337	124.04	23685	\$2,937,971	\$7,642,148	
60	30100130	25169	139.26	2132	\$296,902	141.11	12653	\$1,785,465	125.66	10384	\$1,304,804	\$3,387,172	
61	49750052	66040	144.71	5594	\$809,508	143.26	33200	\$4,756,232	127.57	27246	\$3,475,767	\$9,041,507	
62	99305036	24026	150.87	2035	\$307,020	147.57	12079	\$1,782,498	131.41	9912	\$1,302,514	\$3,392,032	
63	99750054	9247	158.19	783	\$123,863	152.70	4649	\$709,902	135.98	3815	\$518,748	\$1,352,513	
64	99750055	10470	152.53	887	\$135,294	151.98	5264	\$800,023	135.33	4320	\$584,646	\$1,519,963	
65	30010528	7478	140.77	633	\$89,107	138.56	3759	\$520,847	123.38	3085	\$380,641	\$990,596	
66	99750056	9155	153.23	775	\$118,753	152.97	4603	\$704,121	136.22	3777	\$514,489	\$1,337,363	
67	99750057	16803	135.41	1423	\$192,688	138.26	8447	\$1,167,882	123.12	6932	\$853,450	\$2,214,021	
68	83016933	40504	148.42	3431	\$509,229	155.66	20363	\$3,169,705	138.61	16711	\$2,316,341	\$5,995,274	
69	99750132	15211	149.20	1288	\$192,170	152.85	7647	\$1,168,844	136.11	6276	\$854,223	\$2,215,237	
70	30002362	20307	142.81	1720	\$245,633	140.71	10209	\$1,436,508	125.30	8378	\$1,049,756	\$2,731,897	
71	99750159	19092	153.81	1617	\$248,711	155.05	9598	\$1,488,170	138.07	7877	\$1,087,566	\$2,824,447	
72	30001712	17808	148.77	1508	\$224,345	152.28	8953	\$1,363,363	135.60	7347	\$996,267	\$2,583,975	
73	99750169	12203	157.51	1034	\$162,865	148.64	6135	\$911,906	132.36	5035	\$666,435	\$1,741,207	
74	30101897	26015	147.17	2203	\$324,216	150.16	13079	\$1,963,943	133.71	10733	\$1,435,153	\$3,723,312	
75	40005043	6555	166.79	555	\$92,568	162.99	3295	\$537,052	145.14	2704	\$392,456	\$1,022,076	
76	30002028	8969	151.08	760	\$114,821	149.41	4509	\$673,690	133.05	3700	\$492,271	\$1,280,782	
77	99750164	12203	130.42	1034	\$134,854	131.06	6135	\$804,053	116.71	5035	\$587,615	\$1,526,522	
		1623881	11,428.27	137539	\$20,301,103	11,490	816375	\$121,327,584	10,233	669967	\$88,663,724	\$230,292,411	
					\$4,019,618			\$24,022,862				\$17,555,355	\$45,597,835
					\$16,281,484			\$97,304,723				\$71,108,368	\$184,694,575
												\$4,005,837	\$188,700,412
		4437		4437			4437			4437			
		75		75			75			75			
		4512		4512			4512			4512			



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4688 FAX: 603-271-4912 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Acting Commissioner

August 29, 2007

The Honorable Marjorie K. Smith
Chairman
Fiscal Committee of the General Court
State House
Concord, NH 03301

APPROVED BY _____
DATE 10/17/07
PAGE 3
ITEM # FIS-07-292

Information

Pursuant to the provisions of Chapter 263:109, Laws of 2007 (HB2), Rate Setting, this letter contains information about the implementation of rate increases for SFY 2008. This is the second rate setting Information letter for SFY 2008. The first letter was FIS 07-235, reported at the July 24, 2007 Fiscal Committee meeting.

Explanation

Chapter 263:109, Laws of 2007 (HB2), Rate Setting, includes the following section:

109 Department of Health and Human Services; Rate Setting. For the biennium ending June 30, 2009, the commissioner of the department of health and human services shall set rates paid to providers consistent with the operating budget appropriations allotted to pay providers in each program including any rate increases provided in the operating budget. Such rates shall reflect legislative decisions to provide specific rate increases as footnoted in the operating budget. The commissioner shall report quarterly to the fiscal committee of the general court, the governor, the speaker of the house of representatives, and the president of the senate concerning the status of appropriations for payments to providers and the rates established by the department.

In addition, Chapter 262:1, Laws of 2007 (HB1), the operating budget, contains the following footnotes about the appropriations for rate increases in PAU 05-01-08-04-01, Nursing Services, class 87 – Home Health Services.

Prior to implementing the rate increases appropriated in class 87, the Commissioner shall solicit input from the providers. The Commissioner may establish rate increases for such services in consultation with home health service providers, and may target such rate increases to specific home health services.

Implementation Status:

Below are the rate increases established following the July 10, 2007 meeting with the Home Health Association of New Hampshire. HCBC-ECI services affected were nursing, home health aide,

homemaker and respite. Nursing and home health aide rate increases were effective as of August 1, 2007, while homemaker and respite rate increases were effective as of July 1, 2007.

The 2% rates effective July 1, 2007 reflect the percentages in the operating budget. The rates effective August 1, 2007 reflect the dollar value of the rate increase for the state fiscal year but applied to an eleven month period so that the home health agencies do not need to rebill for the July services at the higher rate. Additionally, the discussions with home health providers resulted in a higher rate increase for short visits and no increase for longer visits, consistent with the industries' request during earlier rate reviews and discussions. The intent is to recognize the higher cost of the more frequent short visits, with a higher rate of reimbursement.

Services	SFY07 Rate	SFY08 Rate	Rate Percent
Nursing - Svs of RN, Ea 15 min.	\$20.73	\$21.50	3.7%
Home Health Aide, Ea 15 min. 7 Units or Fewer	\$5.74	\$5.96	3.8%
Home Health Aide, Ea 15 min. 8 Units or Higher	\$5.74	\$5.74	0.0%
Homemaker Services, Ea 15 min.	\$4.38	\$4.47	2.0%
Respite Care, Ea 15 min., HCBC-ECI	\$1.64	\$1.67	2.0%

Crotched Mountain Rehabilitation Center also received a 4.6% rate increase effective July 1, 2007 as provided for in the state operating budget.

My staff is available to discuss these rate increases at your convenience.

Respectfully submitted,



Nicholas A. Toumpas
Acting Commissioner

CC: His Excellency, Governor John H. Lynch
The Honorable Sylvia B. Larsen, President, NH Senate
The Honorable Terie Norelli, Speaker, NH House of Representatives
The Honorable Marjorie K. Smith, Chairman, House Finance Committee
The Honorable Lou D'Allesandro, Chairman, Senate Finance Committee



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857
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Nicholas A. Toumpas
Acting Commissioner

October 1, 2007

The Honorable Marjorie K. Smith
Chairman
Fiscal Committee of the General Court
State House
Concord, NH 03301

APPROVED BY _____
DATE 10/17/07
PAGE 5
ITEM # FIS-07-319

Information

Pursuant to the provisions of Chapter 263:109, Laws of 2007 (HB2), Rate Setting, this letter contains information about the implementation of SFY 2008 rate increases in provider payment accounts for the Office of Medicaid Business and Policy (OMBP) and in the Bureau of Elderly and Adult Services (BEAS).

Explanation

This is the fourth in a series of Information letters on implementing rate increases. The first Information letter was accepted on July 24, 2007, FIS 07-235. The second Information letter relative to acuity-based nursing services was accepted July 24, 2007, FIS 07-236. The third Information letter is dated August 29, 2007 and submitted for the October 17, 2007 Fiscal Committee meeting.

Chapter 263:109, Laws of 2007 (HB2), Rate Setting, includes the following section:

109 Department of Health and Human Services; Rate Setting. For the biennium ending June 30, 2009, the commissioner of the department of health and human services shall set rates paid to providers consistent with the operating budget appropriations allotted to pay providers in each program including any rate increases provided in the operating budget. Such rates shall reflect legislative decisions to provide specific rate increases as footnoted in the operating budget. The commissioner shall report quarterly to the fiscal committee of the general court, the governor, the speaker of the house of representatives, and the president of the senate concerning the status of appropriations for payments to providers and the rates established by the department.

In addition, Chapter 262:1, Laws of 2007 (HB1), the operating budget, contains the following footnotes about the appropriations for rate increases in each division. Rate increase implementation status is included below.

Office of Medicaid Business and Policy, Provider Payments, PAU 05-01-02-01-03

From amounts appropriated herein, the Department shall provide a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective January 1, 2009 for skilled nursing facilities, intermediate care facilities, ambulance services, home health services, wheelchair van, physicians services, dental services, personal care, adult medical day care, and rural health clinic.

Bureau of Elderly and Adult Services, Nursing Services, PAU 05-01-08-04-01

From the amounts appropriated herein, the Department shall provide a 2% rate increase in FY08 effective July 1, 2007, and a 2% rate increase in FY09 effective January 1, 2009 for skilled nursing facilities, ambulance services, wheelchair van, physicians services, dental services personal care, adult medical day care, rural health clinic...(in part)

Implementation status: Rate increases are fully implemented for nine of the provider types, effective July 1, 2007 or as noted below.

Skilled Nursing Facilities: BEAS, through its semi-annual rate setting process sets rates for skilled nursing facilities, which are based on each facility's cost report. These rates are recalculated each February and August. The 2% rate increase will be applied according to this schedule.

Ambulance: OMBP staff met with the President of the Ambulance Association in early July to obtain input regarding funding for the ambulance rate increase should be applied. The President of the Ambulance Association spoke of increased fuel costs and suggested the funds be used to increase the mileage reimbursement rate. Based on that conversation, the ambulance rate funds were targeted toward a mileage reimbursement rate increase rather than for other ambulance services. Based on available funding, the mileage rate was increased 13% from \$2.60 per mile to \$2.94 per mile

Home Health Services: DHHS and the Home Care Association of New Hampshire have engaged in discussions for more than year about how home health rates should be structured. Based on these discussions, funds for SFY 2008 were targeted to increase payment rates for the shorter home health visits – skilled nursing by 3.7% and home health aide visits of less than 2 hours by 3.8%. These increases have been separately reported in the pending August 29, 2007 Information letter.

Wheelchair Van: Five procedure codes apply to wheelchair van services and each was increased 2%.

Physicians: Funding for physician services was targeted toward three procedure categories most in need of a rate increase due to known access issues resulting from extremely low reimbursement rates for these services.

1. Complaints about reimbursement rates for optometric services have been received from vision care providers consistently for the past couple of years. As a result, OMBP staff has had ongoing conversations with the New Hampshire Medical Society, which represents ophthalmologists as one of its physician specialties, the New Hampshire Optometric Association, and individual providers about how to resolve the inadequate rates for their services. The New Hampshire Optometric Society conducted a survey inquiring why more optometrists do not accept Medicaid patients and what issues they see as most critical. This work resulted in the identification of seven procedures—including eye exams, refraction, and fitting of spectacles—in most need of a rate increase. These codes were increased by 35% to 146% bringing the rates up to 60% of the Medicare rate.
2. Complaints about Medicaid reimbursement rates have been received from DCYF/DJJS mental health providers consistently for the past couple of years. DCYF staff and OMBP staff met multiple times during this two-year period to discuss the rates, determine an appropriate rate to pay, and implement consistent with revised DCYF mental health rules. The rate for a psychiatric diagnostic interview was increased 35% bringing that rate up to 60% of the Medicare rate. Using funds provided in the budget for a physician's rate increase toward resolving this critical issue was determined appropriate since over 25% of these services are billed by and paid to medical group practices, a primary provider type within the physician's category of service.
3. With the funds remaining for the physician's rate increase, rates for an additional 10 other selected physician services—immunization, surgery, and treatment of injuries—were chosen for a rate increase. These 10 codes were selected by the Medicaid Medical Director as having the most potential impact to providers. The current reimbursement rates are the most disparate from the Medicare reimbursement rate of all physician codes, and because of the procedure's applicability to the Medicaid population. These codes were increased to 31.5% of Medicare.

Dental: Consistent with rate increases provided in 2003, seventeen (17) dental procedure codes were chosen for rate increases in order to target the services most needed by children in the Healthy Kids--Gold program 0-3 years of age for both periodic and comprehensive oral evaluations as well preventative and restorative treatments. In keeping with past practices, the Department's Dental Director collaborated with the New Hampshire Dental Society and its members in selecting the codes. The Department also considered the rate increases within the context of its compliance with the Hawkins v. Commissioner Court Decree

Personal Care: Only one procedure code applies to personal care services and it was increased 2%.

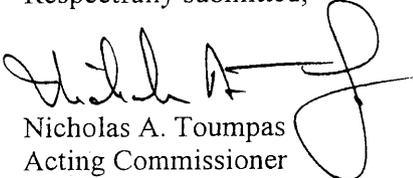
Adult Medical Day Care: Two procedure codes apply to adult medical day care services and both were increased 2%.

Implementation of the rate increase for the Rural Health Clinic (RHC) providers requires additional research and analysis of federal Medicare and Medicaid policy relative to upper payment limits,

The Honorable Marjorie K. Smith, Chairman
October 1, 2007
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review of current NH Medicaid reimbursement methodologies, as well as a state plan change. This rate change will proceed once outstanding questions are resolved.

Respectfully submitted,



Nicholas A. Toumpas
Acting Commissioner

CC: His Excellency, Governor John H. Lynch
The Honorable Sylvia B. Larsen, President, NH Senate
The Honorable Terie Norelli, Speaker, NH House of Representatives
The Honorable Marjorie K. Smith, Chairman, House Finance Committee
The Honorable Lou D'Allesandro, Chairman, Senate Finance Committee

Cost of Rate Increases in the DHHS Budget

UPDATED JULY 22, 2007										
Office of Medicaid & Business Policy										
Provider Payments										
			FY 2008				FY 2009			
	FY 2008	FY 2009	General	Federal	Other	Total	General	Federal	Other	Total
SKILL NURSING FAC NURSING HOME	2% July 1	2% Jan. 1,'09	\$43,982	\$43,982	\$0	\$87,963	\$23,104	\$23,104	\$0	\$46,207
INTERMED CARE FAC NURSE HOME	2% July 1	2% Jan. 1,'09	\$87	\$87	\$0	\$173	\$46	\$46	\$0	\$91
AMBULANCE SERVICE	2% July 1	2% Jan. 1,'09	\$16,924	\$16,924	\$0	\$33,848	\$8,890	\$8,890	\$0	\$17,780
HOME HEALTH SERVICES	2% July 1	2% Jan. 1,'09	\$76,562	\$76,562	\$0	\$153,124	\$40,218	\$40,218	\$0	\$80,436
WHEELCHAIR VAN	2% July 1	2% Jan. 1,'09	\$7,705	\$7,705	\$0	\$15,410	\$4,048	\$4,048	\$0	\$8,095
PHYSICIANS SERVICES	2% July 1	2% Jan. 1,'09	\$409,033	\$409,033	\$0	\$818,065	\$214,865	\$214,865	\$0	\$429,729
DENTAL SERVICE	2% July 1	2% Jan. 1,'09	\$164,328	\$164,328	\$0	\$328,655	\$86,321	\$86,321	\$0	\$172,642
PERSONAL CARE	2% July 1	2% Jan. 1,'09	\$14,726	\$14,726	\$0	\$29,452	\$7,736	\$7,736	\$0	\$15,471
ADULT MEDICAL DAY CARE	2% July 1	2% Jan. 1,'09	\$7,732	\$7,732	\$0	\$15,463	\$4,062	\$4,062	\$0	\$8,123
RURAL HEALTH CLINIC	2% July 1	2% Jan. 1,'09	\$113,209	\$113,209	\$0	\$226,418	\$59,469	\$59,469	\$0	\$118,938
Crotched Mountain	4.6% July 1, 2007		\$45,365	\$45,365	\$0	\$90,729	\$45,365	\$45,365	\$0	\$90,729
TOTAL			\$899,650	\$899,650	\$0	\$1,799,300	\$494,121	\$494,121	\$0	\$988,241
Division for Children, Youth and Families										
			FY 2008				FY 2009			
	FY 2008	FY 2009	General	Federal	Other	Total	General	Federal	Other	Total
Child care Providers	5% July 1	5% July 1	\$94,178	\$1,465,016	\$0	\$1,559,194	\$295,820	\$2,901,673	\$0	\$3,197,493
Residential Providers	2% July 1	2% July 1	\$351,931	\$368,503	\$115,316	\$835,750	\$945,400	\$742,815	\$0	\$1,688,215
Ancillary Service Providers	2% July 1	2% Jan. 1,'09	\$229,688	\$240,505	\$75,261	\$545,454	\$461,236	\$362,400	\$0	\$823,636
TOTAL			\$675,797	\$2,074,024	\$190,577	\$2,940,398	\$1,702,456	\$4,006,888	\$0	\$5,709,344
Bureau of Elderly and Adult Services										
Provider Payments										
			FY 2008				FY 2009			
	FY 2008	FY 2009	General	Federal	Other	Total	General	Federal	Other	Total
SKILL NURSING FAC NURSING HOME	2% July 1	2% Jan. 1,'09	\$28,849	\$57,697	\$28,849	\$115,394	\$88,011	\$88,011	\$0	\$176,022
AMBULANCE SERVICE	2% July 1	2% Jan. 1,'09	\$809	\$1,618	\$809	\$3,236	\$2,468	\$2,468	\$0	\$4,936
HOME HEALTH SERVICES	2% July 1	2% Jan. 1,'09	\$53	\$105	\$53	\$210	\$160	\$160	\$0	\$320
WHEELCHAIR VAN	2% July 1	2% Jan. 1,'09	\$8,607	\$17,214	\$8,607	\$34,427	\$26,258	\$26,258	\$0	\$52,515
PHYSICIANS SERVICES	2% July 1	2% Jan. 1,'09	\$4,804	\$9,607	\$4,804	\$19,214	\$14,654	\$14,655	\$0	\$29,309
DENTAL SERVICE	2% July 1	2% Jan. 1,'09	\$168	\$335	\$168	\$670	\$511	\$511	\$0	\$1,022
PERSONAL CARE	2% July 1	2% Jan. 1,'09	\$16,554	\$33,108	\$16,554	\$66,215	\$50,502	\$50,502	\$0	\$101,004
ADULT MEDICAL DAY CARE	2% July 1	2% Jan. 1,'09	\$1,655	\$3,311	\$1,655	\$6,621	\$5,050	\$5,050	\$0	\$10,100
RURAL HEALTH CLINIC	2% July 1	2% Jan. 1,'09	\$988	\$1,977	\$988	\$3,953	\$3,015	\$3,015	\$0	\$6,030
TOTAL			\$62,485	\$124,970	\$62,485	\$249,940	\$190,629	\$190,629	\$0	\$381,258

Cost of Rate Increases in the DHHS Budget

Long Term Care		FY 2008	FY 2009								
Nursing Homes	2% July 1	2% Jan. 1,'09	\$945,444	\$1,890,888	\$945,444	\$3,781,775	\$0	\$2,747,695	\$2,747,695	\$5,495,390	
Home and Community Based Care (HCBC)	2% July 1	2% Jan. 1,'09	\$174,033	\$348,067	\$174,033	\$696,133	\$0	\$543,236	\$543,236	\$1,086,472	
Case Management	3% July 1	2% Jan. 1,'09	\$0			\$0	\$0			\$0	
Mid-level Care	2% July 1	2% Jan. 1,'09	\$29,673	\$59,347	\$29,673	\$118,693	\$0	\$113,255	\$113,255	\$226,510	
Other Nursing Homes	2% July 1	2% Jan. 1,'09	\$39,916	\$39,916	\$0	\$79,831	\$60,275	\$60,275	\$0	\$99,802	
Crotched Mountain	4.6% July 1, 2007 plus additional appropriation of \$200k per year		\$193,151	\$240,938	\$47,787	\$481,876	\$240,938	\$240,938	\$0	\$481,876	
TOTAL			\$1,382,217	\$2,579,154	\$1,196,937	\$5,158,308	\$301,213	\$3,705,399	\$3,404,186	\$7,390,050	
Bureau of Community Mental Health Services											
			FY 2008				FY 2009				
	FY 2008	FY 2009	General	Federal	Other	Total	General	Federal	Other	Total	
Community Mental Health Centers	2% July 1	2% Jan. 1,'09	\$817,443	\$817,443	\$0	\$1,634,886	\$1,226,165	\$1,226,165	\$0	\$2,452,330	
Family Intensive Treatment Teams											
Community Residences	\$81 to \$94 July 1	\$94 to \$107 July 1	\$375,000	\$375,000	\$0	\$750,000	\$750,984	\$750,984	\$0	\$1,501,968	
TOTAL											
Bureau of Developmental Services											
			FY 2008				FY 2009				
	FY 2008	FY 2009	General	Federal	Other	Total	General	Federal	Other	Total	
Developmental Services	2% July 1	2% Jan. 1,'09	\$1,636,540	\$1,636,540	\$0	\$3,273,080	\$2,471,176	\$2,471,176	\$0	\$4,942,351	
DD Waitlist Increase over FY'06-07 Budget			\$2,662,058	\$2,662,058	\$0	\$5,324,116	\$4,878,917	\$4,878,917	\$0	\$9,757,833	
ABD Waitlist Increase over FY'06-07 Budget			\$14,027	\$30,068	\$0	\$44,095	\$324,886	\$576,824	\$0	\$901,710	
TOTAL											
Total Department of Health & Human Services:			\$3,020,149	\$5,677,798	\$1,449,999	\$10,147,946	\$2,688,419	\$8,397,037	\$3,404,186	\$14,468,893	

Summary of Information and Testimony From Public Hearing

The following provides a high level summary of the testimony from the public hearing held on September 19, 2008 and written comments submitted to DHHS. Although not required under the statute, we accepted written comments for an additional five days after the meeting. Comments received after this time were not summarized, although they will be carefully considered for the next report and other rate setting efforts of the DHHS. Where available, complete comments are provided in *Appendix F: Public Hearing* at the end of this report.

We've addressed expressed methodological concerns where possible in the time available to meet the report submission deadline; additional concerns may be addressed in later releases of this report.

A. Summary of Testimony Given at the Public Hearing

Linda Steir, Owner and Executive Director SarahCare Adult Day Services

- Ms. Steir operates a business providing day services exclusively for senior adults needing assistance. They have 40 clients enrolled with an average daily attendance of 23 clients.
- They can handle up to 50 clients per day, but cannot afford to take on all of the Medicaid clients that are interested in their services because current NH Medicaid daily rates are less than their daily expenses.
- Ms. Steir provided several ideas for addressing the rate issues as related to actual length of stay each day, as stays at her business vary from 4 to 11 hours. She also provided examples of rates paid by other state Medicaid programs.

James Williamson, Executive Director New Hampshire Dental Society

- The New Hampshire Dental Society sees the most value in benchmarking against private health insurance programs in the state, as dental providers compare NH Medicaid rates against these to determine how actively they will serve Medicaid clientele.
- Connecticut Medicaid is now paying rates nearly as high as commercial rates, 30 – 35% higher than what NH Medicaid currently pays. From their perspective this, combined with the presence of a dental school in Connecticut, makes Connecticut a more attractive place to practice.
- They appreciate NH's efforts in focusing on the 48 specific procedures that comprise roughly 95% of the procedures needed to deliver comprehensive care.
- This organization would like to see more Medicaid dental coverage for adults.

Janet Monahan, Deputy Executive Vice President NH Medical Society

- Ms. Monahan asked why the ARNP rates shown on the Benchmarking Summary by Service Group were higher than the Physician rates for primary care treatment services.

**Steve Norton, Executive Director
NH Center for Public Policy Studies**

Mr. Norton commended DHHS for producing the most comprehensive benchmarking report he's seen done by the State and provided two verbal comments:

- For the inpatient hospital analysis DHHS has potentially underestimated NH payments due to the exclusion of catastrophic payments (i.e. neonatal)
- For the outpatient hospital analysis DHHS has potentially overestimated NH payments on these due to the settlement process that occurs at the end of each year.

**Leslie Melby, Vice President, State Government Relations
New Hampshire Hospital Association**

NH Hospital Association's comments related to inpatient and outpatient hospital services:

- They pointed out that Medicare pays critical access hospitals differently than prospective payment system (PPS) hospitals, currently at 101% percent of cost. The report only mentions PPS hospitals.
- New Hampshire's Medicaid reimbursement for hospital services is seriously inadequate when compared to the cost of providing services as well as when compared to the level of Medicaid reimbursement in other states.
- They made several references to Medicaid rates being frozen at 2001 levels.
- They suggested two comparisons that could be made to other state Medicaid programs
- They requested an extension on the deadline for comments.

**Susan Young, Executive Director
Granite State Home Health Association
(An Affiliate of the Home Care Association of New Hampshire)**

- Ms. Young's comments focused primarily on historic information from the rate negotiations that occurred in the process of developing the rate calculation methodology now found in the administrative rule for home health rates (He-W 553) and how this information relates to statements in the report related to the inability to provide meaningful comparisons at this time and statements in the footnotes related to utilization.

B. Summary of Written Comments Submitted After the Public Hearing

Susan Young, Executive Director
Granite State Home Health Association
(An Affiliate of the Home Care Association of New Hampshire)

Ms. Young's comments focused primarily on:

- More specific detail on historic information from the rate negotiations that occurred in the process of developing the rate calculation methodology now found in the administrative rule for home health rates (He-W 553) and how this information relates to statements in the report related to the inability to provide meaningful comparisons at this time and statements in the footnotes related to utilization
- The listing of published rates in Appendix E of the draft report, and the calculation of the average rates listed therein.

Rickey Silverman, Ph.D.
Silverman & Associates, Inc.

Mr. Silverman sent comments addressing NH Medicaid rates for mental health services.

- He pointed out that NH Medicaid rates have not increased since 1998.
- He provided an example of increasing a \$65.00 rate by the Social Security Cost of Living Adjustment each year up through 2007, resulting in a rate of \$85.57.

Angela Boyle, RDH, BS
Public Policy Coordinator
Coalition for NH Oral Health Action

Ms. Boyle's submitted comments related to:

- Attracting and increasing the number of dental providers willing to accept Medicaid patients as related to reimbursement rates.
- The importance of preventative and restorative dental care for the adult Medicaid population.

Tess Stack Kuenning, Executive Director
Vanessa Santarelli, Director of New Hampshire Public Policy
Bi-State Primary Care Association

Ms. Kuenning and Ms. Santarelli submitted comments related to community health centers, including FQHCs and RHCs.

- The main theme of these comments is the adequacy of NH Medicaid provider rates generally and their impact on recruiting and retaining primary care and preventative services providers.
- They indicate that we are at a crisis situation in terms of recruiting and retaining primary care providers, and that without adequate reimbursement rates for primary care and preventative services, we are unable to compete at the national level to recruit providers. New Hampshire currently has at least 50 primary care vacancies that Bi-State is aware of. This limits access to primary care for everyone, not just Medicaid beneficiaries.
- They point out the practice of cost shifting to private insurance holders and its impact on the health care system.

Gina Balkus
Director of Government Relations
Dartmouth-Hitchcock

Ms. Balkus submitted comments that:

- Described Dartmouth-Hitchcock as New Hampshire’s “safety net” for Medicaid and uninsured patients, and how they are disproportionately impacted by the inadequacy of NH Medicaid’s rates.
- Included specific observations related to inpatient, neonatal and outpatient hospital rates, urging DHHS to:
 - Increase the Price Per Point to better reflect the true cost of medical care (inpatient hospital).
 - Increase the per diem rates for neonatal DRGs. They also recommend that DHHS revise the catastrophic payment formula by introducing a “case mix index” threshold so that the catastrophic pool supplements payment for high-cost, high-acuity, truly “catastrophic” care.
 - Develop an outpatient payment formula that pays hospitals for the true cost of care.

Appendix A: Selected Procedures by Service Group and Sub-Group

The following table provides a listing of the procedure codes, DRGS, and revenue codes used for this benchmarking analysis, sorted by service group and sub-group.

Service Group	Service Sub-Group	Code and Description
Ambulance Transportation and Life Support	Advanced Life Support	A0426 ALS 1
		A0427 ALS1-Emergency
		A0433 ALS 2
	Basic Life Support	A0428 BLS
		A0429 BLS-Emergency
	Ground Mileage	A0425 Ground Mileage
ARNP	Preventive	99381 Init Pm E/M, New Pat, Inf
		99382 Init Pm E/M, New Pat 1-4 Yrs
		99383 Prev Visit, New, Age 5-11
		99384 Prev Visit, New, Age 12-17
		99385 Prev Visit, New, Age 18-39
		99386 Prev Visit, New, Age 40-64
		99387 Prev Visit, New, Age 65+
		99391 Per Pm Reeval, Est Pat, Inf
		99392 Prev Visit, Est, Age 1-4
		99393 Prev Visit, Est, Age 5-11
		99394 Prev Visit, Est, Age 12-17
		99395 Prev Visit, Est, Age 18-39
		99396 Prev Visit, Est, Age 40-64
		Treatment
	99202 Office/Outpatient Visit, New	
	99203 Office/Outpatient Visit, New	
	99204 Office/Outpatient Visit, New	
	99205 Office/Outpatient Visit, New	
	99211 Office/Outpatient Visit, Est	
	99212 Office/Outpatient Visit, Est	
	99213 Office/Outpatient Visit, Est	
99214 Office/Outpatient Visit, Est		
99215 Office/Outpatient Visit, Est		

Service Group	Service Sub-Group	Code and Description
Dental Services for Children	Diagnostic	D0120 Periodic Oral Evaluation
		D0140 Limit Oral Eval Problm Focus
		D0150 Comprehensive Oral Evaluation
	Diagnostic Imaging	D0210 Intraor Complete Film Series
		D0272 Dental Bitewings Two Films
		D0274 Dental Bitewings Four Films
	Endodontics	D3220 Therapeutic Pulpotomy
		D3310 Anterior
		D3320 Root Canal Therapy 2 Canals
		D3330 Root Canal Therapy 3 Canals
	Oral Surgery	D7140 Extraction Erupted Tooth/Exr
		D7210 Rem Imp Tooth w Mucoper Flp
		D7240 Impact Tooth Remov Comp Bony
	Preventive	D1120 Dental Prophylaxis Child
		D1203 Topical Fluor wo Prophy Chi
		D1351 Dental Sealant Per Tooth
	Restorative	D2140 Amalgam One Surface Permanen
		D2150 Amalgam Two Surfaces Permane
		D2160 Amalgam Three Surfaces Perma
		D2161 Amalgam 4 or > Surfaces Perm
		D2330 Resin One Surface-Anterior
		D2331 Resin Two Surfaces-Anterior
		D2332 Resin Three Surfaces-Anterio
D2391 Post 1 Srfc Resinbased Cmpst		
D2392 Post 2 Srfc Resinbased Cmpst		
D2393 Post 3 Srfc Resinbased Cmpst		
D2394 Post >=4srfc Resinbase Cmpst		
D2940 Dental Sedative Filling		
FQHC and RHC Clinic Service Encounter Rates	Federally Qualified Health Center	T1015 Clinic Visit/encounter, all inclusive
	Rural Health Clinic	T1015 Clinic Visit/encounter, all inclusive
	Hospital-based Rural Health Clinic	Hospital-based Rural Health Clinic
Inpatient Hospital	Cesarean section w C.C.	
	Cesarean Section w/o C.C.	

Service Group	Service Sub-Group	Code and Description
	Chronic Obstructive Pulmonary Disease	
	Craniotomy Age 0-17	
	ECMO or Trach w MFV 96+ hrs or PDX exc face, mouth & neck w/ maj O.R	
	Extreme Immaturity or Resp Distress (daily rate)	
	Full Term Neonate w Major Problems (daily rate)	
	Neonate Died or Transferred (daily rate)	
	Neonates w/ other significant problems (daily rate)	
	Normal Newborn	
	Prematurity w/ Major Problems (daily rate)	
	Prematurity w/o Major problems (daily rate)	
	Psychoses	
	Rehabilitation	
	TRACH W MV 96+ hrs or PDX exc face, mouth & Neckw/o maj O.R.	
	Vaginal Delivery w/ Complications	
	Vaginal Delivery w/o complications	
Interpreter Services	Interpreter Services - Hearing Impaired, 15 Min	T1013 Sign Lang/Oral Interpreter - Hearing Impaired 1st Hour
	Interpreter Services - Language, 15 Min	T1013 Sign Lang/Oral Interpreter - Hearing Impaired 1st Hour
	Interpreter Services - Each Additional 15 Minutes	T1013 Sign Lang/Oral Interpreter - Hearing Impaired Each Add 15 min
Optometric Services	Fitting of Spectacles	92340 Fitting of Spectacles
		92341 Fitting of Spectacles
	Refraction	92015 Refraction
Outpatient Hospital	Chest X-Ray (2 Views) (71020)	
	Complete CBC w Auto Diff WBC (85025)	
	Emergency (Rev Cd 450)	
	MRI Brain wo Dye (70551)	
	MRI Brain wo&w Dye (70553)	
	MRI Lumbar Spine wo Dye (72148)	
	MRI Neck Spine wo Dye (72141)	
	Operating Room Services (Rev Cd 360)	
	Recovery Room (Rev Cd 710)	
	X-Ray Exam of Ankle (73610)	
Physician Services	Consultations	99241 Office Consultation

Service Group	Service Sub-Group	Code and Description
		99242 Office Consultation
		99243 Office Consultation
		99244 Office Consultation
		99245 Office Consultation
		99251 Inpatient Consultation
		99252 Inpatient Consultation
		99253 Inpatient Consultation
		99254 Inpatient Consultation
		99255 Inpatient Consultation
	Emergency Department Services	99281 Emergency Dept. Visit
		99282 Emergency Dept. Visit
		99283 Emergency Dept. Visit
		99284 Emergency Dept. Visit
		99285 Emergency Dept. Visit
	Hospital Care	99221 Initial Hospital Care
		99222 Initial Hospital Care
		99223 Initial Hospital Care
		99231 Subsequent Hospital Care
		99232 Subsequent Hospital Care
		99233 Subsequent Hospital Care
	Obstetric Services - Antepartum Care, Delivery, Postpartum Care	59400 Obstetrical Care
		59409 Obstetrical Care
		59410 Obstetrical Care
		59412 Antepartum Manipulation
		59414 Deliver Placenta
		59425 Antepartum Care Only
		59426 Antepartum Care Only
		59430 Care After Delivery
		59510 Cesarean Delivery
		59514 Cesarean Delivery Only
		59515 Cesarean Delivery
		59610 VBAC Delivery
		59612 VBAC Delivery Only
		59614 VBAC Care After Delivery

Service Group	Service Sub-Group	Code and Description
		59618 Attempted VBAC Delivery
		59620 Attempted VBAC Delivery Only
		59622 Attempted VBAC After Care
	Obstetric Services - Fetal Non-Stress Test	59025 Fetal Non-Stress Test
	Obstetric Services - Obstetric Ultrasound	76801 Ob US < 14 Wks, Single Fetus
		76802 Ob US < 14 Wks, Addl Fetus
		76805 Ob US >= 14 Wks, Sngl Fetus
		76810 Ob US >= 14 Wks, Addl Fetus
		76811 Ob US, Detailed, Sngl Fetus
		76812 Ob US, Detailed, Addl Fetus
		76813 Ob US Nuchal Meas, 1 Gest
		76814 Ob US Nuchal Meas, Add-On
		76815 Ob US, Limited, Fetus(s)
		76816 Ob US, Follow-Up, Per Fetus
		76817 Transvaginal US, Obstetric
	Primary Care Evaluation & Management - Primary Care Preventive	99381 Init Pm E/M, New Pat, Inf
		99382 Init Pm E/M, New Pat 1-4 Yrs
		99383 Prev Visit, New, Age 5-11
		99384 Prev Visit, New, Age 12-17
		99385 Prev Visit, New, Age 18-39
		99386 Prev Visit, New, Age 40-64
		99387 Init Pm E/M, New Pat 65+ Yrs
		99391 Per Pm Reeval, Est Pat, Inf
		99392 Prev Visit, Est, Age 1-4
		99393 Prev Visit, Est, Age 5-11
		99394 Prev Visit, Est, Age 12-17
		99395 Prev Visit, Est, Age 18-39
		99396 Prev Visit, Est, Age 40-64
	99397 Per Pm Reeval Est Pat 65+ Yr	
	Primary Care Evaluation & Management - Primary Care Treatment	99201 Office/Outpatient Visit, New
		99202 Office/Outpatient Visit, New
		99203 Office/Outpatient Visit, New
		99204 Office/Outpatient Visit, New

Service Group	Service Sub-Group	Code and Description
		99205 Office/Outpatient Visit, New
		99211 Office/Outpatient Visit, Est
		99212 Office/Outpatient Visit, Est
		99213 Office/Outpatient Visit, Est
		99214 Office/Outpatient Visit, Est
		99215 Office/Outpatient Visit, Est
	Psychiatry - Medication Mgt.	90862 Medication Management
Psychology (non CMHC)	Family Psytch w Patient	90847 Family Psytch w Patient
	Psy Dx Interview	90801 Psy Dx Interview
	Psytch, Off, 45-50 Min	90806 Psytch, Off, 45-50 Min

Appendix B: Data and Methods

A. Fee Schedule Data

- NH rates paid from the NH Medicaid fee schedule were obtained from the current Medicaid Management Information System (MMIS), also known as NH AIM.
- Data on payment rates for procedures were obtained from published fee schedules for Medicare and other New England state Medicaid programs in effect on January 1, 2008.
- Commercial insurance rates come from New Hampshire Comprehensive Health Care Information System (NH CHIS) claims data for 2006, therefore reflecting rates that are on average 18 months older than the Medicaid rates being compared. Please see *Appendix E: Commercial Payment Rates for Benchmarks* for more information on this data.

B. Treatment of Facility Based Rates

Two payers, Medicare and the Massachusetts Medicaid program (MassHealth) pay different rates for many procedures depending on site of service. Compared with services provided in a physician's office, rates for professional services are lower when provided in facilities such as a hospital (inpatient or outpatient) or nursing home as some of the cost is covered in the separate facility payment. For these two payers we used a weighted average of rates with weights reflecting the relative share of units provided in facility and non-facility settings.

$$\% \text{ Facility} = \text{Units Facility} / \text{Total Units}$$

$$\text{Calculated Rate} = ((1 - \% \text{ Facility}) * \text{non facility rate}) + (\% \text{ Facility} * \text{facility rate})$$

C. Weighted Rates

To calculate the weighted rates for each procedure subgroup, we performed the following on each subgroup of procedures:

$$\text{Weighted Rate} = \Sigma(\text{Units Prof} * \text{Rate}) / \Sigma \text{Units Prof}$$

In all cases we used NH units for SFY 2007. We utilized this formula to calculate procedure subgroup weighted rates for New Hampshire, the other New England states, Medicare, and commercial insurance.

Weighting rates in this manner provides useful comparisons between physician and ARNP rates and utilization. For instance, the rate calculated for primary care treatment codes is based on a weighted average involving the utilization of CPT codes 99201-99215. Reimbursement rates for the treatment codes vary by level, with 99214 and 99215 having the highest rates for established patients. The weighted rate for ARNP Treatment is higher than the Physicians because ARNPs, on average, billed the highest level established patient treatment visits (99214 and 99215) much more frequently than physicians. This may be due in part to the fact that ARNP visits with patients are often longer than physician encounters, which may justify the higher level codes.

Based on the weighted rates, we calculated the following payments as a percent of NH Medicaid:

- Weighted NH/Weighted NH
- Weighted Other States/Weighted NH
- Weighted Medicare/Weighted NH
- Weighted Commercial/Weighted NH

Appendix C: Who Pays What

The following table provides an overview of which states/Medicare/Commercial pay for each service sub-group.

Service Group	Service Sub-Group	CT	MA	ME	NH	RI	VT	Medicare	Commercial
Ambulance Transportation and Life Support ¹	Advanced Life Support	Yes	Yes						
	Basic Life Support	Yes	Yes						
	Ground Mileage	Yes	Yes						
ARNP ²	Preventive	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Treatment	Yes	Yes						
Dental Services for Children ³	Diagnostic	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Diagnostic Imaging	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Endodontic	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Oral Surgery	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Preventive	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Restorative	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
FQHC and RHC Clinic Service Encounter Rates	Federally Qualified Health Center				Yes				
	Hospital-based Rural Health Clinic				Yes				
	Rural Health Clinic				Yes				
Inpatient Hospital	Cesarean section w C.C.				Yes				
	Cesarean Section w/o C.C.				Yes				
	Chronic Obstructive Pulmonary Disease				Yes				
	Craniotomy Age 0-17				Yes				
	ECMO or Trach w MFV 96+ hrs or PDX exc face, mouth & neck w/ maj O.R				Yes				
	Extreme Immaturity or Resp Distress (daily rate)				Yes				
	Full Term Neonate w Major Problems (daily rate)				Yes				
	Neonate Died or Transferred (daily rate)				Yes				
	Neonates w/ other significant problems (daily rate)				Yes				
	Normal Newborn				Yes				
	Prematurity w/ Major Problems (daily rate)				Yes				
	Prematurity w/o Major problems (daily rate)				Yes				
	Psychoses				Yes				

¹ Ambulance: Maine pays negotiated rates for ambulance services.

² ARNP: Connecticut pays 90% of Physician Rate, Medicare does not pay ARNPs for preventative care

³ Dental: While all New England states pay for dental services, we included only CT in the analysis since they recently increased their rates to draw dentists to that state.

Service Group	Service Sub-Group	CT	MA	ME	NH	RI	VT	Medicare	Commercial
	Rehabilitation				Yes				
	TRACH W MV 96+ hrs or PDX exc face, mouth & Neckw/o maj O.R.				Yes				
	Vaginal Delivery w/ Complications				Yes				
	Vaginal Delivery w/o complications				Yes				
Interpreter Services	Interpreter Services - Each Additional 15 Minutes	No	No	Yes	Yes	No	Yes	No	No
	Interpreter Services - Hearing Impaired, 15 Min	No	No	Yes	Yes	No	Yes	No	No
	Interpreter Services - Language, 15 Min	No	No	Yes	Yes	No	Yes	No	No
Optometric Services	Fitting of Spectacles	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Refraction	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Outpatient Hospital	Chest X-Ray (2 Views) (71020)				Yes				
	Complete CBC w Auto Diff WBC (85025)				Yes				
	Emergency (Rev Cd 450)				Yes				
	MRI Brain wo Dye (70551)				Yes				
	MRI Brain wo&w Dye (70553)				Yes				
	MRI Lumbar Spine wo Dye (72148)				Yes				
	MRI Neck Spine wo Dye (72141)				Yes				
	Operating Room Services (Rev Cd 360)				Yes				
	Recovery Room (Rev Cd 710)				Yes				
	X-Ray Exam of Ankle (73610)				Yes				
Physician Services	Consultations	Yes	Yes						
	Emergency Department Services	Yes	Yes						
	Hospital Care	Yes	Yes						
	Obstetric Services - Antepartum Care, Delivery, Postpartum Care ⁴	Yes	Yes						
	Obstetric Services - Fetal Non-Stress Test	Yes	Yes						
	Obstetric Services - Obstetric Ultrasound ⁵	Yes	Yes						
	Primary Care Evaluation & Management - Primary Care Preventive ⁶	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Primary Care Evaluation & Management - Primary Care Treatment	Yes	Yes						
	Psychiatry - Medication Mgt.	Yes	Yes						
Psychology (non CMHC)	Family Psytch w Patient	Yes	Yes						
	Psy Dx Interview	Yes	Yes						
	Psytch, Off, 45-50 Min	Yes	Yes						

⁴ Obstetric Services - Antepartum Care, Delivery, Postpartum Care: CT pays for only a limited number of procedure codes

⁵ Obstetric Services - Obstetric Ultrasound: ME pays for some of these procedures on a "by report" basis

⁶ Primary Care Evaluation & Management - Primary Care Preventive: Medicare does not pay for preventive visits

Appendix D: Rates, Payment Methodology and Policy – Other New England States and Medicare

The following information provides an overview of how the other New England states, Medicare and commercial insurance pay for the procedures included in this analysis.

A. Ambulance Transportation and Life Support Service Group

We focused on base rates for basic life support (BLS), advanced life support (ALS), and mileage for this benchmarking analysis. Loaded Mileage is the distance traveled while transporting the recipient from the pick-up point to a drop-off point. The mileage rate is for loaded miles only.

1. Rate Information

Following are rates in effect as of January 1, 2008:

Service Group	Procedure w Code	Posted Rates								
		NH	Avg - Other NE States	CT	MA	ME	RI	VT	All Comm	Medicare
Ground Mileage	A0425 Ground Mileage	\$2.96	\$2.46	\$2.88	\$2.82	\$2.00	\$1.75	\$2.84	\$16.44	\$6.25
Advanced Life Support	A0426 ALS 1	\$154.23	\$131.99	\$173.45	\$174.30	NEGOTIATED RATE	\$69.95	\$110.27	\$375.56	\$251.92
	A0427 ALS1-Emergency	\$175.00	\$158.73	\$173.45	\$276.00	NEGOTIATED RATE	\$69.95	\$115.53	\$449.66	\$398.88
	A0433 ALS 2	\$175.00	\$294.27		\$399.45	NEGOTIATED RATE		\$189.09	\$673.07	\$577.33
Basic Life Support	A0428 BLS	\$145.00	\$117.43	\$153.45	\$145.25	NEGOTIATED RATE	\$69.95	\$101.08	\$341.92	\$209.94
	A0429 BLS-Emergency	\$145.00	\$139.22	\$153.45	\$232.40	NEGOTIATED RATE	\$69.95	\$101.08	\$439.17	\$335.90

2. Connecticut ⁷

Reimbursement Guidelines

For all transportation, payments shall be made at the lower of:

- The usual and customary charge to the public, if applicable;
- The Medicare rate, if one exists;
- The fee, as published by the Department in its fee schedule; or
- The amount requested of billed.

Mileage

- Loaded mileage is the distance traveled by a motor vehicle while carrying passengers from a pickup point to a drop-off point. The Department may pay for loaded mileage if the vehicle must cross a town line in order to transport a recipient(s) to or from a

⁷ CT rules and fee schedule found at: <http://www.ctmedicalprogram.com/publications.html#manuals>

medical provider. Loaded mileage shall be paid and calculated by the Department in accordance with PUCA Docket #6770-A and all its supplements.

- Out of State Mileage: no provision found

3. Maine⁸

Reimbursement Guidelines

- The amount of payment for services rendered shall be the lowest of the following:
- The amount listed in Chapter III, Section 5, "Allowances for Ambulance Services."
- The amount allowed by the Medicare Part B carrier.
- The ambulance's usual and customary charge.

It is the responsibility of the provider to seek payment from any other source that is available for payment of the rendered service prior to billing MaineCare.

Mileage

- No definitions or provisions found for Loaded Mileage, mileage, or Out of State Mileage

4. Massachusetts⁹

Reimbursement Guidelines

The rate of payment for a Class I and Class II Ambulance Service is the lowest of the following:

- The provider's usual and customary fee;
- The provider's actual charge; or
- The fee set by the Division of Health Care Finance and Policy

The service codes that must be used when billing for ambulance services are listed in Subchapter 6 of the Transportation Manual.

Mileage

- Loaded Mileage is the distance traveled while a member is in the vehicle.
- When two patients are transported in the same vehicle, payment for the MassHealth member is one-half the base fee. In such instances, the mileage fee applies only once.

⁸ MaineCare rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s005.doc>. Fee can be looked up at: <http://www.maine.gov/dhhs/bms/providerfiles/codes.htm>. MaineCare members pay a co-payment not to exceed \$3.00 per day for services provided, up to \$30.00 per month

⁹ MA rules and fees found in 114.3 CMR 26.00, found at: http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&LO=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_regs_related_pubs&csid=Eeohhs2#114_3_17

5. New Hampshire ¹⁰

Reimbursement Guidelines

- Reimbursement for ambulance transportation is based on a fee schedule determined by the Office of Medical Services.
- Fees are based on base rates, mileage, waiting time, intensive care unit, pediatric incubator, professional attendant, oxygen and medical supplies.

Mileage

- Loaded Mileage is the distance traveled while transporting the recipient from the pick-up point to a drop-off point. The mileage rate is for loaded miles only
- Only one mileage charge per trip is allowed regardless of the number of recipients transported.

6. Rhode Island ¹¹

Reimbursement Guidelines

- The reimbursement rates for Ambulance providers are listed on the Fee Schedule.
- Providers must bill the Medical Assistance Program for their usual and customary rate (UCR) as charged to the general public and not for the published fee schedule amount. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to the Medical Assistance Program.
- Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program.

Mileage

- The first ten miles are included in the base rate for BLS/ALS.
- Each additional mile, up to 50 miles, will be reimbursed. There is no additional reimbursement for more than 50 miles.

7. Vermont ¹²

The following information for Vermont is undergoing updates at this time. Please check their website to see if any updates have been posted.

Reimbursement Guidelines

- Reimbursement basis is the lower of provider's charge or Medicaid rate on file.
- Basic/base rates include all procedures (e.g., administration of medications, application of splints). The OVHA does not accept the modifiers utilized by Medicare. Air mileage is included within the ambulance service code and is not to be billed out separately.
- Other services incidental to the patient's condition, such as disposable supplies, oxygen; tolls and ferry expense are reimbursed when detailed on the claim. The invoice or receipt must be attached.

¹⁰ NH rules found at:

<http://www.nhmedicaid.com/Downloads/Manuals/Transportation%20Provider%20Specific%20Billing%20Guidelines%2011.doc>, fees found at: <http://www.nhmedicaid.com/Downloads/schedules.codes.html>

¹¹ RI rules found at: <http://www.dhs.state.ri.us/dhs/heacre/provsvcs/manuals/ambulance/ambtoc.htm>, fees found at: http://www.dhs.state.ri.us/dhs/heacre/provsvcs/fee_schedule.htm

¹² VT rules found at: <http://ovha.vermont.gov/for-providers/provider-manuals>, fees found at: <http://ovha.vermont.gov/for-providers/claims-processing-1>

- Medicaid is the payer of last resort. All other insurance, Medicare, and town or city government emergency charges must be billed before submitting a claim to Medicaid.

Mileage

- Loaded Mileage is the full number of miles the patient was on board/transported. The unit of service is the loaded mile. The completed claim must show the total loaded miles.

8. Medicare ¹³

Reimbursement Guidelines

Method of payment.

- Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount.
- The fee schedule payment for ambulance services equals a base rate for the level of service plus payment for mileage and applicable adjustment factors.
- Except for services furnished by certain critical access hospitals or entities owned and operated by them, all ambulance services are paid under the fee schedule specified in 42 CFR Ch. IV (10-1-02 Edition) § 414.601.

Mandatory assignment.

- Effective with implementation of the ambulance fee schedule described in § 414.601, for services furnished on or after April 1, 2002, all payments made for ambulance services are made only on an assignment-related basis.
- Ambulance suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect from the beneficiary any amount other than the unmet Part B deductible and Part B coinsurance amounts.

Formula for computation of payment amounts.

- The fee schedule payment amount for ambulance services is computed according to the following provisions. We have included the New Hampshire values for this calculation in Exhibit #1, found at the end of this document.

- Ground ambulance service levels.

- The Conversion Factor (CF) is multiplied by the applicable RVUs for each level of service to produce a service-level base rate.
- The service-level base rate is then adjusted by the GAF. Compare this amount to the actual charge.
- The lesser of the charge or the GAF adjusted base rate amount is added to the payment rate per mile, multiplied by the number of miles that the beneficiary was transported.
- When applicable, the appropriate RAF is applied to the ground mileage rate to determine the appropriate payment rates.
- The RVU scale for the ambulance fee schedule is as follows:

Service level	Relative value units (RVUs)
BLS	1.00
BLS–Emergency	1.60
ALS1	1.20

¹³ ¹³ Medicare rules found at: www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr414_610.pdf, fees found at: http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp#TopOfPage (2007_afs.zip)

ALS1–Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

- Air ambulance service levels.
 - The base payment rate for the applicable type of air ambulance service is adjusted by the GAF and, when applicable, by the appropriate RAF to determine the amount of payment.
 - Air ambulance services have no CF or RVUs.
 - This amount is compared to the actual charge.
 - The lesser of the charge or the adjusted GAF rate amount is added to the payment rate per mile, multiplied by the number of miles that the beneficiary was transported.
 - When applicable, the appropriate RAF is also applied to the air mileage rate.
- Loaded mileage.
 - Payment is made for each loaded mile.
 - Air mileage is based on loaded miles flown as expressed in statute miles.
 - There are three mileage payment rates: a rate for FW services, a rate for RW services, and a rate for all levels of ground transportation.
- Geographic adjustment factor (GAF).
 - For ground ambulance services, the PE portion of the GPCI from the physician fee schedule is applied to 70 percent of the base rate for ground ambulance services.
 - For air ambulance services, the PE portion of the physician fee schedule GPCI is applied to 50 percent of the base rate for air ambulance services.
- Rural adjustment factor (RAF).
 - For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and by 25 percent for miles 18 through 50.
 - The standard mileage rate applies to every mile over 50 miles.
 - For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.
- Multiple patients.
 - The allowable amount per beneficiary for a single ambulance transport when more than one patient is transported simultaneously is based on the total number of patients (both Medicare and non-Medicare) on board.
 - If two patients are transported simultaneously, then the payment allowance for the beneficiary (or for each of them if both patients are beneficiaries) is equal to 75 percent of the service payment allowance applicable for the level of care furnished to the beneficiary, plus 50 percent of the applicable mileage payment allowance.
 - If three or more patients are transported simultaneously, the payment allowance for the beneficiary (or each of them) is equal to 60 percent of the service payment allowance applicable for the level of care furnished to the beneficiary, plus the applicable mileage payment allowance divided by the number of patients on board.
- Point of pick-up.

- The zip code of the point of pick-up must be reported on each claim for ambulance services so that the correct GAF and RAF may be applied, as appropriate.
- Updates.
 - The CF, the air ambulance base rates, and the mileage rates are updated annually by an inflation factor established by law.
 - The inflation factor is based on the consumer price index for all urban consumers (CPI-U) (U.S. city average) for the 12-month period ending with June of the previous year.
- Adjustments.
 - The Secretary will annually review rates and will adjust the CF and air ambulance rates if actual experience under the fee schedule is significantly different from the assumptions used to determine the initial CF and air ambulance rates.
 - The CF and air ambulance rates will not be adjusted solely because of changes in the total number of ambulance transports.

B. ARNP Service Group

1. Rate Information

Following are rates in effect as of January 1, 2008:

ARNP Rates

ALS

Service Group	Procedure w Code	Posted Rates												
		NH	Avg - Other NE States	CT**	MA - NonFac	MA - Fac	Adjusted MA Rate Used	ME	RI	VT	All Comm	Medicare NH non facility	Medicare NH Facility	Adjusted Medicare Rate Used
ARNP Treatment	99201 Office/Outpatient Visit, New	\$20.16	\$24.57	\$20.39	\$29.42	\$17.73	\$28.23	\$21.92	\$16.72	\$35.61	\$49.78	\$36.51	\$21.93	\$35.03
	99202 Office/Outpatient Visit, New	\$33.60	\$43.97	\$35.34	\$50.94	\$35.03	\$50.01	\$32.56	\$27.24	\$63.30	\$90.21	\$62.55	\$42.46	\$61.38
	99203 Office/Outpatient Visit, New	\$42.56	\$62.17	\$52.17	\$75.00	\$53.58	\$73.50	\$48.45	\$29.00	\$93.99	\$129.98	\$91.43	\$65.04	\$89.58
	99204 Office/Outpatient Visit, New	\$63.84	\$92.17	\$78.71	\$113.72	\$88.08	\$111.79	\$68.76	\$45.00	\$133.16	\$171.29	\$139.16	\$108.45	\$136.85
	99205 Office/Outpatient Visit, New	\$80.64	\$113.71	\$98.49	\$142.46	\$115.53	\$140.93	\$87.34	\$46.00	\$169.41	\$236.09	\$174.61	\$141.13	\$172.71
	99211 Office/Outpatient Visit, Est	\$18.38	\$14.32	\$11.74	\$16.84	\$6.78	\$16.53	\$13.17	\$8.05	\$20.94	\$31.01	\$20.15	\$8.34	\$19.78
	99212 Office/Outpatient Visit, Est	\$31.18	\$27.15	\$21.08	\$30.39	\$18.06	\$29.42	\$19.85	\$20.64	\$37.45	\$52.77	\$37.69	\$21.93	\$36.45
	99213 Office/Outpatient Visit, Est	\$42.72	\$38.25	\$33.73	\$48.67	\$33.74	\$47.34	\$28.94	\$20.64	\$51.29	\$77.19	\$60.39	\$41.88	\$58.74
	99214 Office/Outpatient Visit, Est	\$65.79	\$57.35	\$51.07	\$73.71	\$53.27	\$70.90	\$42.50	\$27.00	\$80.45	\$121.50	\$90.67	\$65.47	\$87.21
	99215 Office/Outpatient Visit, Est	\$75.04	\$79.08	\$68.83	\$99.52	\$76.80	\$98.45	\$60.38	\$32.00	\$117.06	\$178.85	\$122.31	\$93.96	\$120.97
ARNP Preventative	99381 Init Pm E/M, New Pat, Inf	\$44.80	\$67.01	\$54.68	\$77.85	\$46.70	\$75.25	\$47.15	\$37.00	\$101.10	\$144.97			\$0.00
	99382 Init Pm E/M, New Pat 1-4 Yrs	\$44.80	\$71.19	\$58.73	\$83.77	\$53.26	\$80.04	\$48.48	\$37.00	\$109.01	\$155.76			\$0.00
	99383 Prev Visit, New, Age 5-11	\$44.80	\$70.08	\$57.48	\$82.47	\$53.26	\$79.02	\$50.40	\$37.00	\$106.81	\$152.76			\$0.00
	99384 Prev Visit, New, Age 12-17	\$47.04	\$76.50	\$62.33	\$89.25	\$60.04	\$85.67	\$49.87	\$42.00	\$116.01	\$164.21			\$0.00
	99385 Prev Visit, New, Age 18-39	\$40.32	\$72.81	\$62.33	\$89.25	\$60.04	\$85.66	\$45.43	\$27.24	\$116.01	\$167.89			\$0.00
	99391 Per Pm Reeval, Est Pat, Inf	\$62.07	\$50.85	\$41.27	\$60.36	\$39.92	\$58.29	\$43.75	\$27.00	\$76.85	\$111.20			\$0.00
	99392 Prev Visit, Est, Age 1-4	\$62.07	\$56.02	\$46.13	\$67.14	\$46.70	\$64.88	\$44.50	\$27.00	\$86.06	\$124.58			\$0.00
	99393 Prev Visit, Est, Age 5-11	\$62.07	\$55.45	\$45.50	\$66.49	\$46.70	\$64.36	\$45.25	\$27.00	\$84.96	\$122.93			\$0.00
	99394 Prev Visit, Est, Age 12-17	\$62.07	\$60.46	\$50.18	\$73.06	\$53.26	\$70.70	\$46.50	\$27.00	\$93.97	\$134.80			\$0.00
	99395 Prev Visit, Est, Age 18-39	\$40.32	\$61.05	\$50.81	\$73.71	\$53.26	\$71.32	\$47.78	\$27.00	\$95.07	\$138.38			\$0.00
99396 Prev Visit, Est, Age 40-64	\$40.32	\$64.80	\$56.07	\$81.13	\$60.04	\$77.49	\$47.78	\$20.64	\$105.01	\$153.11			\$0.00	

2. Connecticut ¹⁴

Medicaid covers the following services provided by Nurse Practitioners (NP):

- Medically necessary and medically appropriate professional services;
- Services provided in the NP's office, client's home, hospital, long term care facility or other medical facility;
- Family planning services;
- Medical and surgical supplies used by the provider in the course of treatment;
- Injectable drugs administered by the NP; and
- EPSDT services.

Payment for NP's is the lowest of:

- The provider's usual and customary charge to the general public;
- The lowest Medicare rate;
- The amount in the applicable fee schedule as published by the Department;
- The amount billed by the provider; or
- The lowest price charged or accepted for the same or substantially similar goods or services by the provided from any person or entity.

NP's are reimbursed 90% of physician rates.

3. Maine ¹⁵

14.04 COVERED SERVICES

A covered service is a service for which payment to a provider is permitted under this Section of the MaineCare Benefits Manual (MBM). Covered services are those reasonably necessary medical, nursing, and remedial services that: are provided in an appropriate setting; reflect coordination and appropriate communication with the prescribing licensed physician or dentist where required by the licensing authority; are within the scope of practice for the advanced practice registered nurse providing the service; and are recognized as standard medical/nursing care authorized by the state or province in which services are provided.

Advanced Practice Registered Nurses must also comply with all applicable service and procedure requirements and guidelines when providing services outlined in the MaineCare Benefits Manual, Chapter I, General Administrative Policies and Procedures, and Chapter II, Section 90, Physician Services.

A.P.R.N.s with prescriptive and dispensing authority (Nurse Practitioners and Certified Nurse-Midwives) are subject to practice within their scope of licensure and approvals by the Maine State Board of Nursing, and must additionally follow guidelines as set forth in the MaineCare Benefits Manual, Chapter II, Section 80, Pharmacy Services, and Chapters II and III, Section 90, Physician Services.

A.P.R.N.s providing psychiatric or psychological services as described in the MaineCare Benefits Manual, Chapter II, Section 90.04, or Chapter II, Section 65, Mental Health Services, are subject to the rules in these sections.

¹⁴ CT Rules found at: <http://www.hrsa.gov/reimbursement/states/Connecticut-Medicaid-Covered-Services.htm>;

¹⁵ ME rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s014.doc>; Rates found at: http://portalxw.bisoex.state.me.us/oms/proc/pub_proc.asp?cf=mm.

Certified Registered Nurse Anesthetists (C.R.N.A.s) are subject to service requirements described in Chapter II, Section 90.04, Physician Services, and must use the appropriate modifier to specify the provision of anesthesia services as indicated in departmental billing instructions. Billing Instructions are available on the department's website at:

http://www.maine.gov/dhhs/bms/providerfiles/provider_billing_manuals.htm

A.P.R.N.s as defined in Section 14.05-1 (Qualified Professional Staff), traveling to visit a member to deliver a covered service may bill for mileage, one-way, beyond a ten (10)-mile radius of point of origin (office or home). MaineCare does not reimburse mileage for trips to the office or hospital where the A.P.R.N. and/or the associated or collaborating physician or dentist is an active member of the medical staff.

14.06 REIMBURSEMENT

For independent practitioners billing for services not billed through hospitals, physicians, or dentists, reimbursement for covered services shall be the lowest of the following:

- A. The amount listed on the Office of MaineCare Services' website, for services as described in Chapters II and III, Section 90, Physician Services, of this manual. Certified Registered Nurse Anesthetists providing anesthesia services shall be reimbursed at seventy-five percent (75%) of the amount for services as described in Chapters II and III, Section 90, Physician Services. A.P.R.N.s providing psychological or psychiatric services shall receive sixty percent (60%) of the amount reimbursed for physician's services as set forth in the MaineCare Benefits Manual, Chapter II, Section 90, Physician Services; or
- B. The lowest amount allowed by the Medicare - Part B carrier, when applicable; or
- C. The provider's usual and customary charge.

The fee schedule for reimbursement of physician services is available on the following website: <http://www.maine.gov/dhhs/bms/providerfiles/codes.htm>.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, workers' compensation, etc.) available for payment of the rendered services, and to seek payment from such resource prior to billing the MaineCare Program.

14.07 BILLING INSTRUCTIONS

Providers must bill in accordance with the Department's current billing instructions and the MaineCare Benefits Manual, Chapter III, Section 90, Physician Services.

The Department requires appropriate billing modifiers to distinguish A.P.R.N. services when billing for anesthesia services. Certified registered nurse anesthetists must refer to the Department's current billing instructions regarding modifier usage when billing for anesthesia services performed and billed directly by a certified registered nurse anesthetist.

4. Massachusetts ¹⁶

433.433: Nurse Practitioner Services

(A) General. 130 CMR 433.433 applies specifically to nurse practitioners. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to nurse practitioners, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements.

(B) Conditions of Payment. The MassHealth agency pays either an independent nurse practitioner (in accordance with 130 CMR 433.433(C)) or the physician employer of a nonindependent nurse practitioner (in accordance with 130 CMR 433.433(D)) for nurse practitioner services provided by a nurse practitioner when:

- (1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR 4.00);
- (2) the nurse practitioner has a current license to practice as a nurse practitioner in Massachusetts from the Massachusetts Board of Registration in Nursing; and
- (3) the nurse practitioner has a current collaborative arrangement with a physician or group of physicians, as required by state law or regulation (including but not limited to 244 CMR 4.00 and 130 CMR 433.433(C)(2)). The MassHealth agency deems this requirement to be met for nonindependent nurse practitioners employed by a physician.

(C) Independent Nurse Practitioner Provider Eligibility.

(1) Submission Requirements. Only an independent nurse practitioner may enroll as a MassHealth provider. Any nurse practitioner applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she is:

- (a) a member of a group practice comprising physicians and other practitioners and is compensated by the group practice in the same manner as the physicians and other practitioners in the group practice;
- (b) a member of a group practice that solely comprises nurse practitioners; or
- (c) in a solo private practice.

(2) Collaborative Arrangement Requirements. The independent nurse practitioner's collaborating physician must be a MassHealth provider who engages in the same type of clinical practice as the nurse practitioner. The nurse practitioner must practice in accordance with written guidelines developed in conjunction with the collaborating physician as set forth in 244 CMR 4.00. The nurse practitioner must submit to the MassHealth agency thorough documentation of the collaborative arrangement, including guidelines and any written agreement signed by the nurse practitioner and the collaborating physician or physicians. The guidelines must specify:

- (a) the services the nurse practitioner is authorized to perform under the collaborative arrangement; and
- (b) the established procedures for common medical problems.

(3) Consultation Between Independent Nurse Practitioner and Collaborating Physician. The MassHealth agency does not pay for a consultation between an independent nurse practitioner and a collaborating physician as a separate service.

(D) Submitting Claims for Nonindependent Nurse Practitioners. Any nurse practitioner who does not meet the requirements of 130 CMR 433.433(C) is a nonindependent nurse

¹⁶ MA rules found at:

http://www.mass.gov/?pageID=eohhs2terminal&L=6&LO=Home&L1=Government&L2=Laws%2C+Regulations+and+Policies&L3=MassHealth+Regulations+and+Other+Publications&L4=Provider+Library&L5=MassHealth+Provider+Manuals&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_manuals_pvman_physician&csid=Eeohhs2 (regs_physician.pdf), and fees at http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&LO=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_regs_related_pubs&csid=Eeohhs2#114_3_17

practitioner and is not eligible to enroll as a MassHealth provider. As an exception to 130 CMR 450.301, an individual physician (who is neither practicing as a professional corporation nor a member of a group practice) who employs a nonindependent nurse practitioner may submit claims for services provided by a nonindependent nurse practitioner employee, but only if such services are provided in accordance with 130 CMR 433.433(B), and payment is claimed in accordance with 130 CMR 450.301(B).

5. New Hampshire ¹⁷

F. AMBULATORY VISITS

Ambulatory visits are services performed anywhere other than the inpatient hospital environment and are limited to eighteen (18) visits per person per fiscal year (July 1 through June 30). Exception to the service limitation exists for recipients under the age of 21, recipients enrolled in special federally approved waiver programs and recipients in a nursing facility. A visit is defined as all ARNP services provided in one day to one recipient by one ARNP. However, if an ARNP sees one recipient twice in the same day it is considered two visits. A visit does not include laboratory tests or diagnostic X-rays, these should be billed as separate details on the claim. ARNP services include outpatient hospital visits, home visits and office visits. The appropriate procedure codes for billing are listed in the Physicians' Current Procedural Terminology (CPT) book.

6. Rhode Island ¹⁸

Covered Nurse Practitioner services are medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a medical setting, or the recipient's home or elsewhere provided with the Nurse Practitioner's scope of practice.

These services are reimbursed according to the Rhode Island Medical Assistance Fee Schedule.

7. Vermont ¹⁹

NURSE PRACTITIONERS

The OVHA enrolls and reimburses nurse practitioners licensed in Vermont. Payment will be made for reimbursable services that are also contained in protocols approved by the Vermont Board of Medical Practice. Nurse practitioners must be identified with the use of the modifier SA, with the exception of the following:

- Laboratory tests
- Injection medications
- Immunizations

¹⁷ NH Rules found at: <http://www.nhmedicaid.com/Downloads/Manuals/Physician%20Provider%20Specific%20Billing%20Guidelines.doc>, Rates taken from NHAIM

¹⁸ RI rules found at: <http://www.hrsa.gov/reimbursement/states/Rhode-Island-Medicaid-Covered-Services.htm>; Fees found at: http://www.dhs.state.ri.us/dhs/heacre/provsvcs/fee_schedule.htm

¹⁹ VT rules found at: <http://www.vtmedicaid.com/Downloads/manuals.html>, CMS1500 08/05 Supplement, pg 29; Fees found at: <http://ovha.vermont.gov/for-providers/claims-processing-1>

8. Medicare²⁰

Legislation calling for Medicare reimbursement for nurse practitioners (NPs) regardless of setting was passed by Congress and signed into law by the president on August 4, 1997. The new legislation became effective January 1, 1998.

This legislation calls for direct reimbursement to nurse practitioners for providing Medicare Part B services that would normally be provided by physicians. The bill states that these services are not restricted by site or geographic location. Under the previous statute, nurse practitioner reimbursement was restricted to rural areas, long term care facilities and a service labeled "incident to" which is limited to follow-up care (i.e. no new patients and no old patients with new problems) in an office setting with a physician on site. It is the intent of this legislation that the "incident to" billing mechanism will no longer need to be used by nurse practitioners who now will be classified as Part B providers. Under this legislation nurse practitioners may see all new patients and old patients without restriction. There are no limitations on CPT codes as long as visits meet the established Medicare E and M requirements. The legislation also calls for nurse practitioners to be reimbursed for assisting at surgery.

Under this legislation, nurse practitioners are being reimbursed at the rate of 80% of the lesser of the actual charge or 85% of the fee schedule amount for physicians (Section 1848). In the case of assistant at surgery, the reimbursement is 80% of the lesser of the actual charge, or 85% of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery. These rates are the same rates that were previously paid to rural nurse practitioners and nurse practitioners providing services in long term care facilities. Nurse practitioners cannot collect fees if their services have been billed through some other mechanism, i.e. payment twice for the same service is prohibited.

Medicare's rules for NPs. Medicare pays NPs under the following terms and conditions:

1. The NP meets Medicare qualification requirements;
2. The practice or facility accepts Medicare's payment, which is 85% of the physician fee schedule rate for bills submitted under an NP's provider number;
3. The services performed are "physician services" or those for which a physician can bill Medicare;
4. The services are performed in collaboration with a physician;
5. The services are within the NP's scope of practice as defined in state law; and
6. No facility or other provider charges or is paid with respect to the furnishing of the services.

Each of these rules or conditions is explained in greater detail below.

Medicare qualifications for NPs. To qualify as an NP eligible to become a Medicare provider, an individual must hold a state license as an NP and be certified as an NP by a recognized national certifying body. The recognized NP national certifying bodies are:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation

²⁰ Medicare rules found at: <http://www.cms.hhs.gov/home/medicare.asp>

- National Certification Board of Pediatric Nurse Practitioners and Nurses
- Oncology Nursing Certification Corporation
- Critical Care Certification Corporation

Effective January 1, 2003, individuals applying for Medicare provider numbers as NPs must possess a master's degree from an NP program, as well as national certification and state licensure.

Medicare pays NPs 85% of physician rate. Medicare pays 80% of the patient's bill for physician services and the patient pays 20%. Medicare reimburses NPs at a rate of 85% of the physician fee, as stated in Medicare's Physicians Fee Schedule.[†] So, Medicare pays NPs 80% of the 85% of the Physicians Fee Schedule rate for a procedure. For example, assume the Physicians Fee Schedule rate for a particular service is \$100. If a physician performs the service, Medicare pays the physician \$80; the patient pays the physician \$20. If an NP performs the service, Medicare pays the NP \$68; the patient pays the NP \$17.

C. Dental Services for Children Service Group

1. Rate Information

Following are rates in effect as of January 1, 2008:

Service Group	Posted Rates			
	NH	Avg - Other NE States	CT	All Comm
DIAG EXAMS	\$37.23	\$44.01	\$44.01	\$48.91
DIAG IMAG	\$27.84	\$36.56	\$36.56	\$43.11
PREVENT	\$29.18	\$38.70	\$38.70	\$44.57
RESTORE	\$103.93	\$134.29	\$134.29	\$160.76
ENDO	\$150.21	\$229.66	\$229.66	\$241.85
ORAL SURG	\$120.94	\$188.03	\$188.03	\$221.00

2. Connecticut ²¹

It is required that the amount billed to the Department represents the provider's usual and customary charge for the services delivered.

Payments will be made at the lower of:

- The usual and customary charge to the public
- The fee as contained in the dental fee schedule published by the Department.
- The amount billed by the provider.

Payment Rate

- The Commissioner of Social Services establishes the fee contained in the Dental Fee Schedule.
- The fees are based on moderate and reasonable rates prevailing in the respective communities where the service is rendered.
- This fee schedule lists the fees for a client under the age of 21. The fee for a client 21 years of age and older is 55% of the fee listed on this schedule.

Please see *Non-Covered Services – All NE States* at the end of the Dental section for the list of uncovered procedures.

III. Payment Limitations

- a. When dental treatment is necessary, the examination and charting of the oral cavity (including filling out the EDS Dental Claim Form) will be included in the total cost of treatment.
- b. The fee for root canal treatment and/or apicoectomies includes all pre and post-operative X-rays, but not the final restoration.

²¹ CT rules are found at: <http://www.ctmedicalprogram.com/publications.html#manuals>; ch7dental.pdf. Fee schedule can be found at: <http://www.ctmedicalprogram.com/publications.html#feesched>; fee_dental_20050701.pdf

- c. Fees listed in the dental fee schedule for oral surgery and exodontias include pre-operative and post-operative care.
- d. Fees for amalgam restoration include local anesthesia, base and polishing where necessary.
- e. Fees for exodontia include local anesthesia.
- f. Dental cleaning for children under 21 years of age is paid at the lower rate for this service as stipulated in the Dental Fee Schedule.
- g. Orthodontics
 - 1. An initial payment and monthly payments are made for active treatment and orthodontic services.
 - 2. The initial payment covers the placement of the initial appliances.
 - 3. No payment is made for monitoring growth and development.
 - 4. A dentist, other than a qualified dentist as defined in these regulations, may receive payment for an orthodontic screening. The screening includes oral examination and/or examination of the patient's records for the purposes of completing Sections I, II and IIIA-D of the Preliminary Handicapping Malocclusion Assessment Record Form, W-1428.
 - 5. The fee for the orthodontic consultation includes a dental screening and the completion of the preliminary assessment form. No separate payment shall be made to a qualified dentist for the orthodontic screening.
 - 6. The number of monthly payments is limited to the number of months of active treatment stipulated in the treatment plan as approved by the Department.
 - 7. The monthly installment rate for active treatment is based on the average of one (1) visit per month and will be payable once a month during the authorized active treatment period no matter how many times the orthodontist sees the patient during this period.
 - 8. Payment for the comprehensive diagnostic assessment includes all diagnostic measures, e.g., X-rays, photographs or slides, and the written treatment plan. No separate payment is made for individual diagnostic materials except the preliminary assessment study models.
 - 9. For a recipient who becomes ineligible for Medicaid during the authorized term of active treatment, the final payment from the Department shall be made for the month in which the recipient becomes ineligible for Medicaid or EPSDT services, whichever comes first.
 - 10. The cost of the initial retainer appliance, including fitting, adjustments and all necessary visits, is included in the first twenty-four (24) monthly active treatment installments.
 - 11. The fee for the replacement of retainer appliances includes the fitting and all necessary visits.
- h. Payment may not be made or may be taken back from the admitting dentist retrospectively if it is determined by CPRO during a retrospective review that the admission was inappropriate.

Provider Setting Limitations

Payment to Salaried Dentists

A dentist who is fully or partially salaried by a General Hospital, Public or Private Institution, Physicians' Group or Clinic may not receive payment from the Department unless that dentist maintains an office for private practice at separate location from the hospital, institution, physician group, or clinic in which the provider is employed. Dentists who are solely hospital, institution, physician group, or clinic based either on a full time or part time salary are not entitled to payment from the Department for services rendered to Title XIX recipients.

3. Maine²²

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

Providers are requested to bill their usual and customary charge for all dental services.

In accordance with policy, the MaineCare Program will pay the lowest of the following:

1. The fee established by MaineCare and noted in the “Maximum Allowance” column of the fee schedule;
2. The lowest amount allowed by Medicare; or
3. The provider's usual and customary charge.

The MaineCare dental fee schedule identifies the following:

- Covered and non-covered services under the MaineCare program
- Services for those under 21 and all ICF-MR residents (with the exception of orthodontics which is not covered for residents of an ICF-MR)
- Coverage for adults 21 and over when allowed under Section 25, Dental Services, of the MaineCare Benefits Manual, Chapter II, 25.04, Special Requirements for Adult Services.

Infection control, O.S.H.A. requirements and other compliance procedures are considered provider standards of care and are not billable to the member or separately reimbursable by MaineCare.

Supplemental Payment²³

A supplemental payment to MaineCare general dental providers is a one-time, per general dental provider, per member, enhanced payment. It is payable to any enrolled general dentist, clinic, or office for:

- Any MaineCare member, age one (1) through twenty (20);
- Whom the MaineCare general dental provider, clinic, or office has not seen in the last three (3) years; and
- Establishes in his or her practice the MaineCare member as a patient of record with the intention of providing comprehensive dental care on an on-going basis.

This enhanced payment is billable only after a required minimum set of services is completed. The required set of services includes an initial oral exam, fluoride treatment (unless refused by the member), prophylaxis, and instruction in the proper care of dentition and gingiva.

Code D0150 must be used to bill the supplemental payment and is allowed only in lieu of billing any other new patient exam, and only after the specified set of services are completed. All other covered services, including the required fluoride treatment, required prophylaxis, and any additional optional services, such as x-rays, or sealants, as appropriate, are separately billable.

²² MaineCare rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s090.doc>, Fees can be looked up at: <http://www.maine.gov/dhhs/bms/providerfiles/codes.htm>

²³ Source: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s025.doc>

Under normal circumstances, all general dental providers requesting this enhanced payment and billing this code are expected to maintain the member as an established patient and provide necessary continuing dental services including, but not limited to: restorations, radiographs, prophylaxis, emergency services, and referrals to specialists as necessary. Providers will be subject to the Department's post payment review and appropriate recoupment of the supplemental payment.

This supplemental payment is not billable by denturists, orthodontists, other dental specialists, or those providers performing only hygienist services, including those entities or sponsoring agencies under public health supervision, those providers at the two Maine Schools of Dental Hygiene, or those providers under contract with the Oral Health Program. Its sole use is limited to general dentists who establish new MaineCare patients into their practice with the intention of providing necessary continuing dental care.

Covered Service:

This column identifies whether a particular service is covered under the MaineCare program, indicated by a "YES," or not covered, indicated by a "NO." It is further divided into two (2) sub columns indicating services for those under 21 and all ICF-MR residents (with the exception of orthodontics which is not covered for residents of an ICF-MR) and the second column, indicating coverage for adults 21 and over when allowed under Section 25, Dental Services, of the MaineCare Benefits Manual, Chapter II, 25.04, Special Requirements for Adult Services.

Please see *Non-Covered Services – All NE States* at the end of the Dental section for the list of uncovered procedures.

Provider Setting Limitations

Denturist Services

In accordance with requirements of this Subsection and Subsection 25.03-6, denturist services shall be reimbursed to licensed denturists enrolled as MaineCare providers for services provided to members eligible for full dentures. Only the services related to providing full dentures will be reimbursed to denturists, using the appropriate codes (identified in the limits column) in Chapter III, Section 25 of the MaineCare Benefits Manual. These related services include making, producing, reproducing, construction, finishing, supplying, altering, or repairing of a complete upper and/or complete lower prosthetic denture.

Hygienist Services

Hygienist services shall be reimbursed to entities enrolled as MaineCare providers employing or sponsoring licensed hygienists providing hygienist services allowed under this Section and under Public Health Supervision. Services reimbursable for hygienists working under Public Health Supervision, dental hygiene schools and the Oral Health Program are designated in Chapter III, Section 25 of this Manual. These services include: prophylaxis, fluoride treatments, oral hygiene instructions and sealants. MaineCare requires entities enrolling as providers to submit documentation of satisfying the requirements for Public Health Supervision status. All hygienists enrolled under Public Health Supervision status must enroll as MaineCare servicing providers with proof of licensure.

The Department will reimburse schools of dental hygiene enrolled as MaineCare providers employing supervising, licensed hygienists and providing hygienist services allowed under this Section. The supervising hygienists must be enrolled as MaineCare servicing providers.

Hygienist Services shall be reimbursed to the Maine Center for Disease Control and Prevention, Oral Health Program, enrolled as a MaineCare provider performing hygienist services through its public health, school-based and/or school-linked programs. Hygienists performing these services must enroll as MaineCare servicing providers under the Maine Center for Disease Control and Prevention, Oral Health Program, with proof of licensure, and documentation of meeting the requirements for Public Health Supervision status.

4. Massachusetts ²⁴

- The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for all dental services purchased by government agencies. DHCFP publishes a comprehensive listing of dental services and rates (114.3 CMR 14.00).
- The MassHealth agency pays for a limited number of the services listed by DHCFP. Refer to Subchapter 6 of the *Dental Manual* for the MassHealth agency's list of covered services.
- Payment is always subject to the conditions, exclusions, and limitations set forth in the regulations in 130 CMR 420.000. Payment for a service will be the lower of the following:
 - (1) The provider's usual charge to the general public for the same or a similar service; or
 - (2) The maximum allowable fee listed in the applicable DHCFP fee schedule.
- Coverage for members under age 21 includes services essential for the prevention and control of dental diseases and the maintenance of oral health, and is more extensive than coverage for members aged 21 years and older.
- Certain procedures are designated "S.P." in the service descriptions in Subchapter 6 and Appendix E of the *Dental Manual*. "S.P." is an abbreviation for separate procedure. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but that commands a separate fee when performed as a separate procedure not immediately related to other services.
- The administration of analgesia and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

Please see *Non-Covered Services – All NE States* at the end of the Dental section for the list of uncovered procedures.

Provider Setting Limitations

Participating Providers

The MassHealth agency makes payment for services described in 130 CMR 420.000 only to providers of dental services who are participating in MassHealth on the date of service. The participating provider is responsible for the quality of all services for which payment is claimed, the accuracy of such claims, and compliance with all regulations applicable to dental services under MassHealth. In order to claim payment, the participating provider must be the dentist who actually performed the service.

²⁴ MA rules found at:

http://www.mass.gov/?pageID=eohhs2terminal&L=6&LO=Home&L1=Government&L2=Laws%2C+Regulations+and+Policies&L3=MassHealth+Regulations+and+Other+Publications&L4=Provider+Library&L5=MassHealth+Provider+Manuals&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_manuals_pvman_dental&csid=Eeohhs2 (regs_dental.pdf), and fees at: http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_3_14.doc

- A dentist who is a member of a group practice can direct payment to the group practice under the provisions of MassHealth regulations governing billing intermediaries in 130 CMR 450.000. The dentist furnishing the services must be enrolled as an individual provider, and must be identified on claims for his or her services.
- A dental school may claim payment for services provided in its dental clinic.
- A dental clinic may claim payment for services provided in its dental clinic.
- A community health center, hospital-licensed health center, managed care organization, or hospital outpatient department may claim payment for services provided in its dental clinic.
- A dental laboratory may claim payment for prosthetic material delivered to a dentist if the material was not otherwise provided or paid for by the dentist.

Noncovered Circumstances

(A) Conditions. The MassHealth agency does not pay providers for dental services under any of the following conditions:

- (1) Services provided in a state institution by a state-employed dentist or a dental consultant;
- (2) Services furnished by a provider whose salary includes compensation for professional services;
- (3) if, under comparable circumstances, the provider does not customarily bill private members who do not have health insurance; or
- (4) if the member is not an eligible MassHealth member on the date of service. The provider must verify the member's eligibility for MassHealth on the date of service even if the provider has obtained prior authorization for the service.

(B) Substitutions.

- (1) If a member desires a noncovered substitute for, or a modification of, a covered item, the member must pay for the entire cost of the service. The MassHealth agency does not pay for any portion of the cost of a noncovered service. In all such instances, before performing noncovered services, the provider must inform the member both of the availability of covered services and of the member's obligation to pay for noncovered services.
- (2) It is unlawful (M.G.L. c. 6A, §35) for a provider to accept any payment from a member for a service or item for which payment is available under MassHealth. If a member claims to have been misinformed about the availability of covered services, it will be the responsibility of the provider to prove that the member was offered a covered service, refused it, and chose instead to accept and pay for a noncovered service.

5. New Hampshire ²⁵

Reimbursement for dental services is established by the Office of Medical Services and is paid on a per procedure basis.

- Covered services vary depending on if the member is under age 21 or not.
- Specific services are allowable for members 21 years of age or older only if for the relief of acute pain or elimination of acute infection.
- Recipients who are residents of a nursing facility shall receive routine and emergency dental services as part of the care provided by the nursing facility. Reimbursement to the provider will be made by the nursing facility.

²⁵ NH rules found at:

<http://www.nhmedicaid.com/Downloads/Manuals/Dental%20Provider%20Specific%20Billing%20Guidelines%20II.doc> , fees found at: <http://www.nhmedicaid.com/Downloads/schedules.codes.html>

**COVERED SERVICES
RECIPIENTS UNDER AGE 21**

1. Prophylaxis;
2. Restorative treatment;
3. Periodic examinations, no more frequently than every one hundred fifty (150) days;
4. Vital pulpotomy;
5. Extractions;
6. General anesthesia;
7. Orthodontic therapy, in crippling cases, when medically necessary and as approved by the Office of Medical Services' dental consultant;
8. X-rays;
9. Palliative treatment;
10. Prosthetic replacement of anterior permanent teeth, canine to canine;
11. Topical fluoride treatment;
12. Root canal therapy;
13. Sedative fillings when necessary for emergency relief of pain; and
14. Any service determined by the Office of Medical Services to be medically necessary to treat or ameliorate any condition identified in an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program screen.

Please see *Non-Covered Services – All NE States* at the end of the Dental section for the list of uncovered procedures.

RECIPIENTS AGE 21 AND OVER

The services listed below are allowable only if for the relief of acute pain or elimination of acute infection and may include:

1. Limited Oral Evaluation - Problem Focused 00140 Allowed at same time as other procedures.
2. Radiographs 00210- 00330 Allowable only as needed for diagnosis of presenting acute condition. Radiographs should be limited to the minimum required for the presenting acute condition.
3. Palliative Treatment 09110 Emergency treatment of dental pain - minor procedures - with brief description.
4. Extractions 07110- 07250 Allowable only for extraction of the causative tooth or teeth.
5. Trauma Treatment As required.

6. Rhode Island²⁶

- Providers must bill the Medical Assistance Program at the same usual and customary rates as charged to the self-pay general public.
- Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to Medical Assistance.
- Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program.

The Medical Assistance Program provides coverage for necessary medical services to recipients who are in two basic benefit levels: Categorically Needy and Medically Needy.

²⁶ RI rules found at: <http://www.dhs.state.ri.us/dhs/heacre/provsvcs/mprovman.htm> (dental.pdf), fees found at: http://www.dhs.state.ri.us/dhs/heacre/provsvcs/fee_schedule.htm

The scope of services varies according to the benefit level. Refer to Section 100-40 in the Provider Reference Manual for further information.

Please see *Non-Covered Services – All NE States* at the end of the Dental section for the list of uncovered procedures.

7. Vermont ²⁷

Dental charges are defined as preventive, diagnostic or corrective procedures involving the oral cavity and teeth.

Reimbursement basis for CPT procedures is the lower of provider's charge or the Medicaid rate on file.

Adult Program:

- The Vermont dental fee schedule identifies covered services for the Adult Program, limited to \$495 per individual per calendar year.
- If an individual reaches their 21st birthday and has received dental care during the course of the year, the dental benefit already paid will be applied to the annual \$495 adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to \$495 and will not begin again until the start of the new calendar year.

Co-Payment:

- Adults are responsible for a co-payment for all dental services. The co-payment amount is \$3/adult/provider/date of service. EDS will automatically deduct the co-payment from the amount paid to the provider.
- Exceptions to Co-Payments:
 - An individual residing in a participating long-term care facility (nursing home). EDS has this information on file and will not deduct the co-payment from the amount paid to the provider.
 - An individual who is pregnant or in the 60-day post pregnancy period. EDS does not have this information on file. When submitting claim forms to EDS for payment, you must indicate pregnancy and 60-day post pregnancy by adding the "HD" modifier to the end of each procedure code. The "HD" modifier must be used for all procedures. For example, when submitting for a periodic oral evaluation, use procedure code D0120HD.
 - An individual who is under 21 years of age and considered a child by The Office of Vermont Health Access.
- Please see *Non-Covered Services – All NE States* at the end of the Dental section for the list of uncovered procedures.

8. Medicare ²⁸

Medicare does not pay for Dental procedures, with the following notable exception :

- Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for

²⁷ VT rules found at: <http://ovha.vermont.gov/for-providers> (dentalsupplement July 2007.pdf), fees found at: <http://ovha.vermont.gov/for-providers/claims-processing-1>, CDT Codes

²⁸ Medicare rules found at: http://www.cms.hhs.gov/PFSlookup/03_PFS_Document.asp, no fees listed

extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw.

- Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances.
- For these cases, coverage falls under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

The dental exclusion was included as part of the initial Medicare program. In establishing the dental exclusion, Congress included a blanket exclusion of dental services. The Congress has not amended the dental exclusion since 1980 when it made an exception for inpatient hospital services when the dental procedure itself made hospitalization necessary.

- Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw.
- Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances.
- Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

Statutory Dental Exclusion

- Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

Background

- The dental exclusion was included as part of the initial Medicare program. In establishing the dental exclusion, Congress did not limit the exclusion to routine dental services, as it did for routine physical checkups or routine foot care, but instead it included a blanket exclusion of dental services.
- The Congress has not amended the dental exclusion since 1980 when it made an exception for inpatient hospital services when the dental procedure itself made hospitalization necessary.

Coverage Principle

- Coverage is not determined by the value or the necessity of the dental care but by the type of service provided and the anatomical structure on which the procedure is performed.

Services Excluded under Part B

The following two categories of services are excluded from coverage:

- A primary service (regardless of cause or complexity) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth, e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw.

- A secondary service that is related to the teeth or structures directly supporting the teeth unless it is incident to and an integral part of a covered primary service that is necessary to treat a non-dental condition (e.g., tumor removal) and it is performed at the same time as the covered primary service and by the same physician/dentist. In those cases in which these requirements are met and the secondary services are covered, the Medicare payment amount should not include the cost of dental appliances, such as dentures, even though the covered service resulted in the need for the teeth to be replaced, the cost of preparing the mouth for dentures, or the cost of directly repairing teeth or structures directly supporting teeth (e.g., alveolar process).

Exceptions to Services Excluded

- The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a RHC/FQHC prior to a heart valve replacement.

9. Commercial Insurance

Covered services vary depending on if the member is under age 21 or not. Specific services are allowable for members 21 years of age or older only if for the relief of acute pain or elimination of acute infection.

10. Non-Covered Services – All NE States

Services not covered by the State Medicaid Programs include, but are not limited to:

NON-COVERED SERVICES	CT ²⁹	MA ³⁰	ME ³¹	NH ³²	RI ³³	VT ³⁴
All other procedures and services not listed in the <i>Dental Manual</i>		X				
Canceled office visits or for appointments not kept	X		X	X	X	
Cosmetic dentistry	X	X		X		
Counseling or member-education sessions		X				
Crowns (Types: ceramco, gold, or other full cast, and porcelain fused to metal)					X	
Crowns for Bicuspid and Molars					X	
Desensitization					X	
Fixed bridges	X				X	
Grafts of any nature		X				
Habit-breaking appliances		X				
Implants	X				X	
Information provided the recipient by telephone	X					
Laminate veneers		X				
Medical or dental treatment of temporomandibular joint (TMJ) disease		X				
Occlusal Equilibration					X	
Occlusal guards for members aged 21 years and older		X				
Office visits to obtain a prescription, the need for which has already been ascertained	X					
Oral-hygiene devices and appliances, dentifrices, and mouth rinses		X				
Orthotic splints, including mandibular orthopedic repositioning appliances (MORAs)		X				
Other specialized techniques and associated procedures		X				
Overdentures and their attachments		X				

²⁹ The following surgical procedures are not covered unless orthodontia has been prior authorized: surgical exposure of impacted or unerupted teeth for orthodontic reasons; osteoplasty (osteotomy) of maxilla and/or other facial bones for midface hypoplasia or retention (LeFort type operation), without bone graft. Admitting services or any inpatient dental services performed by the admitting dentist are not covered if the admission was not approved by the Department or its designate as medically necessary in either a preadmission or retrospective review (CONNCUR).

³⁰ MassHealth does not cover the following dental services, subject to the Early and Periodic Screening, Diagnosis and Treatment provisions set forth at 130 CMR 450.144(A), which provide for prior authorization for medically necessary unlisted, limited, or noncovered services

³¹ Refer to the MaineCare Benefits Manual, Chapter I and the MaineCare Benefits Manual, Section 25, Dental Services, Chapter III for additional listings of non-covered services. The Department does not allow reimbursement for any member in an ICF-MR for orthodontics, orthognathic surgery, or repair of cleft palate procedures except in those cases where said treatment is being performed to correct a post-traumatic or post-surgical disfigurement, or in those cases where these services are a continuation of ongoing treatment started before age twenty-one (21). The Department does not allow reimbursement for any member age twenty-one (21) or older for orthodontics, orthognathic surgery, or repair of cleft palate procedures except in those cases where said treatment is being performed to correct a post-traumatic or post-surgical disfigurement, or in those cases where these services are a continuation of ongoing treatment started before age twenty-one (21), or when these services meet the criteria in Special Requirements for Adult Services, 25-04-2 (B).

³² The following services shall not be covered: Treatment plans and/or equipment that 1) lack effectiveness or have not been proven to be safe as outlined in reputable medical peer review literature or 2) are more costly than lesser costing plans and/or equipment which would provide the recipient with the same expected outcome.

³³ Procedure codes not listed in the Medical Assistance Dental Fee Schedule are services not covered under the Medical Assistance Dental Services Program. The general categories of dental services in this exhibit are not covered, except if deemed medically necessary for patients under 21 years of age.

³⁴ No list of non-covered services found for Vermont

NON-COVERED SERVICES	CT ²⁹	MA ³⁰	ME ³¹	NH ³²	RI ³³	VT ³⁴
Partial dentures where there are at least eight (8) posterior teeth in occlusion, and no missing anterior teeth	X					
Periodontia	X				X ³⁵	
Procedures and techniques that are considered unproven or experimental		X		X	X	
Restorative procedures to deciduous teeth nearing exfoliation	X					
Ridge augmentations		X				
Root Canal Therapy for Bicuspid and Molars					X	
Root canals filled by silver point technique, or paste only		X				
Tooth splinting for periodontal purposes		X				
Transplants	X	X				
Unilateral partials		X				
Unilateral removable appliances	X					
Vestibuloplasty	X					
Behavioral problems				X		
Hospital visits (except for surgical procedures performed)				X		
Services not medically necessary	X			X		

³⁵ RI - Extensive Periodontal Surgery

D. FQHC and RHC Clinic Service Encounter Rates Service Group

1. Rate Information

Due to differing payment methodologies, rate information was not collected for this service group.

2. Connecticut³⁶

Rural Health Clinic (RHC)

Connecticut does not have RHCs.

Federally Qualified Health Centers (FQHC)

The following services may be covered:

- Professional services;
- Supplies and pharmaceuticals incidental to professional services;
- Pharmaceuticals provided by an FQHC in compliance with pharmacy guidelines;
- Obstetrical and perinatal care;
- Clinic visits;
- FQHC professional services provided to FQHC patients if covering inpatient hospital visits;
- Mental health visits provided in compliance with mental health guidelines; and
- Dental services.

There is an encounter-specific reimbursement rate for all “FQHC covered services”. The encounter rate reimburses 100% of reasonable costs.

Initial FFS reimbursement to FQHCs is made per the terms of reimbursement for the performing provider.

Additional reimbursement may be provided based on the provider’s encounter rate as established through the FQHC cost report.

3. Maine³⁷

FQHC

31.04 COVERED SERVICES

All services must be provided within the HRSA-approved scope of service area, or to HRSA-Designated Medically Underserved Populations (MUP) at federally approved center locations such as school-based health centers, and be otherwise provided in conformance with Federal requirements.

Covered services include core services, and other ambulatory services contained in the State’s Medicaid plan, and in the FQHC’s scope of project for base year 1999 as approved by HRSA, either as amended, or as specifically approved by the Commissioner of the Maine Department

³⁶ CT Rules found at: <http://www.hrsa.gov/reimbursement/states/Connecticut-Medicaid-Covered-Services.htm>;

³⁷ ME FQHC Rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s031.doc>; RHC Rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s103.doc>;

of Human Services (DHS). FQHCs must submit their HRSA-approved scope of project for base year 1999, or if established after 1999, for their first year of operation, and all subsequent HRSA-approved amendments to scope of project.

31.04-1 **Core services** include:

- A. services provided by physicians, physician assistants, advanced practice registered nurses, clinical psychologists, licensed clinical social workers, and licensed clinical professional counselors;
- B. services and supplies furnished as incident to services of approved and appropriate licensed practitioners. In order for incidental services to be covered, FQHC employees must perform the incidental service, unless it is an FQHC service routinely performed by contracted personnel or providers. Services provided by auxiliary personnel not in the employ of the FQHC, even if provided on the physician's order or included in the FQHC's bill, are not covered as incident to a physician's service. Thus, non-physician diagnostic and therapeutic services that an FQHC obtains, for example, from an independent laboratory, an independent licensed or otherwise qualified provider, or a hospital outpatient department are not covered FQHC services;
- C. visiting nurse services (as described in Section 31.04-4).

31.04-2 **Ambulatory services** include the following:

- A. Any other ambulatory service, including any incidental supplies associated with the performance of a service that is provided by the FQHC, and that is also included in the State's Medicaid Plan, are reimbursable. (These services must be provided in accordance with all applicable sections of the MaineCare Benefits Manual in order to be reimbursable.);
- B. Asthma self-management services are reimbursable if they are based on the Open Airways or Breathe Easier curricula. Any other asthma management service that is approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America, are also reimbursable.

Each program must have:

- 1. a physician advisor;
 - 2. a primary instructor (a licensed health professional or a health educator with baccalaureate degree);
 - 3. a pre and post assessment for each participant which shall be kept as part of the member's record;
 - 4. an advisory committee which may be part of an overall patient education advisory committee; and
 - 5. a physician referral for all participants.
- C. Reimbursement for Ambulatory Diabetes Education and Follow-Up (ADEF) Services, or for similar services approved by a Centers for Medicare and Medicaid Services (CMS) approved national accreditation organization, will be reimbursed when a provider enrolled with the Maine Diabetes Control Project furnishes this service to a MaineCare member whose physician has prescribed this program for the management of the member's diabetes. The service is:

1. a pre-assessment interview to determine the member's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals;
2. a group class instruction covering the comprehensive curriculum outlined by the Maine Diabetes Control Project and based on the individualized education plan;
3. a meal planning interview to determine the member's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals;
4. a post-service interview to assess and document what the member has learned during the service, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalize behavioral goals; and
5. follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the member's behavior change goals. At a minimum, three-month, six-month, and one-year follow-up visits from the date of the last class are required to complete the member's participation in the service.

When the MaineCare member is under age 21, this service will also be reimbursed when provided to the person/people who provide the member's daily care.

- D. **Smoking Cessation Counseling** will be reimbursed for up to three (3) sessions per calendar year, per member, per physician or other provider who is licensed to prescribe. Smoking cessation counseling may be billed alone, or in combination with other FQHC services. Documentation of the smoking cessation counseling must be contained in the medical record. Documentation must include:

1. an ICD-9 diagnosis code of 305.1 (tobacco use disorder);
2. an assessment of the member's willingness to quit smoking, or of his or her progress in quitting;
3. documentation of any ongoing barriers to quitting or staying tobacco-free; and
4. a brief outline of whatever motivational or educational information was provided.
5. the name and license level of person providing the smoking cessation services.

31.04-3 **Off-site delivery of services** furnished by health center staff are reimbursable when they are provided away from the center and when it is documented in the member's chart that it is the most clinically appropriate setting for the provision of services. Examples of off-site service locations include: a nursing facility, an emergency room, an inpatient hospital, or a member's home.

31.04-4 **Visiting nurse services** will be reimbursed when:

- A. a registered nurse or licensed practical nurse provides the services to a member who is homebound;
- B. the services are provided in accordance with a written plan of treatment;

- C. the member's record documents that the member would not otherwise receive these services;
- D. the services are provided in an area for which the Secretary of the US Department of Health and Human Services has determined there is a shortage of home health agencies; and
- E. the health center that provides in-home services by a registered or licensed practical nurse is licensed by the State of Maine as a home health service provider.

31.04-5 **Interpreter Services** - Refer to Chapter I of the MaineCare Benefits Manual for information about the reimbursement for interpreter services.

31.05 NONCOVERED SERVICES

Unless the Commissioner of DHS specifically approves an additional service, covered services are limited to those services HRSA approved in the FQHC's scope of project. See Chapter I of the MaineCare Benefits manual for additional details on non-covered services.

31.07 REIMBURSEMENT

Reimbursement for Federally Qualified Health Center services is made on the basis of "reasonable cost" as determined by the Medicare Principles of Reimbursement. Reimbursement will be made for services provided in accordance with these rules.

Effective January 1, 2001, federally qualified health centers will be reimbursed on the basis of 100% of the average of their reasonable costs of providing MaineCare-covered services during calendar years 1999 and 2000, adjusted to take into account any increase or decrease in the approved scope of services furnished during the provider's fiscal year 2001 (calculating the amount of payment on a per visit basis). At the start of each subsequent year, beginning in CY 2002, each FQHC is entitled to the payment amount (on a per visit basis) to which the center was entitled under the Act in the previous fiscal year, inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in any rate adjustment for the approved scope of service changes furnished during that fiscal year. Until the initial new payment rate is calculated according to this methodology, federally qualified health centers will be paid at their current plan rate, which will be retroactively adjusted once the new payment rate is calculated. Newly qualified FQHCs after fiscal year 2000 will have initial payments established either by reference to payments to other centers in the same or adjacent areas, or in the absence of such other centers, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other centers.

Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. An additional visit of any kind will only be reimbursed for unforeseen circumstances as documented in the member's record.

Federally qualified health centers are required to file a Medicare annual cost report with appropriate addenda to the Department of Human Services Division of Audit within one hundred and fifty (150) days of their fiscal year end, unless an extension has been granted before the one hundred and fifty (150) days has expired by the Division of Audit. In addition, FQHCs must notify the Division of Audit on a timely basis if the year-end for the agency changes. Cost reports must be submitted to the Division of Audit, Department of Human Services, 11 State House Station, Augusta, Maine 04333-0011. Furthermore, for the purpose of establishing baseline information on FQHCs, FQHCs must submit their HRSA Plan of Project for the Fiscal Year

1999, or for their first year of operation for FQHCs approved after Fiscal Year 1999, plus any subsequent approved Plan of Project amendments.

An FQHC request for a rate adjustment due to a substantial change in the type of service provided (equivalent to a change in scope of project) must be received no later than one hundred and fifty (150) days after the FQHC's fiscal year end in which the change in scope occurred. The FQHC will be required to submit documentation showing that the Health Resources and Services Administration (HRSA) had approved its change in scope of project, and a cost report reflecting at least six (6) months of financial data and narrative documenting the change. The Department will respond to the Health Center's request for a rate adjustment within sixty (60) days. If the Department determines that a related rate adjustment is warranted, the incremental cost per encounter from this change may be added to the calculations that set the existing rate, and a new rate may be established. This new rate will be based on the reasonable costs associated with the CMS-approved changes as determined by the Department, and will become effective on the date the change of scope was implemented by the FQHC.

An FQHC change in scope of service may also be based on a change specifically approved by the Commissioner of the Department of Human Services.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, workers' compensation, etc.) that is available for payment of the rendered service, and to seek payment from such resources prior to billing MaineCare.

31.08 **COPAYMENT**

- A. Beginning July 1, 2004 providers will charge a copayment to each MaineCare member receiving services, unless the member is exempt under the provisions of Chapter I of the MaineCare Benefits Manual. The amount of the copayment shall not exceed \$3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 or more	\$3.00

- B. The member shall be responsible for copayments up to \$30.00 per month whether the copayment has been paid or not. After the \$30.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services. Providers are subject to the Department's copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

31.09 **BILLING INSTRUCTIONS**

Billing must be accomplished in accordance with the Department's "MaineCare Billing Instructions for HCFA-1500 Claim Form."

Effective
4/21/04

The Core Services code T1015 is to be billed when the services provided fall into the Core Services categories described under Covered Services, Section 31.04-1. The daily services(s) for the core category are totaled and, indicating one unit of service, listed on one line of the HCFA-1500 claim form. The Ambulatory Services code FQH3 is to be billed when the services fall into the Ambulatory Services categories described under Covered Services, Section 31.04-2. The daily service(s) for the ambulatory category are totaled and, indicating one unit of service, listed on one line of the HCFA-1500 claim form.

All other services listed in Chapter III, Allowances for Federally Qualified Health Center Services, must be billed on separate lines on the HCFA-1500 claim form.

Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, advanced nurse practitioner or visiting nurse, and in addition to that encounter, is seen by a licensed clinical psychologist, clinical social worker, clinical professional counselor or a clinical nurse specialist licensed as a psychiatric registered nurse on the same day. An additional visit of any other kind will only be reimbursed for unforeseen circumstances as documented in the member's record. The goal remains to treat the whole individual during one visit.

Effective
4-21-04

Federally qualified health centers may be reimbursed in excess of their core and additional (same day) visit rates when providing the following services delineated in the respective sections of the MaineCare Benefits Manual: Primary Care Case Management Services per Chapter VI, Section 1; or Interpreter Services per Chapter I, Section 1.06-3.

Effective
4-21-04

Any additional center visits that are required in the patient's treatment plan that do not qualify as center visits for reimbursement purposes, are non-billable.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from other third party payers prior to billing MaineCare for a rendered service. For patients who are eligible for both Medicare and MaineCare, MaineCare will provide reimbursement for only Medicare coinsurance and deductible and other costs customarily reimbursed by MaineCare.

If a member has capitated third party coverage other than MaineCare, and if that third party carrier requires a member co-pay but makes no fee-for-service payment to cover FQHC services, MaineCare reimbursement will be limited to the amount of the co-pay alone.

Centers have the option of obtaining a separate MaineCare provider billing number for the limited purpose of fee-for-service billing and reimbursement for such services as x-ray, EKG, inpatient hospital visits and other Medicare defined non-FQHC services that are billable under Medicare Part B. If a center chooses to bill fee for service for these Medicare defined non-FQHC services, they may not report costs related to these services on their MaineCare cost report.

In the future, the Bureau of Medical Services will replace its current "local" billing codes with standard CPT and HCPCS procedure codes to the greatest extent possible to comply with federal requirements for standardized coding. Providers will be notified in writing when the procedure code changeover will occur. Until receiving written notification to change billing codes, providers are expected to utilize the procedure codes and associated billing instructions in Chapter III, Section 3.

Rural Health Clinic

103.04 COVERED SERVICES

Covered services include core services, and other ambulatory services.

103.04-1 Core Services

- A. services provided by physicians, physician assistants, advanced practice registered nurses, psychologists, clinical social workers, and clinical professional counselors;
- B. services and supplies furnished as incident to services of conditionally, temporarily, fully licensed, otherwise legally recognized or approved practitioners who are designated in Section 103.06-1 of this Manual; and
- C. basic laboratory services essential for the immediate diagnosis and treatment of illness or injury, including, but not limited to:
 - 1. chemical examination of urine by stick or tablet method or both (including urine ketones);
 - 2. hemoglobin test or hematocrit;
 - 3. blood sugar test;
 - 4. examination of stool specimens for occult blood;
 - 5. pregnancy tests; and
 - 6. primary culturing for transmittal to a certified laboratory.

Note: To qualify for reimbursement, laboratory services must be in compliance with the rules implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA "88") and any related amendments.

- D. emergency medical care treating life-threatening injuries and acute illnesses, including drugs and biologicals such as:
 - 1. analgesics
 - 2. local anesthetics
 - 3. antibiotics
 - 4. anticonvulsants
 - 5. antidotes and emetics
 - 6. serums and toxoids
- E. visiting nurse services (as described in 103.04-4).

103.04-2 Other Ambulatory Services include:

- A. Podiatric services for the diagnosis and treatment of problems concerning the human foot. These are limited by the conditions in Chapter II, Section 95, Podiatry Services, of the MaineCare Benefits Manual.
- B. Prevention, Health Promotion and Optional Treatment Services (PHPOT) provided to eligible children in accordance with Chapter V, Section 2, of the MaineCare Benefits Manual.
- C. Asthma self-management services are reimbursable if they are based on the Open Airways or Breathe Easier curricula. Any other asthma management service which is approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America, is also reimbursable.

Each asthma self-management service must have:

1. physician advisor;
2. primary instructor (a licensed health professional or a health educator with baccalaureate degree);
3. pre-assessment and post-assessment for each participant which shall be kept as part of the member's record;
4. an advisory committee which may be part of an overall patient education advisory committee; and
5. a physician referral for all participants.

Note: Providers should bill the actual cost of the asthma self-management services upon completion of the service, using the procedure code listed in Chapter III, Section 103.

D. Ambulatory Diabetes Education and Follow-Up (ADEF) Services, or similar services approved by the American Diabetes Association (ADA) will be reimbursed when a provider enrolled with the Maine Diabetes Control Project furnishes this service to a MaineCare member whose physician has prescribed this service for the management of the member's diabetes. The service includes:

1. a pre-assessment interview to determine the member's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals;
2. group class instruction covering the comprehensive curriculum outlined by the Maine Diabetes Control Project and based on the individualized education plan;
3. a meal planning interview to determine the member's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals;
4. A post-assessment interview to assess and document what the member has learned during the service, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalize behavioral goals; and
5. follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the member's behavior change goals. At a minimum, three-month, six-month, and one-year follow-up visits from the date of the last class are required to complete the member's participation in the service.

When the MaineCare member is under age 21, this service will also be reimbursed when provided to the person/people who provide the member's daily care.

E. Smoking Cessation Counseling will be reimbursed for up to three (3) sessions per calendar year, per member, per physician or other provider who is licensed or legally approved to prescribe. Smoking cessation counseling may be billed alone, or in combination with other RHC services. Documentation of the smoking cessation counseling must be contained in the medical record. Documentation must include:

1. An ICD-9 diagnosis code of 305.1 (tobacco use disorder);
2. An assessment of the member's willingness to quit smoking, or of his or her progress in quitting;
3. Documentation of any ongoing barriers to quitting or staying tobacco-free;
4. A brief outline of whatever motivational or educational information was provided; and
5. The name and license level of person providing the smoking cessation services.

103.04-3 **Off-site delivery of services** furnished by clinic staff are reimbursed when rural health clinic services are provided away from the clinic and when it is documented in the member's chart that it is the most appropriate setting for the provision of services. Examples of off-site service locations include: a nursing facility, an emergency room, or a member's home.

103.04-4 **Visiting nurse services** will be reimbursed when:

- A. a registered nurse or licensed practical nurse provides the services to a member who is homebound;
- B. the services are provided in accordance with a written plan of treatment;
- C. the member's record documents that the member would not otherwise receive these services;
- D. the services are provided in an area that the Secretary of the U.S. Department of Health and Human Services has determined has a shortage of home health agencies; and
- E. the rural health clinic that provides in-home services by a registered licensed practical nurse is licensed by the State of Maine as a home health service provider.

103.04-5 **Interpreter Services** – Refer to Chapter I of the MaineCare Benefits Manual for information about reimbursement for interpreter services.

103.05 **NON-COVERED SERVICES**

All services must be provided geographically in the Federally defined service area, and/or be otherwise provided in conformance with Federal requirements. See Chapter I of the MaineCare Benefits Manual for other details on non-covered services.

103.07 **REIMBURSEMENT**

- A. Provider based clinics are reimbursed in accordance with the Medicare Principles of Reimbursement which apply to the hospital, nursing facility, or home health agency to which the clinic is attached.
- B. Independent clinics are reimbursed at a per unit of service rate established by the Medicare fiscal intermediary.
- C. Effective January 1, 2001, rural health clinics will be reimbursed on the basis of 100% of the average of their reasonable costs of providing MaineCare-covered services during calendar years (CY) 1999 and 2000, adjusted to take into account any increase or decrease in the approved scope of services furnished during the provider's fiscal year 2001 (calculating the amount of payment on a per visit basis).

Effective
4-21-04

At the start of each subsequent year, beginning in CY 2002, each RHC is entitled to the payment amount (on a per visit basis) to which the clinic was entitled under the Act in the previous fiscal year, inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in any rate adjustment for the approved scope of service changes furnished during that fiscal year. Until the initial new payment rate is calculated according to this methodology, rural health clinics will be paid at their current plan rate, which will be retroactively adjusted once the new payment rate is calculated. Newly qualified RHCs after fiscal year 2000 will have initial payments established either by reference to payments to other centers in the same or adjacent areas, or in the absence of such other centers, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other clinics.

- D. Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, nurse practitioner or visiting nurse, and in addition to that encounter, is seen by a licensed clinical psychologist, clinical social worker, clinical professional counselor, clinical nurse specialist, or a registered nurse certified in the specialized field of mental health, on the same day. An additional visit of any kind will only be reimbursed for unforeseen circumstances as documented in the member's record.
- E. In accordance with Chapter I, Section 1, of the MaineCare Benefits Manual, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, worker's compensation, etc.) that are available to pay for the rendered service, and to seek payment from such resources prior to billing MaineCare.

103.08 COPAYMENT

- A. Providers will charge a copayment to each MaineCare member receiving services, unless exempt per the provisions of Chapter I of the MaineCare Benefits Manual. The amount of the copayment shall not exceed \$3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 or more	\$3.00

- B. The member shall be responsible for copayments up to \$30.00 per month whether the copayment has been made or not. After the \$30.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services. Providers are subject to the Department's copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

103.09 BILLING INSTRUCTIONS

Billing must be accomplished in accordance with MaineCare Billing Instructions for Claim Form HCFA 1500.

Additional clinic visits, required in the member's treatment plan that do not qualify as clinic visits for reimbursement purposes, such as a visit for venipuncture only, are non-billable and are included in the clinic's cost based reimbursement.

If a member has third party coverage other than MaineCare, and if that third party carrier requires a copay but makes no fee-for-service payment in order to cover rural health clinic services, MaineCare reimbursement will be limited to the amount of the co-pay alone. Clinics have the option of obtaining a separate MaineCare provider billing number for the limited purpose of fee for service billing and reimbursement for such services as X-ray, EKG, inpatient hospital visits and other Medicare defined non-RHC Services that are billable under Medicare Part B.

In the future, the Bureau of Medical Services will replace its current "local" billing codes with standard CPT and HCPCS procedure codes to the greatest extent possible to comply with federal requirements for standardized coding. Providers will be notified in writing when the procedure code changeover will occur. Until receiving written notification to change billing codes, providers are expected to utilize the procedure codes and associated billing instructions in Chapter III, Section 103.

4. Massachusetts³⁸

MassHealth covers medically necessary services provided in clinics such as Community Health Centers and other freestanding clinics. Massachusetts does not have facilities designated as Rural Health Clinics.

Federally Qualified Health Centers (FQHC) – Community Health Centers (CHC)

Covered services include, but are not limited to:

- Pediatric services;
- Internal medicine;
- Obstetrics/gynecology;
- Health education;
- Medical social services; and
- Nutrition services.

The following services are required to be provided either on-site or by referral:

- Audiology;
- Dental services;
- EKG;
- Home health;
- Laboratory services;
- Medical specialty services such as cardiology and neurology;
- Mental health center services, including psychological testing;
- Occupational therapy;
- Pharmacy;
- Physical therapy;
- Podiatry;

³⁸ MA Rules found at: <http://www.hrsa.gov/reimbursement/states/Massachusetts-Medicaid-Covered-Services.htm>;

- Radiology services;
- Speech/language therapy; and
- Vision care.

CHCs must be nonprofit organizations licensed as freestanding clinics and certified by the Division.

The maximum allowable fees for CHC services are the lowest of the following:

- The CHC's usual and customary charge;
- The CHC's actual charge submitted; or
- The maximum allowable fee listed in the applicable DHCFFP fee schedule.

5. New Hampshire ³⁹

Rural Health Clinics

REIMBURSEMENT

- A. Recipient encounters with more than one health professional, or multiple encounters with the same health professional, which take place on the same day for the same diagnosis or treatment, shall be counted as one encounter. Cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment on the same day may be billed as a separate encounter.
- B. Payment shall be made in accordance with the fee schedules established by the Office of Medical Services.
- C. In field 24D, on detail 1, enter the encounter procedure code for your clinic. Also enter the appropriate HCPC procedure codes for services actually rendered on concurrent details. Payment will be made for the encounter procedure code only.

ENCOUNTER CODE BILLING

New Hampshire Medicaid requires that Rural Health Clinics bill their encounters using a state-specific procedure code on the HCFA 1500 claim form.

In order to meet cost reporting requirements, in addition to billing the state-specific procedure code, subsequent details of the HCFA 1500 claim form must list the CPT performed, and the usual and customary charges for that code.

Below are services which may be included in the encounter rate and should be listed following the encounter rate on the HCFA 1500:

PROCEDURE CODE	TOS	DESCRIPTION
99201	1	New patient, office visit, level 1
99202	1	New patient, office visit, level 2
99203	1	New patient, office visit, level 3
99204	1	New patient, office visit, level 4
99205	1	New patient, office visit, level 5
99211	1	Established patient, office visit, level 1
99212	1	Established patient, office visit, level 2
99213	1	Established patient, office visit, level 3

³⁹ NH Rules found at:

<http://www.nhmedicaid.com/Downloads/Manuals/Rural%20Health%20Provider%20Specific%20Billing%20Guidelines.doc>;

PROCECURE CODE	TOS	DESCRIPTION
99214	1	Established patient, office visit, level 4
99215	1	Established patient, office visit, level 5
99050	1	Services after hours, in addition to basic service
90844	1	Medical psychotherapy
57452	2	Colposcopy, simple
57454	2	Colposcopy with biopsy
57511	2	Cryocautery
10060	2	Excision/biopsy, simple
11420	2	Excision, benign lesion .5
11422	2	Excision 1.1 - 2.0 cm lesion
12001	2	Simple repair, 2.5 cm or less
10120	2	Foreign body removal
17110	2	Wart removal
17340	2	Wart removal with cryautery
58300	2	IUD insertion
99301	1	Nursing facility assessment, level 1
99302	1	Nursing facility assessment, level 2
99303	1	Nursing facility assessment, level 3
99311	1	Nursing facility subsequent assessment, level 1
99312	1	Nursing facility subsequent assessment, level 2
99313	1	Nursing facility subsequent assessment, level 3
99381	1	New patient > 1 yr. of age, preventative
99382	1	New patient, 1 - 4 yrs. of age, preventative
99383	1	New patient, 5 - 11 yrs. of age, preventative
99384	1	New patient, 12 - 17 yrs. of age, preventative
99385	1	New patient, 18 - 39 yrs. of age, preventative
99386	1	New patient, 40 - 64 yrs. of age, preventative
99387	1	New patient, 65 + yrs. of age, preventative
99391	1	Established patient, > 1 yr. of age, well child exam
99392	1	Established patient, 1 - 4 yrs. of age, well child exam
99393	1	Established patient, 5 - 11 yrs. of age, well child exam
99394	1	Established patient, 12 - 17 yrs. of age, well child exam
99395	1	Established patient, 18 - 39 yrs. of age, preventative
99396	1	Established patient, 40 - 64 yrs. of age, preventative
99397	1	Established patient, 65 + yrs. of age, preventative

HOSPITAL SERVICES

Procedures performed in a hospital can be billed on a fee-for-service basis. Below is a listing of codes which may be billed fee-for-service:

PROCEDURE CODE	TOS	DESCRIPTION
99221	1	Initial inpatient, level 1
99222	1	Initial inpatient, level 2
99223	1	Initial inpatient, level 3
99231	1	Subsequent hospital care, level 1
99323	1	Subsequent hospital care, level 2
99233	1	Subsequent hospital care, level 3
99431	1	Newborn care
99433	1	Subsequent newborn care
99238	1	Hospital discharge

PROCEDURE CODE	TOS	DESCRIPTION
99281	1	Emergency room visit, level 1
99282	1	Emergency room visit, level 2
99283	1	Emergency room visit, level 3
99284	1	Emergency room visit, level 4
99285	1	Emergency room visit, level 5
99291	1	Critical care, 1st hour
99292	1	Critical care, each additional 30 minutes
54150	2	Circumcision
59409	2	Vaginal Delivery
59514	8	Assist C-section
62270	2	Lumbar puncture
53670	2	Catherization, bladder
36406	2	Venipuncture < age 3, other vein
99251	3	Inpatient hospital consult, level 1
99252	3	Inpatient hospital consult, level 2
99253	3	Inpatient hospital consult, level 3
99254	3	Inpatient hospital consult, level 4
99255	3	Inpatient hospital consult, level 5
99218	1	Initial observation care, level 1
99219	1	Initial observation care, level 2
99220	1	Initial observation care, level 3

COVERED SERVICES

Rural Health Clinic visits may include:

1. the services of a physician, when the physician has an agreement to be paid by the clinic for such services;
2. the services of a nurse practitioner or physician assistant provided within the scope of their training and/or certification;
3. services and supplies that are furnished as incidental to a physician's, nurse practitioner's or physician assistant's professional services;
4. laboratory services essential to the immediate diagnosis and treatment of the patient; or
5. part-time or intermittent visiting nurse services when provided:
 - a. To a homebound patient, excluding individuals in hospitals or skilled nursing facilities;
 - b. Under a plan of care written by the supervising physician, physician attendant or nurse practitioner and reviewed at least every sixty (60) days by the supervising physician; or
 - c. In areas designated by the Department of Health and Human Services as having a shortage of home health agencies.
6. other ambulatory services provided within the scope of the rural health clinic practice.

FEDERALLY QUALIFIED HEALTH CENTERS

The following guidelines represent the billing requirements for the Federally Qualified Health Centers (FQHC).

RECIPIENT ELIGIBILITY

All Medicaid recipients are eligible for Federally Qualified Health Center services when the services are performed by a qualified health center.

PROVIDER PARTICIPATION

To participate in the NH Medicaid program, all providers must:

- A. be licensed/certified in the state in which they practice;
- B. enroll in the NH Medicaid program;
- C. adhere to billing guidelines detailed in this provider manual;
- D. be designated by the Health Care Financing Administration (HCFA);
- E. adhere to the billing guidelines outlined in this manual.

COVERED SERVICES

Federally qualified health center services are defined as follows:

- 1. Physician services.
- 2. Services and supplies incident to physician services (including drugs and biologicals that cannot be self-administered).
- 3. Pneumococcal vaccine and its administration.
- 4. Influenza vaccine and its administration.
- 5. Physician assistant services.
- 6. Nurse practitioner services.
- 7. Clinical psychologist services.
- 8. Clinical social worker services.
- 9. Services and supplies incident to clinical psychologist and clinical social worker services as would otherwise be covered if furnished by or incident to physician services.

REIMBURSEMENT

Reimbursement for Federally Qualified Health Center core services shall be at the encounter rate as determined by the Medicare fiscal intermediary.

In field 24D, on detail 1, enter the encounter procedure code for your clinic. Also enter the appropriate HCPC procedure codes for services actually rendered on concurrent details.

Payment will be made for the encounter procedure code only.

Reimbursement for Federally Qualified Health Center services provided off-site and listed below will be at the NH Medicaid fee for service rate:

ENCOUNTER CODE BILLING

New Hampshire Medicaid requires that Federally Qualified Health Centers bill their encounters using a state-specific procedure code on the HCFA 1500 claim form.

In order to meet cost reporting requirements, in addition to billing the state-specific procedure code, subsequent details of the HCFA 1500 claim form must list the CPT performed, and the usual and customary charges for that code.

Below are services which may be included in the encounter rate and should be listed following the encounter rate on the HCFA 1500:

PROCECURE CODE	TOS	DESCRIPTION
99201	1	New patient, office visit, level 1
99202	1	New patient, office visit, level 2
99203	1	New patient, office visit, level 3
99204	1	New patient, office visit, level 4
99205	1	New patient, office visit, level 5
99211	1	Established patient, office visit, level 1

PROCECURE CODE	TOS	DESCRIPTION
99212	1	Established patient, office visit, level 2
99213	1	Established patient, office visit, level 3
99214	1	Established patient, office visit, level 4
99215	1	Established patient, office visit, level 5
99050	1	Services after hours, in addition to basic service
90844	1	Medical psychotherapy
57452	2	Colposcopy, simple
57454	2	Colposcopy with biopsy
57511	2	Cryocautery
10060	2	Excision/biopsy, simple
11420	2	Excision, benign lesion .5
11422	2	Excision 1.1 - 2.0 cm lesion
12001	2	Simple repair, 2.5 cm or less
10120	2	Foreign body removal
17110	2	Wart removal
17340	2	Wart removal with cryautery
58300	2	IUD insertion
99301	1	Nursing facility assessment, level 1
99302	1	Nursing facility assessment, level 2
99303	1	Nursing facility assessment, level 3
99311	1	Nursing facility subsequent assessment, level 1
99312	1	Nursing facility subsequent assessment, level 2
99313	1	Nursing facility subsequent assessment, level 3
99381	1	New patient > 1 yr. of age, preventative
99382	1	New patient, 1 - 4 yrs. of age, preventative
99383	1	New patient, 5 - 11 yrs. of age, preventative
99384	1	New patient, 12 - 17 yrs. of age, preventative
99385	1	New patient, 18 - 39 yrs. of age, preventative
99386	1	New patient, 40 - 64 yrs. of age, preventative
99387	1	New patient, 65 + yrs. of age, preventative
99391	1	Established patient, > 1 yr. of age, well child exam
99392	1	Established patient, 1 - 4 yrs. of age, well child exam
99393	1	Established patient, 5 - 11 yrs. of age, well child exam
99394	1	Established patient, 12 - 17 yrs. of age, well child exam
99395	1	Established patient, 18 - 39 yrs. of age, preventative
99396	1	Established patient, 40 - 64 yrs. of age, preventative
99397	1	Established patient, 65 + yrs. of age, preventative

HOSPITAL SERVICES

Procedures performed in a hospital can be billed on a fee-for-service basis. Below is a listing of codes which may be billed fee-for-service:

PROCEDURE CODE	TOS	DESCRIPTION
99221	1	Initial inpatient, level 1
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99223	1	Initial inpatient, level 3
99231	1	Subsequent hospital care, level 1
99323	1	Subsequent hospital care, level 2
99233	1	Subsequent hospital care, level 3
99431	1	Newborn care

PROCEDURE CODE	TOS	DESCRIPTION
99433	1	Subsequent newborn care
99238	1	Hospital discharge
99281	1	Emergency room visit, level 1
99282	1	Emergency room visit, level 2
99283	1	Emergency room visit, level 3
99284	1	Emergency room visit, level 4
99285	1	Emergency room visit, level 5
99291	1	Critical care, 1st hour
99292	1	Critical care, each additional 30 minutes
54150	2	Circumcision
59409	2	Vaginal Delivery
59514	8	Assist C-section
62270	2	Lumbar puncture
53670	2	Catherization, bladder
36406	2	Venipuncture < age 3, other vein
99251	3	Inpatient hospital consult, level 1
99252	3	Inpatient hospital consult, level 2
99253	3	Inpatient hospital consult, level 3
99254	3	Inpatient hospital consult, level 4
99255	3	Inpatient hospital consult, level 5
99218	1	Initial observation care, level 1
99219	1	Initial observation care, level 2
99220	1	Initial observation care, level 3

6. Rhode Island ⁴⁰

Rural Health Clinic (RHC)

Covered RHC services are as follows:

- Services furnished by a physician;
- Services furnished by a physician assistant, nurse practitioner or nurse midwife; and
- Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife.

There is an encounter-specific reimbursement rate for all RHC covered services. The encounter rate reimburses 100% of reasonable costs.

Initial FFS reimbursement to RHCs is made per the terms of reimbursement for the performing provider.

Additional reimbursement may be provided based on the provider's encounter rate as established through the RHC cost report.

Federally Qualified Health Centers (FQHC)

The following services may be covered:

- Professional services;
- Supplies and pharmaceuticals incidental to professional services;
- Pharmaceuticals provided by an FQHC in compliance with pharmacy guidelines;
- Obstetrical and perinatal care;

⁴⁰ RI rules found at: <http://www.hrsa.gov/reimbursement/states/Rhode-Island-Medicaid-Covered-Services.htm>; Fees found at: http://www.dhs.state.ri.us/dhs/heacre/provsvcs/fee_schedule.htm

- Clinic visits;
- FQHC professional services provided to FQHC patients if covering inpatient hospital visits;
- Mental health visits provided in compliance with mental health guidelines.

There is an encounter-specific reimbursement rate for all FQHC covered services. The encounter rate reimburses 100% of reasonable costs.

Initial FFS reimbursement to FQHCs is made per the terms of reimbursement for the performing provider.

Additional reimbursement may be provided based on the provider's encounter rate as established through the FQHC cost report.

7. Vermont ⁴¹

Rural Health Clinic (RHC)

Reimbursable RHC services are:

- Services performed by a physician who is employed by the clinic to provide such services;
- Services and supplies incident to a physician's service (within certain limitations);
- Nurse practitioner and physician assistant services if they are furnished by a qualified professional employed by the clinic and furnished under the medical supervision of a physician; and
- Services and supplies incident to a nurse practitioner's or physician assistant's services (within certain limitations).

Reimbursement for primary care is on interim, cost-based encounter rates determined using Medicare principles and a final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.

Reimbursement for dental services is fee-for-service with a cost settlement at year's end.

Reimbursement for other ambulatory services is according to the Medicaid FFS rate on file.

Federally Qualified Health Centers (FQHC)

Covered core services for FQHCs are

- Those services furnished by a physician, physician assistant or advanced practice nurse;
- Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant or advanced practice nurse.
- Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if certain conditions are met.

Covered non-core services are those services that include the following:

- Physical therapy;
- Speech pathology and audiology;
- Dental services;
- Podiatry;
- Optometric and/or optician services;
- Chiropractic services;

⁴¹ VT Rules found at: <http://www.hrsa.gov/reimbursement/states/Vermont-Medicaid-Covered-Services.htm>;

- Transportation services; and
- Mental health services provided by a clinical psychologist, clinical social worker, advanced practice nurse certified by a national certifying organization in the specialty of psychiatry, or a professional counselor.

Reimbursement for primary care is based on interim, cost-based encounter rates determined using Medicare principles and receiving the higher of encounter cost or PPS payment at the final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.

Reimbursement for dental services is fee-for-service with a cost settlement at year's end.

8. Medicare ⁴²

Medicare Claims Processing Manual Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

10 - General Differences Between RHCs and FQHCs

(Rev. 1, 10-01-03)

A3-3642, A3-3643

10.1 - Rural Health Clinics (RHCs)

(Rev. 1, 10-01-03)

A3-3642B-E, B3-9200

Rural health clinics (RHCs) are clinics that are located in areas that are designated both by the Bureau of the Census as rural and by the Secretary of DHHS as medically underserved. RHCs have been eligible for participation in the Medicare program since March 1, 1978. Services rendered by approved RHCs to Medicare beneficiaries are covered under Medicare effective with the date of the clinic's approval for participation. Covered services are described in the Medicare Benefit Policy Manual, chapter 13.

10.2 - Federally Qualified Health Centers (FQHCs)

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in §1861(aa)(4) of the Social Security Act (the Act) and are described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 13.

The FQHC services consist of services that are similar to those provided in rural health clinics (RHC) but also include preventive primary services, as described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 13.

An RHC cannot be concurrently approved for Medicare as both an FQHC and an RHC.

10.3 - Claims Processing Jurisdiction for RHCs and FQHCs

(Rev. 1, 10-01-03)

A3-3642, B3-9200.1

The RHCs and FQHCs bill the intermediary (FI) for RHC or FQHC services, on Form CMS-1450.

United Government Systems processes all claims from independent FQHCs. Provider-based FQHC claims are processed by the FI servicing the provider.

The FI servicing the provider processes provider-based RHC claims.

⁴² Medicare rules located at: <http://www.cms.hhs.gov/center/fqhc.asp> (bp102c13.pdf and clm104c09.pdf)

Claims processing jurisdiction for independent RHCs (i.e., those that are not part of a hospital, SNF, or HHA) is shared among regional FIs. See <http://www.cms.hhs.gov/contacts/incardir.asp> for a listing of RHC regional FIs.

If the entity decides to become a physician directed clinic instead of an RHC or FQHC, the entity will be paid for services under physician payment rules including billing to the carrier on Form CMS-1500.

If the RHC/FQHC continues an election to be paid under the Part B payment methodology, they should continue to use Form CMS-1500, and bill the carrier while that option is in effect. In such cases, the RHC/FQHC is not entitled to payment for any additional benefits provided under the FQHC benefit package.

20 - Method of Medicare Payment for RHC and FQHC Services (Rev. 1, 10-01-03) A3-3642, A3-3643, RHC-500, RHC-504

20.1 - Payment Rate for Independent and Provider Based RHCs and FQHCs (Rev. 1426; Issued: 02-01-08; Effective: 01-01-08; Implementation: 02-12-08)

Payment to independent provider-based RHCs and FQHCs for covered RHC/FQHC services furnished to Medicare patients is made by means of an all-inclusive rate for each visit. (Prior to January 1, 1998, provider based RHCs were paid on a reasonable cost basis.) The encounter rate includes covered services provided by an RHC/FQHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies. The rate does not include services that are not defined as RHC/FQHC services. These rates will be updated annually via Recurring Update Notifications.

The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. (See the Medicare Benefit Policy Manual, Chapter 13, for definitions of these personnel. See also the Medicare Benefit Policy Manual, Chapter 13, for conditions of coverage for visiting nurse services). Encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist: (a) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; (b) the patient has a medical visit and a clinical psychologist or clinical social worker visit.

20.2 - Calculation of the Encounter “Per Visit” Rate (Rev. 1, 10-01-03) RHC-500, PM A-99-10

Provider based and independent RHCs/FQHCs must furnish their FI with information currently collected on the Medicare cost reporting form for independent FQHC/RHCs (Form CMS-222). This form contains the minimum statistical visit data and other information necessary to enable the FI to calculate a cost-per-visit, apply FQHC/RHC productivity standards, and apply the FQHC/RHC payment cap. Providers must identify all incurred costs applicable to furnishing covered clinic/center services. This includes RHC/FQHC direct costs, any shared costs applicable to the RHC/FQHC, and the RHCs/FQHCs appropriate share of the parent provider’s overhead costs. Total RHC/FQHC costs applicable to furnishing covered RHC/FQHC services are to be included in the calculation of the

RHC/FQHC cost-per-visit, using the methodology employed on the Form CMS-222 cost reporting forms and instructions.

If the RHC/FQHC is in the initial reporting period, the all-inclusive rate is determined on the basis of a budget the RHC/FQHC submits. The budget estimates the allowable cost to be incurred by the RHC/FQHC during the reporting period and the number of visits for RHC/FQHC services expected during the reporting period. RHCs/FQHCs supply this information using Form CMS-222-92.

In determining the payment rate for new RHCs/FQHCs and for those who have submitted cost reports, the FI applies screening guidelines and the maximum payment per visit limitation as described in §20.4.

For subsequent reporting periods, the all-inclusive rate is determined, at the discretion of the FI, on the basis of a budget or the prior year's actual costs and visits with adjustments to reflect anticipated changes in expenses or utilization.

20.3 - Calculation of Payment

(Rev. 1, 10-01-03)

RHC-500

The interim Medicare payments are based on the all-inclusive rate per visit established by the Medicare FI. The rate is paid, subject to the Medicare deductible and coinsurance requirements, for each covered visit with a Medicare beneficiary. No deductible applies to FQHC services provided at FQHCs. Only FQHC services are exempt from the deductible.

20.4 - Determination of Payment

(Rev. 1, 10-01-03)

RHC-500

The payment rate is calculated, in general, by dividing the total allowable cost by the number of total visits for RHC/FQHC services.

At the end of the reporting period, RHCs/FQHCs submit a report to the FI of actual allowable costs and actual visits for RHC/FQHC services for the reporting period. Also RHCs/FQHCs submit any other information as may be required. (See §30.5.) After reviewing the report, the FI divides actual allowable costs by the number of actual visits to determine a final rate for the period. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the clinic's productivity, a payment limit, and psychiatric services limit as explained in §40.3, §20.6, and §60.

20.5 - Annual Reconciliation

(Rev. 1, 10-01-03)

RHC-500

At the end of the reporting period, the FI determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. (See §30.)

20.6 - Maximum Payment Per Visit

(Rev. 1, 10-01-03)

RHC-505

20.6.1 - Rural Health Clinics

(Rev. 1, 10-01-03)

PM A-99-08, A-00-30

Section 1833(f) of the Act established the initial payment limit for RHC services provided from April 1, 1988 through December 31, 1988, at \$46 per visit. For services furnished on or

after January 1 of each subsequent year, the RHC payment limit is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physician services. The MEI is defined in §1842(b)(3) and (i)(3) of the Act and 42 CFR 405.504(a)(3). The MEI percentage increase is updated annually, which yields a per visit payment limit that is also updated annually. The CMS will formally update these numbers each year through a program memorandum.

Since §1833(f) of the Act provides that each payment limit applies to services provided during a calendar year, it is possible for different payment limits to apply during one reporting period. Medicare visits to which different payment limits apply and the resulting Medicare costs must be separately identified on Form CMS-222-92.

20.6.2 - Federally Qualified Health Centers

(Rev. 1, 10-01-03)

RHC-500

The FQHC payment methodology includes one urban and one rural payment limit. For services furnished on or after January 1 of each subsequent year, the FQHC payment limit is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physicians services. CMS will formally review and update the payment limits annually via program memorandum.

An FQHC is designated as an urban or rural entity based on the urban and rural definitions in §1886(d)(2)(D) of the Act. If the FQHC is located within a Metropolitan Statistical Area (MSA) or New England County Metropolitan area (NECMA), then the urban limit applies. If the FQHC is not in an MSA or NECMA and cannot be classified as a large or other urban area, the rural limit applies. Rural FQHCs cannot be reclassified into an urban area (as determined by the Bureau of Census) for FQHC payment limit purposes.

Section 1833(f) of the Act provides that each RHC payment limit applies to services provided during a calendar year. Since the FQHC payment limit application is consistent with §1833(f) of the Act, it is possible for different payment limits to apply during one reporting period. Medicare visits to which different payments limits apply and the resulting Medicare costs must be separately identified on Form CMS-222-92.

20.6.3 - Exceptions to Maximum Payment Limit (Cap) in Encounter Payment Rate for Provider-Based RHCs

(Rev. 1, 10-01-03)

All RHCs based in hospitals with less than 50 beds are eligible to receive an exception to the per visit payment limit.

From January 1, 1998 through June 30 2001, this exemption was limited to rural hospitals with less than 50 beds. Rural hospitals are those hospitals not located in a metropolitan statistical area as defined by 42 CFR 412.62(f)(1)(ii)(A).

This exception to the payment limit does not apply to provider-based FQHCs. Similarly, there is no exception available for independent RHCs or FQHCs.

To determine number of beds, use the definition in 42 CFR 412.105(b) to determine the number of beds for the current cost reporting period.

A hospital-based RHC can also receive an exception to the per visit payment limit if its hospital has an average daily patient census that does not exceed 40 and the hospital meets the following conditions: (a) It is a sole community hospital. (b) It is located in an 8-level or 9-level nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture.

20.7 - Special Rules for FQHC Networks

(Rev. 1, 10-01-03)

RHC-505.3

An FQHC network consists of a group of two or more FQHCs that are owned, leased, or through any other device, controlled by one organization. FQHCs that are part of networks have the option to file either a single consolidated cost report for the entire network or separate cost reports for each site within the network.

20.7.1 - Separate Payment Limits for Individual Cost Reports

(Rev. 1, 10-01-03)

RHC-505.3.A

If an FQHC network chooses to file individual cost reports for each site, then they are paid the lower of their specific all-inclusive rate or their appropriate payment limit for each site. The appropriate payment limit depends on the geographic designation (either urban or rural). The home office must allocate costs that are applicable to individual sites appropriately to each site within the network. These allocations are subject to FI review and are included in the respective encounter rates.

20.7.2 - Consolidated Payment Limit for Networks Having Mixture of Urban and Rural Sites

(Rev. 1, 10-01-03)

RHC-505.3.B

If the network includes both urban and rural sites, the FQHCs are paid the lower of the network all-inclusive rate or a single weighted payment limit calculated for the entire network. The payment limit is weighted by the percentage of urban and rural visits as a percentage of total visits for the entire FQHC network. The urban payment limit is weighted by the percentage of visits attributed to urban sites and the rural payment limit is weighted by the percentage of visits attributed to rural sites.

A weighted calculation based on the 1991 urban limit of \$72.39 and rural limit of \$62.25 is illustrated below. This FQHC network illustration contains three urban sites and two rural sites.

FQHC Site	Limit Adjusted By Percent of Total Visits
Urban Site #1	25% of total network visits
Urban Site #2	22% of total network visits
Urban Site #3	18% of total network visits
Total Urban Limit Component	65% x \$72.39 = \$47.05
Rural Site #1	20% of total network visits
FQHC Site Limit Adjusted By Percent of Total Visits	
Rural Site #2	15% of total network visits
Total Rural Limit Component	35% x \$62.25 = \$21.79

Weighted Limit	\$47.05 (Urban Weight)
	+\$21.79 (Rural Weight)
	\$68.84

The 1991 weighted FQHC payment limit for this example is \$68.84. The entire network is paid the lower of the urban/rural network weighted payment limit or the network all-inclusive rate (total costs divided by visits) for each covered visit.

The annual adjustment is applied to the urban and rural payment limits prior to the network single weighted payment limit calculation.

20.7.3 - Consolidated Payment Limit for FQHC Networks With All Urban or All Rural Sites

(Rev. 1, 10-01-03)

RHC-505.3.C

If the network includes **all urban or all rural** sites, the FQHC is paid the lower of the network all-inclusive rate or the applicable network urban/rural payment limit. The consolidated weighted payment limit calculation is applicable only to networks with a mixture of both urban and rural sites.

30 - Annual Reconciliation With Cost Report

(Rev. 1, 10-01-03)

RHC-506

30.1 - Submission of Cost Report

(Rev. 1, 10-01-03)

RHC-506

On or before the last day of the fifth month following the close of RHC/FQHC reporting period, the RHC/FQHC must submit to its FI a cost report showing the actual costs incurred and the total number of visits for RHC/FQHC services the period. Using this information, the FI determines the total payment amount due for covered services furnished to Medicare beneficiaries.

30.2 - Payment Reconciliation

(Rev. 1, 10-01-03)

RHC-506.1

The FI compares the total payment due with the total payments made for services furnished during the reporting period. If the total payment due exceeds the total payments made, the RHC/FQHC has been underpaid. The underpayment is made up by a lump sum payment. If the total payment due is less than the total payments made, the RHC/FQHC has been overpaid for services furnished to Medicare patients. Methods for recovery of overpayment are discussed in [§30.4](#).

30.3 - Notice of Program Reimbursement

(Rev. 1, 10-01-03)

RHC-506.2

When the FI determines the total reimbursement due and the amount of any overpayment or underpayment, it gives the RHC/FQHC a written notice of program reimbursement (NPR). The NPR sets out the FI's determination of the total payment due and the amount of any

overpayment or underpayment. The notice also advises the RHC/FQHC appeal rights if it should disagree with the determination. See Chapter 29 for a complete discussion of claim appeals procedures

30.4 - Recovery of Overpayments

(Rev. 1, 10-01-03)

RHC-506.3

Once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government.

When the NPR is received stating the amount of the overpayment, the RHC/FQHC is required to immediately make a lump sum refund to the FI. If the RHC/FQHC is unable to make a lump sum refund, it may work out arrangements with the FI for recovery through an extended repayment schedule. Generally, the period of recovery is not to exceed 12 months from the date of the NPR. If, however, the RHC/FQHC demonstrates that repayment within the 12-month period creates a financial hardship, the period for recoupment may be extended.

30.5 - Reporting Requirements for Cost Report

(Rev. 1, 10-01-03)

RHC-507

The RHC/FQHC must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors. The data must be maintained on the accrual basis of accounting. However, a government institution that operates on a cash basis of accounting may maintain data other than capital expenditure data on a cash basis. If records are maintained on a cash basis, RHCs/FQHCs need adjust only a relatively few items from the cash basis to an accrual basis at the end of the reporting period to meet the accrual requirement. These adjustments need not be recorded in formal accounting records. It is acceptable for these adjustments to be made in supplementary records. These adjustments are necessary, for example, if expenses are prepaid, if expenses are incurred in one reporting period and paid in a later period, supplies are bought in one period for use during later periods, or capital assets are expensed instead of depreciated.

Cost information must be current, accurate and in sufficient detail to support payments made for services rendered to Medicare beneficiaries. This includes all ledgers, records and original evidences of cost (e.g., purchase requisitions, purchase orders, invoices, vouchers, payroll vouchers) that pertain to the determination of reasonable cost. Financial and statistical records must be maintained in a consistent manner from one period to another.

30.5.1 - Definitions

(Rev. 1, 10-01-03)

RHC-507.B

Accrual Basis of Accounting - Revenue and expense are identified with specific periods of time (such as a month or year) to which they apply regardless of when revenue is received or disbursement made for expenses.

Cash Basis of Accounting - Revenue and expense are recorded on the books of account when they are received and paid, respectively, without regard to the period to which they apply.

Government Institution - This is an RHC/FQHC owned and operated by a Federal, State or local government agency.

30.6 - When to Submit Cost Reports

(Rev. 1, 10-01-03)

RHC-508

The RHC/FQHC must submit an annual report covering a 12-month period of operations based upon its reporting period. (The first and last reporting periods may be less than 12 months.) RHCs/FQHCs select any annual period for Medicare reporting purposes, but this reporting period is subject to approval by the FI. Once RHCs/FQHCs have selected a reporting period and have obtained the approval of the FI, they must adhere to the period initially selected unless a change has been authorized in writing by the FI. Such a change is made only after the FI has established that the reason for such a change is valid. For detailed explanation of Cost Reporting Periods, see Medicare Provider Reimbursement Manual (PRM) 15-II, Chapter 1, §102. For a detailed explanation of Cost Report Due Dates see PRM 15-II, Chapter 1, §104.

If RHCs/FQHCs do not furnish any covered services to Medicare beneficiaries or where RHCs/FQHCs have low utilization of covered services by Medicare beneficiaries during the entire cost reporting period, RHCs/FQHCs do not need to file a full cost report to comply with the program cost reporting requirements. For a detailed explanation of the conditions under which less than full cost report may be filed, see PRM 15-II, Chapter 1, §110. Also, see §110 for an explanation of what is to be filed to comply with the cost reporting requirements for a “No Utilization Cost Report” or a “Low Utilization Cost Report.”

NOTE: While some providers, particularly pediatric centers, may not provide services to Medicare beneficiaries, they should still file a complete and full cost report to ensure that the appropriate increase to their interim rate is made.

30.7 - Penalty for Failure to File Cost Reports Timely

(Rev. 1, 10-01-03)

RHC-508.C

Failure to submit cost reports within the time frames specified previously may result in a reduction or suspension of payments.

Failure to submit cost reports may result in the treatment of all previous payments made during the current reporting period as overpayments.

30.8 - Filing Consolidated Worksheets Rather Than Individual Cost Reports

(Rev. 1, 10-01-03)

RHC-508.D

If RHCs/FQHCs are part of the same organization with one or more RHCs/FQHCs, they may elect to file consolidated worksheets rather than individual cost reports. Under this type of reporting, each RHC/FQHC in the organization need not file individual cost reports. Rather, the group of RHCs/FQHCs may file a single report that accumulates the costs and visits for all RHCs/FQHCs in the organization. In order to qualify for consolidation reporting, all RHCs/FQHCs in the group must be owned, leased, or through any other device, controlled by one organization.

RHCs/FQHCs make the election to file consolidated worksheets in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC/FQHC may not revert to individual reporting without the prior approval of the FI.

40 - Allowable Costs

(Rev. 1, 10-01-03)

RHC-501

Allowable costs are the costs actually incurred by the RHC/FQHC that are reasonable in amount and necessary and proper to the efficient delivery of services.

The allowability of costs is governed by the applicable Medicare principles of reimbursement for provider costs as set forth in 42 CFR 413 and the PRM. These are the general Medicare

principles that define allowable costs of hospitals and other facilities paid on a reasonable cost or cost related basis. The lesser of cost or charges principal does not apply to independent and provider-based RHCs and FQHCs. For a detailed explanation of the reimbursement policy concerning allowable cost see PRM 15-I.

Typical allowable costs include, to the extent reasonable:

- Compensation for the services of physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers compensated by the RHC/FQHC;
- Compensation for the duties that a supervising physician is required to perform;
 - Costs of services and supplies incident to the services of a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, or clinical social worker;
 - Overhead costs, including RHC/FQHC administration, costs applicable to the use and maintenance of the RHC/FQHC facility, and depreciation costs;
 - The costs of physician services furnished under agreements with the RHC/FQHC; and
 - If the RHC/FQHC is located in an area with a shortage of home health agency (HHA) services, the cost of visiting nurse services and related supplies furnished.

40.1 - Costs Excluded from Allowable Costs

(Rev. 1, 10-01-03)

RHC-501.1

Items and services not covered under the Medicare program, e.g., dental services, eyeglasses, and routine examinations are not allowable. Preventive primary physical examinations targeted to risk are allowable at FQHCs.

Items and services that are covered under Part B of Medicare, but are not included in the definition of RHC/FQHC services, e.g., routine diagnostic and laboratory services, independent laboratory services, durable medical equipment, and ambulance services are not allowable on the cost report. However, the provider of these services may bill for these items separately.

40.2 - Allowable Costs Subject to Tests of Reasonableness

(Rev. 1, 10-01-03)

RHC-502

Allowable costs are limited to amounts that are reasonable. The CMS has established screening guidelines which FIs use to test the reasonableness of an RHC/FQHCs productivity and a payment limit which the per visit rate may not exceed. Costs for which screening guidelines have not been established by CMS are disallowed to the extent the FI determines they are unreasonable.

40.3 - Screening Guidelines of RHC/FQHC Health Care Staff Productivity

(Rev. 1, 10-01-03)

RHC-503

Payments for services are subject to guidelines to test the reasonableness of the productivity of the clinic/center's health care staff. These guidelines are applied to staff for RHC/FQHC services furnished both at the clinic/center's site and in other locations. They are as follows:

- At least 4,200 visits per year per full time equivalent physician employed by the clinic/center;
- At least 2,100 visits per year per full time equivalent physician assistant or nurse practitioner employed by the clinic/center; or

- If staffing levels consist of various combinations of physicians and nurse practitioners or physician assistants, a combined screening approach may be used. For example, if a clinic/center has three physicians and one nurse practitioner, calculate the screening guidelines as follows:

$$3 \times 4,200 = 12,600;$$

$$1 \times 2,100 = 2,100 \quad (12,600 + 2,100 = 14,700).$$

Another example is a clinic/center with four nonphysician practitioners ($4 \times 2,100 = 8,400$).

- The number of full time equivalent employees (FTE) of each type (i.e., physician, physician assistant, or nurse practitioner) is determined by the following formula. Divide the total number of hours per year worked by all employees of that type by the greater of:
 - The number of hours per year for which one employee of that type must be compensated to meet the clinic/center's definition of an FTE. (If the clinic/center is open on a full time basis, the usual definition of an FTE is 2,080 hours per year, 40 hours per week for 52 weeks); or
 - 1,600 hours per year (40 hours per week for 40 weeks).

FIs may waive the productivity guideline in cases in which a clinic/center has demonstrated reasonable justification for not meeting the standard. In these cases in which an exception is granted, the FI, no longer restricted by the number of actual visits, sets the number of visits that it determines is reasonable. For example, the guideline number is 4,200 visits, and the clinic/center has furnished only 1,000 visits. The FI does not accept the 1,000 visits as reasonable but permits 2,500 visits to be used in the calculation.

40.4 - All Inclusive Rate of Payment

(Rev. 1, 10-01-03)

RHC-504, A3-3628

Payments to RHCs/FQHCs for covered RHC/FQHC services furnished to Medicare beneficiaries are made on the basis of an all-inclusive rate per covered visit (except for pneumococcal and influenza vaccines and their administration, which are paid at 100 percent reasonable cost). The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, clinical nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. (See the Medicare Benefit Policy Manual, Chapter 13, for definitions of these personnel.) Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment or the patient has a medical visit and a mental health visit. Mental health visit means a face-to-face encounter between an RHC/FQHC patient and a clinical psychologist or clinical social worker.

40.5 - Bad Debts

(Rev. 1, 10-01-03)

RHC-504.1A

RHCs/FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.80. For FQHCs, bad debts are limited to Medicare coinsurance amounts that remain unpaid by the Medicare beneficiary since no deductible is applied to FQHC services. RHCs may claim unpaid deductible also. The RHC/FQHC must establish that reasonable efforts were made to collect these coinsurance amounts in order to receive payment for bad debts. When either waives coinsurance or deductible (RHC) it may not claim bad debt amounts for which it assumed the beneficiary's liability.

40.6 - Calculation of Medicare Program Payment

(Rev. 1, 10-01-03)

RHC-500.B

The RHC/FQHC's interim Medicare payments are based on the all-inclusive rate per visit established by the FI. The rate is paid, subject to the Medicare deductible and coinsurance requirements, for each covered visit with a Medicare beneficiary. No deductible applies to FQHC services provided at FQHCs. Only FQHC services are exempt from the deductible.

40.7 - Determination of Payments

RHC-500.C

The payment rate is calculated, in general, by dividing total allowable cost by the number of total visits for RHC/FQHC services. An interim rate is determined at the beginning of the reporting period on the basis of RHC/FQHC's estimated allowable costs and estimated visits for RHC/FQHC services, as reported on the Independent Rural Health Clinic/Freestanding Federally Qualified Health Center Worksheets, Form CMS-222-92.

The facility is paid this rate the following year minus any coinsurance and/or deductible reported on the claim.

This rate may be adjusted during the reporting period at the FI's discretion.

50 - Deductible and Coinsurance

(Rev. 1, 10-01-03)

RHC-504.1

50.1 - Part B Deductible

(Rev. 1, 10-01-03)

RHC-500.B

In each calendar year, a cash deductible must be satisfied before payment can be made under supplementary medical insurance (SMI). Currently, the cash deductible is \$100; this amount is subject to change.

Bills count toward the deductible on the basis of incurred, rather than paid, expenses. For RHC/FQHC services deductible is based on billed charges. Noncovered expenses do not count toward the deductible. Even though an individual is not eligible for the entire calendar year, i.e., his/her insurance coverage begins after the first month of the year or he/she dies before the last month of the year, he/she is still subject to the full Part B cash deductible. Medical expenses incurred in any portion of the year preceding entitlement to SMI are not credited toward the Part B deductible.

The Part B deductible does not apply to FQHC services. It does apply to non-FQHC services billed to the carrier or FI and to RHC services.

Deductible for non-RHC/FQHC services billed by the parent provider is based on rules for the host provider.

50.2 - Part B Coinsurance

(Rev. 1, 10-01-03)

RHC-500.B

After the deductible has been satisfied, RHCs will be paid 80 percent of the all-inclusive interim encounter payment rate. The patient is responsible for a coinsurance amount of 20 percent of the charges after deduction of the deductible. Note that 20 percent of charges may not be equal to 20 percent of the encounter rate, e.g., if the charges are not equal to the encounter rate.

On claims to the carrier, e.g., independent RHC/FQHC claims for non-RHC/FQHC services, coinsurance is established based on 20 percent of the allowed amount.

On provider based RHC/FQHC claims for non-RHC/FQHC services coinsurance is based on the rules applicable to the parent provider type and the type of service.

60 - Mental Health Services Limit

(Rev. 1, 10-01-03)

RHC-612, RHC-613, A3-3185

60.1 - Definition of Mental Health Services in RHC/FQHC

(Rev. 1, 10-01-03)

RHC-419.2.C

Mental, psychoneurotic, and personality disorders are defined as the specific psychiatric conditions described in the American Psychiatric Association's "Diagnostic and Statistical Manual-Mental Disorders." The mental health payment limitation applies to expenses incurred in connection with one of these psychiatric conditions. It is applicable to physicians' services or items and supplies furnished by physicians. No distinction is made when applying the limitation between the services of psychiatrists and nonpsychiatric physicians.

Therapeutic services furnished by other health practitioners are subject to the mental health treatment limitation when rendered in connection with a condition included in the definition of "mental, psychoneurotic, and personality disorders."

Charges for initial diagnostic services (i.e., psychiatric testing and evaluation used to diagnose the patient's illness) are not subject to this limitation. The limitation is applied only to therapeutic services.

Thus, the following types of diagnostic services would be exempt from the limitation:

- Psychiatric testing - this refers to use of actual testing instruments such as intelligence tests;

- Psychiatric consultations - evaluation made by a physician or non-physician for purposes of preparing a report for the attending physician; or

- Initial psychiatric visits - evaluation made by a physician who will test the patient

60.2 - Application of Limit

(Rev. 167, 04-30-04)

RHC-613, A3-3185.1

The beneficiary is responsible for at least 37.5 percent of the all-inclusive rate for psychiatric therapy services. Additionally, the beneficiary is responsible for the coinsurance and any unmet deductible (for RHCs only) that is based on the remaining 62.5 percent of the reasonable charges. Therefore, the patient's liability is a two-part calculation as follows:

Part 1 - 62.5% limitation:

1. Multiply the charges for revenue code 0900 by 37.5%.

Part 2 - Deductible and coinsurance calculation:

1. Multiply charges for revenue code 0900 by 62.5% to calculate recognized charges.
2. For RHCs, apply any portion of recognized charges necessary toward the deductible, if it is applicable and has not yet been fully satisfied. For FQHCs, there is no deductible obligation; therefore, this step is not applicable.
3. Multiply remaining recognized charges by 20% to calculate coinsurance.

Total beneficiary liability for RHCs is 37.5 percent of revenue code 0900 charges plus 20 percent of recognized charges (coinsurance) plus any unmet deductible (as calculated from recognized charges.)

Total beneficiary liability for FQHCs is 37.5 percent of revenue code 0900 charges plus 20 percent of recognized charges (coinsurance.)

Use the following computation to determine Medicare payment for FQHCs and for RHCs when the deductible has already been completely satisfied or will be completely satisfied by the current claim. The computation for Medicare payment is as follows:

- 1 - Subtract the 37.5 psychiatric liability (plus for RHCs any amount applied toward the deductible) from the clinic's/center's all-inclusive payment rate.
- 2 - Multiply the remainder by 80%.

The following examples illustrate how payment is made to a clinic and how beneficiary liability is computed for the outpatient psychiatric limitation for RHC services.

Assume the deductible is \$100 for the following examples:

EXAMPLE A:

Total outpatient mental health limit amount for therapy is \$60.00. The all-inclusive rate is \$48.00. No part of the deductible has been met. In this instance, the RHC total charges are applied to the beneficiary deductible. The beneficiary's liability is the full \$60 and \$37.50 is applied toward the deductible (62.5 percent of \$60).

Medicare makes no payment to the RHC/FQHC.

EXAMPLE B:

Total outpatient mental health limit amount for therapy is \$64. The RHC all-inclusive rate is \$48. Thirty-seven dollars and fifty cents is applied toward the deductible from example A.

The computation for patient liability is as follows:

$$\text{Part 1: } \$64 \times 37.5\% = \$24.$$

$$\text{Part 2: } \$64 \times 62.5\% = \$40, \text{ which is applied to the deductible.}$$

No Medicare payment can be made since only \$77.50 of the deductible has been met. The beneficiary is liable for the full \$64 charges.

EXAMPLE C:

Total outpatient mental health limit amount for therapy is \$48. The RHC all-inclusive rate is \$48. The beneficiary deductible is credited with \$77.50.

The computation for patient liability is as follows:

$$\begin{array}{l} \text{Part } \$48 \times \\ \text{1: } 37.5\% \end{array} = \$18.$$

$$\begin{array}{l} \text{Part } \$48 \times \\ \text{2: } 62.5\% \end{array} = \$30. \$22.50 \text{ is applied to the deductible. } \$7.50 \times 20\% = \$1.50 \text{ coinsurance. Total beneficiary liability} = \$18 \text{ (Part 1) plus } \$22.50 \text{ (deductible) plus } \$1.50 \text{ (coinsurance) } = \$42.00.$$

The computation for Medicare payment is as follows:

The all-inclusive rate minus the beneficiary liability of \$42.00 leaves \$6.00 to be paid to the clinic.

EXAMPLE D:

Total outpatient mental health limit amount for therapy is \$40. Ninety dollars of nonpsychiatric expenses had previously been incurred and applied to the deductible. The RHC all-inclusive rate is \$48.

The computation for patient liability is as follows:

$$\begin{array}{r} \text{Part} \\ 1 \end{array} \quad \begin{array}{r} \$40 \text{ X} \\ 37.5\% \end{array} \quad = \$15.00$$

$$\begin{array}{r} \text{Part} \\ 2 \end{array} \quad \begin{array}{r} \$40 \text{ X} \\ 62.5\% \end{array} \quad = \$25.00.$$

\$10 of deductible remains to be met.

$$\$25.00 - \$10.00 \text{ X } 20\% = \$3.00 \text{ coinsurance.}$$

$$\text{Total beneficiary liability} = \$15.00 + \$10 + \$3.00 = \$28.00.$$

The computation for Medicare payment is as follows:

The all-inclusive rate of \$48.00 minus the beneficiary liability of \$28.00 leaves \$20.00

Medicare payment to the clinic.

70 - Determining How Much to Charge Patient Before Billing Is Submitted for Part B Payment

(Rev. 1, 10-01-03)

RHC-608

The RHCs/FQHCs should ask the patient for any evidence that he/she has met the deductible, such as a Medicare Summary Notice. They may take into account any other available information of the patient's deductible status, such as its billing history records.

Where the deductible is met for RHCs collect no more than 20 percent of the charges. For RHC services where the deductible is known to be met in part, no more than the unmet deductible and 20 percent of the remaining charge may be collected. When the deductible is not met or its status is unknown, collect no more than the cash deductible and 20 percent of the balance. Once RHCs have billed the FI for services, they do not collect or accept any additional money from the patient for such services until the FI notifies the RHC of how much of the deductible has been met.

For FQHC services, the Part B deductible does not apply. Collect no more than 20 percent of the charges.

100 - General Billing Requirements

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

General information on basic Medicare claims processing can be found in this manual in:

- Chapter 1, "General Billing Requirements,"

(<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>) for general claims processing information;

- Chapter 2, "Admission and Registration Requirements,"

(<http://www.cms.hhs.gov/manuals/downloads/clm104c02.pdf>) for general filing requirements applicable to all providers.

For Medicare institutional claims:

- See Chapter 25 “Completing and Processing *the CMS-1450 Data Set*” (<http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf>) for general requirements for completing the institutional claim data set (paper and HIPAA Version (837)).

NOTE: Chapter 25 lists all revenue codes available; however RHCs and FQHCs are limited to the revenue codes listed in B-Service Level Information, below.

- See the Medicare Claims Processing Manual on the CMS Web site for general Medicare institutional claims processing requirements, such as for timely filing and payment, admission processing, Medicare Summary Notices, and required claim data elements that are applicable to RHCs and FQHCs.
- See §10.3 in this chapter for claims processing jurisdiction for RHC and FQHC claims
- Contact your fiscal intermediary (FI) for basic training and orientation material if needed.

The focus of this chapter is RHCs and FQHCs, meaning only institutional claims using TOBs 71x and 73x, not any other provider or claim types. Professional claims completed by physicians and non-institutional practitioners are sent to Medicare carriers in the ASC 837P ANSI X-12 format for professional claims or on Form CMS-1500.

The RHC and FQHC benefits provide specific primary or professional medical services, to Medicare beneficiaries in underserved or specially designated areas. These benefits are equivalent to certain physician or practitioner services. Provision of these services in underserved or specially designated areas may qualify the provider to receive specific types of grants or funding. Limited services are provided under the RHC and FQHC benefits. Generally, only those services that are included in the RHC and FQHC benefits are billed on these claims.

- The RHC and FQHC benefits are defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (<http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf>.)

The core services of the benefits are professional, meaning the hands-on delivery of care by medical professionals. Some preventive services, however, are also encompassed in primary care under the benefits, and these services may have a technical component, such as a laboratory service or use of diagnostic testing equipment. For FQHCs only: Certain mandated preventive services include a laboratory test that is included in the FQHC visit rate. (See CFR 42 405.2446 (b)(9) and 405.2448 (b) and the RHC/FQHC specific billing instructions in A and B, below.) In general, if NOT part of the RHC or FQHC benefits, technical services, (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims. All services in the RHC and FQHC benefits are reimbursed through a single all-inclusive rate paid for each patient encounter or visit. The visit rate includes: covered services provided by an RHC or FQHC physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker or, in very limited situations, visiting nurse; and related services and supplies. The rate does not include services that are not defined as RHC or FQHC services.

The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, clinical

social worker or in very limited situations, visiting nurse, during which an RHC or FQHC service is rendered. These services are reimbursed by the Medicare Part B trust fund. RHC services are subject to the Medicare coinsurance and deductible rules. FQHC services are subject to the Medicare coinsurance rules but are exempt from the Medicare deductible rules.

A. Claim-Level Information

The RHCs and FQHCs bill FIs on institutional claims, either on the ASC 837I ANSI X-12 format for institutional claims or the UB-04/Form CMS-1450, using type of bill (TOB) 71x for RHCs, and 73x for FQHCs.

The following rules apply specifically to all RHC and FQHC claims:

- Bill types 71x and 73x **MUST** be used on institutional claims for RHC and FQHC benefit services for **BOTH** independent and provider-based facilities.
- The third digit of TOBs 71x and 73x provides additional information regarding the individual claim. When the third digits, called frequency codes, are used on RHC or FQHC claims the TOBs are:

⌚③ 710 or 730 = non-payment/zero claim (a claim with only noncovered charges)

⌚③ 711 or 731 = Admit through discharge (original claim)

⌚③ 717 or 737 = Replacement of prior claim (adjustment)

⌚③ 718 or 738 =Void/cancel prior claim (cancellation)

NOTE: “x” represents a digit that can vary.

- RHC and FQHC claims cannot overlap calendar years. Therefore, the statement dates, or from and through dates of the claim, must always be in the same calendar year, and periods of billing ranging over 2 calendar years must be split into 2 separate claims for the 2 different calendar years.

- RHC TOB 71x claims and FQHC TOB 73x claims are defined as outpatient institutional claims under HIPAA and should follow the guidelines below:

B. Service-Level Information

Only four types of services are billed on TOBs 71x and 73x:

- Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052x;
- Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); and
- Telehealth originating site facility fees are billed under revenue code 0780.
- FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006. (FQHCs only)

All charges are entered in the following revenue code lines:

- 052x – Free-Standing Clinic; or

- 0900 – Behavioral Health Treatment/Services, General Classification (previously 0910);
- 0780 –Telemedicine, General Classification; and/or
- 0519 - Clinic, Other Clinic (only for the FQHC supplemental payment)

NOTE: Telehealth is not an RHC or FQHC service. As appropriate, however, the telehealth originating site facility fee is billed by the RHC or FQHC using revenue code 0780, in addition to the appropriate visit billed in revenue code 052x or 0900. For information on billing for the FQHC supplemental payment see section 110.3 of this chapter. Revenue code 052x, “Free-Standing Clinic”, is used to bill for all professional services under the RHC and FQHC benefits, other than those services subject to the Medicare outpatient mental health treatment limitation (0900) or for the FQHC supplement payment (0519) (FQHCs only).

- For dates of service prior to July 1, 2006, the values for all four digits of revenue code 052x are:
 - o 0520 = Free-Standing Clinic – to be used by all FQHCs;
 - o 0521 = Rural Health Clinic – to be used by RHCs; and
 - o 0522 = Rural Health Home – to be used by RHCs in home settings.
- For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment (FQHCs only):
 - o 0521 = Clinic visit by member to RHC/FQHC;
 - o 0522 = Home visit by RHC/FQHC practitioner;
 - o 0524 = Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF;
 - o 0525 = Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility;
 - o 0527 = RHC/FQHC Visiting Nurse Service(s) to a member’s home when in a home health shortage area; and
 - o 0528 = Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)

Revenue code 0900 (“Behavioral Health Treatments/Services, General Classification”) is used for services subject to the Medicare outpatient mental health treatment limitation on claims with dates of service on or after October 16, 2003, that are received on and after October 1, 2004; for claims received before October 1, 2004, and for all claims with dates of service before October 16, 2003, use revenue code 0910 (“Behavioral Health Treatments/Services-Extension of 0900, Reserved for National Use”, formerly “Psychiatric/Psychological Services, General Classification”) instead.

Revenue code 0780 (“Telemedicine, General Classification”) is used to bill for the telehealth originating site facility fee. Telehealth originating site facilities’ fees billed using revenue code 0780 are the only line items allowed on TOBs 71x/73x that are NOT part of the RHC and FQHC benefits.

- These line items require use of HCPCS code Q3014 in addition to the revenue code (0780) to indicate the facility fee is being billed.

- These are the only services billed on TOB 73x that will be subject to the Part B deductible.
- See chapter 15, §270 of Pub. 100-02, Medicare Benefit Policy Manual, (<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>) for coverage requirements and the definition of telehealth services.

For dates of service from January 1, 2002, through March 31, 2005, HCPCS codes were required for selected screening and preventive services with statutory frequency limitations. For details, see section 120 of this chapter and chapter 18 of this manual (<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>). Additionally, Independent FQHC services were billed using one of five HCPCS codes, and hospital-based FQHC services were billed with one of a series of HCPCS codes. The hospital-based HCPCS codes were 99201-99205 and 99211-99215 respectively. Effective with dates of service on and after April 1, 2005, RHCs and FQHCs are no longer required to use HCPCS codes when billing for RHC or FQHC services. Charges for each visit are combined and entered on one revenue code line.

- See chapter 1, §60 (<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>) of this manual for information on billing noncovered charges or claims to FIs;
- Line items on outpatient claims under HIPAA require reporting of a line-item service date for each iteration of each revenue code. A single date should be reported on a line item for the date the service was provided, not a range of dates. Most if not all RHC and FQHC services are provided on a single day.
 - o For services that do not qualify as a billable visit, the usual charges for the services are added to those of the appropriate (generally previous) visit. RHCs/FQHCs use the date of the visit as the single date on the line item.
- Units are reported based on visits, which are paid based on the all-inclusive rate no matter how many services are delivered. Only one visit is billed per day unless the patient leaves and later returns with a different illness or impairment suffered later on the same day (and medical records should support these cases). Units for visits are to be reported under revenue codes 052x or 0900 (0910 depending on the date), as applicable.
- No type of technical services, such as a laboratory service, or technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x. Technical services specifically included in these benefits or expressly applicable to the 71x/73x TOBs in other instructions are bundled into the visit rate. Consequently they are not separately identified on the claim.

If technical services/components not part of either the RHC or FQHC benefits are performed in association with professional services or components of services billed on 71x/73x claims, how the technical services/components are billed depends on whether the RHC or FQHC is independent or provider-based:

- o Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers in the designated claim format (837P or Form CMS-1500.) See chapters 12 (<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>) and 26 (<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>) of this manual for billing instructions.
- o Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI; see the applicable chapter of this manual based on the base-provider type, such as

(<http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>) for outpatient hospital services, chapter 6 (<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>) for inpatient SNF services chapter 7 for Outpatient SNF services, etc.

The following three sections describe other billing rules applicable to RHC and FQHC claims and services.

110 - Special FQHC Requirements

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Effective April 1, 2005 FQHCs need not report HCPCS codes for FQHC services. For earlier dates some requirements to report HCPCS codes apply. For details on these requirements, see the following two subsections.

110.1 - Reporting of Preventive Services in the FQHC Benefit by Independent FQHCs (Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Claims with Dates of Service on or After April 1, 2005

Preventive services that are part of the FQHC benefit no longer require HCPCS codes. These services are included in the encounter bundle billed under revenue code 0520.

NOTE: However, though HCPCS code 90749 is no longer required, a visit is not billed if an immunization is the only service the FQHC provides. See instructions in §100B - Service Level Information, above.

B. Claims with Dates of Service Before April 1, 2005

For claims submitted by independent FQHCs with dates of service before April 1, 2005, Medicare instructions to FIs required HCPCS code reporting for specific preventive services that are part of the FQHC benefit as follows:

a. Preventive Medicine Evaluation and Service Management

Covers services related to a physical exam, history, and interventional counseling. Independent FQHCs should continue to follow their FI's instructions for HCPCS coding of service. No replacement code.

b. FQHC Preventive Laboratory Procedure

Cholesterol screening, stool testing, dipstick urinalysis, and thyroid function test (HCPCS code 89399 until December 31, 2003).

NOTE: HCPCS code 89399 is reported only if the FQHC actually performs the laboratory test. When the FQHC draws the specimen but orders the test to be done in an independent lab, this code should not be reported. In addition, you must use this code only when done in conjunction with a face-to-face encounter during the same visit. This code is discontinued after December 31, 2003.

c. FQHC Preventive Medicine Intervention

Counseling and risk identification without the physical exam; additional counseling. Independent FQHCs should continue to follow their FI's instructions for HCPCS coding of service. No replacement code.

d. FQHC Acute Care Visit

No preventive services rendered (HCPCS code 99212).

e. Immunizations

(HCPCS code 90749).

See sections 120 and 130 below for information on billing preventive or lab services, applicable to RHCs/FQHCs as specified therein.

Billing requirements claim forms/formats do not allow for more than one HCPCS code to be reported per line item. Therefore, in situations where an independent FQHC provides more than one preventive service during the course of a visit, and these services are billed under

different HCPCS codes listed above, the independent FQHC must report separate lines for the clinic visit revenue code (0520) for each preventive service provided to show each HCPCS code. All but the first line item for that date is billed with a 0 in the units and total charges field. The first line item for the visit is billed with units equaling 1, representing the single encounter that day, and usual total charges are reported for the encounter on that line. The FQHC must report only 1 unit per visit regardless of the number of preventive services provided during a visit.

In addition, in situations where the independent FQHC provides more than one of the preventive services in a specific grouping under a single HCPCS during the course of a visit, the independent FQHC must report the appropriate HCPCS code for that group only once. For example, if the independent FQHC provides a dipstick urinalysis and a thyroid function test during the same visit, AND those are the only services provided in the encounter, a single line item would be billed with only 1 unit.

When independent FQHCs provide immunizations, they report HCPCS code 90749 only when the immunization(s) is given in conjunction with another service during a particular visit. If the sole purpose of the visit is to obtain an immunization, HCPCS code 90749 is not reported since a visit is not billed if this is the only service the FQHC provides.

Where an independent FQHC does not provide any preventive service during the course of a visit, the FQHC must report HCPCS code 99212 (no preventive service rendered). Therefore, every claim from an independent FQHC must contain at least one of the HCPCS codes described above.

110.2 - Reporting of Specific HCPCS Codes for Hospital-based FQHCs (Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Claims With Dates of Service on or After April 1, 2005

Effective April 1, 2005, hospital-based FQHCs are no longer required to report any specific HCPCS codes when billing for FQHC services.

B. Claims With Dates of Service Before April 1, 2005

For claims submitted by hospital-based FQHCs with dates of service before April 1, 2005, Medicare instructions for billing to FIs required HCPCS code reporting for specific services in the following HCPCS ranges:

99201-99205, 99211-99215, as appropriate.

Similar requirements were never developed for other types of provider-based FQHCs.

110.3 – Billing for Supplemental Payments to FQHCs Under Contract with Medicare Advantage (MA) Plans

(Rev. 794, Issued: 12-29-05; Effective: 01-01-06; Implementation: 04-03-06)

This section provides basic instructions on calculating and billing for the supplemental payments to FQHCs under contract with MA Plans.

Title II of the Medicare Modernization Act (MMA) established the MA program. The MA program replaces the Medicare + Choice (M+C) program established under Part C of the Act. Effective for services furnished on or after January 1, 2006, during contract years beginning on or after such date, Section 237 of the MMA requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

This new supplemental payment for covered FQHC services furnished to MA enrollees augments the direct payments made by the MA organization to FQHCs for all covered FQHC services. The Medicare all-inclusive payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare

program, is based on the FQHC's unique cost-per-visit as calculated by the Medicare Fiscal Intermediary (FI) based on the Medicare cost report. FQHC's seeking payment under Section 237 of the MMA must submit to their FI copies of their contracts under each MA plan. In order to implement this new supplemental payment provision, the FI must determine if the Medicare cost-based payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC at least quarterly. In determining the supplemental payment, the statute also excludes in the calculation of the supplemental payments any financial incentives provided to FQHCs under their MA arrangements, such as risk pool payments, bonuses, or withholds. The FQHC supplemental payment shall be based on a per visit calculation subject to an annual reconciliation. The supplemental payments, as required by the MMA, for FQHC covered services rendered to beneficiaries enrolled in MA plans will be calculated by determining the difference between 100 percent of the FQHC's all-inclusive cost-based per visit rate and the average per visit rate received by the FQHC from the MA organization for payment under that MA plan, less the amount the FQHC may charge to MA enrollees permitted under Federal law i.e., any beneficiary cost sharing allowed under the MA enrollee's plan.

Each eligible FQHC seeking the supplemental payment is required to submit (for the first two rate years) to the FI an estimate of the average MA payments (per visit basis) for covered FQHC services. Every eligible FQHC seeking the supplemental payment is required to submit a documented estimate of their average per visit payment for their MA enrollees, for each MA plan they contract with, and any other information as may be required to enable the FI to accurately establish an interim supplemental payment.

Expected payments from the MA organization would only be used until actual MA revenue and visits collected on the FQHC's cost report can be used to establish the amount of the supplemental payment.

Effective January 1, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the FI shall use actual MA revenue and visit data along with the FQHC's final all-inclusive payment rate, to determine the FQHC's final actual supplemental per visit payment. Once this amount (per visit basis) is determined it will serve as the interim rate for the next full rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment thereon will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the FI. Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the FI on type of bill (TOB) 73x with revenue code 0519 for the amount of the interim supplemental payment rate (FQHC interim all-inclusive rate – estimated average payment from the MA plan plus any beneficiary cost sharing = billed amount > 0). Do not submit revenue codes 0520 and/or 0900 on the same claim as revenue code 0519. Healthcare Common Procedure Coding System (HCPCS) coding is not required.

For services of plan years beginning on and after January 1, 2006 and before an interim supplemental rate can be determined by the FI based on cost report data, FIs shall calculate an interim supplemental payment for each MA plan the FQHC has contracted with using the documented estimate provided by the FQHC of their average MA payment (per visit basis) under each MA plan they contract with. Once an interim supplemental rate is determined for

a previous plan year based on cost report data, use that interim rate until the FI receives information that changes in service patterns that will result in a different interim rate. FIs shall calculate an interim supplemental payment rate for each MA plan the FQHC has contracted with. Reconcile all interim payments at cost settlement.

Do not apply the Medicare deductible in calculating the FQHC interim supplemental payment. Do not apply the original Medicare co-insurance (20%) to the FQHC all inclusive rate when calculating the FQHC interim supplemental payment. Any beneficiary cost sharing under the MA plan is included in the calculation of the FQHC interim supplemental payment rate.

FIs shall submit all claims to CWF for approval. CWF will verify each beneficiary's enrollment in an MA plan for the line item date of service (LIDOS) on the claim. CWF shall reject all claims for the FQHC interim supplemental payment for beneficiaries who are not MA enrollees on the same date as the LIDOS on the claim. FIs shall RTP such claims to the FQHCs. FIs shall not make payments to an FQHC for the interim supplemental payment and the all-inclusive rate for claims with the same LIDOS for the same beneficiary. The beneficiary is never liable for any part of the supplemental payment amount owed the FQHC. FIs shall accept TOB 73x with revenue code 0519 and pay the interim supplemental payment rate for each qualified visit billed.

FIs shall at cost settlement determine the FQHC's final supplemental payment.

120 – General Billing Requirements for Preventive Services (Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Professional components of preventive services are part of the overall encounter, and for TOBs 71x/73x, have always been billed on lines with revenue code 052x. In addition to previous requirements for independent FQHCs exclusively, all RHCs/FQHCs had been required to report HCPCS codes for certain preventive services subject to frequency limits. Detailed billing instructions for preventive benefits and vaccines are found in chapter 18 of this manual (http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf). Physician or base-provider claims would reflect these services under specific HCPCS codes.

RHCs/FQHCs do not receive any reimbursement on TOBs 71x/73x for technical components of such services. The associated technical components are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits. Therefore, CMS concluded that the enforcement of the frequency limits was accomplished for RHCs/FQHCs via the technical components of the services they do not bill themselves, and no specific data had to be provided on TOBs 71x and 73x to further enforce these statutory limits. Therefore, as of April 1, 2005, RHCs and FQHCs do not have to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71x/73x. Though most preventive services have HCPCS codes that allow separate billing of professional and technical components, mammography and prostate PSA do not. However, RHCs/FQHCs still must provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using revenue code 052x and no HCPCS coding (dates of service April 1, 2005 and after). For vaccines, RHCs/FQHCs do not separately report for influenza virus or pneumococcal pneumonia vaccines on the 71x/73x claims. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items billed are billed in addition to the encounter. Hepatitis vaccine is also reimbursed through the cost report, though it is not paid at the same 100% rate as the other 2 vaccines. Therefore, no line items specifically for this service are billed on RHC/FQHC claims in addition to the encounter. An encounter can not be billed if the vaccine administration is the only service the FQHC provides.

130 - Laboratory Services

(Rev. 1, 10-01-03)

PM A-99-8

The RHCs must furnish the following lab services to be approved as an RHC. However, these and other lab services that may be furnished are not included in the encounter rate and must be billed separately.

- Chemical examinations of urine by stick or tablet method or both;
 - Hemoglobin or hematocrit;
 - Blood sugar;
 - Examination of stool specimens for occult blood;
 - Pregnancy tests; and
 - Primary culturing for transmittal to a certified laboratory (No CPT code available).

Effective January 1, 2001, independent RHCs/FQHCs bill all laboratory services to the carrier, and provider based RHCs/FQHCS bill all lab tests to the FI under the host provider's bill type. In either case payment is made under the fee schedule. HCPCS codes are required for lab services.

Refer to Chapter 16 for general billing instructions.

Refer to §40.4 for lab services included in the all-inclusive rate.

140 - FI/Carrier Coordination

(Rev. 1, 10-01-03)

B3-9204.D

140.1 - FI Responsibility for Notifying Carrier

(Rev. 1, 10-01-03)

B3-9204.D

Physicians associated with an RHC/FQHC may provide some services that are paid by the FI and some services that are paid by the carrier.

Within 60 days of certification of the RHC, the FI must send the carrier servicing the area in which the RHC is located, and also the RRB carrier the following information:

1. The names of all physicians associated with the clinic, their relationships with the clinic, and the address of any place other than the clinic where the physician renders services;
2. A copy of any written compensation agreement between the physician and the clinic; and
3. The names of **all** RHC physicians who must also provide coverage at the emergency room of hospitals at which they have staff privileges;

The FI will provide updates for accretions or deletions to the above information within 45 days of the occurrence.

140.2 - Special Carrier Actions Relating to RHCs/FQHCs

(Rev. 1, 10-01-03)

B3-9204

The carrier, upon receipt of the notification that an independent RHC or FQHC has been approved, will contact the clinic and the associated physicians to determine if the RHC/FQHC will provide services that are covered by the program but not included in the definition of RHC/FQHC services. The carrier will instruct the RHC/FQHC and associated physician on the billing procedures for non-RHC/FQHC services.

Carriers should be aware that certain items and services furnished by clinics might be covered under the Medicare program but are not included in the definition of RHC or FQHC services. These services are listed in the Medicare Benefit Policy Manual, Chapter

13. The provider of these services should bill the carrier. Provider based RHCs/FQHCs will bill the FI. Carrier payment depends upon the usual carrier payment rules for the service, e.g., fee schedule.

The carrier also must edit claims to assure that it pays only for the non-RHC/FQHC services provided. Carriers should return inappropriate RHC/FQHC claims to the provider with a message to bill the FI.

181 - Diabetes Self-Management Training (DSMT) Services Provided by RHCs and FQHCs

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Previously, DSMT type services rendered by qualified registered dietitians or nutrition professionals were considered incident to services under the FQHC benefit, if all relevant program requirements were met. Therefore, separate all-inclusive encounter rate payment could not be made for the provision of DSMT services. With passage of DRA, effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these services provided they meet all program requirements. See Pub. 100-04, chapter 18, section 120. Payment is made at the all-inclusive encounter rate to the FQHC. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying DSMT services. To receive payment for DSMT services in addition to a separate payment for an otherwise qualifying FQHC visit when the other services are provided on the same date, the DSMT services must be billed on TOB 73X with HCPCS codes G0108 or G0109, as appropriate, and with one of the following revenue codes, 0520, 0521, 0522, 0524, 0525, 0527, 0528 or 0900 as appropriate.

Separate payment to RHCs for these practitioners/services continues to be precluded as set forth in regulations at §414.63 and 64 as well as in Medicare Internet Only Manuals. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note that the provision of these services by registered dietitians or nutritional professionals, are considered incident to services and do not constitute an RHC visit, in and of themselves.

Medicare Benefit Policy Manual

Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

70.2 - Covered Nonphysician Practitioner RHC/FQHC Services

(Rev. 1, 10-01-03)

RHC-408.2

Nonphysician practitioner (refer to list in [§30.1](#)) services are professional services performed for a patient. Services include diagnosis, treatment, therapy and consultation. The service must be rendered directly by the practitioner, i.e., the practitioner must either examine the patient in person or be able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization is possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

In general, Medicare covers services provided by nonphysician practitioners which would be considered covered physician services under Medicare (see [§50](#)), and which are permitted by State laws and clinic or center policies to be furnished by a nurse practitioner or physician assistant, or a certified nurse midwife. As with physician services under Medicare, a service will not be covered if it is not reasonable and

necessary for the treatment of a patient's illness or condition or to improve the functioning of a malformed body member.

70.3 - Services by Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives as RHC/FQHC Services

(Rev. 1, 10-01-03)

RHC-408.3

In determining whether the professional services of a nurse practitioner, physician assistant or certified nurse midwife are RHC/FQHC services, the following general rules apply.

70.3.1 - Services at the Clinic or Center

(Rev. 1, 10-01-03)

RHC-408.3.A

The professional services of full time or part time nurse practitioner or physician assistant (including services furnished by certified nurse midwives) performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

70.3.2 - Services Away From the Clinic or Center

(Rev. 1, 10-01-03)

RHC-498.3.B

Full-time and part-time nurse practitioners, physician assistants (including nurse midwives) who are employees of an RHC or FQHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home. These services are RHC/FQHC services and are reimbursable only to the clinic or center.

A nurse practitioner, physician assistant (including nurse midwives) who is not compensated by the clinic/center for services in locations other than the clinic/center, may bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.

70.4 - Effect of State Law

(Rev. 1, 10-01-03)

RHC-408.4

The services of a nurse practitioner and physician assistant (including services of certified nurse midwives) are covered if the practitioner or assistant is legally permitted to furnish them in the State in which they are performed. The coverage of nurse practitioner and physician assistant services is also subject to any State restrictions as to setting and supervision. Thus, when State law requires that physician assistant, nurse practitioner, or certified nurse midwife be furnished under the direct supervision of a physician, Medicare cannot cover such services furnished without physician supervision or under only general (i.e., other than direct on the premises) physician supervision.

70.5 - Effect of Clinic or Center Policies

(Rev. 1, 10-01-03)

RHC-408.5

Nurse practitioner and physician assistant services (including services of certified nurse midwives) must be furnished in accordance with written policies governing the furnishing of services by the clinic/center to its patients. The clinic or center is required to have this as a condition for RHC or FQHC approval. These policies must specify what

services nurse practitioners, physician assistants, and nurse midwives may furnish to clinic or center patients. The RHC and FQHC are expected to comply with such policies and operate within their bounds. Services that do not comply with the policies of the RHC or FQHC are not covered.

70.6 - Physician Supervision

(Rev. 1, 10-01-03)

RHC-408.6

Clinics or centers which are not physician- directed must have an arrangement with a physician which provides for the supervision and guidance of physician assistants and nurse practitioners. The arrangement must be consistent with State law and provide for at least one onsite supervisory visit by the physician every two weeks (except in extraordinary circumstances). The physician must be a doctor of medicine or osteopathy. See the State Operations Manual for examples of extraordinary circumstances. In the case of a physician-directed clinic or center, the general supervision of physician assistants and nurse practitioners must be performed by one or more of the clinic or center's staff physicians.

80 - Services and Supplies Incident to Nurse Practitioner's, Certified Nurse Midwives's or Physician Assistant's Services

(Rev. 1, 10-01-03)

RHC-410

80.1 - Basic Requirements

(Rev. 1, 10-01-03)

RHC-410.1

To be covered as a RHC or FQHC service, the service or supply must be:

- Of a type commonly furnished in physician's offices;
- Of a type commonly rendered either without charge or included in the RHC or FQHC's bill;
- Furnished as an incidental, although integral, part of professional services furnished by a nurse practitioner, physician assistant, or certified nurse midwife;
- Furnished under the direct, personal supervision of a physician, nurse practitioner, physician assistant, or a certified nurse midwife; and
- In the case of services, furnished by a member of the clinic or center's staff who is an employee of the clinic or center.

80.2 - Scope of Coverage

(Rev. 1, 10-01-03)

RHC-410.2

Services and supplies covered under this provision are generally the same as described in [§60](#) as incident to a physician's services and include services and supplies incident to the services of a nurse practitioner, physician assistant, or a certified nurse midwife.

80.3 - Direct, Personal Supervision

(Rev. 1, 10-01-03)

RHC-410.3

This requirement is met in the case of a nurse practitioner, physician assistant, or certified nurse midwife who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC.

90 - Conditions for Coverage of Visiting Nurse Services
(Rev. 1, 10-01-03)
RHC-412

90.1 - General Requirements
(Rev. 1, 10-01-03)
RHC-412.1

Visiting nurse services are covered as RHC or FQHC services if:

- The RHC or FQHC is located in an area in which CMS has determined that there is a shortage of home health agencies (see [§90.2](#) below);
- The services are rendered to patients who are homebound (see [§§90.3](#) and [90.4](#));
- The patient is furnished part time or intermittent nursing care by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by the RHC/FQHC (see [§90.5](#)); and
- The services are furnished under a written plan of treatment, as described in [§90.6](#).

90.2 - Shortage of Home Health Agencies
(Rev. 1, 10-01-03)
RHC-412.2

The RHC or FQHC may be reimbursed for visiting nurse services furnished to Medicare patients if it is located in an area CMS has determined to have a shortage of home health agencies. CMS considers that a shortage of home health agencies exists if an RHC or FQHC:

- Is located in a county, parish or similar geographic area in which:
 - o There is no participating home health agency under Medicare; or
 - o Adequate home health services are not available to clinic or center patients even though a participating home health agency is in the area;
- Has patients whose homes are not within the area serviced by a participating home health agency; or
- Have patients, whose homes are not within a reasonable traveling distance, considering the area's climate and terrain, to a participating home health agency.

An RHC which believes that its area meets these conditions and wishes to offer visiting nurse services must make a written request to the State Agency along with written justification that the area it serves meets one of the above conditions. The State Agency decides whether the clinic qualifies to offer this benefit.

An FQHC which believes its area meets these conditions and wishes to offer visiting nurse services must make written request to its CMS RO along with written justification that the area it serves meets one of the above conditions. The CMS RO will decide whether the center qualifies to offer this benefit.

90.3 - Services Are Furnished to Homebound Patients
(Rev. 1, 10-01-03)

RHC-412.3, A-01-21 added per CMS comment

The visiting nurse benefit is restricted to patients who are homebound

See [§30](#) of the Medicare Benefit Policy Manual, Chapter 7, Home Health Services, for a description of "homebound."

The visiting nurse benefit is restricted to patients who are homebound.

90.4 - Patient's Place of Residence

(Rev. 1, 10-01-03)

RHC-412.4

See §30.1.2 of the Medicare Benefit Policy Manual, Chapter 7, Home Health Services, for a description of “the patients place of residence.”

90.5 - Services Furnished by Licensed Nurse

(Rev. 1, 10-01-03)

RHC-412.5

The services must be furnished by a registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.).

1. A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, the reviewer considers both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice. Some services may be classified as a skilled nursing service on the basis of complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters, and if reasonable and necessary to the treatment of the patient’s illness or injury, would be covered on that basis. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient’s condition is such that the service can be safely and effectively provided only by a nurse.
2. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by a nonmedical person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.
3. A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient’s family, or other caregivers. Where the patient needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.
4. The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient’s illness or injury within the context of the patient’s unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient’s illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient’s particular medical needs, and accepted standards of medical and nursing practice. A patient’s overall medical condition is a valid factor in deciding whether skilled services are needed. A patient’s diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

**90.6 - Services Furnished Under Plan of Treatment
(Rev. 1, 10-01-03)**

RHC-412.6

Items and services must be furnished under a written plan established by a supervising physician, nurse practitioner, physician assistant, or a certified nurse midwife. A supervising physician of the RHC or FQHC must review it at least once every 60 days. The plan must relate the items and services to the patient's condition. Home nursing visits furnished before the plan is put into writing are covered if authorized in writing by the supervising physician.

The plan of care must contain all pertinent diagnoses, including the beneficiary's mental status, the types of services, supplies, and equipment ordered, the frequency of the visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, discharge plans, and any additional items the home health agency or physician chooses to include.

The signature of the supervising physician, nurse practitioner, physician assistant, or certified nurse midwife must be obtained on a plan prior to the submission of claims to the intermediary. The plan must be incorporated into the clinic or center's permanent record for the patient. Any charges must be made in writing and signed by the supervising physician. The physician must sign all changes in orders for dangerous drugs and narcotics.

Each review of the patient's plan must contain the initials of the physician and show the date performed. The clinic or center's records need not be forwarded to the intermediary for review but must be retained in the clinic or center's files.

If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated for the purpose of Medicare coverage unless:

- The supervising physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient, or
- It is clear from the facts in the case that nursing visits are required at intervals less frequently than once every 60 days, but the intervals are predictable, e.g., it is predictable that a visit is required only every 90 days for the purpose of changing a silicone catheter.

**100 - Clinical Psychologist Services Away and at the RHC/FQHC Clinic or Center
(Rev. 1, 10-01-03)**

RHC-419.1

**100.1 - Clinical Psychologist (CP) Defined
(Rev. 1, 10-01-03)**

RHC-419.1.A

To qualify as a CP, a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology from a program in clinical psychology of an educational institution that is accredited by an organization recognized by the Council on Post-Secondary Accreditation;
- Meet licensing or certification standards for psychologists in independent practice in the State in which he or she practices; and
- Possess two years of supervised clinical experience, at least one of which is post-degree.

**100.2 - Qualified Clinical Psychologist Services Defined
(Rev. 1, 10-01-03)**

RHC-419.1.B

Effective July 1, 1990, the diagnostic and therapeutic services of CPs, and services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. However, the CP must be legally authorized to perform the services under applicable licensure laws of the State in which they are furnished.

100.3 - Types of Covered Clinical Psychologist Services

(Rev. 1, 10-01-03)

RHC-419.1.C

The CPs may provide the following services:

- Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and regulation.
- Services and supplies furnished incident to a CP's services are covered if the requirements that apply to services incident to a physician's services, as described in §60, are met and they are furnished by an employee of the RHC or FQHC. To be covered, these services and supplies must be:
 - o Mental health services that are commonly furnished in CPs' offices;
 - o An integral, although incidental, part of professional services performed by the CP; and
 - o Performed under the direct personal supervision of the CP, i.e., the CP must be physically present and immediately available.

Appropriate State laws and regulations governing a CP's scope of practice must be considered.

100.4 - Noncovered CP Services

(Rev. 1, 10-01-03)

RHC-419.1.D

The services of CPs are not covered if they are otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by State law to perform them. For example, [§1862\(a\)\(1\)\(A\)](#) of the Act excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, even though State law authorizes the services, the services of a CP that are determined to be not reasonable and necessary are not covered.

100.5 - Requirement for Consultation

(Rev. 1, 10-01-03)

RHC-419.1.E

The CP must provide written notification to the patient's designated attending or primary care physician that services are being provided to the patient, or must consult directly with the physician to consider medical conditions that may be contributing to the patient's symptoms, unless the patient specifically requests that such notification or consultation not be made.

100.6 - Outpatient Mental Health Services Limitation for CP Services

(Rev. 1, 10-01-03)

RHC-419.1.F

All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health services limitation (i.e., only 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). The limitation does not apply to diagnostic services.

100.7 - CP Services at the Clinic or Center

(Rev. 1, 10-01-03)

RHC-419.1.G

The services of a CP performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

100.8 - CP Services Away From the Clinic or Center

(Rev. 1, 10-01-03)

RHC-419.1.H

Clinical psychologists who are employees of an RHC or FQHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home. These services are RHC/FQHC services and are reimbursable only to the clinic or center. A clinical psychologist who is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.

110 - Clinical Social Worker (CSW) Services Away and at the RHC/FQHC Clinic or Center

(Rev. 1, 10-01-03)

RHC-419.2

The RHC/FQHC services include the services provided by a clinical social worker.

110.1 - Clinical Social Worker Defined

(Rev. 1, 10-01-03)

RHC-419.2.A

A clinical social worker is an individual who:

- Possesses a master's or doctor's degree in social work;
- Has performed at least two years of supervised clinical social work; and
- Either:
 - Is licensed or certified as a clinical social worker by the State in which the services are performed; or
 - In the case of an individual in a State that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, SNF, or clinic

110.2 - Clinical Social Worker Services Defined

(Rev. 1, 10-01-03)

RHC-419.2.B

Clinical social worker services for the diagnosis and treatment of mental illnesses and services and supplies furnished incident to such services are covered as long as the CSW is legally authorized to perform them under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed. The services that are covered are those that are otherwise covered if furnished by a physician or as an incident to a physician's professional service. Services furnished to an inpatient or

outpatient that a hospital is required to provide as a requirement for participation are not included.

110.3 - Covered CSW Services

(Rev. 1, 10-01-03)

RHC-419.2.C

Clinical social worker services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. (See [§60](#).) Coverage is limited to the services a CSW is legally authorized to perform in accordance with State law, including services and supplies furnished incident to such services and are those that are otherwise covered if furnished by a physician or incident to a physician's professional service. The services of a CSW may be covered in an RHC/FQHC if they are:

- The type of services that are otherwise covered if furnished by a physician, or incident to a physician's service;
- Performed by a person who meets the above definition of a CSW; and
- Not otherwise excluded from coverage.

State law or regulatory mechanism governing a CSW's scope of practice in the service area must be considered. Development of a list of services within the scope of practice is encouraged.

110.4 - Noncovered CSW Services

(Rev. 1, 10-01-03)

CSW services are not covered if they are otherwise excluded from Medicare coverage even though a CSW is authorized by State law to perform them. For example, the Medicare law excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

110.5 - Outpatient Mental Health Services Limitation

(Rev. 1, 10-01-03)

All covered therapeutic services furnished by qualified CSWs are subject to the outpatient psychiatric services limitation (i.e., only 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). The limitation does not apply to diagnostic services.

110.6 - Services at the Clinic or Center

(Rev. 1, 10-01-03)

RHC-419.2.F

The services of clinical social workers performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

110.7 - Services Away From the Clinic or Center

(Rev. 1, 10-01-03)

RHC-419.2.G

Clinical social workers who are employees of an RHC or FQHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home. These services are RHC/FQHC services and are reimbursable only to the clinic or center.

A clinical social worker that is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.

E. Inpatient Hospital Service Group

1. Rate Information

Due to differing payment methodologies, rate information was not collected for this service group.

2. Connecticut⁴³

Connecticut Department of Social Services reimburses inpatient acute care services based on an interim per diem rate subject to cost settlement.

A target amount per discharge from the most recently filed cost report is increased by the estimated Federal Tax Equity and Fiscal Responsibility Act (TEFRA) update factors from the cost report period to the interim rate period. The product will be the rate period estimated target amount per discharge.

The Department divides the estimated target amount per discharge by the average length of stay as calculated from the most recently filed cost report to determine an interim per diem rate of payment. The sum of this calculation is the Medicaid interim per diem rate.

3. Maine⁴⁴

45.03 DURATION OF CARE

All hospital admissions and continued stays must be certified for medical necessity and length of stay through an appropriate utilization review plan.

45.04 COVERED SERVICES

45.04-1 Semi-Private Accommodations

Reimbursement will be made for eligible members for placement in semi-private accommodations (two (2) or more beds).

45.04-2 Intensive Care or Coronary Care

Accommodations in an intensive care unit or a coronary care unit are reimbursable if ordered by the patient's physician as medically necessary.

45.04-3 Drugs and Biologicals

A. Drugs and Biologicals

Drugs, vaccines, cultures, and other preparations made from living organisms and their products, used in diagnosing, immunizing, or treating members (biologicals) are covered. Drugs and biologicals furnished by a hospital for a patient's use outside of the hospital are not covered as inpatient services.

⁴³ CT Rules found at: <https://www.ctdssmap.com/CTPortal/Information/Publications/tabid/40/Default.aspx>;
https://www.ctdssmap.com/CTPortal/Information_Get%20Download%20File_tabid_44_Default.aspx_Filename=ch7_iC_hospital_V1.0.pdf&.pdf

⁴⁴ ME Rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s045.doc>.

B. Hospital Pharmacies Affiliated with a Nursing Facility

A hospital that is affiliated with a nursing facility through common ownership or control is allowed to dispense covered MaineCare prescription drugs through its pharmacy to members in that nursing home. The drugs must be dispensed by a registered pharmacist according to dispensing regulations.

Billing must be accomplished in accordance with MBM Section 80, Pharmacy Services, and Section 67, Nursing Facility Services.

45.04-4 Supplies, Appliances and Equipment

Supplies, appliances and equipment are covered if they are surgically implanted or are an integral part of a hospital procedure and it would be medically contraindicated to limit the patient's use of the item to his or her hospital stay (e.g.: cardiac valves, pacemakers, tracheotomy tubes, halovests, titanium rods, etc.).

A temporary or disposable item that is medically necessary to facilitate the patient's discharge from the hospital, and is required until the patient can obtain a continuing supply, is covered as an inpatient service for up to a ten (10) day supply.

Except as noted above, supplies, appliances, including prosthetic devices, and equipment furnished to an inpatient or outpatient for use outside of the hospital must have prior authorization in accordance with and meet criteria in Chapter II, Section 60, Supplies and Durable Medical Equipment, of this Manual, and reimbursement must be made to a supplier of durable medical equipment. MaineCare will not reimburse a hospital or supplier of durable medical equipment for the rental or purchase of a therapy bed (specialty air beds built into a hospital bed frame).

45.04-5 Ancillary, Diagnostic and Therapeutic Services

Ancillary, diagnostic and therapeutic services that are medically necessary are covered services subject to limitations in Section 45.05.

45.04-6 Swing-Bed and Days Awaiting Placement Services

The provision of acute care services to a member in a swing-bed must be consistent with requirements set forth in this Section of the Manual.

NF swing-bed and days awaiting placement services must meet all state and federal laws, including federal Medicaid laws and regulations and the Nursing Facility Services requirements set forth in Section 67 of this Manual, and members must be eligible for NF level of services as determined by an assessment conducted by the Department or its Authorized Agent. Members in swing-bed and days awaiting placement are exempt from both: i) pre-admission screening for mental illness and mental retardation; and ii) Minimum Data Set + (MDS+) resident assessment screening.

45.04-7 Asthma Self-Management Services

Asthma self-management services are reimbursable if they are based on the Open Airways or Breathe Easier curricula or any other asthma management services that are approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America.

Each service must have:

- A. a physician advisor;
- B. a primary instructor (a licensed health professional or a health educator with a baccalaureate degree);
- C. a pre and post assessment for each member that shall be kept as part of the member's record;
- D. an advisory committee that may be part of an overall patient education advisory committee; and
- E. a physician referral for all participants.

45.04-8 **Outpatient Diabetes Education and Follow-Up Services**

Outpatient Diabetes Education and Follow-Up Services will be reimbursed when a provider enrolled with the Maine Diabetes Control Project furnishes this service to a MaineCare member whose physician or primary care provider has prescribed this service for the management of the member's diabetes. The services consist of:

- 1. A pre-assessment interview determining the member's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals;
- 2. A group class instruction covering the comprehensive curriculum outlined by the Maine Diabetes Control Project and based on the individualized education plan;
- 3. A meal planning interview to determine the member's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals;
- 4. A post service interview to assess and document what the member has learned during the service, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalize behavioral goals; and
- 5. Follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the member's behavior change goals. At a minimum, three (3) month, six (6) month, and one (1)-year follow-up visits (from the date of the last class) are required to complete the member's participation in the service. When the MaineCare member is under age twenty-one (21), MaineCare will also reimburse for this service when provided to the people who provide the member's daily care.

45.04-9 **Hospital Based Physician Services**

Effective July 1, 2006, only provider practices that qualify as "provider-based" entities under 42 C.F.R. § 413.65 are covered services.

45.05 **RESTRICTED SERVICES**

45.05-1 **Whole Blood and Packed Red Blood Cells**

Each eligible member may receive as many pints of whole blood and packed red blood cells as are medically necessary.

In the case of a MaineCare member who is also receiving Title XVIII benefits, MaineCare will pay for the first three pints of blood, not covered under Title XVIII. Whole blood (provided the hospital cannot obtain a replacement donation) and packed red blood cells will be reimbursable only for each pint administered. Reimbursement

will not be made on the basis of replacing two pints of blood for each pint received by the member regardless of whether the blood (either fully or partially) is provided from a blood bank or from a donor.

45.05-2 Newborn Infants

MaineCare reimburses for services provided to newborn infants of MaineCare mothers during the time the mother is hospitalized. MaineCare will pay for services to the newborn after the mother is discharged, if these services are certified by the physician as being medically necessary and the infant is MaineCare eligible.

45.05-3 Abortions, Sterilizations and Hysterectomies

MaineCare will only reimburse hospitals for these services if documentation meets the requirements of Chapter II, Section 90, Physician Services.

45.05-4.1 Dental Services

Dental services provided in a hospital setting are only covered for emergency care.

45.05-5 Private Rooms for Patients with Infectious Diseases

MaineCare will reimburse for private rooms for patients with infectious diseases when medically necessary to meet the patient's medical needs or to prevent the spread of disease.

The designee of the committee charged with infection control must document the medical necessity in the patient's medical record. The designee must formally inform the committee of his or her decisions regarding assigning private rooms to patients with infectious disease. The committee must record the designee's actions in its minutes.

45.05-6 Restricted Physician Services Associated With Hospital Services

Unless prior authorization (PA) has been granted by the Department, DHHS will not reimburse hospitals for costs associated with any restricted physician services performed in the hospital, as noted in Chapter II, Section 90, Physician Services, of this Manual.

45.05-7 Organ Transplant Procedures

Please refer to Chapter II, Section 90, Appendix A, Physician Services of this Manual for specific information related to MaineCare coverage of and criteria for transplant procedures.

45.05-8 Leave of Absence- Days Awaiting Nursing Facility Placement

All hospitals must inform patients who are in days awaiting NF placement, in writing, of their right to thirty-six (36) overnight leaves of absence as outlined in the MaineCare Benefits Manual, Chapter II, Section 67.05. MaineCare will reimburse a hospital to reserve a bed for a member on an overnight leave of absence if the following conditions are met:

- A. The patient's plan of care provides for such an absence;
- B. The member takes no more than a total of thirty-six (36) days in leaves of absence during the twelve (12) month period from July 1 through June 30, with no more than three (3) days occurring each calendar month;
- C. The Department is called for prior authorization; and

- D. The Department is notified if the member does not return to the facility within the prior authorized leave period.

45.05-9 Outpatient Observation Services

MaineCare only reimburses for observation or testing when ordered by a physician. Outpatient observation must not exceed forty-eight (48) hours.

45.05-10 Physical, Occupational and Speech Therapy for Adults

Physical, occupational and speech therapy for members age twenty-one (21) and over must be provided in accordance with Section 68, Occupational Therapy Services; Section 85, Physical Therapy Services; and Section 109, Speech and Hearing Services, respectively, including any limitations or requirements for rehabilitation detailed in those Sections of the MBM.

45.06 NON-COVERED SERVICES

45.06-1 Private Room

Accommodations in a private room will not be reimbursable unless they meet conditions spelled out in Section 45.05-5 above.

Hospitals may not bill a MaineCare member for the difference between a private room rate and a semi-private room rate unless the member requests a private room and signs a written statement acknowledging that he or she is to be billed the difference.

45.06-2 Routine Physician Visits

Routine physician visits are not reimbursable for members awaiting placement in a NF or in swing beds.

45.06-3 Admission Not Certified By Utilization Review

MaineCare will not reimburse for a hospital admission that is not certified by a utilization review.

The only exception to this policy is when a member is admitted prior to utilization review for an acute condition that requires medically necessary treatment that is only available in a hospital and it is medically necessary for the treatment to be delivered prior to the time it feasible for the case to be reviewed. Services rendered prior to the review are not reimbursable unless the utilization review is conducted within one (1) business day of the admission. (For example, if a member is admitted on a Friday at 6:00 P.M., is first reviewed on Monday at 11:00 A.M. and denied at that time: three (3) days are reimbursable.) The member or responsible party must be notified in writing if these criteria will not be met and all or part of the admission will not be a MaineCare covered service; and must sign an acknowledgement of financial responsibility for this non-covered service.

45.06-4 Unauthorized Days Awaiting Placement or NF-level Swing Bed Services

MaineCare will not reimburse for any days awaiting placement or NF level services providing swing beds that have not been approved by the Department or its Authorized Agent.

45.09 REIMBURSEMENT

See Chapter III, Section 45, Principles of Reimbursement for Hospital Services.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing the MaineCare Program, including billing Medicare, as described under Title XVIII.

45.10 CO-PAYMENT FOR INPATIENT SERVICES, OUTPATIENT HOSPITAL CLINIC SERVICES

- A. A co-payment will be charged to each MaineCare member receiving either inpatient or outpatient hospital services. Two separate co-payments will be charged if the member receives both inpatient and outpatient services. The amount of the co-payment shall not exceed three dollars (\$3.00) per day for either category of hospital services provided, according to the following schedule:

MaineCare Payment for Service	Maximum Member Co-payment Per Day
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 or more	\$3.00

- B. The member shall be liable for co-payments up to a maximum of thirty dollars (\$30.00) per calendar month for each category: inpatient or outpatient service, and regardless of whether there are multiple hospital service providers within the same month. After the maximum thirty dollar (\$30.00) monthly cap(s) has been charged to the member, the member shall not be liable for additional co-payments and the provider(s) shall receive full MaineCare reimbursement.
- C. No provider may deny services to a member for failure to pay a co-payment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the co-payment. A member's inability to pay a co-payment does not, however, relieve him/her of liability for a co-payment.
- D. Providers are responsible for documenting the amount of co-payments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous co-payments.

Co-payment exemptions and dispute resolution procedures are contained in Chapter I.

45.11 BILLING INSTRUCTIONS

Eff. 9/1/07

- A. For all inpatient services, providers must bill in accordance with the Department's billing requirements set forth in "Billing Instructions: Claim Form UB-92" or successor forms or instructions.
- B. For all services provided on or after September 1, 2007 by primary care practices that are considered Medicare provider based entities, providers must bill in accordance with

the Department's billing requirements set forth in "Billing Instructions: Claim Form CMS-1500" or successor instructions.

- C. For all outpatient services, other than those identified in B above, providers may bill using either the UB-92 or successor form or the CMS-1500, in accordance with the applicable MaineCare billing instructions.
- D. Providers should request reimbursement for all services provided on the same day on the same claim form.
- E. Only providers that qualify as "provider based" entities under 42 CFR 413.65 may bill under this Section of the MaineCare Benefits Manual.
- F. Copies of MaineCare billing instructions may be downloaded at http://www.maine.gov/bms/providerfiles/provider_billing_manuals.htm.

4. Massachusetts ⁴⁵

Inpatient Services – SPAD (Standard Payment Amount per Discharge) is the hospital-specific all inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is complete payment for an acute episode of illness, excluding the additional payment of outlier days, transfers per diems and administrative days.

114.1 Division of Health Care Finance and Policy. 36.05

(a) The Medicaid rate of payment for covered inpatient services consists of a single hospital-specific standard payment amount per discharge (SPAD). This hospital-specific payment amount equals the sum of:

- a statewide average payment amount per discharge;
- a pass-through payment amount per discharge for malpractice, organ acquisition and direct medical education costs; and,
- a capital payment amount per discharge.

(b) Standard Payment Amount per Discharge (SPAD). The standard payment amount per discharge for each hospital is derived by multiplying the RY07 statewide average payment amount per discharge of \$4,022.98 by each hospital's MassHealth casemix index adjusted for outlier acuity and the Massachusetts specific wage area index. To develop the Hospital's RY 07 casemix index, EOHHS used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCP's database as of June 30, 2006, for the period October 1, 2004, through September 30, 2005, which was then matched with the MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix index calculations.

5. New Hampshire ⁴⁶

INPATIENT SERVICES

⁴⁵ MA Rules found at:

http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_regs_related_pubs&csid=Eeohhs2#114_1_36; 114_1_36.pdf

⁴⁶ NH Rules found at:

<http://www.nhmedicaid.com/Downloads/Manuals/Hospital%20Provider%20Specific%20Billing%20Guidelines%20II.doc>

- A. NH Medicaid recipients are eligible to receive inpatient services, which are those rendered to a patient who has been admitted to a hospital by the recommendation of a physician or dentist to receive room, board and professional services on a continuous daily basis. For New Hampshire hospitals, the Northeast Health Care Quality Foundation, formerly referred to as (PRO) determines the quality, necessity and appropriateness of care and length of stay. For border hospitals, the Foundation (PRO, PSRO) or other appropriate utilization review organizations within their state determines the quality, necessity and appropriateness of care and length of stay. Payment for inpatient care in New Hampshire and border hospitals is made for acute care days only as approved by the Foundation (PRO, PSRO) or other appropriate utilization review organizations.
- B. For Medicare recipients, the 60-day "lifetime reserve" for Medicare inpatient hospital benefits must be used before NH Medicaid inpatient hospital benefits are applicable.

NOTE: The 60 - day lifetime reserve does not affect Part B Medicare Coverage.

INPATIENT REIMBURSEMENT

The NH Medicaid Program reimburses by a prospective payment system based on diagnostic related groups (PPS/DRG) for all inpatient hospital services.

The PPS/DRG system for inpatient hospital services includes the following provisions and components:

- A. The Medicare table of DRG coding and the HSI Medicare grouper used to assign DRG's.
- B. Medicare relative weights and outlier trim points are utilized, except where otherwise specified.
- C. Generally, the table of DRG's relative weights and trim points are updated concurrently with Medicare changes.
- D. Relative weights and trim points may be changed more frequently or at different intervals for certain DRG's.
- E. The rate for each DRG is determined by NH Medicaid, taking into account hospital costs, available NH Medicaid funds and other economic indicators.
- F. Pricing is prospective; actual payments will be retrospective upon discharge.
- G. Prices are adjusted at least annually, with more frequent adjustments for certain DRG's.
- H. All hospitals, in-state, border and out-of-state are paid the same rate per DRG point, except for certain psychiatric and physical rehabilitation units/facilities and for certain neonatal DRG's, as follows:
 1. Psychiatric DRG's 425 through 432 in scatter beds in all general hospitals are paid a higher rate than would normally result from Medicare relative weights.
 2. Psychiatric DRG's 425 through 432 in Medicare certified Distinct Part Units of in-state hospitals only, are paid a higher peer group rate.
 3. Psychiatric DRG's 425 through 432 in Designated Receiving Facilities (DRF's) of in-state hospitals only, are paid different higher rates, initially based on a blend of a peer group and facility-specific rates.
 4. Rehabilitation DRG 462 of in-state physical rehabilitation specialty hospitals and of Medicare certified Distinct Part Units are paid at a flat rate per discharge, not to exceed the average peer Medicare TEFRA limit, with NO outlier payments allowed.

5. Neonatal DRG's 385 through 390 are reimbursed on a per diem basis of 65% of the full outlier amount.
- I. Interim billing and/or periodic interim payments (PIP's) ARE NOT made.
- J. Capital, direct medical education and non-physical anesthetist costs are allowed as pass-through payments for in-state facilities only. Payments are made quarterly.
Note: "Pass through payments" are additional funds paid quarterly to in-state hospitals that meet certain requirements. These requirements are concerned with:
 - (1) Capital-related costs; and
 - (2) Direct medical education activities.
- K. Indirect medical education costs (IME) for in-state teaching hospitals only, are recognized and paid per discharge, as an addition to the DRG/outlier amount.
- L. Day outliers, except where otherwise specified, are allowed and reimbursed on a per diem basis, at 60% of the full per diem amount.
- M. Cost outliers are neither recognized nor reimbursed.
- N. Payment rates are based on the relative weights and price per point in effect at the time of discharge.

Transfer Patients

Acute Facility to Acute Facility

Hospitals which transfer patients to the same type of provider/subprovider are paid at the outlier per diem basis (100% of the full per diem) not to exceed the DRG rate allowed. When billing, the UB-92 must indicate a patient status code 02 in form locator 22.

Hospitals which transfer patients to a different type of provider/subprovider are paid according to the straight DRG payment (plus an outlier payment when appropriate). When billing, the UB-92 must indicate a patient status code 05 in form locator 22.

For Psychiatric Units, a transfer to NH Acute Psychiatric Service (APS) State Hospital is considered the same type of facility.

Receiving acute hospitals and distinct part units will continue to be paid the DRG rate plus an outlier payment when appropriate.

*Please Note: Receiving facilities **MUST** bill on a paper UB 92 claim form.*

Acute Facility to different facility and returned to Acute Facility

If the patient is Medicaid eligible for the entire hospital stay, and, the patient has been transferred to different levels of care, i.e. acute care to psychiatric care, then returned to acute care, please use the following guidelines:

If the recipient is transferred back to the original facility, the claim should be continued on the original care claim started from the first stay. This one claim should be submitted as follows:

1. Date of Service - Must include the actual date of admit and the actual final discharge date for the first facility. Must also include the admit date and final or second discharge date.
2. Billed Amount - Must include the total billed amount minus the non covered service days (inclusive in non covered days, all ancillary charges) the patient was at the other facility.
3. Patient Status - Patient status code will be the actual disposition at the time of the final discharge.
4. Use appropriate revenue code for accommodation days, total units need to include ALL days from the first and last part of the patient stay.

5. For ALL non-covered days, use Revenue Code 180 or 182 for the days the recipient was at the other type facility.
6. Use form locator 36 to indicate dates of non-covered service, and form locator 84, Remarks section stating “ Patient transferred to different type facility, not a duplicate claim.”

Note: Any claim which includes Revenue Code 180 or 182 must be submitted on a paper UB 92 claim form.

Please see pages 2-17 for an Acute Facility Example.

Rehabilitation Hospitals

In-state rehabilitation hospitals/facilities are paid a flat reimbursement rate with no outliers allowed. Please refer to the DRG Repricing Manual, Peer Group 3 for calculating information.

Readmissions

Readmissions occurring within 7 days from the date of discharge for the same diagnosis shall be reviewed by the Peer Review Organization (PRO) for appropriateness.

Split Eligibility

Split billing is necessary when the patient is NOT NH Medicaid eligible for the entire length of the acute inpatient hospital stay.

When a NH Medicaid patient is eligible for only a part of the hospital stay, the NH Medicaid reimbursement shall be paid at the outlier per diem, not to exceed the DRG allowed. The DRG rate shall be considered payment in full for all services rendered on those days for which the patient was eligible for NH Medicaid.

When submitting a split claim for payment, if the recipient is eligible for only a portion of the hospital stay, NOT including the date of discharge, bill with patient status code 24 in field 22 on the UB-92. The covered days MUST EQUAL THE DATES of the patient’s eligibility.

When submitting a split claim for payment, if the recipient is eligible for only a portion of the hospital stay, which INCLUDES the date of discharge, bill with patient status code 25 in field 22 on the UB-92. The covered days MUST EQUAL THE DATES of the patient’s eligibility MINUS THE DISCHARGE.

NOTE: Please see pages 2-18 and 2-19 for split bill claim examples.

Acute Facility including Non-Acute Days Billing

If the patient is Medicaid eligible for the entire hospital stay, but, a portion of the patient’s stay was deemed NOT MEDICALLY NECESSARY by the Foundation (see below) or in-house quality assurance group, the non-acute days need to be billed as leave days.

If a claim is submitted when a portion of the recipient’s stay was deemed not medically necessary, the one claim should be billed as follows:

1. Date of Service - Must include the actual date of admit through to actual discharge date.
2. Billed Amount - Must include the total billed amount minus the non covered service days the patient was treated at the Acute Facility.
3. Patient Status - Patient status code will be the actual disposition at the time of the final discharge field 22.
4. Use appropriate revenue code for medically necessary accommodation days. For non-covered days, use Revenue Code 180 or 182.
5. Use form locator 36 to indicate dates of non-medically necessary.

Note: Any claim which includes Revenue Code 180 or 182 must be submitted on a paper UB 92 claim form.

NOTES: Please see page 2-20 for leave days claim example.

6. Rhode Island ⁴⁷

Inpatient hospital services are those services and items normally furnished by a hospital for the care and treatment of patients. Such items and services must be provided under the direction of a physician in a state licensed institution maintained primarily for the treatment and care of patients with disorders other than mental disease.

Reimbursement Guidelines

Inpatient hospitals are reimbursed at a ratio of cost to charge Guidelines. Room and board codes specific to each hospital are reimbursed at their charges times the inpatient RCC percentage. Inpatient reimbursement for ancillary services is the total of the claims billed amount times the RCC percentage for each allowable detail line.

Providers must submit their room and board charges to DHS for the following fiscal year by the 15th of the month prior to the beginning of their fiscal year to ensure proper reimbursement for that fiscal year. The hospital should submit room and board charges on the schedule which follows in this section to ensure proper reimbursement. If a recipient's hospital stay spans fiscal years and there is a change in the room and board rate, two separate claims must be submitted. One claim is for the dates of service up to and including the last day of one fiscal year, and the second claim begins with the first day of the new fiscal year. The following procedures would be followed when billing for the hospital stays involving two fiscal year reimbursement rates:

- The type of bill for the first bill would be 112 or 122 indicating an interim bill. The patient status would be 30 indicating still a patient.
- Only the room and board codes for dates of service prior to October 1st would be indicated on this bill. The from and to dates on the bill would be from admission to September 30th. For the second bill, the bill type (114 or 124) would indicate a final bill. This claim would include all ancillary charges for all dates of service as well as the room and board charges from October 1st until discharge. The patient discharge status would be other than 30 depending upon the type of discharge. The from date of service would be October 1st to discharge date. As you're probably aware, Final Rules for the new HIPAA Transaction Sets were published in the Federal Register on August 17, 2000. The countdown to implementation has begun (October 2002) and DHS and EDS are committed to compliance before the deadline.

Co-Payment

There is no co-payment required from a recipient for an inpatient hospital stay.

Other Institutions

DHS will only reimburse the admitting facility for services provided to an eligible recipient during their entire length of stay. If a recipient is sent to another facility for services not available at the admitting facility, those charges must be billed on the admitting facility's bill to DHS. If the second facility submits a bill to DHS, it will be denied. Reimbursement will be determined at the admitting facility's RCC.

⁴⁷ RI Rules found at: <http://www.dhs.state.ri.us/dhs/heacre/provsvc/manuals/hospital/inpat.htm>:

Covered Services

Refer to the listing of revenue codes in the appropriate Appendix.

All medically necessary services are covered for Medicaid eligible recipients, including:

- bed and board in semi-private accommodations;
- nursing services (other than the services of a private duty nurse or attendant) and related services that are ordinarily furnished by the hospital for the care and treatment of inpatients, such as;
 - the use of hospital facilities
 - medical social services
 - drugs and biologicals for use in the hospital
 - supplies, appliances and equipment for use in the hospital
 - other diagnostic or therapeutic items or services not specifically listed but which are ordinarily furnished to inpatients

This is not an all-inclusive list.

24 Hours Minimum Inpatient Stay

Hospital inpatient stays must be at least 24 hours. Recipients whose stay is less than 24 hours must be billed as outpatients.

Day of Admission

The day of admission is a covered day under Medical Assistance.

Administratively Necessary Days (AND)

Administratively Necessary Days (AND) are billed by indicating revenue code 159 and the number of AND days on the claim form. Payment of AND days is made at each hospital's calculated flat rate times the inpatient RCC. The directions for billing these days are contained in Section 400 of the Provider Reference Manual.

Non-covered Services

Refer to the listing of revenue codes in the appropriate Appendix. Non-covered services for an inpatient hospital stay include all personal care items and comfort items as indicated in revenue codes 990 - 999 and all special charges as indicated in revenue codes 220-229. The day of discharge and private rooms are not covered.

Private rooms (Revenue codes 110-119 and 140-149) are covered at the semi-private rate.

Limitations/ Special Requirements

Psychiatric Services

Payment is made to inpatient psychiatric hospitals only for those recipients under age 21 (up to age 22 if the individual is receiving such services immediately before reaching age 21) or age 65 and over.

Psychiatric hospitals are reimbursed at a ratio of cost to charge (RCC) percentage.

Out-Of-State Hospital Prior Authorization

All out-of-state hospital admissions require prior authorization (PA).

The telephone number for out-of-state hospital authorizations is 401-464-2176 (fax # 401-464-1876). This may also require follow-up with a written request.

Claims Billing Guidelines

Newborn Claims: Claims for newborns must be submitted with an actual or pseudo-social security number (SSN) for the child and/or the mother's social security number. All newborn claims submitted will suspend for Medical Assistance Identification (MID) number

verification. The claim will deny if the child's SSN is not on the MMIS. This can be verified using REVS. These claims must be billed with admit status of 04, indicating newborn.

Interim Billing: Bill type 112, 113, 114, 122, 123 and 124 is to be used only for fiscal year rate changes where split billing is required.

Late Charges: Late charges are billable services. Claims should be submitted using the bill type 115 or 125 to indicate this. Only the late charges should actually be submitted on this bill type.

7. Vermont ⁴⁸

As of January 1, 2008, Vermont instituted an Inpatient Prospective Payment System, similar to that used by Medicare. This system uses Diagnostic Related Groups with relative weights that are multiplied by the Vermont Price Per Point.

8. Medicare ⁴⁹

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

The base payment rate is divided into a labor-related and nonlabor share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the nonlabor share is adjusted by a cost of living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high-percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payment for hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculation.

Also, if the hospital is an approved teaching hospital it receives a percentage add-on payment for each case paid through IPPS. This add-on known as the indirect medical education (IME) adjustment, varies depending on the ratio of residents-to-beds under the IPPS for operating costs, and according to the ratio of residents-to-average daily census under the IPPS for capital costs.

⁴⁸ VT rules found at: <http://ovha.vermont.gov/for-providers/provider-manuals>; cms02-15-08.pdf

⁴⁹ Medicare rules found at: <http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021929&intNumPerPage=10> (The Provider Reimbursement Manual - Part 1, Chapter 24 -Payment to Providers, pr1_2400_to_2409.4.doc);

Finally, for particular cases that are unusually costly, known as outlier cases, the IPPS payment is increased. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRF-adjusted base payment rate, plus any DSH or IME adjustments.

F. Interpreter Services Service Group

1. Rate Information

Following are rates in effect as of January 1, 2008:

Service Group	Procedure w Code	Procedure Modifier Code 1	Procedure Modifier Code 2	Posted Rates								
				NH	Avg - Other NE States	CT	MA	ME	RI	VT	All Comm	Medicare
Interpreter Services	T1013 Sign Lang/Oral Interpreter - Hearing Impaired - 15 Min	UA	U1	\$6.25	\$17.50	N/A	N/A	\$20.00	N/A	\$15.00	N/A	N/A
	T1013 Sign Lang/Oral Interpreter - Language - 15 Min	UC	U1	\$3.75	\$17.50	N/A	N/A	\$20.00	N/A	\$15.00	N/A	N/A
	T1013 Sign Lang/Oral Interpreter - Hearing Impaired Each Add 15 min	UA	U2	\$2.25	\$17.50	N/A	N/A	\$20.00	N/A	\$15.00	N/A	N/A
	T1013 Sign Lang/Oral Interpreter - Language Each Add 15 min	UC	U2	\$2.25	\$17.50	N/A	N/A	\$20.00	N/A	\$15.00	N/A	N/A

2. Connecticut

Connecticut does not pay Medicaid providers for Interpreter Services.

3. Maine ⁵⁰

1.06-3 Interpreter Services

- A. Providers must ensure that MaineCare members are able to communicate effectively with them regarding their medical needs. MaineCare will reimburse providers for interpreters required for limited and non-English speaking members and/or deaf/hard of hearing members, when these services are necessary and reasonable to communicate effectively with members regarding health needs. Interpreter services can only be covered in conjunction with another covered MaineCare service or medically necessary follow-up visit(s) to the initial covered service. Interpreter travel time is covered but wait time is not.
- B. Family members or personal friends may be used as interpreters, but cannot be paid. "Family" means any of the following: husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit.

Effective
12/12/07

Effective
12/12/07

⁵⁰ ME Rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c1s.doc>

Family members or friends, with the exception of those individuals under the age of 18, may be used as non-paid interpreters if:

1. Requested by the member; and
 2. The use of this friend or family member does not compromise the effectiveness of services or violate the member's confidentiality; and
 3. The member is advised that an interpreter is available at no charge to the member.
- C. If a paid interpreter is hired, providers can select the interpreter. However, should the interpreter provide transportation to the member, MaineCare will not reimburse the interpreter for transporting the member while concurrently billing for interpreter services. All interpreter services must be provided in accordance with the Americans with Disabilities Act.
- D. When providers request reimbursement for any interpreter services, the services must be included in the member record. Documentation must include a statement verifying the interpreter qualifications, date, time and duration of service, language used, the name of the interpreter, and the cost of performing the service.
- E. Providers are responsible for ensuring that interpreters protect patient confidentiality and adhere to an interpreter code of ethics. Providers shall document that interpreters have provided evidence of having read and signed a code of ethics for interpreters equivalent to the model included as Appendix #1. This shall be deemed as compliance with this requirement.

F. Interpreter Codes

Providers must use the following code when billing for reimbursement for interpreters for both deaf/hard of hearing members, and for language interpreters required for non-English speaking members:

T1013 Sign language or oral interpreter services per fifteen minutes.

G. Interpreters for Deaf/Hard of Hearing Member

Providers of interpreter services must be licensed by the Maine Department of Professional and Financial Regulation as: Certified Interpreters/Transliterated,

Certified Deaf Interpreters, Limited Interpreters/Transliterated, or as Limited Deaf Interpreters.

MaineCare will pay for two interpreters for deaf MaineCare members who utilize non-standard signing and request a relay interpreting team including a deaf interpreter, for whom signing is in his/her native language, working with a hearing interpreter.

Note: Any other codes for interpreter services for deaf/hard of hearing members currently listed in the specific service sections of the MaineCare Benefits Manual are no longer valid.

H. Language Interpreters

Providers may obtain language interpreter services either through local resources, national language interpreter services such as the "Pacific Interpreters, Language

Line,” or comparable services. Wherever feasible, local and more cost effective interpreter resources are to be used.

In all cases, the provider must include in the member’s record the date and time of the interpreter service, duration, language used and the name of the interpreter. For language interpreters required for non-English speaking members, providers must use:

Effective
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T1013GT Interpreter services provided via documented use of Pacific Interpreters, Language Line, or equivalent telephone interpreting service, must be by report with copies of the invoice attached.

I. Exceptions

Hospitals, private non-medical institutions, intermediate care facilities for people with mental retardation, and nursing facilities may not bill separately for either language or deaf/hard of hearing interpreter services. For hospitals, private non-medical institutions, ICF-MRs, and nursing facilities, these costs will be allowable and are included in the calculation of reimbursement.

Effective
12/12/07

- J. The Department will not pay for interpreter services when there is a primary third party payor since the primary third party payor is required to cover the interpreter services.

4. Massachusetts

Massachusetts does not pay Medicaid providers for Interpreter Services.

5. New Hampshire ⁵¹

REIMBURSEMENT FOR INTERPRETER SERVICES

The department and EDS continue to be involved in various aspects of a statewide effort to ensure the availability of, and access to, language and deaf and hard of hearing interpreter services necessary for individuals to meaningfully access medical services.

Interpreters are typically considered to be part of a medical provider’s overhead or administrative costs. In order to assist with access to interpreter services, NH Title XIX recognizes that rates paid for medical services may not include enough for all of the expenditures a provider incurs in arranging for interpreter services. In order to allow more for interpreter services, yet still comply with federal regulations, NH Title XIX has been reimbursing Title XIX enrolled interpreters for their services. NH Title XIX can also reimburse medical providers for interpreter services as long as the interpreter is considered to be the provider of the interpreter service and is Title XIX enrolled.

There are specific requirements that must be met in order for this to happen. If you would like to receive reimbursement through Title XIX for interpreter services, please refer to the appendix in the back of this bulletin, titled, “Payment to Medicaid Providers for Interpreter Services Provided to Allow Medicaid Recipients to Receive the Provider’s Medicaid Covered Service”.

⁵¹ NH information found at: www.nhmedicaid.com/Downloads/Bulletins/Jun06Quarterly.pdf

The outlined procedures allow for a medical provider to employ, or to bill on behalf of, a sign or language interpreter. Please note that providers who receive cost-based reimbursement may not bill for interpreter services.

If you have any questions, please contact the EDS Communications Unit at 1-800-423-8303 (NH and VT only) or (603) 224-1747

**PAYMENT TO MEDICAID PROVIDERS FOR INTERPRETER SERVICES
PROVIDED TO ALLOW MEDICAID RECIPIENTS TO RECEIVE THE
PROVIDER'S MEDICAID COVERED SERVICE**

WHICH MEDICAID PROVIDERS CAN BILL FOR INTERPRETER SERVICES?

Medicaid providers and/or settings which are not reimbursed by Medicaid through a cost-based reimbursement methodology (or for whom cost-based reimbursement does not include interpreter costs, e.g. outpatient hospital setting) can bill for interpreter services.

Providers and/or settings (as well as individual interpreters who provide services to patients of these providers or settings) that cannot bill include:

- Inpatient hospital providers
- FQHC's/RHC's
- Nursing Facilities
- Any other provider who receives cost based reimbursement or an all-inclusive payment rate.

WHO BILLS AND/OR RECEIVES THE PAYMENT FOR INTERPRETER SERVICES?

- For medical providers who employ sign or language interpreters:
 - Interpreter enrolls individually as the performing provider;
 - Interpreter bills individually under their own provider number or the medical provider bills on behalf of the individual interpreter using the interpreter's provider number; and
 - Interpreter specifies that their payments go to their employing agency, such as XYZ Agency's group tax ID number (Interpreter's provider # is tied to the employing agency due to the "pay to" status. Separate provider # would be needed if employed by other agencies.)

- For medical providers billing on behalf of interpreters who are not employees:
 - Interpreter enrolls individually as the performing provider;
 - Interpreter bills individually under their own provider number or the medical provider bills on behalf of the individual interpreter using the interpreter's provider number; and
 - Interpreter specifies that their payments go to an agency.

Additionally, there must be an agreement (regarding payment for interpreter services to that individual) between the performing provider and the agency.

- For medical providers who want to provide patient access to interpreters, but don't want to be involved in the employment of, or billing of, interpreters:

- Language and sign language interpreters are eligible to enroll as individual Medicaid providers with payment going to that individual under his/her social security number or individual tax ID number.
- Please note that medical provider groups (e.g., physician groups, outpatient hospitals, dentists) cannot bill interpreter services directly. Only the above billing scenarios whereby the individual performing provider (interpreter) enrolls will work.

HOW DOES ONE ENROLL AS AN INTERPRETER?

- Each language and sign language interpreter must complete a provider enrollment package available through EDS.

HOW DOES ONE BILL FOR SERVICES?

- Billing is done on the HCFA/CMS 1500 form.

CODE	MODIFIER	MODIFIER	RATE/UNIT	MAXIMUMS	HOURLY EQUIVALENT
T1013	UA (Sign interpreter)	U1 (15 minute units making up the 1 st hour)	\$6.25/unit	Max of 4 units	\$25.00/hour
T1013	UA (Sign interpreter)	U2 (each additional 15 st minute unit beyond 1 st four units)	\$2.25/unit	N/a	\$9.00/hour
T1013	UC (Language)	U1 (15 minute units making up the 1 st hour)	\$3.75/unit	Max of 4 units	\$15.00/hour
T1013	UC (Language)	U2 (each additional 15 st minute unit beyond 1 st four units)	\$2.25/unit	N/a	\$9.00/hour

Electronic billing software is also available; providers are encouraged to bill electronically as it facilitates accurate and timely claim preparation and processing. Once you are enrolled, you may contact your EDS provider representative at 225-4899 (toll free 1-800-423-8303) for information about electronic billing.

OTHER REQUIREMENTS

Medicaid has two federal options for paying for interpreter services: (a) paying as an interpreter service, or (b) paying as part of the fee structure set for providers, in other words, rolling the cost into the provider rates as the portion of the rate assumed to cover administrative costs. Because we pay as an interpreter service (option a), it needs to remain clear that the interpreter (not the outpatient hospital, the physician, etc) is the provider and does receive reimbursement for the service. Were we, at some other time, to select option (b), medical providers would not bill separately for interpreter services; it would be assumed that the rates paid to providers would cover this expense, much the same as for administrative costs.

MEDICAID RULES

Rules regarding interpreter services are found at He-W 522 and should be followed, with the exception of 522.02(b)(2) which only allows reimbursement for sign language interpreters if the provider of the medical service has fewer than 15 employees. This is an outdated requirement and will be removed when the rule is readopted.

6. Rhode Island

Rhode Island does not pay Medicaid providers for Interpreter Services.

7. Vermont ⁵²

2.6.6 Interpreter Services at Medical Sites

The OVHA shall ensure availability of interpreter services at medical delivery sites to enrollees who speak a language other than English as a first language, or who are hearing-impaired, and who request such assistance. Where reasonable and practicable, the OVHA shall make interpreters available in-person. Where this is not practicable, interpreters must be made available by telephone.

INTERPRETER

When the physician pays an interpreter to interpret for a beneficiary who does not speak the same language as the physician/staff, or to use sign language for interpretation with a hearing impaired beneficiary, the physician may bill procedure code T1013 per 15 minutes. FQHC/RHC providers must bill Interpreter services on the T1013 using their non-FQHC/RHC numbers.

Procedure Code	Provider Type	Provider Specialty	P.A.C.	Pricing Effective Date	Pricing End Date	Max Allowable	PA	Type of Service
T1013	000	000	3	20040201	23821231	\$15.00	N	MEDICAL CARE

Dental Procedure/Fee Schedule Page 21 Effective 01/01/08

	CODE	DESCRIPTION	FEE	A	PROGRAM
H. Interpreter Services:	T1013	Interpreter Services – 15 minutes	\$15.00	0	Y

- Interpreter services must be submitted on a CMS-1500 medical claim form.
- Indicate the number of 15 minute increments (units) in section 24G of the CMS-1500 claim form.
- This procedure is not subject to the Adult Program \$495 annual maximum benefit.

8. Medicare

Medicare does not pay Medicaid providers for Interpreter Services.

⁵²VT Rules found at: <http://ovha.vermont.gov/for-providers/provider-manuals> and http://ovha.vermont.gov/for-providers/2ovha_dental_procedure-fee_schedule_effective_01-01-08.pdf/view?searchterm=interpreter;
Fees found at: <http://ovha.vermont.gov/for-providers/claims-processing-1>

9. Commercial Insurance

Commercial insurance does not pay Medicaid providers for Interpreter Services.

G. Outpatient Hospital Service Group

1. Rate Information

Due to differing payment methodologies, rate information was not collected for this service group.

2. Connecticut ⁵³

Services covered:

- Medically necessary medical care and procedures ordered by a physician or dentist;
- Family planning, abortion and hysterectomies, subject to certain limitations;
- EPSDT services;
- Dental services.

Hospital outpatient services are limited to one visit per day to the same outpatient clinic.

Outpatient clinics are paid at a reasonable rate to be determined by the reasonable cost of such services, not to exceed 116% of the combined average fee of the general practitioner and specialist for an office visit according to the fee schedule for practitioners of the healing arts. The payment rate for ancillary or special services (except for clinical diagnostic laboratory services subject to the Medicare Fee Schedule) provided at an outpatient clinic visit is based on the ratio of cost to charge (RCC). RCC factored special services are developed from the annual hospital audited fiscal year end reports. Some services are on fixed fees.

3. Maine ⁵⁴

45.11 BILLING INSTRUCTIONS

Eff. 9/1/07

- A. For all inpatient services, providers must bill in accordance with the Department's billing requirements set forth in "Billing Instructions: Claim Form UB-92" or successor forms or instructions.
- B. For all services provided on or after September 1, 2007 by primary care practices that are considered Medicare provider based entities, providers must bill in accordance with the Department's billing requirements set forth in "Billing Instructions: Claim Form CMS-1500" or successor instructions.
- C. For all outpatient services, other than those identified in B above, providers may bill using either the UB-92 or successor form or the CMS-1500, in accordance with the applicable MaineCare billing instructions.
- D. Providers should request reimbursement for all services provided on the same day on the same claim form.
- E. Only providers that qualify as "provider based" entities under 42 CFR 413.65 may bill under this Section of the MaineCare Benefits Manual.

⁵³ CT Rules found at: <http://www.hrsa.gov/reimbursement/states/Connecticut-Medicaid-Covered-Services.htm>;

⁵⁴ ME Rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s045.doc>;

F. Copies of MaineCare billing instructions may be downloaded at http://www.maine.gov/bms/providerfiles/provider_billing_manuals.htm

4. Massachusetts ⁵⁵

Out-Patient Services – MassHealth reimburses hospitals for outpatient services using the PAPE (Payment Amount per Episode) methodology developed as part of the annual MassHealth Acute Hospital RFA (request for application). The PAPE system consolidates all outpatient services (surgeries, clinic visits, ancillary services, etc. except laboratory) provided to a single patient in a single day into one PAPE. A case mix factor, which measures the level of services provided at a hospital, is applied to the statewide average; these factors are review annually. The PAPE method thus does not reflect the exact cost for services provided during the day; rather it is an average of low and high-cost procedures typically provided by a hospital. Currently average PAPE payment range from \$124 to \$1,500 depending on hospital case mix (with a state average of about \$138)

Lab Services are paid separately for PAPE and are based on a Fee Schedule. Generally Medicaid lab fees are paid at 80% of Medicare. There is no retrospective settlement.

Outpatient services are limited by medical necessity and include the following:

- Emergency services;
- Follow-up or after-care specialty clinics;
- General or family medicine;
- Laboratory;
- X-ray;
- Other diagnostic services;
- Outpatient surgery; and
- Physical medicine and rehabilitation.

Acute hospital outpatient departments and hospital-licensed health centers are paid for services provided to eligible members according to the rate for services established in the signed provider agreement with the Division.

Non-acute hospital outpatient departments are paid according to the MassHealth outpatient payment methodology established for each hospital by the Massachusetts Division of Health Care Finance and Policy (DHCFP).

5. New Hampshire ⁵⁶

Outpatient hospital services are covered when those services are rendered:

As preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services;

- Within specified service limits;
- By or under the direction of a physician or dentist;
- To a recipient who has not been admitted as an inpatient; and

⁵⁵ MA Rules found at:

http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_regs_related_pubs&csid=Eeohhs2#114_1_36 ; and <http://www.hrsa.gov/reimbursement/states/Massachusetts-Medicaid-Covered-Services.htm>;

⁵⁶ NH Rules found at: <http://www.hrsa.gov/reimbursement/states/New-Hampshire-Medicaid-Covered-Services.htm>; and

- For a period of time not to exceed 24 hours.

Payment is made in accordance with fee schedules developed by DHHS for the individual services provided.

6. Rhode Island ⁵⁷

Reimbursement Guidelines

Outpatient hospital services are reimbursed at a ratio of cost to charge (RCC) percentage of their billed amount. This percentage is determined yearly by DHS.

Laboratory Services

Laboratory services, revenue code range 300 – 319, are reimbursed based on the Medicare usual and customary rate (UCR) for the procedure code. Panel billing for laboratory services is required.

Surgical Services

Surgical services performed by the facility are reimbursed at the outpatient surgical RCC percentage of charges.

Dialysis

Dialysis facilities must bill on a UB-92 claim form using an outpatient bill type.

Reimbursement is based on the revenue codes billed to define the type of dialysis treatment rendered. Revenue codes 821, 831, 841, and 851 are all covered dialysis types and include all dialysis-related services rendered to the End Stage Renal Disease (ESRD) recipient, with the exception of the following codes:

- Revenue code 634 and 635 for Epogen, 1 unit equals 1000 units.
- Revenue code 636 for Calcijex (billed in conjunction with HCPCS code J0635), 1 unit equals 100mg. Limited to one unit per day.
- Revenue code 636 for Infed (billed in conjunction with HCPCS code J1760), 1 unit equals 100 mg. Limited to one unit per day.

All dialysis facility billings are reimbursed from the fee schedule for Hemodialysis, Peritoneal, Continuous Ambulatory Peritoneal Dialysis (CAPD), and Continuous Cycling Peritoneal Dialysis (CCPD).

Professional Services

Professional services provided in an outpatient setting by hospital-based physicians must be billed on the HCFA 1500 claim form. A physician provider number must be obtained through the provider enrollment process to correctly bill for professional services. Refer to Section 100-20 of the Provider Manual for enrollment information.

Multiple Surgical Procedures

Multiple surgical procedures performed in an outpatient setting will be reimbursed on a decreasing percentage basis. The first or primary rate will be covered at 100% of the allowed rate; the secondary procedure is covered at 50% of the allowed rate; and the tertiary procedure is covered at 25% of the allowed rate. There is no additional reimbursement on the fourth or subsequent procedures. When billing for multiple procedures, the surgical codes must be listed in order of complexity..

⁵⁷ RI Rules found at: <http://www.dhs.state.ri.us/dhs/heacre/provsvcs/manuals/hospital/outpat.htm>

Emergency Room Co-Payment

Recipients are responsible for a co-pay for emergency room (ER) visits if the services billed are deemed not to be a true emergency. The co-payment is not imposed for children under 18, IV-E and IV-E foster care children, adoption assistance children, pregnant women, and institutionalized individuals.

Emergency services are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The following list should be referenced to determine if a co-payment is to be collected.

Description of Emergency	ICD-9 Code
Chest pain	780-799
Shortness of breath or difficulty breathing	460-519
Sudden High fever in children under five years, loss of vision, hearing memory, motion or speech, allergic reaction with swollen tongue or fullness of throat, seizures, convulsion or unconsciousness	320-389
Suspected poisoning	001-009; 960-979
Drug overdose	960-979
Suicide attempt	300-316
Mental retardation	317-319
Psychotic behavior	290-299
Complications of pregnancy	630-676
Sudden vaginal bleeding	623.8
Premature labor	644.2
Suspected miscarriage	634.9
Broken bones	800-999

The hospital must bill the Medical Assistance Program with the appropriate ICD-9 diagnosis code, in form locator 66-77 on the UB-92 and description of emergency services. A provider may not deny service to a recipient who cannot pay the co-payment at the time the service is delivered.

Covered Services

All medically necessary services are reimbursable.

Refer to the appropriate Appendix.

Medicaid covers observation for a limit of two days. After two days, the patient must be discharged to home or admitted as an inpatient. If admitted, the second observation day is billable on an outpatient claim and the admission is separately billable on an inpatient claim. If a patient is admitted to observation status from the emergency room, both services are reimbursable on the same outpatient claim form. Observation status should be billed on a separate detail using revenue code 760, 762, or 769.

Non-covered Services

Refer to the appropriate Appendix.

Multiple emergency room, clinic or outpatient visits are allowed for the same date of service (DOS). These may require supportive documentation to verify that services were medically necessary on the same DOS.

Venipuncture, handling fees and STAT charges are not reimbursable.

Limitations/ Special Requirements

Procedure codes requiring prior authorization (PA) are listed in Section 600-10 of the Provider Reference Manual. In addition, any unlisted CPT code billed requires PA. When requesting authorization, medical justification must be documented. PA procedures are contained in Section 200-30 of the Provider Reference Manual.

Claims Billing Guidelines

When a recipient is admitted as an inpatient from the ER, an outpatient claim and an inpatient claim must both be billed.

Late charges are billable services and should be indicated through the use of bill type 135.

Only late charges should be submitted using this bill type.

Billing a span of dates in form locator six (6) to denote the from and through dates of service is not allowed except when billing for non-consecutive outpatient therapy services within a one month period. Billing for a span of dates should not exceed one calendar month.

Other Institutions

DHS will only reimburse the admitting facility for services provided to an eligible recipient during their entire length of stay. If a recipient is sent to another facility for services not available at the admitting facility, those charges must be billed on the admitting facility's bill to DHS. If the second facility submits a bill to DHS, it will be denied. Reimbursement will be determined at the admitting facility's RCC.

7. Vermont⁵⁸

Office of Vermont Health Access new outpatient prospective payment system became effective with services provided as of May 1, 2008. The fee schedule was developed using the Medicare OPSS Addendum B effective January 1, 2008 as the basis. The fee schedule will be updated annually in line with changes to Medicare's Addendum B. The fees on OVHA's fee schedule are derived from three sources.

- Medicare OPSS- If OVHA covers the service, then the payments to hospitals is the national median value as shown on the Medicare OPSS Addendum B effective 1/1/08.
 - Hospitals with Sole Community Hospital status in Medicare as well as Vermont Critical Access Hospitals will receive a 7.1% upward adjustment to the published fee for any service that is paid in the Medicare OPSS. The adjustment does not apply to non-OPSS services.
 - There are a few services paid in Medicare OPSS that are not covered by OVHA in the hospital setting.
- Medicare Clinical lab Fee Schedule (CLAB) – Effective 5/1/08, hospital will receive the maximum fee allowable under the CLAB. This is a change in reimbursement for hospitals only.

⁵⁸ VT rules found at: <http://www.hrsa.gov/reimbursement/states/Vermont-Medicaid-Covered-Services.htm>:

- OVHA’s Fee Schedule – Hospitals are paid for services covered by OVHA that do not have a fee in either the Medicare OPPS or Medicare CLAB using OVHA’s fee schedule to non-hospital-only fee schedule as well.

There are some situations where OVHA covers a service for which no fee is available. These services will be paid using a hospital-specific cost-to-charge ratio (CCR) multiplied by covered charges. The CCR used for payment is the same CCR used to calculate outlier payments for both inpatient and outpatient services. The hospital-specific CCRs are updated annually along with other OPPS-related changes.

8. Medicare ⁵⁹

Medicare originally based payments for outpatient care on hospitals’ costs, but CMS began using the outpatient prospective payment system in August 2000. The OPPS is a fee schedule. It sets payments for individual services using a set of relative weights, a conversion factor and adjustments for geographic differences in input prices. Hospitals can also receive additional payments in the form of outlier adjustments for extraordinary high-cost services and pass-through payments for some new technologies.

The unit of payment under the OPPS is the individual service as identified by Healthcare common Procedure Coding system codes. CMS classifies services in ambulatory payment classifications (APCs) on the basis of clinical and cost similarity. All services within an APC have the same payment rate.

In setting the payment rates in the OPPS, CMS intends to cover hospitals’ operating and capital costs for the services they furnish. CMS pays separately professional services, such as physician services. CMS determines the payment rate for each service by multiplying the relative weight for the service’s APC by the conversion. The conversion factor is the hospitals wage index 60% adjusted for area wages plus non-labor-related portion (40%). The relative weight for an APC measures the resource requirement of the service and is based on the median cost of services in that APC.

In addition, CMS assigns some new services to “new technology” APCs based on similarity of resource use. Services remain in these APCs for two to three years, while CMS collects the data necessary to develop payment rates for them.

⁵⁹ Medicare rules found at: http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp

H. Physician and Optometric Service Groups

All NE states and Medicare utilize a fee schedule for physician services payments. Some states take other variables into account, paying the lowest rate of all variables considered. Medicare takes setting into account more than the New England states do.

1. Rate Information

Following are rates in effect as of January 1, 2008:

Physician and Optometric Rates

Service Group	Procedure w Code	Posted Rates													
		NH	Avg - Other NE States	CT	MA - NonFac	MA - Fac	MA - Global	Adjusted MA Rate Used	ME	RI	VT	All Comm	Medicare - NH non facility	Medicare - NH Facility	Adjusted Medicare Rate Used
Physician Primary Care Evaluation and Management	99201 Office/Outpatient Visit, New	\$20.16	\$25.03	\$22.65	\$29.42	\$17.73		\$28.23	\$21.92	\$16.72	\$35.61	\$49.78	\$36.51	\$21.93	\$35.03
	99202 Office/Outpatient Visit, New	\$33.60	\$44.96	\$39.27	\$50.94	\$35.03		\$50.01	\$32.56	\$27.24	\$63.30	\$90.21	\$62.55	\$42.46	\$61.38
	99203 Office/Outpatient Visit, New	\$42.56	\$63.62	\$57.97	\$75.00	\$53.58		\$73.50	\$48.45	\$29.00	\$93.99	\$129.98	\$91.43	\$65.04	\$89.58
	99204 Office/Outpatient Visit, New	\$63.84	\$94.35	\$87.45	\$113.72	\$88.08		\$111.79	\$68.76	\$45.00	\$133.16	\$171.29	\$139.16	\$108.45	\$136.85
	99205 Office/Outpatient Visit, New	\$80.64	\$116.44	\$109.43	\$142.46	\$115.53		\$140.93	\$87.34	\$46.00	\$169.41	\$236.09	\$174.61	\$141.13	\$172.71
	99211 Office/Outpatient Visit, Est	\$18.38	\$14.64	\$13.04	\$16.84	\$6.78		\$16.53	\$13.17	\$8.05	\$20.94	\$31.01	\$20.15	\$8.34	\$19.78
	99212 Office/Outpatient Visit, Est	\$31.18	\$27.73	\$23.42	\$30.39	\$18.06		\$29.42	\$19.85	\$20.64	\$37.45	\$52.77	\$37.69	\$21.93	\$36.45
	99213 Office/Outpatient Visit, Est	\$42.72	\$39.19	\$37.48	\$48.67	\$33.74		\$47.34	\$28.94	\$20.64	\$51.29	\$77.19	\$60.39	\$41.88	\$58.74
	99214 Office/Outpatient Visit, Est	\$65.79	\$58.77	\$56.74	\$73.71	\$53.27		\$70.90	\$42.50	\$27.00	\$80.45	\$121.50	\$90.67	\$65.47	\$87.21
	99215 Office/Outpatient Visit, Est	\$75.04	\$81.00	\$76.48	\$99.52	\$76.80		\$98.45	\$60.38	\$32.00	\$117.06	\$178.85	\$122.31	\$93.96	\$120.97
	99381 Init Pm E/M, New Pat, Inf	\$44.80	\$68.52	\$60.75	\$77.85	\$46.70		\$75.25	\$47.15	\$37.00	\$101.10	\$144.97			\$0.00
	99382 Init Pm E/M, New Pat 1-4 Yrs	\$44.80	\$72.83	\$65.26	\$83.77	\$53.26		\$80.04	\$48.48	\$37.00	\$109.01	\$155.76			\$0.00
	99383 Prev Visit, New, Age 5-11	\$44.80	\$71.67	\$63.87	\$82.47	\$53.26		\$79.02	\$50.40	\$37.00	\$106.81	\$152.76			\$0.00
	99384 Prev Visit, New, Age 12-17	\$47.04	\$78.23	\$69.25	\$89.25	\$60.04		\$85.67	\$49.87	\$42.00	\$116.01	\$164.21			\$0.00
	99385 Prev Visit, New, Age 18-39	\$40.32	\$74.54	\$69.25	\$89.25	\$60.04		\$85.66	\$45.43	\$27.24	\$116.01	\$167.89			\$0.00
	99386 Prev Visit, New, Age 40-64	\$40.32	\$86.31	\$81.21	\$104.16	\$73.65		\$99.98	\$46.83	\$27.24	\$136.81	\$195.81			\$0.00
	99387 Prev Visit, New, Age 65+	\$40.32	\$93.06	\$88.01	\$113.27	\$80.49		\$108.59	\$48.73	\$27.24	\$148.40	\$226.21			\$0.00
	99391 Per Pm Reeval, Est Pat, Inf	\$62.07	\$52.00	\$45.86	\$60.36	\$39.92		\$58.29	\$43.75	\$27.00	\$76.85	\$111.20			\$0.00
	99392 Prev Visit, Est, Age 1-4	\$62.07	\$57.30	\$51.25	\$67.14	\$46.70		\$64.88	\$44.50	\$27.00	\$86.06	\$124.58			\$0.00
	99393 Prev Visit, Est, Age 5-11	\$62.07	\$56.72	\$50.55	\$66.49	\$46.70		\$64.36	\$45.25	\$27.00	\$84.96	\$122.93			\$0.00
99394 Prev Visit, Est, Age 12-17	\$62.07	\$61.85	\$55.75	\$73.06	\$53.26		\$70.70	\$46.50	\$27.00	\$93.97	\$134.80			\$0.00	
99395 Prev Visit, Est, Age 18-39	\$40.32	\$62.46	\$56.45	\$73.71	\$53.26		\$71.32	\$47.78	\$27.00	\$95.07	\$138.38			\$0.00	
99396 Prev Visit, Est, Age 40-64	\$40.32	\$66.36	\$62.30	\$81.13	\$60.04		\$77.49	\$47.78	\$20.64	\$105.01	\$153.11			\$0.00	
Obstetric Services	59400 Obstetrical Care	\$1,200.00	\$1,678.05	\$2,972.89			\$2,045.18	\$2,045.18	\$1,230.00	\$815.00	\$1,327.16	\$2,552.00	\$1,623.33	\$1,623.33	\$1,623.33
	59409 Obstetrical Care	\$900.00	\$861.87	\$1,448.03			\$851.74	\$851.74	\$650.00	\$428.40	\$931.18	\$1,230.00	\$714.69	\$714.69	\$714.69
	59410 Obstetrical Care	\$965.00	\$944.05	\$1,623.85			\$980.17	\$980.17	\$700.00	\$450.00	\$966.23	\$1,377.00	\$826.49	\$826.49	\$826.49
	59412 Antepartum Manipulation	\$75.00	\$61.51				\$80.05	\$80.05	\$54.08	\$50.40		\$179.00	\$96.42	\$96.42	\$96.42
	59414 Deliver Placenta	\$56.40	\$82.83				\$101.75	\$101.75	\$84.60	\$62.75	\$82.21	\$145.00	\$85.38	\$85.38	\$85.38
	59425 Antepartum Care Only	\$250.00	\$295.51	\$697.46	\$472.68	\$361.16		\$448.28	\$185.92	\$108.00	\$37.89	\$423.00	\$405.00	\$308.51	\$383.89
	59426 Antepartum Care Only	\$290.00	\$514.17	\$1,233.79	\$843.56	\$637.70		\$822.11	\$325.85	\$151.20	\$37.89	\$705.00	\$724.53	\$544.94	\$705.82
	59430 Care After Delivery	\$20.00	\$103.74	\$237.29	\$153.56	\$139.15		\$150.55	\$71.36	\$21.60	\$37.90	\$181.00	\$130.09	\$117.09	\$127.38
	59510 Cesarean Delivery	\$1,200.00	\$1,812.18	\$3,373.59			\$2,309.68	\$2,309.68	\$1,235.46	\$815.00	\$1,327.16	\$2,857.00	\$1,837.57	\$1,837.57	\$1,837.57
	59514 Cesarean Delivery Only	\$900.00	\$945.85	\$1,708.74			\$1,006.12	\$1,006.12	\$654.82	\$428.40	\$931.18	\$1,244.00	\$844.93	\$844.93	\$844.93
	59515 Cesarean Delivery	\$965.00	\$1,049.89	\$1,940.65			\$1,182.80	\$1,182.80	\$709.79	\$450.00	\$966.23	\$1,627.00	\$996.33	\$996.33	\$996.33

Physician and Optometric Rates

Service Group	Procedure w Code	Posted Rates													
		NH	Avg - Other NE States	CT	MA - NonFac	MA - Fac	MA - Global	Adjusted MA Rate Used	ME	RI	VT	All Comm	Medicare - NH non facility	Medicare - NH Facility	Adjusted Medicare Rate Used
	59610 VBAC Delivery	\$1,200.00	\$1,385.63				\$2,138.92	\$2,138.92	\$1,230.00	\$846.45	\$1,327.16	\$2,721.00	\$1,707.89	\$1,707.89	\$1,707.89
	59612 VBAC Delivery Only	\$965.00	\$771.11				\$955.89	\$955.89	\$650.00	\$547.37	\$931.18	\$1,235.00	\$801.06	\$801.06	\$801.06
	59614 VBAC Care After Delivery	\$1,000.00	\$831.14				\$1,066.78	\$1,066.78	\$700.00	\$591.54	\$966.23	\$1,349.00	\$896.20	\$896.20	\$896.20
	59618 Attempted VBAC Delivery	\$1,200.00	\$1,483.83				\$2,422.24	\$2,422.24	\$1,235.46	\$950.47	\$1,327.16	\$3,433.00	\$1,921.83	\$1,921.83	\$1,921.83
	59620 Attempted VBAC Delivery Only	\$965.00	\$828.97				\$1,100.58	\$1,100.58	\$654.82	\$629.31	\$931.18	\$1,379.00	\$921.86	\$921.86	\$921.86
	59622 Attempted VBAC After Care	\$1,000.00	\$908.33				\$1,283.21	\$1,283.21	\$709.79	\$674.10	\$966.23		\$1,081.64	\$1,081.64	\$1,081.64
	59025 Fetal Non-Stress Test	\$25.00	\$37.71	\$75.73			\$48.01	\$48.01	\$24.09	\$26.01	\$14.70	\$68.00	\$43.13	\$43.13	\$43.13
	76801 Ob US < 14 Wks, Single Fetus	\$55.92	\$79.26	\$85.28			\$109.20	\$109.20	\$65.94	\$52.22	\$83.64	\$96.00	\$133.84	\$133.84	\$133.84
	76802 Ob US < 14 Wks, Addl Fetus	\$43.57	\$53.33	\$51.72			\$66.23	\$66.23	\$42.89	\$40.87	\$64.92	\$128.00	\$77.71	\$77.71	\$77.71
	76805 Ob US >= 14 Wks, Sngl Fetus	\$64.00	\$88.03	\$88.60			\$113.42	\$113.42	by report	\$36.00	\$114.10	\$216.00	\$144.48	\$144.48	\$144.48
	76810 Ob US >= 14 Wks, Addl Fetus	\$138.00	\$68.50	\$61.70			\$78.96	\$78.96	by report	\$48.00	\$85.35	\$183.00	\$99.48	\$99.48	\$99.48
	76811 Ob US, Detailed, Sngl Fetus	\$145.89	\$162.66	\$149.09			\$190.36	\$190.36	\$121.29	\$136.22	\$216.33	\$390.00	\$220.68	\$220.68	\$220.68
	76812 Ob US, Detailed, Addl Fetus	\$85.53	\$101.32	\$94.61			\$131.93	\$131.93	\$72.86	\$81.12	\$126.08	\$238.00	\$144.51	\$144.51	\$144.51
	76813 Ob US Nuchal Meas, 1 Gest	\$72.02	\$86.85	\$80.25			\$103.00	\$103.00	\$60.38	\$70.80	\$119.81	\$185.00	\$131.66	\$131.66	\$131.66
	76814 Ob US Nuchal Meas, Add-On	\$47.32	\$57.27	\$52.15			\$67.01	\$67.01	\$40.04	\$47.27	\$79.87	\$135.00	\$83.44	\$83.44	\$83.44
	76815 Ob US, Limited, Fetus(s)	\$45.00	\$60.77	\$57.89			\$74.22	\$74.22	by report	\$36.00	\$74.96	\$140.00	\$92.35	\$92.35	\$92.35
	76816 Ob US, Follow-Up, Per Fetus	\$40.00	\$61.27	\$61.51			\$79.11	\$79.11	by report	\$36.00	\$68.46	\$141.00	\$102.88	\$102.88	\$102.88
76817 Transvaginal US, Obstetric	\$58.29	\$62.40	\$63.38			\$81.37	\$81.37	\$48.32	\$53.87	\$65.04	\$149.00	\$97.61	\$97.61	\$97.61	
Emergency Department Services	99281 Emergency Dept. Visit	\$16.80	\$14.86	\$11.73			\$15.57	\$15.57	\$15.30	\$15.48	\$16.20	\$30.00	\$19.31	\$19.31	\$19.31
	99282 Emergency Dept. Visit	\$24.64	\$23.24	\$22.47			\$29.63	\$29.63	\$19.42	\$17.91	\$26.76	\$48.00	\$36.29	\$36.29	\$36.29
	99283 Emergency Dept. Visit	\$40.32	\$42.92	\$36.77			\$48.06	\$48.06	\$31.65	\$38.00	\$60.12	\$93.00	\$58.35	\$58.35	\$58.35
	99284 Emergency Dept. Visit	\$60.48	\$71.40	\$66.73			\$87.79	\$87.79	\$49.43	\$59.20	\$93.87	\$152.00	\$107.90	\$107.90	\$107.90
	99285 Emergency Dept. Visit	\$94.08	\$109.58	\$99.93			\$131.19	\$131.19	\$77.39	\$92.55	\$146.86	\$239.00	\$160.84	\$160.84	\$160.84
Psychiatry - Medication Mgt	90862 Medication Management	\$26.18	\$31.94	\$31.36	\$41.16	\$36.29		\$36.71		\$15.60	\$44.09	\$89.00	\$52.61	\$43.94	\$51.87
Hospital Care	99221 Initial Hospital Care	\$62.72	\$52.48	\$51.84			\$68.14	\$68.14	\$37.87	\$38.18	\$66.38	\$110.00	\$84.76	\$84.76	\$84.76
	99222 Initial Hospital Care	\$96.32	\$77.16	\$72.85			\$95.69	\$95.69	\$63.05	\$44.00	\$110.19	\$173.00	\$116.69	\$116.69	\$116.69
	99223 Initial Hospital Care	\$112.00	\$105.14	\$106.23			\$139.52	\$139.52	\$80.30	\$46.00	\$153.63	\$248.00	\$171.61	\$171.61	\$171.61
	99231 Subsequent Hospital Care	\$24.64	\$24.96	\$21.83			\$28.75	\$28.75	\$23.96	\$17.00	\$33.28	\$54.00	\$35.37	\$35.37	\$35.37
	99232 Subsequent Hospital Care	\$33.60	\$41.26	\$39.01			\$51.26	\$51.26	\$31.78	\$29.72	\$54.52	\$92.00	\$63.27	\$63.27	\$63.27
	99233 Subsequent Hospital Care	\$47.04	\$57.15	\$55.67			\$73.13	\$73.13	\$49.78	\$29.72	\$77.47	\$132.00	\$90.67	\$90.67	\$90.67
Consultations	99241 Office Consultation	\$34.72	\$33.97	\$30.68	\$39.55	\$25.60		\$37.09	\$27.76	\$25.59	\$48.71	\$72.00	\$48.25	\$31.31	\$45.27
	99242 Office Consultation	\$47.04	\$59.59	\$56.11	\$72.62	\$53.80		\$69.90	\$45.95	\$37.00	\$88.99	\$130.00	\$89.33	\$66.09	\$85.97

Physician and Optometric Rates

Service Group	Procedure w Code	Posted Rates													
		NH	Avg - Other NE States	CT	MA - NonFac	MA - Fac	MA - Global	Adjusted MA Rate Used	ME	RI	VT	All Comm	Medicare - NH non facility	Medicare - NH Facility	Adjusted Medicare Rate Used
	99243 Office Consultation	\$72.80	\$78.20	\$76.75	\$99.61	\$74.62		\$97.27	\$61.28	\$37.00	\$118.71	\$176.00	\$122.58	\$92.25	\$119.74
	99244 Office Consultation	\$87.36	\$118.61	\$112.11	\$145.82	\$116.93		\$142.59	\$121.31	\$49.00	\$168.02	\$261.00	\$179.57	\$144.92	\$175.69
	99245 Office Consultation	\$114.24	\$139.49	\$138.96	\$180.89	\$148.11		\$177.83	\$112.32	\$51.00	\$217.34	\$332.00	\$221.39	\$182.01	\$217.72
	99251 Inpatient Consultation	\$35.84	\$29.10	\$27.96			\$36.67	\$36.67	\$18.23	\$27.86	\$34.79	\$70.00	\$45.47	\$45.47	\$45.47
	99252 Inpatient Consultation	\$47.04	\$51.93	\$45.05			\$58.90	\$58.90	\$43.46	\$42.11	\$70.12	\$110.00	\$72.34	\$72.34	\$72.34
	99253 Inpatient Consultation	\$72.80	\$70.48	\$66.65			\$87.38	\$87.38	\$57.32	\$45.00	\$96.06	\$159.00	\$108.22	\$108.22	\$108.22
	99254 Inpatient Consultation	\$87.36	\$97.36	\$96.03			\$125.89	\$125.89	\$72.37	\$54.00	\$138.53	\$228.00	\$156.42	\$156.42	\$156.42
	99255 Inpatient Consultation	\$114.24	\$124.78	\$119.89			\$156.96	\$156.96	\$101.06	\$55.00	\$190.98	\$306.00	\$192.77	\$192.77	\$192.77
Optometric Services	92015 Refraction	\$20.70	\$29.55	\$42.72	\$47.53	\$15.08	\$0.00	\$45.93	\$4.50	\$0.00		\$30.85			\$0.00
	92340 Fitting of Spectacles	\$4.90	\$25.52	\$24.20	\$31.03	\$14.48	\$0.00	\$30.90	\$14.40	\$18.00	\$29.00	\$29.05			\$0.00
	92341 Fitting of Spectacles	\$37.50	\$26.94	\$27.23	\$34.72	\$18.17	\$0.00	\$33.60	\$22.92	\$20.00		\$31.83			\$0.00
	92002 Eye Exam, New Patient	\$41.08	\$37.50	\$34.58	\$55.81	\$35.04	\$0.00	\$55.81	\$37.33	\$28.07	\$31.72	\$70.37	\$67.27	\$41.67	\$67.27
	92004 Eye Exam, New Patient	\$74.03	\$61.96	\$62.91	\$100.41	\$67.30	\$0.00	\$100.41	\$64.72	\$28.07	\$53.71	\$104.65	\$126.19	\$86.41	\$126.19
	92012 Eye Exam Established Pat	\$37.70	\$34.21	\$32.11	\$51.40	\$27.71	\$0.00	\$51.40	\$32.29	\$28.07	\$27.19	\$67.84	\$71.15	\$43.19	\$71.15
	92014 Eye Exam & Treatment	\$55.67	\$47.57	\$47.17	\$75.63	\$45.12	\$0.00	\$75.63	\$47.91	\$28.07	\$39.08	\$85.25	\$103.14	\$66.52	\$103.14

2. Connecticut ⁶⁰

- The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.
- Payment rates shall be the same for in-state and out-of-state providers.
- Payment shall be made at the lowest of:
 - The provider's usual and customary charge to the general public;
 - The lowest Medicare rate;
 - The amount in the applicable fee schedule as published by the department;
 - The amount billed by the provider; or
 - The lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

The department shall pay providers:

- Only for those procedures listed in the provider's fee schedule. The department shall not pay for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;
- For services provided in the office, a hospital, the client's home, a long-term care facility, or other medical care facility;
- For laboratory service limited to services provided by Medical Assistance providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- For medical and surgical supplies used by the provider in the course of treatment of a client;
- For injectable drugs which are payable by the department and administered by a provider;
- For a second opinion for surgery when requested voluntarily by the Medical Assistance client or when required by the department. The department shall pay the consulting provider for services performed according to the established fees for consultation;
- For family planning services as described in the Regulations of Connecticut State Agencies; and
- For HealthTrack Services and HealthTrack Special Services.

3. Maine ⁶¹

- MaineCare reimburses physicians using a fee schedule known as the MaineCare rate of reimbursement
 - The fees or cap associated with service codes are in the MaineCare claims processing database, and are available to any provider who requests a paper or electronic copy. The information is also available on the Office of MaineCare Services website: <http://www.maine.gov/bms/provider.htm>.

⁶⁰ CT rules are found at: <http://www.ctmedicalprogram.com/publications.html#manuals>; ch7physician.pdf. Fee schedule can be found at: <http://www.ctmedicalprogram.com/publications.html#feesched>; fee_physician_20060501.pdf, and fee_lab_20060701.pdf.

⁶¹ MaineCare rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s090.doc> (10-144 Chapter 101 MAINECARE BENEFITS MANUAL, CHAPTER II), Fees can be looked up at: http://portalxw.bisoex.state.me.us/oms/proc/pub_proc.asp?cf=mm. MaineCare members pay a co-payment not to exceed \$3.00 per day for services provided, up to \$30.00 per month

- Providers must bill using their usual and customary charges and reimbursement will be in accordance with the criteria cited below.
- Providers must bill medical supplies and therapeutic injections at their cost, using NDC codes where available.
- MaineCare will reimburse the lowest of the following for covered services:
 - The MaineCare rates of reimbursement as found in this Section and posted in the fee schedule on the MaineCare website. See the rates listed by procedure code on the BMS website, at www.maine.gov/bms
 - MaineCare physician fee schedule rates (other than drug prices) for new or changed CPT or HCPCS codes are determined based on the following benchmark:
 - For services provided on or after July 1, 2005, the fee for service rate is set at fifty-three percent (53%) of the lowest level in the current Medicare fee schedule for Maine in effect at that time; or
 - The lowest amount allowed by Medicare Part B for Maine area “99” non-facility fee schedule; or
 - The provider’s usual and customary charges; or
 - The amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third party payment as set in MBM, Chapter I.
- MaineCare considers a claim paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.
- MaineCare determines drug fee schedules for ***Drugs Administered by Other than Oral Methods*** by the lower of:
 - Ninety five percent (95%) of Average Wholesale Price (AWP); or
 - The lowest price that the product or drug can be obtained by the provider

90.04 COVERED SERVICES⁶²

A covered service is a service for which the Department may make payment. The Department covers those reasonably necessary medical and remedial services that are provided in an appropriate setting and recognized as standard medical care required for the prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary for health and well-being.

The Department will not give additional reimbursement to physicians who are salaried by a hospital for services billed by the hospital and whose payment is included in the hospital cost report for services provided while a member is hospitalized as an inpatient or receiving outpatient services.

When a non-MaineCare provider covers the practice for a MaineCare provider and performs services, MaineCare will only reimburse the MaineCare billing provider. The MaineCare billing provider must maintain adequate records to document the actual servicing provider. The MaineCare billing provider is responsible for reimbursing the non-MaineCare provider.

Providers should direct any questions about coverage of particular services to the Provider Relations Unit prior to provision of the service. Providers should contact the provider relations specialist assigned to their geographic area.

90.04-1 Anesthesiology Services

⁶² Source: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s090.doc>

The Department covers anesthesiology services when personally performed by the qualified servicing provider. The services include the following activities:

- A. Pre-operative evaluation;
- B. Anesthetic plan;
- C. Personal participation in the most demanding parts of the anesthesia service, including induction, emergency, and supervision of all personnel associated with delivery of the anesthetic agent;
- D. Observation of the course of the anesthetic procedure at frequent intervals; and
- E. Physical availability of the anesthesiologist in the operating room or delivery room suite.

However, during the performance of the activities described in subparagraphs (C), (D), and (E), the physician shall not be responsible for the care of more than four (4) other patients concurrently, or the service may not be described as being personally performed, and would not be a covered service under this subsection.

1. Reimbursement of Anesthesiology Services

MaineCare covers anesthesiology services by computing a price based on a basic value for each procedure with time unit values added to administer the procedure. The Department assigns a basic value to specific procedures that require anesthesia. Time required to administer the anesthetic is then billed in fifteen (15) minute units. To bill properly, providers bill fifteen (15) minute units of value for every fifteen (15) minutes required, added to the basic value assigned for the procedure.

Billable anesthesia time starts at the beginning of the administration of the anesthesia and ends when the member is safely placed under customary post-operative supervision. Providers may include the time spent administering regional and local injections and placing catheters and other monitoring devices in billable time for the delivery of the anesthesia services. Providers should bill these procedures separately only when they are performed independently and not in conjunction with an anesthesia service.

2. Requirements for Billing Anesthesia Services

MaineCare requires providers to use the latest Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Technology (CPT) procedure codes when billing for anesthesia services. These codes already have associated values assigned for each procedure and available modifiers to describe unusual situations.

3. Anesthesia for Non-Surgical Services

When billing for anesthesia for all non-surgical diagnostic, medical services, or dental services, providers should bill the appropriate code for the procedure, with the appropriate anesthesia modifier to indicate that anesthesia was provided for a procedure not usually requiring anesthesia.

4. Anesthesia Administered by Operating Surgeon

MaineCare will make no allowance for topical anesthesia, local infiltration, or digital block anesthesia administered by the operating surgeon. When the surgeon provides regional or general anesthesia, the Department will reimburse for the basic anesthesia value without added time units.

5. Anesthesia Administered by Certified Registered Nurse Anesthetists (CRNA)

MaineCare will reimburse anesthesia performed by certified registered nurse anesthetists (CRNAs) at seventy-five percent (75%) of the amount allowed for physician services. Providers should add the appropriate modifier identified in billing instructions.

90.04-2 **Vision Services**

Ophthalmologic procedures for diseases of the eye are covered when billed with appropriate CPT codes. Vision services must meet the guidelines detailed in MBM, Section 75, Vision Services.

90.04-3 **Laboratory Services**

Allowances for laboratory procedures apply to lab services provided by physicians or by independent laboratories. Providers must be willing to participate in proficiency testing. Tests that produce an index or ratio based on mathematical calculations using two (2) or more separate results may not be billed as separate tests, i.e., A/G ratio, free thyroxine index, etc.

MaineCare reimburses for tests that are frequently done as a group (panel) on automated equipment as a group under a single code in its reimbursement rate. For any combination of these tests, providers must bill the appropriate CPT code that correctly designates the tests included in the panel. MaineCare will reimburse no more than the price of the most appropriate panel for any tests performed individually on the same day.

Please refer to MBM, Chapter II, Section 55, regarding Laboratory Services provided in a physician's office and referrals for laboratory services.

90.04-4 **Obstetrical Services for Pregnant Women**

A. **Provider Qualifications**

MaineCare reimburses for obstetric services provided to a woman who is pregnant only when the provider meets at least one of the following criteria:

- Is board eligible or certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics or the appropriate approved specialty board of the American Osteopathic Association;
- Is employed by or affiliated with a federally qualified health center (as defined in §1905(l)(2)(B) of the Act);
- Holds admitting privileges at a hospital participating in an approved MaineCare plan;
- Is a member of the National Health Service Corps; or
- Documents a current, formal consultation and referral arrangement with an obstetrician or family practitioner who has the certification described in above in Section 90.04-16 (A) for purposes of specialized treatment and admission to a hospital; or
- Is an approved provider of services in a rural health center (RHC), ambulatory care clinic, or is otherwise approved by the Department as a primary care provider (PCP).

B. **Obstetrical Services**

Obstetrical care services include antepartum care, delivery, postpartum care, and other services normally provided in uncomplicated maternity care. Antepartum care includes usual prenatal services (e.g., initial and subsequent history, physical examination, recording of weight, blood pressure, fetal heart tones, maternity counseling, etc.). Delivery includes management of labor and vaginal delivery (with or without episiotomy, with or without forceps), or cesarean section, and resuscitation of newborn infant when necessary. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, including routine postpartum visits.

MaineCare covers treatment of medical complications of pregnancy (e.g., toxemia, cardiac problems, neurological problems, etc.) or other problems requiring additional or unusual services and requiring hospitalization.

When a non-MaineCare provider covers the practice for a MaineCare provider and performs obstetrical services, MaineCare will only reimburse the MaineCare billing provider. The MaineCare billing provider must maintain adequate records to document the actual servicing provider. The MaineCare billing provider is responsible for reimbursing the non-MaineCare provider.

C. Reimbursement for Obstetrical Care

MaineCare provides two methods for maternity care billing, global charge basis or per service charge basis. Physicians may choose only one of the two (2) methods for each delivery as set forth below:

- Global charge basis. Several procedure codes are all-inclusive of delivery, antepartum, and postpartum care and can be used to bill one all-inclusive charge following the member's delivery. Providers may not bill a global charge for patients who were not MaineCare eligible during the entire pregnancy.
- Providers may bill total maternity care codes (global charge basis) only in those instances where the provider performs each of the components of maternity care, and only if eight (8) or more visits over a period of at least four (4) months are provided during the antepartum phase of maternity care. Providers may bill maternity related office visits in excess of eleven visits in addition to the global code.
- Per service charge basis. Providers may bill on per service basis for maternity care.

90.04-5 Psychiatric Services

MaineCare covers psychiatric services as defined below when provided by or under the direct supervision of a psychiatrist who is board eligible or certified by the American Board of Psychiatry and Neurology; or, American Osteopathic Board of Neurology and Psychiatry as documented by written evidence from such Board; or in the case of Doctors of Medicine; have completed three years of post graduate training in psychiatry approved by the Educational Council of the American Medical Association and having written evidence of such training. Providers practicing in Canadian provinces must meet comparable psychiatry certification guidelines. (Refer to Section 90.04-17 for services provided by other qualified providers.)

A. Covered Services

The Department will reimburse for psychiatric outpatient services for up to five (5) services in any consecutive seven (7) day period, except when a member requires services for an emergency situation. An emergency situation is when there is sudden, disordered, or socially inappropriate behavior that requires therapeutic response in order to prevent life threatening or psychologically damaging consequences. MaineCare will reimburse for up to eight (8) emergency therapy visits per emergency, for no more than two (2) hours within a single twenty-four (24) hour period. When the same provider performs two (2) services for the same member on any one day, MaineCare will reimburse for only one (1) service, at the higher payment rate of the two (2) services. Providers must use appropriate CPT codes when providing psychotherapy services. MaineCare members receiving psychotherapy services under this section of the MaineCare Benefits Manual are ineligible to receive comparable or duplicative services, during the same time period, except as otherwise noted in MBM, Chapter II, Section 14, Advanced Practice Registered Nurse (APRN) Services, Chapter II, Section 37, Home Based Mental Health Services, Chapter II, Section 45, Hospital Services, Chapter II, Section 100, Psychological Services, Chapter II, Section 65, Mental Health Services, or Chapter II, Section 46, Psychiatric Facility Services.

MaineCare reimburses for the following services:

1. Medication management or drug therapy, defined as the prescription by a physician of psychoactive drugs to favorably influence a present mental illness or to preclude the recurrence of a mental illness, will not be reimbursed as a separate charge if no other psychiatric service is provided; providers should bill medication management as an office visit.
2. Evaluation and Diagnosis is the formulation or evaluation of a treatment plan for the member that includes a direct encounter between the member and the provider.
3. Psychotherapy, both with the individual member and his or her family, is a method of treatment of mental disorders using the interaction between the therapist and a member or a family member in an individual or group setting to promote emotional or psychological change to alleviate mental disorder. MaineCare covers psychotherapy only when the MaineCare member is present and participating in the psychotherapy session.
Providers must keep clinical records that include, but are not limited to: the member's name, address, attending physician, other providers, and the member's history, diagnosis, and treatment plan, treatment documentation, and any discharge/ closing summaries. The provider of the therapy service shall sign all entries.
4. Electro-shock Treatment i.e., the administration of a stimulating electric current to the head, affecting the brain cortex and producing a changed level of consciousness of the patient.
5. Inpatient Services, including admission, daily care, and inpatient psychotherapy.
Hospital admission is the initial hospital visit, comprehensive and complete diagnostic history and physical examination, preparation of hospital records and initiation of diagnostic and treatment services.
Daily Care, i.e., is the interval history, examination and treatment of members in an inpatient hospital setting. MaineCare will reimburse for as many inpatient hospital visits per week as are medically necessary.
Providers must include a personalized plan of care in the medical record that itemizes the type of psychiatric services needed, how the service can best be delivered, short and long-range goals, and a discharge plan.
6. Psychometric Testing for diagnostic purposes to determine the level of intellectual function, personality characteristics, etc., through the use of standardized test instruments. Testing for educational purposes is not a covered service.
Psychometric testing includes the administration of the test, the interpretation of the test, and the preparation of test reports. Providers do not have to include preliminary diagnostic interviews or subsequent consultation visits in the limits or rates for psychological testing.
MaineCare limits reimbursement for psychological testing sessions to no more than four (4) hours for each test, except for the following:
 1. Each Halstead-Reitan Battery is limited to no more than seven (7) hours (including testing and assessment). This test is limited to cases where there is a question of a neuropsychological deficit.
 2. Testing for intellectual level is limited to no more than two (2) hours for each test.
 3. Each self-administered test is limited to thirty (30) minutes.
 4. MaineCare limits reimbursement for psychometric testing to a total of four (4) hours.

90.04-6 Medical Imaging Services

Chapter II, Section 101, of the MaineCare Benefits Manual further details Medical Imaging Services. Medical Imaging Services are comprised of two parts, A) the professional component, and B) the administrative and technical component, and are reimbursed using a global fee unless standard modifiers are utilized to identify that only one component was provided. Providers must follow HCPCS and CPT guidelines for radiology using appropriate modifiers.

MaineCare does not reimburse for repeat x-ray examinations of the same body part for the same condition required because of technical or professional error in the original x rays.

90.04-7 Drugs Administered By Other Than Oral Method in the Office Setting

Drugs and biologicals must meet all the general requirements for coverage of items as incidental to a physician's services. MaineCare does not cover the dispensing of prescription and nonprescription drugs and biologicals to members.

To be reimbursable, a drug or biological must meet all of the following criteria:

1. The drug or biological cannot be self-administered;
2. It is not an immunization;
3. It is reasonable and necessary for the diagnosis or treatment of the illness or injury for which it is administered; and
4. It has not been determined by the Food and Drug Administration (FDA) to be less than effective.

Physicians must bill following the Department's billing instructions when billing for these injectables. Although drugs must have an assigned J-code to be eligible for reimbursement, providers must also indicate National Drug Code (NDC) codes on the claim in order to be reimbursed. MaineCare will not reimburse claims for injectables without both a valid J-code and NDC. Instructions for billing and a crosswalk of J-codes and NDC codes are available on the Office of MaineCare Services (OMS) website. Providers must bill acquisition cost only, excluding shipping and handling.

MaineCare covers orthopedic shoes when prescribed by a physician, but they may not be billed under physician services. The provision and billing of shoes must comply with the guidelines of MBM, Chapter II, Section 60, Medical Supplies and Durable Medical Equipment.

90.04-9 Computerized Axial Tomography (CAT) Scans

MaineCare reimburses CAT scans of the head and full body. Please refer to Chapter II, Section 101, of the MaineCare Benefits Manual, regarding requirements for Computerized Axial Tomography Scans.

90.04-10 Medical Supplies & Durable Medical Equipment

Providers may bill for those supplies needed in performing office procedures that are above and beyond what is usually used in a normal office visit. MaineCare reimburses acquisition cost only, excluding shipping and handling.

MaineCare reimburses for certain medical and durable medical equipment (e.g., essential prosthesis, braces, intermittent positive pressure breathing (IPPB) machines, oxygen, etc.) when prescribed. Physicians providing this equipment must inform members of their freedom of choice to obtain these items from other suppliers. MaineCare shall not reimburse physicians for both prescribing and supplying durable medical equipment to the same member unless the durable medical equipment is otherwise unobtainable or the item typically requires no maintenance or replacement during the period used by a member. If these circumstances do exist, reimbursement to the prescribing physician for also supplying an item shall be on the basis of the reasonable acquisition cost of the item to the physician.

Providers must maintain documentation of acquisition cost, including receipts and a copy of the original invoice, and make such documentation available to the Department upon request. Providers must also maintain documentation supporting the necessity of providing the supplies and/or equipment during the office visit. MaineCare shall not reimburse physicians for on-going medical supplies that are obtained through providers enrolled as Medical Supplies and Durable Medical Equipment Providers.

90.04-12 Reimbursement for Services of Interns, Residents, and Locum Tenens

MaineCare does not reimburse for services of interns and residents provided in a hospital or hospital affiliated facility or physician's office when the cost of the services of interns and residents is included in hospital reimbursement. Residents, locum tenens and temporaries must enroll as servicing providers under a physician's practice in order for their services to be reimbursed by MaineCare.

90.04-12 Insurance Coverage - Service Benefit

When a member is covered by insurance with a service benefit principle, the insurance payment is considered payment in full in accordance with the service benefit agreement between the physician and the insurance company. MaineCare should not be billed in such instances.

90.04-13 Mileage

Physicians may bill for mileage, one-way, beyond a ten (10) mile radius of point of origin (office or home). MaineCare does not reimburse mileage for trips to a hospital, nursing facility, ICF, or residential care facility where the physician is an active member of the medical staff or where the physician has ownership.

90.04-14 Preventive Services

MaineCare reimburses for preventive and routine physical examinations for children and adults. Physicians must complete the appropriate rider to the MaineCare Provider/Supplier Agreement to participate in preventive health services. Providers must also follow specific guidelines for preventive services.

MaineCare does not cover physical exams performed solely for the purpose of school, sports, disability benefits, life or health insurance coverage, Workers' Compensation, the Driver Education and Evaluation Program (DEEP), work, or any other reason not related to medical necessity.

Except when medically contra-indicated, immunization(s) must be given at time of examination(s) as appropriate for age and health history.

MaineCare covers the following preventive services:

A. Preventive Health: Children and Adults:

MaineCare reimburses certain preventive services when using the following guidelines:

1. For Children:

MaineCare covers initial, inter-periodic and periodic screening, diagnosis, and treatment services (formerly called EPSDT) for children and young adults up to the age of twenty-one (21) when performed in accordance with the Bright Futures Guidelines for Preventive Child Health Supervision. Physicians must complete a rider to the MaineCare Provider/ Supplier Agreement, perform exams according to these guidelines, and submit the completed Bright Futures Assessment Form. Physicians must also comply with Chapter II, Section 94, Prevention, Health Promotion, and Optional Treatment Services for Members Under Age twenty-one (21).

2. For Adults:
MaineCare covers initial and periodic comprehensive health histories and examinations for adults age twenty-one (21) and older. The frequency of routine physicals for adults must not exceed one time per twelve (12)-month period. Covered screening services include, but are not limited to, those recommended by the United States Preventive Service Task Force. Physicians should bill the preventive medicine evaluation and management procedure codes.

90.04-15 Physician Services for Children Under Age Twenty-one

MaineCare reimbursement is available for physician services provided to a child under age twenty-one (21) only when the provider meets at least one of the following criteria:

- A. Is board eligible or certified in family practice, pediatrics, or internal medicine by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or the appropriate approved specialty board of the American Osteopathic Association;
- B. Is employed by or affiliated with a federally qualified health center as defined in §1905(1)(2)(B) of the Act;
- C. Holds admitting privileges at a hospital participating in MaineCare;
- D. Is a member of the National Health Service Corps;
- E. Documents a current, formal consultation and referral arrangement with a pediatrician or family practitioner who has the certification described above in Section 90.04-15 (A) for purposes of specialized treatment and admission to a hospital; or
- F. Is an approved provider of services in a rural health center (RHC), ambulatory care clinic, or is otherwise approved as a provider under MBM, Chapter II, Section 94, Prevention, Health Promotion, and Optional Treatment Services for Members Under Age Twenty-one (21).

90.04-16 Services by Other Providers in Association with Physician Services

When employed in a physician's practice, services provided by the following professionals practicing within the scope of their certification and licensure are reimbursable:

- Advanced Practice Registered Nurse (APRN);
- Audiologist;
- Certified Clinical Nurse Specialist (CNS);
- Certified Nurse Midwife (CNM);
- Certified Nurse Practitioner (NP);
- Certified Registered Nurse Anesthetist (CRNA);
- Licensed Clinical Professional Counselor (LCPC);
- Licensed Clinical Social Worker (LCSW);
- Licensed Master Social Worker (LMSW);
- Licensed Professional Counselor (LPC);
- Nurse Practitioner (NP);
- Occupational Therapist (OT);
- Physician's Assistant (PA);
- Physical Therapist (PT);
- Registered Nurse First Assist (RNFA).

The following criteria must be met prior to reimbursement of these services:

- A. The servicing provider must be enrolled with MaineCare as a servicing provider within the physician's practice, and must bill in accordance with MaineCare and HCFA 1500 billing instructions;
- B. The servicing provider must be providing services within the scope of practice of his or her license;
- C. The servicing provider must be licensed to practice in accordance with current laws and regulations in the state or province in which he or she is practicing;
- D. The services must be provided under the delegation or supervision of a MaineCare enrolled physician licensed under state or provincial law to practice medicine or osteopathy. The responsible supervising physician shall be available at all times for consultation with all servicing providers identified in Section 90.04-17. MaineCare does not cover supervision of servicing providers. Consultation may occur in person, by telephone or by some other appropriate means consistent with instant communication.
Servicing providers must be an integral part of the physician's practice, and must be based within the setting/facility.
- E. Audiologists practicing under a physician's supervision and billing under physician's services are also subject to the provisions found in MBM Chapter II, Section 10, when billing in accordance with MBM, Chapter III, Section 90.
- F. When offering psychiatric services under the supervision of a physician, other qualified providers, as noted above, must be supervised by a physician who is specialized in the practice of psychiatry, as detailed in Section 90.04-5. Psychiatric services covered under this Section may be provided in an individual, family, or group setting.

90.04-17 **Interpreter Services**

Please see MBM Chapter 1, Section 1.06-3 for the requirements for Interpreter services.

90.04-18 **Team Conferences**

MaineCare covers face-to-face medical conferences by a physician or servicing provider with an interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care when the member is not present. MaineCare does not cover conferences between staff of the same clinic or agency or team conferences by telephone.

90.04-19 **Tobacco Cessation**

MaineCare covers the following services when they are performed under the direct care or supervision of a physician and in accordance with the following requirements: MaineCare covers counseling and treatment for tobacco dependence to educate and assist members with smoking cessation. Services may be provided in the form of brief individualized behavioral therapy, which must be documented in the medical record. Providers must educate members about the risks of smoking, the benefits of quitting and assess the member's willingness and readiness to quit. Providers should identify barriers to cessation, provide support, and use techniques to enhance motivation for each member. Providers may also use pharmacotherapy for those members for whom it is clinically appropriate and who are assessed as willing and ready to quit, or in the process of quitting. Providers may bill these services alone or in addition to other outpatient evaluation/management services provided on the same date of service. MaineCare only reimburses separately for these additional services when used for the express purpose of counseling and/or risk factor reduction directed at tobacco addiction, and only when used

in conjunction with an appropriate tobacco use disorder documented in the medical record. MaineCare limits covered services to three (3) sessions per member, per calendar year, per provider.

90.04-20 **Prescriptions**

Any prescriber who has an individual DEA number must use that identifier when writing prescriptions, rather than a number assigned to an institution.

90.04-21 **Independent Procedures**

Providers may not bill separately for services commonly carried out as an integral part of a total service (e.g.: dipstick urinalysis). However providers may bill separately for independent service not immediately related to other services.

90.04-22 **Consultation and Referral**

MaineCare distinguishes a consultation from a referral. A consultation includes services rendered by a physician whose opinion or advice is requested by another provider for the further evaluation and or management of the member.

If the consulting physician assumes responsibility for the continuing care of the member, any subsequent services rendered by this physician are not considered to be consultation. A referral is the transfer of the total or specific care of a member from one provider to another.

90.04-23 **Immunizations, Therapeutic Injections, and Hyposensitization**

When provided as part of an examination and/or treatment, MaineCare will reimburse for the services described below in addition to the office visit. However, when the only service provided is immunization, therapeutic injection, or hyposensitization the rate is all-inclusive.

- a. **Immunizations:** Immunization codes include both administration of and the immunological material. Providers should report the size of the dose administered when billing for immunizations. To be reimbursed for the immunological materials, providers must bill only the acquisition cost of the serum, excluding shipping and handling, plus the appropriate code for administration of the immunization. MaineCare does not cover documentation of immunizations. MaineCare only reimburses for the materials used for oral or intra-nasal immunizations, without an administration fee.
 1. **Vaccines Distributed by the State of Maine Center for Disease Control and Prevention (formerly Bureau of Health) Immunization Program:**
Providers should bill for administration of vaccines distributed by the Bureau of Health in accordance with Office of MaineCare Services billing instructions. Providers should direct any questions about the administration of State supplied vaccines to the Maine Center for Disease Control and Prevention.
 2. **Vaccines Not Distributed by the Maine Center for Disease Control and Prevention:**
When not supplied by the Maine Center for Disease Control and Prevention, providers should bill therapeutic injections and immunizations using the proper NDC code. The charged amount for the therapeutic and immunological material must reflect the acquisition cost of the material to the provider. Providers must keep copies of invoices in their files. Any vaccine that could be obtained by distribution from the Maine Center for Disease Control and Prevention is not reimbursable, e.g., Measles, Mumps and Rubella (MMR).
MaineCare will only reimburse the provider fee for the administration of such a vaccine.

- b. Therapeutic injections: Providers should consult MaineCare billing instructions to bill therapeutic injections using the proper code for the type of injection delivered. The charged amount for the therapeutic material must reflect the acquisition cost of the material to the provider.
- c. Hyposensitization: Hyposensitization codes include allergy sensitivity testing only; the allergenic extract is billed separately.

90.04-24 Prepaid Kits Purchased From the Maine Center for Disease Control and Prevention, Health and Environmental Testing Laboratory

The Maine Center for Disease Control and Prevention, Health and Environmental Testing Laboratory has specimen kits available for use in submitting certain specimens to the State laboratory for analysis. Providers must purchase these kits from the State laboratory. When a provider uses a kit to collect a specimen from a MaineCare member, providers should notify the State laboratory of the name and MaineCare ID number of the member for whom the kit was used. The State laboratory will then bill the kit to MaineCare. A replacement kit will be sent to the provider.

90.04-25 Surgical Services

a. General Information

Allowances for surgery include payment for the following (all-inclusive) services:

1. Pre-operative visits in the hospital;
2. The surgery itself (including anesthesia that is not regional or general); and
3. Normal follow-up care for thirty (30) days following the surgery, regardless of treatment setting.

b. Post-Operative Treatment

In most cases, MaineCare does not pay additionally for post-operative treatment.

Exceptions may be made under the following circumstances:

1. There are complications requiring additional or unusual services may be allowed. The claim will be manually reviewed.
2. The allowances for diagnostic procedures include the procedure and the follow-up care related to the recovery from the procedure itself. Care related to the condition diagnosed as a result of the procedure is not included and may be billed separately.

c. CPT Coding for Common Situations

MaineCare requires use of standard CPT codes and modifiers. Providers should consult current CPT and HCPCS publications for these modifiers. The following are examples of situations that often arise in regard to surgical procedures. Special CPT modifiers may be required for these situations:

1. Additional Surgical Procedures: When an additional surgical procedure is carried out within the thirty (30) day follow-up period for a previous surgery, the follow-up periods will continue concurrently to their normal termination. (e.g.: surgery done on 9/1/02, thirty (30) day follow-up period through 10/1/02; subsequent surgery done on 9/12/02, thirty (30) day follow-up period through 10/12/02.)
2. Incidental Procedures: Certain procedures are commonly carried out as an integral part of a total service and are not covered separately. When an incidental procedure (e.g. incidental appendectomy, lysis of adhesions, excision of scar, puncture of ovarian cyst) is performed through the same incision, the allowance will be for the major procedure only.
3. Independent Procedures: No allowance will be made for services listed in CPT coding as "independent procedures" when they are carried out as a part of a total service. However, when such a procedure is carried out as a separate entity, not

immediately related to other services, the procedure will be covered. (e.g.: cystoscopy in conjunction with bladder surgery does not warrant additional payment; cystoscopy in conjunction with hysterectomy is an independent procedure .)

4. Multiple Surgical Procedures: When multiple or bilateral surgical procedures are performed at the same operative setting and add significant time or complexity to patient care, the total reimbursement equals the allowance for the major procedure plus fifty percent (50%) of the allowance for the lesser procedure(s).
5. Assistance at Surgery: MaineCare will reimburse for a physician as a surgical assistant (including physician's assistants and Registered Nurse First Assistants) for major surgery at twenty percent (20%) of the surgical allowance. Providers should use the appropriate modifier code when reporting a surgical assist.
6. Co-Surgeons: When the skills of two (2) physicians are required to perform the procedure, providers may allocate the allowance according to the responsibility and work done. The physicians must make the Department aware of the allowance distribution.
7. Surgical Team: Allowances for surgery performed under the surgical team concept will be determined on a "By Report" basis.

90.04-26 Oral and TMJ Surgery Billed with CPT codes

Providers of oral and temporomandibular joint (TMJ) surgery must also comply with all applicable rules of MBM, Chapter II and III, Section 25, Dental Services, including but not limited to urgent care guidelines and prior authorization. All TMJ surgeries require prior authorization.

90.04-27 Chiropractic Services

Chiropractic services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 15, Chiropractic Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-28 Occupational Therapy Services

Occupational therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 68, Occupational Therapy Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-29 Physical Therapy Services

Physical therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 85, Physical Therapy Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-30 Speech Therapy Services

Speech therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 105, Speech and Hearing Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

Maine – Primary Care Physician Incentive Payment ⁶³

Primary Care Provider Incentive Payment

- The Primary Care Physician Incentive Payment (PCPIP) rewards physicians who have provided quality primary care to MaineCare members.

⁶³ Source: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s090.doc>

- Physicians receive scores in various categories such as the number of MaineCare patients, emergency room utilization and prevention/quality.
- Each physician's practices are compared to other physicians in his/her primary care specialty and then are given an overall ranking.
- Physicians ranking above the twentieth percentile will receive a monetary share of their specialty pool, based on percentile.
- The twentieth percentile and below do not receive a monetary share of their specialty pool.
- The following describes how the incentives are calculated:
 1. **Access** - Forty Percent (40%)
 - Total number of unduplicated MaineCare members served per quarter.
 - Total number of health care providers accepting new MaineCare members.
 2. **Utilization** – Thirty Percent (30%)
 - Emergency visit and/or hospitalization rate per quarter for physicians unduplicated MaineCare members per quarter.
 3. **Quality** - Thirty Percent (30%)
 - Preventive measures score higher.
 - Comparison of quality indicators (QI) among specialty groups.

Examples:

Childhood immunization - percentage of children in the practice immunized by age two against DPT, polio, measles/ mumps/rubella, type B influenza, and hepatitis B.

Adolescent immunization - percentage of adolescents in practice's children who have had following immunizations by age thirteen: second dose of measles/mumps/rubella, hepatitis B, tetanus/ diphtheria booster, and chicken pox.

Prenatal Care - percentage of women in practice who delivered a baby in previous year and received prenatal care in the first trimester.

Post-delivery checkup - percentage of mothers in practice who had a checkup within six weeks after delivery.

Mammography - percentage of women in practice ages fifty-two (52) to sixty-nine (69) who had a mammogram in previous year.

Pap test - percentage of women in practice ages twenty-one (21) to sixty-four (64) who had a pap test for cervical cancer in previous year.

Board certification - percentage of practice board certified in appropriate discipline.

The specific indicators utilized will be selected quarterly as necessary to obtain targeted quality of care evaluations. The same criteria shall be used among similar groups of physicians, i.e., family practitioners/general practitioners, internal medicine, pediatrics, etc.

4. **Member Satisfaction** (percent allocation to be determined in second year of physician assessment)
 - Percentage of members who change primary physician.
 - Percentage of members who report they are completely or very satisfied with their care.
5. **Determination of Physician Incentive Payments**
 - The elements described above will be the basis for placing each participating

MaineCare physician in an octal grouping as follows:

Group	Octal	Percentile	Payment Amount
Group 1 Percentile – 60% of Total Payment	Octal 1	90 – 100	Thirty percent (30%) of Group 1 payment
	Octal 2	80 – 89	Twenty percent (20%) of Group 1 payment
	Octal 3	70 – 79	Ten percent (10%) of Group 1 payment
Group 2 Percentile – 25% Of Total Payment	Octal 4	60 - 69	Ten percent (10%) of Group 2 payment
	Octal 5	50 - 59	Eight percent (8%) of Group 2 payment
	Octal 6	40 - 49	Seven percent (7%) of Group 2 payment
Group 3 Percentile – 15% Of Total Payment	Octal 7	30 - 39	Ten percent (10%) of Group 3 payment
	Octal 8	20 - 29	Five percent (5%) of Group 3 payment
-	-	0 - 19	No Payment

4. Massachusetts ⁶⁴

- The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for physician services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000, and is made at the lowest of the following:
 - (1) The physician's usual and customary fee;
 - (2) The physician's actual charge submitted; or
 - (3) The maximum allowable fee listed in the applicable DHCFP fee schedule, subject to any fee reductions enacted into law.

- The DHCFP fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:
 - (1) 114.3 CMR 16.00: Surgery and Related Anesthesia Care
 - (2) 114.3 CMR 17.00: Medical and Related Anesthesia Care
 - (3) 114.3 CMR 18.00: Radiology
 - (4) 114.3 CMR 20.00: Clinical Laboratory Services

433.404: Nonpayable Circumstances

(A) The MassHealth agency does not pay a physician for services provided under any of the following circumstances.

- (1) The services were provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.
- (2) The services were provided by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not

⁶⁴ MA rules found at:

http://www.mass.gov/?pageID=eohhs2terminal&L=6&LO=Home&L1=Government&L2=Laws%2C+Regulations+and+Policies&L3=MassHealth+Regulations+and+Other+Publications&L4=Provider+Library&L5=MassHealth+Provider+Manuals&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_manuals_pvman_physician&csid=Eeohhs2 (regs_physician.pdf), (Administrative and Billing Regulations, Subchapter Number and Title: 2. Administrative Regulations, Page: 2-22 All Provider Manuals, Transmittal Letter: ALL-154; Date: 04/01/03 (regs_allprovider.pdf)) and fees at

http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&LO=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_regs_related_pubs&csid=Eeohhs2#114_3_17;

legally responsible for the management of the member's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.

(3) The services were provided by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.

(4) The services were provided in a state institution by a state-employed physician or physician consultant.

(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The MassHealth agency does not pay a physician for performing, administering, or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the MassHealth agency will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(C) The MassHealth agency does not pay a physician for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

(D) The MassHealth agency does not pay a physician for otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 433.404.

433.405: Maximum Allowable Fees

(A) The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for physician services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000, and is made at the lowest of the following:

- (1) the physician's usual and customary fee;
- (2) the physician's actual charge submitted; or
- (3) the maximum allowable fee listed in the applicable DHCFP fee schedule, subject to any fee reductions enacted into law.

(B) The DHCFP fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:

- (1) 114.3 CMR 16.00: Surgery and Related Anesthesia Care
- (2) 114.3 CMR 17.00: Medical and Related Anesthesia Care
- (3) 114.3 CMR 18.00: Radiology
- (4) 114.3 CMR 20.00: Clinical Laboratory Services

433.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that the MassHealth agency will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The MassHealth agency does not pay claims for services requiring individual

consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. See 130 CMR 433.410 for report requirements.

(B) The MassHealth agency determines the appropriate payment for a service requiring individual consideration in accordance with the following standards and criteria:

- (1) the amount of time required to perform the service;
- (2) the degree of skill required to perform the service;
- (3) the severity and complexity of the member's disease, disorder, or disability;
- (4) any applicable relative-value studies;
- (5) any complications or other circumstances that the MassHealth agency deems relevant;
- (6) the policies, procedures, and practices of other third-party insurers;
- (7) the payment rate for drugs as set forth in the MassHealth pharmacy regulations at 130 CMR 406.000; and
- (8) for drugs or supplies, a copy of the invoice from the supplier showing the actual acquisition cost.

433.407: Service Limitations: Professional and Technical Components of Services and Procedures Additional limitations are set forth in 130 CMR 433.413 and 433.437.

(A) Definitions.

- (1) Mobile Site – any site other than the physician's office, but not including community health centers, hospital outpatient departments, or hospital-licensed health centers.
- (2) Professional Component – the component of a service or procedure representing the physician's work interpreting or performing the service or procedure.
- (3) Technical Component – the component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedure, excluding the physician's professional component.

(B) Payment. A physician may bill for the professional component of a service or procedure or, subject to the conditions of payment set forth in 130 CMR 433.407(C), both the professional and technical components of the service or procedure. The MassHealth agency does not pay a physician for providing the technical component only of a service or procedure.

(C) Conditions of Payment for the Provision of Both the Professional and Technical Components of a Service or Procedure. Only the physician providing the professional component of the service or procedure may bill for both the professional and technical components. This constitutes a limited exception to 130 CMR 450.301. A physician may bill for providing both the professional and technical components of a service or procedure in the physician's office when the physician owns or leases the equipment used to perform the service or procedure, provides the technical component (either directly or by employing a technician), and provides the professional component.

433.413: Office Visits: Service Limitations

(A) Time Limit. Payment for office visits is limited to one visit per day per member per physician.

(B) Office Visit and Treatment/Procedure. The physician may bill for either an office visit or a treatment/procedure, but may not bill for both an office visit and a treatment/procedure for the same member on the same date when the office visit and the treatment/procedure are performed in the same location. This limitation does not apply to tobacco cessation counseling services provided by a physician or a qualified staff member under the supervision of a physician on the same day as a visit.

This limitation does not apply to a treatment/procedure that is performed as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit (see 130 CMR

450.140 et seq.); in such a case, the physician may bill for both an EPSDT visit and a treatment/procedure. Examples of treatment/procedures are suturing, suture removal, aspiration of a joint, and cast application or removal. X rays, laboratory tests, and certain diagnostic tests may be billed in addition to an office visit.

(C) Immunization or Injection. When an immunization or injection is the primary purpose of an office or other outpatient visit, the physician may bill only for the injectable material and its administration. However, when the immunization or injection is not the primary purpose of the office or other outpatient visit, a physician may bill for both the visit and the injectable material, but not for its administration. (See 130 CMR 433.440 on drugs dispensed in a physician's office.) The MassHealth agency does not pay for the cost of the injectable material if:

- (1) the Massachusetts Department of Public Health distributes the injectable material free of charge; or
- (2) its cost to the physician is \$1.00 or less.

(D) Family Planning Office Visits. The MassHealth agency pays for office visits provided for the purposes of family planning. The MassHealth agency pays for any family planning supplies and medications dispensed by the physician at the physician's acquisition cost. To receive payment for the supplies and medications, the provider must attach to the claim a copy of the actual invoice from the supplier.

433.414: Hospital Emergency Department and Outpatient Department Visits

(A) Emergency Department Treatment. The MassHealth agency pays a physician for medical care provided in a hospital emergency department only when the hospital's claim does not include a charge for the physician's services.

(B) Emergency Department Screening Fee. For a member enrolled in the PCC Plan for whom no emergency services were provided, The MassHealth agency pays the hospital-emergency-department physician a screening fee for assessing the level of care required by the member's condition when:

- (1) the level of care is determined to be primary care; or
- (2) the level of care is determined to be urgent and the member's PCC denies a referral between the hours of 8:00 A.M. and 9:59 P.M.

(C) Outpatient Department Visits. The MassHealth agency pays either a physician or a hospital outpatient department, but not both, for physician services provided in an outpatient department.

433.415: Hospital Services: Service Limitations and Screening Requirements

(A) Hospital inpatient visit fees apply to visits by physicians to members hospitalized in acute, chronic, or rehabilitation hospitals. Payment is limited to one visit per day per member for the length of the member's hospitalization.

(B) The MassHealth agency does not routinely pay for visits to members who have undergone or who are expected to undergo surgery, since the allowable surgical fees include payment for the provision of routine inpatient preoperative and postoperative care. In unusual circumstances, however, the MassHealth agency does pay for such visits.

(C) The MassHealth agency pays only the attending physician for hospital visits, with the following exceptions.

- (1) The MassHealth agency pays for consultations by a physician other than the attending physician. (See 130 CMR 433.418 for regulations about consultations.)
- (2) If it is necessary for a physician other than the attending physician to treat a hospitalized member, the other physician's services are payable. An explanation of the necessity of such visits must be attached to the claim. The MassHealth agency will review the claim and determine appropriate payment to the other physician.

433.416: Nursing Facility Visits: Service Limitations

(A) Requirement for Approval of Admission. The MassHealth agency seeks to ensure that a MassHealth member receives nursing facility services only when available alternatives (see 130 CMR 433.476 through 433.483) do not meet the member's need, and that every member receiving nursing facility services is placed appropriately according to the medical eligibility criteria, in accordance with 130 CMR 456.409 through 456.411.

(B) Service Limitations. Payment for a visit by a physician to members in nursing facilities or rest homes is limited to one visit per member per month, except in an emergency. Any medically necessary care required for the follow-up of a condition during the month must be billed as subsequent nursing facility care.

433.417: Home Visits: Service Limitations

Payment for a visit by a physician to a member's home is limited to one visit per member per day. (For information on additional home health services covered by MassHealth, see 130 CMR 433.478.)

433.418: Consultations: Service Limitations

The MassHealth agency pays for only one initial consultation per member per case episode. Additional consultation visits per episode are payable as follow-up consultations.

433.419: Nurse Midwife Services

(A) General. 130 CMR 433.419 applies specifically to nurse midwives. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to nurse midwives, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements.

(B) Conditions of Payment. The MassHealth agency pays either an independent nurse midwife (in accordance with 130 CMR 433.419(C)) or the physician employer of a nonindependent nurse midwife (in accordance with 130 CMR 433.419(D)) for nurse midwife services provided by a nurse midwife when:

- (1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR 4.00);
- (2) the nurse midwife has a current license to practice as a nurse midwife in Massachusetts from the Massachusetts Board of Registration in Nursing; and
- (3) the nurse midwife has a current collaborative arrangement with a physician or group of physicians, as required by state law or regulation (including but not limited to 244 CMR 4.00 and 130 CMR 433.419(C)(2)). The MassHealth agency deems this requirement to be met for nonindependent nurse midwives employed by a physician.

(C) Independent Nurse Midwife Provider Eligibility.

(1) Submission Requirements. Only an independent nurse midwife may enroll in MassHealth as a provider. Any nurse midwife applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she is:

- (a) a member of a group practice comprising physicians and other practitioners and is compensated by the group practice in the same manner as the physicians and other practitioners in the group practice;
- (b) a member of a group practice that solely comprises nurse midwives; or
- (c) in a solo private practice.

(2) Collaborative Arrangement Requirements. The independent nurse midwife's collaborating physician must be a MassHealth provider who engages in the same type of clinical practice as the nurse midwife. The nurse midwife must practice in accordance

with written guidelines developed in conjunction with the collaborating physician as set forth in 244 CMR 4.00. The nurse midwife must submit to the MassHealth agency thorough documentation of the collaborative arrangement, including guidelines and any written agreement signed by the nurse midwife and the collaborating physician or physicians. The guidelines must specify:

- (a) the services the nurse midwife is authorized to perform under the collaborative arrangement; and
- (b) the established procedures for common medical problems.

(3) Consultation Between Independent Nurse Midwife and Collaborating Physician. The MassHealth agency does not pay for a consultation between an independent nurse midwife and a collaborating physician as a separate service.

(D) Submitting Claims for Nonindependent Nurse Midwives. Any nurse midwife who does not meet the requirements of 130 CMR 433.419(C) is a nonindependent nurse midwife and is not eligible to enroll as a MassHealth provider. As an exception to 130 CMR 450.301, an individual physician (who is neither practicing as a professional corporation nor is a member of a group practice) who employs a nonindependent nurse midwife may submit claims for services provided by a nonindependent nurse midwife employee, but only if such services are provided in accordance with 130 CMR 433.419(B), and payment is claimed in accordance with 130 CMR 450.301(B).

433.420: Obstetric Services: Introduction

The MassHealth agency offers two methods of payment for obstetric services: the fee-for-service method and the global-fee method. Fee for service requires submission of claims for services as they are performed and is available to a provider for all covered obstetric services. The global fee is available only when the conditions specified in 130 CMR 433.421 are met.

433.421: Obstetric Services: Global-Fee Method of Payment

(A) Definition of Global Fee. The global fee is a single inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The global fee is available only when the conditions in 130 CMR 433.421 are met.

(B) Conditions for Global Fee.

(1) Primary Provider. A physician or independent nurse midwife who assumes responsibility for performing or coordinating a minimum of six prenatal visits, the delivery, and postpartum care for the member is the primary provider. In a group practice or when a back-up physician is involved, the primary provider is not required to perform all the components of a global delivery directly. Another member of the practice or a back-up physician can perform services; he or she is a referred provider. Only providers in the same group practice or back-up physicians are considered referred providers.

(2) Payment to Primary Provider. Only the primary provider may claim payment of the global fee. A physician who is a primary provider may claim payment of the global fee for the obstetric services provided by a nurse, nurse practitioner, nurse midwife, or physician assistant employed by the physician. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).) All global-fee claims must use the delivery date as the date of service.

(3) Standards of Practice. All of the components of a global fee must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.

(4) Coordinated Medical Management. The physician and nurse, nurse practitioner, nurse midwife, or physician assistant employed by the physician, or an independent nurse midwife must provide referral to and coordination of the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:

- (a) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;
 - (b) coordination of medical management with necessary referral to other medical specialties and dental services; and
 - (c) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.
- (5) Health-Care Counseling. In conjunction with providing prenatal care, the physician and nurse, nurse practitioner, physician assistant, or nurse midwife employed by the physician, or the independent nurse midwife must provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:
- (a) EPSDT screening for teenage pregnant women;
 - (b) smoking and substance abuse;
 - (c) hygiene and nutrition during pregnancy;
 - (d) care of breasts and plans for infant feeding;
 - (e) obstetrical anesthesia and analgesia;
 - (f) the physiology of labor and the delivery process, including detection of signs of early labor;
 - (g) plans for transportation to the hospital;
 - (h) plans for assistance in the home during the postpartum period;
 - (i) plans for pediatric care for the infant; and
 - (j) family planning.
- (6) Obstetrical-Risk Assessment and Monitoring. The physician and nurse, nurse practitioner, physician assistant, or nurse midwife employed by the physician, or the independent nurse midwife must manage the member's obstetrical-risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services are paid separately and should be billed for on a fee-for-service basis. Such services may include, but are not limited to, the following:
- (a) counseling specific to high-risk patients (for example, antepartum genetic counseling);
 - (b) evaluation and testing (for example, amniocentesis); and
 - (c) specialized care (for example, treatment of premature labor).
- (C) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same member, the following conditions apply.
- (1) The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and postpartum care) are provided directly by the primary provider, by a nurse, nurse practitioner, nurse midwife, or physician assistant employed by the physician, or by a referred provider, that is, a member of the same group practice or a back-up physician. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).)
 - (2) If the primary provider bills for the global fee, no referred provider may claim payment from the MassHealth agency. Payment of the global fee constitutes payment in full both to the primary provider and each referred provider.
 - (3) If the primary provider bills for the global fee, any provider who is not a referred provider but who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no other provider may claim payment for the delivery.
 - (4) If the primary provider bills on a fee-for-service basis, any other provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services provided to the same member.

(D) Recordkeeping for Global Fee. The primary provider is responsible for documenting, in accordance with 130 CMR 433.409, all the service components of a global fee. This includes services performed by referred providers or employees of the primary provider. All hospital and ambulatory services, including risk assessment and medical visits, must be clearly documented in each member's record in a way that allows for easy review of her obstetrical history.

(130 CMR 433.422 and 433.423 Reserved)

433.424: Obstetric Services: Fee-for-Service Method of Payment

The fee-for-service method of payment is always available to a provider for obstetric services covered by the MassHealth agency. If the global-fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the MassHealth agency only on a fee-for-service basis, as specified below.

(A) When there is no primary provider for the obstetric services performed for the member, each provider may claim payment only on a fee-for-service basis.

(B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.

(C) When an independent nurse midwife is the primary provider and the collaborating physician performs a cesarean section, the independent nurse midwife may claim payment for the prenatal visits only on a fee-for-service basis. The collaborating physician may claim payment for the cesarean section only on a fee-for-service basis.

(D) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services

The MassHealth agency pays for ophthalmic materials in accordance with the vision care regulations at 130 CMR 402.000. The MassHealth agency pays for eye examinations subject to the following limitations.

(A) Comprehensive Eye Examinations.

(1) The MassHealth agency does not pay for a comprehensive eye examination if the service has been provided

(a) within the preceding 12 months, for a member under 21 years of age; or

(b) within the preceding 24 months, for a member 21 years of age or older.

(2) The restrictions at 130 CMR 433.425(A)(1) do not apply if one of the following complaints or conditions is documented in the member's medical record:

(a) blurred vision;

(b) evidence of headaches;

(c) systemic diseases, such as diabetes, hyperthyroidism, or HIV;

(d) cataracts;

(e) pain;

(f) redness; or

(g) infection.

(B) Consultation Service. The MassHealth agency pays for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) Screening Services. The MassHealth agency does not pay for a screening service if two screening services have been furnished to the member within the preceding 12 months.

(D) Comprehensive Eye Examinations and Screening Services. A comprehensive eye examination includes a screening service. If the provider performs both a screening

service and a comprehensive eye examination for the same member, the MassHealth agency pays for only the comprehensive eye exam.

(E) Tonometry. The MassHealth agency does not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, consultation, or screening service. When a tonometry is performed as a separate service to monitor a member who has glaucoma, the provider must use the appropriate service code.

433.431: Physical Medicine: Service Limitations

(A) The services listed in 130 CMR 433.431 are payable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician, subject to all general conditions of payment, including the requirement to obtain prior authorization as described in 130 CMR 433.408.

(B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are covered by MassHealth upon referral by a physician (see 130 CMR 433.471).

(C)

(1) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 433.431(C)(2).

(2) In certain instances, the specialized knowledge and judgment of a licensed physician or licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed physician or a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed physician or licensed therapist, rather than a nonphysician or non-therapist, must be documented in the medical record.

433.432: Other Medical Procedures

(A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed in addition to an office visit.

(B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure.

(C) Pulmonary Procedures. Fees for pulmonary procedures include payment for laboratory procedures, interpretations, and physician's services. These services may be billed in addition to an office visit.

(D) Dermatological Special Procedures. These services may be billed in addition to an office visit.

(E) Unlisted Procedures. Providers may bill for unlisted procedures only if there is no "Not otherwise classified" code.

433.434: Physician Assistant Services

(A) General. 130 CMR 433.434 applies specifically to physician assistants. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to physician assistants, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements. Services provided by a physician assistant must be limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.00).

(B) Conditions of Payment. The MassHealth agency pays the physician employer of a physician assistant (in accordance with 130 CMR 433.434(E)) for services provided by a physician assistant when the:

- (1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.05);
- (2) physician assistant has a current license or certificate of registration from the Massachusetts Board of Registration of Physician Assistants. Services provided by a physician assistant who possesses only a temporary license to practice, who has failed the certifying examination, or whose license has expired or is suspended are not payable; and
- (3) services are provided pursuant to a formal supervisory arrangement with a physician, as further described under 130 CMR 433.434(C).

(C) Supervisory Arrangement Requirements.

(1) The services of a physician assistant must be performed under the supervision of a physician. For purposes of 130 CMR 433.434, "supervision" or "supervise" means that the supervising physician is principally responsible for all medical decisions relating to physician assistant services and is either:

- (a) immediately available to the physician assistant in person or by means of a communication device; or
- (b) in actual physical attendance at and during the provision of those physician assistant services identified in written guidelines as requiring the physician's physical presence. (See 130 CMR 433.434(C)(3).)

(2) The physician assistant's supervising physician must be a MassHealth provider who engages in the same type of clinical practice as the physician assistant. Such supervising physician must be the physician assistant's employer or a physician member of the physician assistant's employer group. (See 130 CMR 433.434(E).)

(3) The physician assistant must practice in accordance with written guidelines developed in conjunction with the supervising physician as set forth in 263 CMR 5.04. The guidelines must specify:

- (a) what services the physician assistant can perform;
- (b) the established procedures for common medical problems; and
- (c) those services for which the supervising physician must be physically present.

(4) The physician assistant's supervising physician must designate another licensed physician to provide temporary supervision in circumstances where the supervising physician is unavailable. Such designated physician must be a MassHealth provider who engages in the same type of clinical practice as the supervising physician. The name of such physician must be documented in the member's records.

(5) The physician assistant's supervising physician is, in all cases, responsible for ensuring that each task performed by a physician assistant is properly supervised, even under circumstances involving temporary supervision by another physician pursuant to 130 CMR 433.434(C)(2).

(6) A supervising physician may not supervise more than the number of physician assistants allowed in 263 CMR 5.00.

(D) Nonpayable Services.

(1) Physician supervision of or consultation with a physician assistant is not payable as a separate service.

(2) The MassHealth agency does not pay for surgical assistance provided by a physician assistant.

(E) Submitting Claims for Physician Assistants. A physician assistant is not eligible to enroll as a MassHealth provider. As an exception to 130 CMR 450.301(A), a physician or group practice who is an employer of a physician assistant may submit claims for services provided by a physician assistant employee but only if such services are provided in accordance with 130 CMR 433.434, and payment is claimed in accordance with 130 CMR 450.301(B).

433.436: Radiology Services: Introduction

The MassHealth agency pays for radiology services only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Services Provided by an Independent Diagnostic Testing Facility (IDTF). The MassHealth agency pays an IDTF as defined in 130 CMR 433.401 for applicable diagnostic tests in accordance with the independent diagnostic testing facility regulations at 130 CMR 431.000.

(B) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X rays must be labeled adequately with the following:

- (1) the member's name;
- (2) the date of the examination;
- (3) the nature of the examination; and
- (4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays physicians in accordance with the DHCFP fee schedule. The MassHealth agency does not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the MassHealth agency does pay a physician for interpreting an X ray that was previously read and taken in a different hospital.

(B) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays the physician in accordance with the DHCFP fee schedule.

(C) Surgical Introductions and Interpretations. The MassHealth agency pays a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

- (1) Only one surgical introduction per operative session is payable in accordance with the DHCFP fee schedule.
- (2) In a single operative session:
 - (a) no more than three additional surgical introductions using the same puncture site are payable, each in accordance with the DHCFP fee schedule; and
 - (b) no more than three additional selective vascular studies using the same puncture site are payable, each at the maximum allowable fee.
- (3) Interpretations are payable in accordance with the DHCFP fee schedule, up to a maximum of three.

(D) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a member by one or more physicians are payable only if sufficient documentation for each is shown in the member's medical record.

(E) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component is divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a member are payable under MassHealth.

(A) Provider Eligibility. The MassHealth agency pays for laboratory tests only when they are performed on a member by a physician or by an independent clinical laboratory certified by Medicare.

(B) Payment.

(1) Except for the circumstance described in 130 CMR 433.438(B)(2), the MassHealth agency pays a physician only for laboratory tests performed in the physician's office. If a physician uses the services of an independent clinical laboratory, the MassHealth agency pays only the laboratory for services provided for a member.

(2) A physician may bill the MassHealth agency for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(C) Information with Specimen. A physician who sends a specimen to an independent clinical laboratory participating in MassHealth must also send the following:

- (1) a signed request for the laboratory services to be performed;
- (2) the member's MassHealth identification number; and
- (3) the physician's name, address, and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The MassHealth agency does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the MassHealth agency will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per member specimen, regardless of the number of tests to be performed on that specimen.

(B) Professional Component of Laboratory Services. The MassHealth agency does not pay a physician for the professional component of a clinical laboratory service. The MassHealth agency pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The MassHealth agency does not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. Payment for laboratory services includes payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the physician performing the tests.

(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(E) Forensic Services. The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438, including but not limited to:

- (1) tests performed to establish paternity;
- (2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and
- (3) post-mortem examinations.

(130 CMR 433.440 Reserved)

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency will pay a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(D)(1) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for:

- (1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment. This specifically includes, but is not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries.
- (2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).
- (3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of physical disease or defect, or traumatic injury.
- (4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable.
- (5) services otherwise identified in the MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable.
- (6) otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

433.452: Surgery Services: Payment

The maximum allowable fees for the surgery services apply to surgery procedures performed in any setting. The MassHealth agency pays a physician for either a visit or a treatment/procedure, whichever commands a higher fee. The MassHealth agency does not pay for both a visit and a treatment/procedure provided to a member on the same day when they are performed in the same location. All maximum allowable fees for surgery procedures include payment for the initial application of casts, traction devices, or similar appliances.

(A) Obstetrics. Obstetric fees include payment for procedures performed and care given to a member in a hospital or at home. However, the MassHealth agency will give individual consideration to a claim for extended obstetric preoperative or postoperative care due to unusual circumstances, if the physician requests it and attaches adequate medical documentation to the claim form.

(B) Inpatient Services.

- (1) For surgery procedures performed on an inpatient in a licensed hospital, the fees include payment for preoperative diagnosis and postoperative care during the period of hospitalization.
- (2) The MassHealth agency will give individual consideration to a claim for extended preoperative or postoperative care due to unusual circumstances if the physician requests it and attaches adequate medical documentation to the claim form.
- (3) A physician who performs an inpatient surgery procedure but does not provide the postoperative care will be paid 85 percent of the maximum allowable fee. The physician

providing the postoperative care will be paid according to the applicable office, hospital, or home visit fee.

(C) Surgical Assistants. The MassHealth agency pays a surgical assistant at 15 percent of the allowable fee for the surgical procedure. The MassHealth agency will not pay for a surgical assistant if a surgical assistant is used in less than five percent of the cases for that procedure nationally. In addition, the MassHealth agency will not pay for a surgical assistant if:

- (1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 433.452(D) or a two-surgeon modifier pursuant to 130 CMR 433.452(E); or
- (2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure(s) and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency will pay for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery.

(D) Team Surgery. Under some circumstances, the MassHealth agency pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery." The MassHealth agency pays a single consolidated payment for team surgery to the director of the surgical team. To receive payment, the director of the team must use the team surgery modifier. Payment includes all surgical assistant fees. The director of the surgical team is expected to distribute the MassHealth payment to the other physician members of the surgical team.

(E) Two Surgeons (Co-Surgery). The MassHealth agency pays for co-surgery when two surgeons work together as primary surgeons performing distinct parts of a reportable procedure. To receive payment, each surgeon must use the two surgeons modifier. The MassHealth agency pays 57.5 percent of the allowable fee to each of the two surgeons. Payment includes all surgical assistant fees.

(F) Multiple Procedures. In most circumstances, the MassHealth agency will pay for only one operative procedure in a single operative session. For example, it is inappropriate to request payment for both an exploratory laparotomy and an appendectomy, or for both an arthrotomy and a meniscectomy. When two definitive procedures are performed during the same operative session, and neither procedure is designated "I.P." (for independent procedure) (see 130 CMR 433.452(G)), the full maximum allowable fee will be paid for one procedure, and 50 percent of the maximum allowable fee will be paid for each additional procedure.

(G) Independent Procedures. A number of surgery procedures are designated "I.P." in Subchapter 6 of the *Physician Manual*. I.P. is an abbreviation for independent procedure. An independent procedure is reimbursable only when no other procedure is performed during the same operative session, unless one of the exceptions in 130 CMR 433.452(G)(1) through (3) applies.

(1) When during the same operative session an additional surgery procedure performed by the same physician is designated "I.P." and requires an unrelated operative incision, the full maximum allowable fee will be paid for the procedure with the largest fee, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein. In the event that two or more procedures are scheduled at the largest amount, the full maximum allowable fee will be paid for only one of the procedures, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein.

(2) When during the same operative session one or more of the surgery procedures performed by the same physician is designated "I.P." and does not require an unrelated operative incision, the maximum allowable fee will be paid for the procedure commanding the largest fee, and no payment will be made for any other procedure.

(3) When during the same operative session all of the surgery procedures performed by the same physician are designated "I.P." and one or more requires an unrelated operative incision, payment is determined on the basis of individual consideration.
(130 CMR 433.453 Reserved)

450.232: Rates of Payment to In-State Providers

Payment to all providers is made in accordance with the payment methodology applicable to the provider, subject to federal payment limitations. Without limiting the generality of the foregoing, payment to a Massachusetts in-state noninstitutional provider for any medical services payable under MassHealth is made in accordance with the applicable payment methodology established by DHCFP, or the Division, subject to any applicable federal payment limit (see 42 CFR 447.304).

450.233: Rates of Payment to Out-of-State Providers

(A) Payment to an out-of-state institutional provider for any medical service payable under MassHealth is made by the Division at the lesser of:

- (1) the rate of payment established for the medical service under the other state's Medicaid program;
- (2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or
- (3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider must submit to the Division a copy of the applicable rate schedule under its state's Medicaid program.

(C) Payment to an out-of-state noninstitutional provider for any medical service payable under MassHealth is made in accordance with the applicable fee schedule established by DHCFP or the Division, subject to any applicable federal payment limit (see 42 CFR 447.304).

(130 CMR 450.234 Reserved)

16.03: General Rate Provisions

(1) Rate Determination. Rates of payment to which 114.3 CMR 16.00 applies shall be the lowest of:

- (a) The eligible provider's usual fee to patients other than publicly-aided patients; or
- (b) The eligible provider's actual charge submitted; or
- (c) The schedule of allowable fees set forth in 114.3 CMR 16.04 and 16.05 in accordance with 114.3 CMR 16.03.

(2) Supplemental Payment

(a) Eligibility. An eligible provider may receive a supplemental payment for services to publicly aided individuals eligible under Titles XIX and XXI of the Social Security Act if the following conditions are met:

- 1. the eligible provider is employed by a non-profit group practice that was established in accordance with St.1997 c.163 and is affiliated with a Commonwealth-owned medical school;
- 2. such non-profit group practice shall have been established on or before January 1, 2000 in order to support the purposes of a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school; and
- 3. the services are provided at a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school.

(b) Payment Method. This supplemental payment may not exceed the difference between:

1. payments to the eligible provider made pursuant to the rates applicable under 114.3 CMR 16.03(1), and
 2. the Federal upper payment limit set forth in 42 CFR 447.325.
- (3) Rate Variations Base on Practice Site. Payments for certain services that can be routinely furnished in physicians' offices are reduced when such services are furnished in facility settings. 114.3 CMR 16.05 establishes facility setting fees applied to services rendered in a facility when a practice site differential is warranted.
- (4) Allowable Mid-Level Fee for Qualified Mid-Level Practitioners. Payments for services provided by eligible licensed nurse practitioners, eligible licensed nurse midwives and eligible licensed physician assistants as specified in 114.3 CMR 16.02 shall be 85% of the fees contained in 114.3 CMR 16.00.
- (5) Preoperative and Postoperative Care. All allowable fees are maximum amounts to be paid and apply primarily to services rendered to registered bed patients in licensed hospitals and freestanding ambulatory surgical centers. The maximum allowable fees for surgical services include the following: routine preoperative care; the operation *per se*, including local infiltration, metacarpal/digital block or topical anesthesia when used, and the normal, uncomplicated follow-up care. This concept is referred to as a "package" for surgical procedures.
- (6) Obstetrical Services. Obstetrical fees contained in 114.3 CMR 16.05 are intended to include only the procedure or procedures performed and care to the publicly-aided patient while hospitalized with the exception of global delivery (59400, 59510, 59610, 59618). Outpatient antepartum and postpartum obstetrical care may be billed under the appropriate medical procedure code in accordance with 114.3 CMR 17.00 *Medicine*. Medical problems complicating labor and delivery management or medical complications of pregnancy may require additional resources or services and should be identified by utilizing the appropriate procedure codes in 114.3 CMR 17.00 in addition to the procedure codes for maternity care listed herein.
- (7) Casts and Appliances. All maximum allowable fees include the initial application of a cast, traction device or similar appliance.
- (8) Individual Consideration. See description under 16.02: *General Definitions*.
- (9) CPT Category III Codes. All surgery related CPT category III codes are included as a part of this regulation and have an assigned fee of IC.
- (10) PCC Plan Enhanced Fee. Primary Care Clinicians (PCCs) receive an enhanced rate for certain types of primary and preventive care visits provided to their PCC Plan members. The \$10.00 enhanced fee is added to the procedure code billed. The MassHealth agency pays PCCs an enhanced fee for primary care services, in accordance with the terms of the PCC provider contract.

16.05: Maximum Allowable Fees - Surgical Services

- (1) Surgical and Obstetrical Services. The allowable fees for surgical and obstetrical services shall be the fees listed in 114.3 CMR 16.05(4).
- (2) Unless otherwise specified, guidelines, notes and definitions provided in the 2007 CPT coding Handbook are applicable to the use of the procedure codes and descriptions listed below.
- (3) Modifiers
 - 26: Professional Component. The component of a service or procedure representing the physicians' work interpreting or performing the service or procedure. When the physician component is reported separately, the addition of the modifier '-26' to the procedure code will allow the professional component allowable fee (PC Fee) contained in 114.3 CMR 16.05(4) to be paid.

-50: Bilateral Procedures. Unless otherwise identified in the procedure code listing, Bilateral procedures performed at the same operative session must be identified by the appropriate service code describing the first procedure. The second bilateral procedure is identified by adding the modifier '-50' to the end of the service code. The addition of the modifier '-50' to the second bilateral codes allows 50% of the allowable fee contained in 114.3 CMR 16.05(4) to be paid to the eligible provider for the second bilateral procedure.

-51: Multiple Procedures. This modifier must be used to report multiple procedures performed at the same session. The service code for the major procedure or service must be reported without a modifier. The secondary, additional or lesser procedure(s) must be identified by adding the modifier '- 51' to the end of the service code for the secondary procedure(s). The addition of the modifier '-51' to the second and subsequent procedure codes allows 50% of the allowable fee contained in 114.3 CMR 16.05(4) to be paid to the eligible provider.

NOTE: This modifier should not be used with designated "add-on" codes or with codes in which the narrative begins with "each additional".

-52: Reduced Services. Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier '- 52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

-54: Pertains to surgical care only. When one eligible physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier '- 54' to the appropriate procedure code. This allows 85% of the allowable fee contained in 114.3 CMR 16.05(4) to be paid to the physician performing the surgery.

-55: Pertains to postoperative management only. When one eligible physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier '-55' to the appropriate procedure code. This allows 15% of the allowable fee contained in 114.3 CMR 16.05(4) to be paid to the physician.

-59: Distinct Procedural Service. To identify a procedure distinct or independent from other services performed on the same day add the modifier '-59' to the end of the appropriate service code. Modifier '-59' is used to identify services/procedures that are not normally reported together, but are appropriate under certain circumstances, for example, different site or organ system. However when another already established modifier is appropriate it should be used rather than modifier '-59'.

-62: Pertains to two surgeons. When two eligible surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier '-62' to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the procedure once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate codes(s) may also be reported with the modifier "-62" added. The addition of the modifier '-62' to the procedure code allows 57.5% of the allowable fee contained in 114.3 CMR 16.05(4) to be paid to each surgeon. No separate payment will be made for assisting surgical services in these cases; it is included in the total surgical fee listed.

-66: Pertains to team surgery. This modifier must be used to identify highly complex procedures (requiring the concomitant services of several eligible physicians, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment) carried out under the "surgical team" concept. The unit fee is payable to the "director" of the surgical team and includes all assistant surgeon fees, there are no

separate payments for assisting surgical services. The director of the surgical team is expected to distribute the unit fee to the eligible members of the surgical team.

-76: Repeat Procedure by Same Physician. The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier '-76' to the repeated procedure/service or the separate five digit modifier code 09976 may be used.

-77: Repeat Procedure by Another Physician. The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier '-77' to the repeated procedure/service or the separate five digit modifier code 09977 may be used.

-78: Return to the Operating Room for a Related Procedure during the Postoperative period. The physician may need to indicate that another procedure was performed during that postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier '-78' to the related procedure, or by using the separate five digit modifier 09978. (For repeat procedures on the same day, see '-76'.)

-79: Unrelated Procedure or Service by the Same Physician during the Postoperative Period. The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier '-79' or by using the separate five digit modifier 09979. (For repeat procedures on the same day, see '-76'.)

-80: Pertains to assistant surgeons. Surgical assistant services may be identified by adding the modifier '-80' to the usual procedure code. This allows 15% of the allowable fee contained in 114.3 CMR 16.05(4) to be paid to the eligible assistant surgeon.

-82: Pertains to assistant surgeons when qualified resident surgeon not available. Surgical assistant services may be identified by adding modifier '-82' to the usual procedure code when a qualified resident surgeon is not available. This allows 15% of the allowable fee contained in 114.3 CMR 16.05(4) to be paid to the eligible assistant surgeon.

-HN: Bachelor's Degree Level. (Use to indicate Physician Assistant) (This modifier is to be applied to service codes billed by a physician which were performed by a physician assistant employed by the physician or group practice.)

-SA: Nurse Practitioner rendering service in collaboration with a physician. (This modifier is to be applied to service codes billed by a physician which were performed by a non-independent nurse practitioner employed by the physician or group practice.) (An independent nurse practitioner billing under his/her own individual provider number should not use this modifier.)

-SB: Nurse Midwife. (This modifier is to be applied to service codes billed by a physician which were performed by a non-independent nurse midwife employed by the physician or group practice.) (An independent nurse midwife billing under his/her own individual provider number should not use this modifier.)

-TC: Technical Component. The component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedures, excluding the physician's professional component.

When the technical component is reported separately the addition of modifier '-TC' to the procedure code will allow the technical component allowable fee (TC Fee) contained in 114.3 CMR 16.05(4) to be paid.

5. New Hampshire ⁶⁵

Reimbursement guidelines for physician services in New Hampshire vary by procedure, but most are included on the NH Medicaid fee schedule.

A. AMBULATORY VISITS

Ambulatory visits are services performed anywhere other than the inpatient hospital environment and are limited to eighteen (18) visits per person per State fiscal year (July 1 through June 30). Exception to the service limitation exists for recipients under the age of 21, recipients enrolled in special federally approved waiver programs and recipients in a nursing facility. A visit is defined as all physician services provided in one day to one recipient by one physician. However, if a physician sees one recipient twice in the same day it is considered two visits. A visit does not include laboratory tests or diagnostic X-rays, these should be billed as a separate detail. Physician services do include outpatient hospital visits, home visits and office visits. The appropriate procedure codes for billing are listed in the Physicians' Current Procedural Terminology (CPT) book.

E. INJECTIONS

NH Medicaid reimburses for the administration of injections when provided as part of an examination and/or treatment in accordance with the following guidelines:

1. HCPCS Codes J0110 - J7350 include the administration cost as well as the cost of the drug. In this case, injections may be billed separately or in conjunction with an office visit.

NOTE: Immunizations, allergies, allergy testing, etc. are billed according to HCPCS codes for the complete service. These services will be reimbursed at a global fee.

2. HCPCS Codes J9000 - J9900 include the cost of the chemotherapy drug only. The administration cost is not included. In this case, NH Medicaid will reimburse for injections using the HCPCS Codes J9000 - J9900 series, and HCPCS Code 99070 for the cost of administering the injection.
3. Some vaccines are available free of charge from the New Hampshire Division of Public Health. They are not reimbursable by the NH Medicaid Program. However, the cost of administering the vaccines may be billed using HCPCS code 99070.

Questions pertaining to the availability of these vaccines should be directed to:

New Hampshire Division of Public Health
6 Hazen Drive
Concord, New Hampshire 03301
Telephone: 1-800-852-3542 ext. 4463

F. INPATIENT HOSPITAL VISITS

A visit will be paid to only one physician per day unless the patient presents with two or more unrelated diagnoses which are of an acute nature and warrant the concurrent care of two physicians.

When services are provided by a specialist on a consulting basis the initial visit is coded as a consultation. If the consulting physician assumes responsibility for management of a portion or all of the patient's condition(s), subsequent visits by the consultant must be billed as routine hospital visits.

⁶⁵ NH rules found at: <http://www.nhmedicaid.com/Downloads/manuals.html>; Fees taken from NHAIM

Individual consideration will be given for cases requiring additional consultative services due to complications or the seriousness of the patient's condition. In order to receive reimbursement for these services a written referral from the attending physician must be submitted with the claim.

G. LABORATORY AND RADIOLOGY SERVICES

Payment will be made in accordance with fee allowances established by the Division of Human Services. Automated tests are not paid for as individual tests if broken out of an automated laboratory report. Only the fee for the automated panel procedure will be paid. For specimens taken by a physician and sent to an outside laboratory, an allowance is made to the physician for securing and handling the specimen. This must be billed using CPT procedure code 99000. This service is billable for all specimens sent to each lab. Unusual services are considered "By Report".

Claims with dates of service September 1, 1992 to present will be denied if independent clinical laboratories have not submitted their Clinical Laboratory Improvement Act (CLIA) certification number to EDS.

Independent clinical laboratories enrolled in CLIA prior to June 1, 1993 are granted retroactive dates of enrollment back to September 1, 1992.

Independent clinical laboratories not enrolled in CLIA prior to June 1, 1993 will not be granted retroactive effective dates of enrollment back to September 1, 1992. The effective date will be the date your enrollment was processed by EDS.

Copies of your CLIA Certification number can be forwarded to EDS at the address below:

EDS Federal Corporation
Attn.: CLIA
P.O. Box 2040
Concord, N.H. 03302-2040

X-ray services, other than therapeutic x-rays, are limited to fifteen (15) services (procedure codes) per recipient per State fiscal year (July 1 thru June 30).

When billing for the professional component(s) only (supervision, interpretation, and written report) you must use modifier 26 next to the appropriate procedure code in field 24D on the HCFA 1500 claim form.

When billing the technical component(s) only (taking the film), you must use modifier TC next to the appropriate procedure code in field 24D on the HCFA 1500 claim form.

Complete x-ray procedures which include both the professional and technical component(s) do not require a modifier with the procedure code.

Please be sure to bill appropriately if you are providing either the professional component(s) or the technical component(s) **only**. An adjustment will be required should you bill for both components in error.

H. NURSING FACILITY CALLS

Routine visits to nursing facilities are limited to one visit per calendar month. Acute care visits are not subject to service limitations for nursing facility patients.

I. OBSTETRICAL SERVICES

Obstetrical services are considered surgical procedures (type of service 2) and are exempt from physician services limits. Obstetrical care includes prenatal care, delivery and postpartum care.

Maternity Care and Delivery

Delivery includes vaginal delivery (with or without episiotomy, with or without forceps) or Cesarean section, and resuscitation of newborn infant when necessary. Postpartum care includes hospital and office visits following vaginal or Cesarean section delivery.

For medical complications of pregnancy (e.g., toxemia, cardiac problems, neurological problems, etc.) or other problems requiring additional or unusual services and requiring hospitalization, utilize procedure codes related to medical management.

Providers may now be reimbursed for identifying overall needs of pregnant women, and are encouraged to use standardized risk assessment forms (e.g. Hollister form). This service may be billed once per pregnancy, in addition to global or individual services, and must:

- address risk status relative to overall health, family/social support, and the use of alcohol, tobacco and other substances.
- be provided by an MD or ARNP during the first 14 weeks of pregnancy.
- be documented by an assessment form retained in the medical record.
- be billed with type of service 9 and procedure code X9400, in field 24C and 24D on the HCFA 1500..

To use global delivery codes, the provider must have rendered at least three prenatal visits, the delivery services and the postpartum care, and the woman must have been NH Medicaid eligible throughout this service delivery period. In the event of patient non-compliance with any one office visit, the provider must make a minimum of two attempts (by telephone and/or by mail) to engage her in care, and these attempts must be documented in the medical record to be able to bill global delivery codes. If the woman either was not NH Medicaid eligible during the minimum service delivery period, or the minimum amount of care was not provided and documented, the provider must not bill a global code. The delivery only codes, 59514 (C-Section only), 59515 (C-Section, including post-partum care), 59409 (Vaginal Delivery Only), and 59410 (Vaginal Delivery Including Post Partum Care), all type of service 2, must then be used.

If a pregnant, NH Medicaid-eligible woman is accepted into care during the first trimester and is seen according to the American College of Obstetrics and Gynecology (ACOG) guidelines, or more often if medically indicated, the provider may choose to bill for the recipient's care using the individual service and delivery codes, thereby generating reimbursement in excess of the global rate. Individual prenatal and postpartum office visits can not be billed in addition to the global fee.

J. CONSULTATIONS

A consultation is considered to include those services rendered by a physician whose opinion or advice is requested by another physician or agency in the evaluation and/or treatment of a patient's illness. If the consultant physician thereupon assumes the continuing care of the patient as the attending physician, any subsequent service(s) rendered by him/her will no longer be considered as a consultation. When billing a consultation, type of service 3 should be used in field 24C on the HCFA 1500 beside the related procedure code.

A referral is considered to be the transfer of the total or specific care of a patient from one physician to another and is not a consultation.

K. SURGICAL SERVICES

Surgical services consist of cutting procedures, for the treatment of illnesses and injuries, the treatment of fractures and dislocations, the treatment of burns, and invasive diagnostic and treatment services.

Surgical procedures performed in the inpatient hospital setting, which include surgery, assistance at surgery and anesthesia services will not be counted against the recipient's inpatient physician hospital benefits.

Allowances

Allowances paid for surgical procedures include the following:

1. Related office visits within 5 days of surgery.
2. Admission and preoperative visits in the hospital and/or Emergency Room.
3. The surgery itself; and
4. Normal uncomplicated follow-up care for 30 days following the surgery regardless of treatment setting, by any member of the operating team.

Preoperative visits and consultation by the operating surgeon in the hospital that are necessary to examine the patient, complete the hospital records, and initiate the treatment program are included in the surgical allowance.

Follow-up care includes normal postoperative care. Payment for pre or postoperative complications requiring additional and unusual services will be considered on a "By Report" basis only.

Incidental Procedures

Those procedures which are commonly carried out as an integral part of a total service do not justify a separate allowance, and no payment will be made. Some examples of incidental procedures are incidental appendectomy, sterilization during a C-section and lysis of adhesions during abdominal surgery.

Multiple Surgical Procedures

In the event that more than one surgical procedure in different operative fields is performed at the same time, allowance shall be made for the procedure for which the highest allowance is provided plus up to 50% of the allowance for the lesser procedure (s), except as otherwise specified.

When a second procedure in the same operative field adds significantly in time and complexity to the operation, payment will be made at up to 100% of NH Medicaid allowance for the highest benefit, and an additional allowance for the lesser procedure (s) will be determined by the Office of Medical Services on a "By Report" basis. Operative notes must be attached to the claim.

When two separate surgical procedures in different operative fields are performed by physicians of different operative specialties, 100% of the appropriate allowance will be allowed to each.

Surgical Assistants

Physicians who act as surgical assistants during operations for which an assistant's fee is justifiable may be paid up to 20% of the surgical allowance.

"By Report"

Certain services or procedures that require special skill or additional time must be reviewed on an individual basis by the Division of Human Services. The provider must attach a statement or report to the claim when submitted to EDS for processing. The "By-Report" must describe in detail the service or procedure performed. This statement must include pertinent information concerning the nature, extent and need for the procedure; the time

involved; skill and necessary equipment, size, number; location of lesions or lacerations and post operative diagnosis. Anesthesiologists must also attach a copy of the anesthesia record. Services which are commonly performed as part of a total charge cannot be billed as a separate charge. If an "Independent Procedure" is performed as a separate service, and not related to other services, the procedure will justify an allowance. An operative report may be requested by the Office of Medical Services if certain independent procedure charges are billed concurring with other surgical procedures. All services outlined in this section are reimbursed under the NH Medicaid Program if performed by a licensed, enrolled physician. Consideration of allowances for procedures identified as "By Report" require the following information:

1. Pre and postoperative diagnoses.
2. Description of the operation (operative record) and anesthesia record.
3. Operative time.
4. Date of service.

Allowances for surgery performed under the team concept will be determined "By Report". Attach a copy of the operative note to the claim.

Follow-up Period

When an additional surgical procedure is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal termination.

Amputations

Amputations following major vascular reconstruction procedures, when performed within fourteen (14) days following initial surgery by the same surgeon, will be compensated at up to 50% of the usual allowance.

Bilateral Procedures

Bilateral procedures which are not listed in the HCPCS Code should be billed "By Report". The allowance for the second side will be up to 50%.

NON-COVERED SERVICES

Services not covered by the NH Medicaid Program include, but are not limited to:

1. acupuncture
2. biofeedback
3. broken appointments
4. cosmetic surgery
5. detoxification centers
6. dietary services and/or exercise programs for the treatment of obesity
7. exams to determine educability
8. experimental or investigational surgery as determined by Medicare guidelines
9. hypnosis, except when performed by a psychiatrist as part of an established treatment plan
10. occupational ailments or injury
11. operations for impotency
12. physician care in a non-medical government or public institution
13. reversal of voluntary sterilization
14. routine foot care
15. services or items that are free to the public
16. sex change operations

17. TENS and SENS
18. visual training

If any of the above services are provided to a NH Medicaid recipient, you must inform them it is non-covered by NH Medicaid **prior to** providing the service. The recipient is then responsible for payment if they choose to proceed with the service.

6. Rhode Island ⁶⁶

Reimbursement Guidelines

- Payment for a covered service rendered by a provider is made at the lower of the actual charge for the service or the Rhode Island Medical Assistance Program reimbursement rate.
- Under Medicare rules, the provider must accept assignment on the Medicare claim.
- For a service rendered to a Medical Assistance recipient concurrently covered by Medicare, the Medical Assistance Program will pay the appropriate deductible and/or coinsurance up to the Medical Assistance allowed amount.
- A provider who participates in the program agrees to accept the Medical Assistance Program rate of reimbursement as payment in full.
- With the exception of DHS-authorized deductible, co-payment or spend-down liability amounts, no supplemental payment may be required.
- DHS will not permit any arrangement that would require recipients or anyone else to provide supplementary payment.
- With the exception of EPSDT services, if a recipient requires a non-covered service and the provider chooses to give it, the provider can bill the recipient directly for that service.

7. Vermont ⁶⁷

Reimbursement Guidelines

- Attending Physician - Reimbursement basis is the lower of provider's charge or Medicaid rate on file. The unit of service is the CPT procedure.
- Anesthesiologist/Anesthetist - - Reimbursement basis is the lower of provider's charge or Medicaid rate on file for the procedure. The unit of service is 15 (or 30) minutes.
- Assistant Surgeon – Reimbursement is 25% of allowed amount paid to surgeons. Reimbursement is limited to certain surgical procedures needing assistance.
- Pathologists – Reimbursement will be made in accordance with Medicare's *Medigram 83-11* and subsequent Medigrams. The unit of service is the CPT procedure.
- Psychiatry - - Reimbursement basis is the lower of provider's charge or Medicaid rate on file. The unit of service is per visit or for time elapsed.
- Surgeons - - Reimbursement basis is the lower of provider's charge or the Medicaid rate on file. The unit of service is the surgical procedure.
- Physician Assistant - - Reimbursement basis is the lower of provider's charge or ninety percent (90%) of the Medicaid rate on file for a physician providing the same service. The unit of service is the procedure.

⁶⁶ RI rules found at: <http://www.dhs.state.ri.us/dhs/heacre/provsvcs/manuals/physicians/phytoc.htm> , fees found at: http://www.dhs.state.ri.us/dhs/heacre/provsvcs/fee_schedule.htm

⁶⁷ VT rules found at: <http://www.vtmedicaid.com/Downloads/manuals.html> (providermanualjune2007.pdf), fees found at: <http://ovha.vermont.gov/for-providers/claims-processing-1>

8. Medicare⁶⁸

Medicare carriers use the Physician Fee Schedule to price claims for physician services under Medicare. This schedule contains the facility and non-facility fee schedule amount for all services paid for under this fee schedule. CMS generates schedules for each state (carrier and locality), and posts them on their website. Information on the calculations used to determine these fees can be found at: http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp.

This file contains information on services covered by the Medicare Physician Fee Schedule (MPFS). For more than 10,000 physician services, the file contains the associated relative value units (RVUs), a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).

The Medicare physician fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's RVU (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

Section 121 of the Social Security Act Amendments of 1994 required HCFA to replace the existing charge-based practice expense RVUs for all Medicare Physician Fee Schedule services with new resource-based ones. The Balanced Budget Act of 1997 required a four-year transition from the existing charge-based system to the new resource-based system beginning on January 1, 1999. In 2002, the practice expense relative value units are based entirely on the resource-based system.

Under the resource-based system, we have developed practice expense RVUs specific to the facility and non-facility settings.

- Generally, the facility practice expense RVUs will be used for services performed in: inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs), inpatient psych facilities, comp inpatient rehabilitation facilities, community mental health centers, military treatment facilities, ambulance (land), ambulance (air or water), psychiatric facility partial hospital, and psychiatric resort treatment centers.
- The non-facility practice expense RVUs will be used for services furnished in all other settings.
- Note: A procedure performed in an ASC that is not on the ASC list is reimbursed on the basis of the non-facility practice expense RVUs. Outpatient rehabilitation services usually will be reimbursed on the basis of the non-facility practice expense RVUs.

We did not develop non-facility practice expense RVUs for some services which, either by definition or in practice, are never (or rarely) performed in a non-facility setting. For example, by definition, the initial hospital care codes (CPT 99221-99223) are provided only in the hospital inpatient setting. Also, many major surgical procedures with a 90-day global period are almost always performed in the hospital inpatient setting. These facility-only codes are identified by a >NA= in the >NA Indicator= field.

⁶⁸ Medicare rules found at: http://www.cms.hhs.gov/PFSlookup/03_PFS_Document.asp and http://www.cms.hhs.gov/MLNProducts/65_ophthalmology.asp; fees found at: http://www.cms.hhs.gov/PhysicianFeeSched/01_Overview.asp#TopOfPage

The payment formula is as follows:

Non-Facility Pricing Amount =

$[(\text{Work RVU} * \text{Work GPCI}) + (\text{RB Non-Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor}$

Facility Pricing Amount =

$[(\text{Work RVU} * \text{Work GPCI}) + (\text{RB Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor}$

The Medicare limiting charge is set by law at 115% of the payment amount for the service furnished by the nonparticipating physician. However, the law sets the payment amount for nonparticipating physicians at 95% of the payment amount for participating physicians (i.e., the fee schedule amount). Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925 (or 109.25%). Therefore, to calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925. The result is the Medicare limiting charge for that service for that locality to which the fee schedule amount applies.

NOTE: CPT Codes and descriptions only are copyright 2006 American Medical Association all rights reserved.

To obtain a copy of all field definitions and downloadable payment or RVU files, visit the pages listed in the "Related Links Inside CMS" section at the bottom of this page.

PFALLyyA.ZIP

(yy = Year) This file contains the facility and non-facility fee schedule amount for all services paid for under the Medicare Physician Fee Schedule. Medicare carriers use the Physician Fee Schedule to price claims for physician services under Medicare.

RVUyy A.ZIP

(yy = Year) This file contains the relative value units, status indicators, and payment policy indicators for procedure codes and procedure/modifier code combinations subject to the Medicare Physician Fee Schedule. A separate file containing the geographic practice cost indices (GPCIs) is also provided.

The information provided on the physician fee schedule (PFS) web page relates to payment under the PFS and related information concerning the development of the payment amounts. This information is intended for physicians/non-physicians who provide services to Medicare beneficiaries. This information is updated on regular basis when there are payment/policy changes.

The formula for calculating 2008 physician fee schedule payment amount is as follows:

2008 Non-Facility Pricing Amount =

$((\text{Work RVU} * \text{Budget Neutrality Adjustor (0.8806)}) (\text{round product to two decimal places}) * \text{Work GPCI}) + (\text{Transitioned Non-Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor}$

2008 Facility Pricing Amount =

$$\frac{((\text{Work RVU} * \text{Budget Neutrality Adjustor (0.8806)}) (\text{round product to two decimal places}) * \text{Work GPCI}) + (\text{Transitioned Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})}{\text{Conversion Factor}}$$

(Note: When applying the 0.8806 work adjustor to the work RVU you must round the product to two decimal places.)

I. Psychology (Non CMHC) Service Group

1. Rate Information

Following are rates in effect as of January 1, 2008:

		Posted Rates										
Service Group	Procedure w Code	NH	Avg - Other NE States	CT	MA	ME	RI	VT	All Comm	Medicare - NH non facility	Medicare - NH Facility	Adjusted Medicare Rate Used
Psychology (Non CMHC)	90801 Psy Dx Interview	\$87.82	\$76.48	\$65.21	\$122.91	\$82.28	\$36.00	\$75.99	\$89.00	\$148.04	\$125.59	\$147.47
	90806 Psytx, Off, 45-50 Min	\$65.00	\$60.44	\$41.96	\$79.33	\$73.60	\$48.50	\$58.81	\$69.00	\$87.54	\$81.63	\$87.52
	90847 Family Psytx w Patient	\$58.00	\$59.83	\$49.68	\$93.89	\$59.82	\$25.20	\$70.56	\$70.00	\$106.31	\$100.40	\$106.31

2. Connecticut ⁶⁹

Sec. 17b-262-471 Services Covered and Limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed psychologist which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for the following psychological services:

(1) Psychodiagnostic Evaluations

(A) Intellectual Evaluation - Individual

Evaluation of intellectual functioning by means of appropriate psychological procedures, such as the Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children, and Stanford-Binet Intelligence Scale;

(B) Scholastic Achievement or Group Intelligence

(i) Scholastic Achievement: Determination of acquired abilities in areas of educational achievement through the administration and evaluation of tests, California Reading Test, and Wide Range Achievement Test; and

(ii) Group Intellectual Evaluation: Determination of intellectual functioning by means of group intelligence tests such as the Lorge-Thorndike Intelligence Test, Otis Quick-Scoring Mental Ability Test, and California Short-Form Test of Mental Maturity;

⁶⁹ CT Rules found at: <http://www.ctmedicalprogram.com/publications.html#manuals>, which is no longer available. The current website, <https://www.ctdssmap.com/ctportal/Default.aspx?>, does not allow access to manuals unless you are an enrolled provider. Rates found at: <https://www.ctdssmap.com/CTPortal/Provider/Provider%20Fee%20Schedule%20Download/tabId/52/Default.aspx>

(C) Personality Diagnosis and Evaluation Study of personality dynamics, interpersonal relations, emotional adjustment, and stability, through the utilization of psychological procedures such as Rorschach, MMPI, Thematic Apperception Test, Children's Apperception Test, and Figure-Drawing;

(D) Evaluation of Organic Brain Involvement: Organicity Assessment of functions requiring memory, concept formation, visual motor skills, by means of psychological procedures such as the Wechsler Memory Scale, Goldstein-Scheerer Battery Graham-Kendall Memory for Designs, and Bender Visual Motor Gestalt Test;

(E) Evaluation of Aptitudes, Interests, and Educational Adjustment Assessment of vocational aptitudes and interests and educational achievement by means of such procedures as manipulation tests of dexterity and coordination, vocational aptitude tests, interest tests, and achievement tests; and

(F) Neuropsychological Evaluation Assessment of perceptual or motor functions; attention; memory; and learning; intellectual processes; and emotion, behavior, and personality by means of appropriate psychological procedures administered by a qualified neuropsychologist, such as the Wechsler Adult Intelligence Scale, the Wide Range Achievement Test, the Wechsler Memory Scale, the Luria Nebraska Neuropsychological Battery, and the Halstead-Reitan Neuropsychological Battery.

(2) Counseling and Psychotherapy

(A) Diagnostic Interview

Initial contact, review of available records, and personal interview with subject.

Applicable only when formal testing is not possible;

(B) Individual Counseling or Psychotherapy; and

(C) Group Counseling or Psychotherapy.

(3) Staff Consultation

Attendance at staff conferences to present and to discuss psychological findings in planning for the individual; and

(4) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) a diagnostic interview or psychodiagnostic evaluation procedure is limited to one of each in any twelve month period per psychologist for the same client;

(2) only one unit of individual counseling or psychotherapy and one unit of group counseling or psychotherapy shall be paid for on the same day;

(3) the department shall not pay for more than one psychodiagnostic evaluation in any twelve month period when performed by the same psychologist for the same client;

(4) group psychotherapy sessions shall be limited in size to a maximum of eight persons per group session regardless of the payment source of each participant;

(5) only two staff consultations, as described in subdivision (3) of subsection (a) of section 17b-262-471, shall be allowed per year per client per psychologist; and

(6) services covered are limited to those listed in the department's published fee schedule.

Sec. 17b-262-472 Services Not Covered

The department shall not pay for the following psychological services:

(a) information or services furnished by the psychologist to the client over the telephone;

- (b) all evaluations, diagnostic interviews, and therapy services performed in hospital inpatient or outpatient settings;
- (c) concurrent services involving similar treatment modalities for the same client by different health professionals;
- (d) cancelled office visits or for appointments not kept; and
- (e) psychological services which are primarily for vocational or educational guidance.

Sec. 17b-262-474 Billing Procedures

- (a) Claims from psychologists shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.
- (b) The amount billed to the department shall represent the psychologist's usual and customary charge for the services delivered.
- (c) Claims submitted for services not requiring prior authorization shall include the name of the physician, person, or agency making the referral--if there was a referral.
- (d) When a psychologist is requested to attend a staff conference for a Medical Assistance Program client, the name of the referring practitioner, clinic, or agency shall be entered in the appropriate section of the claim form.
- (e) Neuropsychological evaluations shall be billed as one unit regardless of the number of sessions.

Sec. 17b-262-475 Payment

- (a) Psychologists who are fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive payment from the department unless the psychologist maintains an office for private practice at a separate location from the hospital, institution, or clinic in which the psychologist is employed and bills for a service provided to the psychologist's private practice client at the psychologist's private practice location only.
- (b) Payment for services directly performed by a psychologist in private practice shall be made at the lowest of:
 - (1) the provider's usual and customary charge to the general public;
 - (2) the lowest Medicare rate;
 - (3) the amount in the applicable fee schedule as published by the department;
 - (4) the amount billed by the provider; or
 - (5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

Sec. 17b-262-476 Payment Rate

The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

Sec. 17b-262-477 Payment Limitations

- (a) The psychologist's interview of the client's family during the course of treatment in the psychologist's office shall be paid at the rate for individual therapy regardless of the number of persons in attendance.
- (b) The fees for evaluative and treatment services, as stipulated in the psychologist's fee schedule, represent one unit of service, and only one unit shall be billed per day per service regardless of the number of days to complete the unit billed.
- (c) The department shall not reimburse the psychologist for services performed by allied health professionals or paraprofessionals who are in the employ of the

psychologist. The psychologist shall be paid for services only to the clients personally being treated by the psychologist.

3. Maine ⁷⁰

100.04 COVERED SERVICES

A covered service is a service which is face-to-face contact with a member(s) for which payment to a provider is permitted under the rules of this manual. The types of psychological services that are covered for eligible members are those that can be identified by applying the following criteria:

100.04-1 Psychologist's Services

The following services are covered when provided by a psychologist in private practice:

Eff. 10-31-04

- A. Psychological evaluation;
- B. Psychotherapy (individual, group and family);
- C. Psychological testing; and
- D. Collateral contact.

100.04-2 Psychological Examiner's Services

The following services are covered when provided by a psychological examiner practicing within the scope of his or her license:

Eff. 10-31-04

- A. Psychological testing;
- B. Intervention Services: consultation, behavior management, or social skills training when performed under the direct supervision of a licensed psychologist; and
- C. Collateral contact.

100.04-3 Chronic Pain Management Services

- A. Services for the treatment of chronic pain are covered when provided by a psychologist in private practice who is approved by the Bureau of Medical Services to provide chronic pain management services and as stipulated in the provider's Letter of Approval with the Bureau of Medical Services subject to limitations specified in 100.05-7.
- B. Covered chronic pain management services includes:

Eff. 10-31-04

- 1. Psychological evaluation;
- 2. Intervention services including consultation, behavior management, relaxation training and self-management;
- 3. Cognitive therapy (individual, group, family); and
- 4. Collateral contact.

Therapy services are limited to 16 total hours per year. The services limitation of 16 total hours does not apply to services to members under the

⁷⁰ ME rules found at: <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s100.doc>; Rates found at:

age of 21 years, chronic pain management services, emergency services, psychological examiner intervention services, collateral contacts and psychological testing.

100.05-1 Group Psychotherapy

A. In group psychotherapy, enrolled membership in the group must be between 4 and 10, inclusive. Enrolled membership refers to people who are regular members of the group, whether or not they are in attendance at every session. The group has no more than 2 members of the same family. Group psychotherapy sessions have a duration of 60-90 minutes and usually occur with an average frequency of once a week or less. Members receiving group psychotherapy services shall be eight (8) years of age or older, unless members less than eight (8) years of age are receiving therapy in a group to specifically address attention deficit or a severe childhood trauma which may include, but is not limited to, having lost or had a serious threat to one's life or physical integrity, having had a serious threat or harm to a parent or sudden destruction of one's home or community. Group psychotherapy services provided by co-therapists must be claimed at the rate for group therapy by a psychologist co-therapist.

B. Reimbursement for group psychotherapy services shall not exceed ninety (90) minutes per week except for:

1. Members in an inpatient psychiatric facility, for whom service shall be provided in accordance with the plan of care;
2. Members who are in a group therapy that is designated for the purpose of treatment for trauma, for example: sex abuse treatment, or domestic abuse treatment;
3. Children receiving group therapy that is designated for the purpose of treatment for attention deficit or severe childhood trauma as defined above;
4. Members who are in a group therapy that is designated for the purpose of sex offender treatment; or
5. Members who are receiving partial hospitalization services.

Eff. 10-31-04

100.05-2 Family Therapy

A. Family psychotherapy involves at least one child (who may be an adult child) and requires the presence of two or more family members at most sessions. At least one family member receiving family therapy services at a session must be a MaineCare member. Only one psychologist may be reimbursed for the same family therapy session.

B. Reimbursement for family psychotherapy services shall not exceed ninety (90) minutes per week except for:

1. Members in an inpatient psychiatric facility, for whom service shall be provided in accordance with the plan of care;

Eff. 10-31-04

2. Members who are in family therapy that is designated for the purpose of treatment for trauma, for example: sex abuse treatment, or domestic abuse treatment;
3. Children receiving family therapy that is designated for the purpose of treatment for attention deficit or severe childhood trauma as defined above;
4. Members who are in a family therapy that is designated for the purpose of sex offender treatment; or
5. Members who are receiving partial hospitalization services.

100.05-3 Individual Psychotherapy

Reimbursement for individual psychotherapy shall be limited to two (2) hours per week, except when a member requires services for an emergency situation. MaineCare will reimburse for emergency psychotherapy that meets the definition in 100.01-10 up to eight (8) visits; no more than two (2) hours will be reimbursed within a single twenty-four (24) hour period. MaineCare reimbursement for individual psychotherapy will be made to only one psychological services provider at any given time, unless temporary coverage is provided in the absence of the member's usual provider or when another professional opinion is required.

100.05-4 Psychological Testing

Psychological testing includes the administration of the test, the interpretation of the test, and the preparation of test reports. Not included are preliminary diagnostic interviews or subsequent consultation visits.

Reimbursement for psychological testing sessions shall be limited to no more than four (4) hours except for the following:

- A. Each Halstead-Reitan Neuropsychological Battery or any other comparable Neuropsychological Battery is limited to no more than seven (7) hours (including testing and assessment). This is to be limited to use only when there is a question of a neuropsychological and cognitive deficit;
- B. Testing for Intellectual Level alone is limited to no more than two (2) hours;
- C. Each self administered test is limited to 30 minutes; or
- D. Behavioral Assessment.

100.05-5 Psychological Evaluations

Reimbursable psychological evaluations are limited to those needed to determine whether or not to treat, how to treat and when to stop treatment. Reimbursement for a psychological evaluation does not include psychological testing.

Reimbursement for psychological evaluations must not exceed two (2) hours.

100.05-6 Collateral Contacts

Collateral contact means a face-to-face contact on behalf of the member by a mental health professional to seek information, or discuss the member's case with other professionals, caregivers, or others included in the treatment plan in order to achieve continuity of care, coordination of services and the most appropriate mix of services for the member.

100.05-7 Chronic Pain Management Services

Reimbursement for chronic pain management services is limited in the following ways:

- A. Only those services provided to MaineCare members demonstrating a pattern of inappropriate and suboptimal use of health care services related to their chronic pain will be eligible for reimbursement. Further, a member's condition must be either inadequately controlled by available standard therapies or potentially controlled more cost effectively by appropriate psychological treatment of the chronic root condition. Inappropriate and suboptimal use of health care services includes, but is not limited to, frequent use of physician office services or hospital emergency department services for treatment of the manifestations of a chronic illness, rather than the chronic illness itself; or a member's use of a number of different physicians within a circumscribed time period for treatment of the same condition; or drug-seeking behaviors related to an incompletely addressed or undiagnosed underlying chronic condition. Similarly, a member's failure to demonstrate the expected therapeutic response to usual and standard therapies such that the member's physician suspects there may be a psychological obstacle to that member's improvement is an example of a situation where a member may be an appropriate candidate for chronic pain management services and where such services would be eligible for reimbursement.
- B. Those psychological therapeutic techniques employed must be within the licensed psychologist's scope of practice and must be recognized in the peer clinical literature as appropriate to the chronic condition under treatment.
Note: The 16 hours limitation would not begin for members with Medicare coverage or other third party health insurance until the coverage for psychological services by the other payor has been exhausted.

Eff. 10-31-04

100.07 **REIMBURSEMENT**

The maximum allowance for psychological services shall be the lowest of the following:

- A. The amount listed in allowances for psychological services.
- B. The amount allowed by Medicare.
- C. The provider's usual and customary charge.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing the MaineCare Program.

100.08 **COPAYMENT**

A. A copayment will be charged to each MaineCare member receiving services.

The amount of the copayment shall not exceed \$2.00 per day for services provided, according to the following schedule:

MaineCare Payment Member for Services Copayment

\$10.00 or less \$.50

\$10.01 - 25.00 \$1.00

\$25.01 or more \$2.00

B. The member shall be responsible for copayments up to \$20.00 per month whether the copayment has been paid or not. After the \$20.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

C. No provider may deny services to a member for failure to pay a copayment.

Providers must rely upon the member's representation that he or she does not have the cash available to pay the copayment. A member's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.

D. Providers are responsible for documenting the amount of copayments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

E. Copayment exemptions and dispute resolution procedures are described in Chapter I of the MaineCare Benefits Manual.

4. Massachusetts ⁷¹

411.408: Maximum Allowable Fees

The Massachusetts Division of Health Care Finance and Policy determines the maximum allowable fees for psychological testing. The fees include payment for the complete cost of interviewing and testing the member, scoring the test, interpreting the results, and writing the report. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 411.000 and 450.000. Payment for a service is made at the lower of the following:

(A) the psychologist's usual and customary charge to the general public for the same or similar service; or

(B) the maximum allowable fee listed in the applicable Division of Health Care Finance and Policy fee schedule.

(130 CMR 411.409 Reserved)

433.428: Psychiatry Services: Introduction

(A) **Covered Services.** The MassHealth agency pays for the psychiatry services described in 130

CMR 433.429.

(B) **Noncovered Services.**

(1) **Nonphysician Services.** The MassHealth agency does not pay a physician for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician.

(2) **Research and Experimental Treatment.** The MassHealth agency does not pay for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a member's clinical need.

(3) **Nonmedical Services.** The MassHealth agency does not pay a physician for nonmedical services, including, but not limited to, the following:

(a) vocational rehabilitation services;

⁷¹ MA rules found at:

http://www.mass.gov/?pageID=eohhs2terminal&L=6&LO=Home&L1=Government&L2=Laws%2C+Regulations+and+Policies&L3=MassHealth+Regulations+and+Other+Publications&L4=Provider+Library&L5=MassHealth+Provider+Manuals&sid=Eohhs2&b=terminalcontent&f=masshealth_provider_manuals_pvman_psychologist&csid=Eohhs2; Rates found at:

http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&LO=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&sid=Eohhs2&b=terminalcontent&f=dhcfp_government_regs_related_pubs&csid=Eohhs2#114_3_17

- (b) educational services;
- (c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is payable);
- (d) street-worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);
- (e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and
- (f) biofeedback.

(4) Nonmedical Programs. The MassHealth agency does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other noncovered services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The MassHealth agency does not pay for psychological testing provided by a physician.

(C) Recordkeeping (Medical Records) Requirements. In addition to the provisions in 130 CMR 433.409, the following specific information must be included in the medical record for each member receiving psychiatric services:

- (1) the condition or reason for which psychiatric services are provided;
- (2) the member's diagnosis;
- (3) the member's medical history;
- (4) the member's social and occupational history;
- (5) the treatment plan;
- (6) the physician's short- and long-range goals for the member;
- (7) the member's response to treatment; and
- (8) if applicable, a copy of the signed consent for electroconvulsive therapy.

(D) Frequency of Treatment. The MassHealth agency pays a physician for only one session of each type of service provided to a member in one week except for crisis intervention, as described below.

(1) In a crisis, as defined in 130 CMR 433.429(K), the MassHealth agency will pay a physician for extra sessions. The physician must bill for these services using the service code for crisis intervention and must document the following in the member's record:

- (a) the member is in a state of marked life change or crisis;
- (b) the member's ability to function is likely to deteriorate; and
- (c) the plan of treatment is to resume or to initiate regular weekly sessions after the resolution of the crisis.

(2) Although prior authorization is still required after 17 treatment sessions, the MassHealth agency will pay a physician for more than one type of service provided to a member in one week if the additional service or services are medically necessary. The member's record must document the circumstances necessitating the provision of more than one type of service. The record must make clear that the substitution of one type of service for another would not adequately benefit the member and that an additional type of service is necessary.

433.429: Psychiatry Services: Scope of Services

130 CMR 433.429 describes the services that a psychiatrist may provide, including the limitations imposed on those services by the MassHealth agency. For all psychotherapeutic

services, the majority of time must be spent as personal interaction with the member; a minimal amount of time must be spent for the recording of data.

(A) Individual Psychotherapy. The MassHealth agency pays a physician for individual psychotherapy provided to a member only when the physician treats the member. This service includes diagnostics.

(B) Family and Couple Therapy. The MassHealth agency pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one hour per session per week, regardless of the number of family members present or the presence of a cotherapist.

(C) Group Therapy. The MassHealth agency pays for therapy provided to a group of persons, most of whom are not related by blood, marriage, or legal guardianship. The MassHealth agency pays for group therapy only if the session lasts for at least 90 minutes with the physician. Payment is limited to one fee per group member with a maximum of 10 members per group regardless of the presence of a cotherapist.

(D) Diagnostic Services. The MassHealth agency pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(E) Reevaluation. Without prior authorization, the MassHealth agency pays for the reevaluation of a member who has been out of treatment for at least six months and who has used up the lifetime benefit of 17 treatment sessions. A provider may bill for a maximum of two one-hour units per member per calendar year for the purpose of designing a treatment plan and requesting prior authorization for a particular number of sessions.

(F) Long-Term Therapy. The MassHealth agency defines long-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to extend more than 17 sessions.

(G) Short-Term Therapy. The MassHealth agency defines short-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to terminate within 17 sessions.

(H) Medication Review. The MassHealth agency pays for a member visit to the physician specifically for the prescription, review, and monitoring of medication. If this service is not combined with psychotherapy, it must be billed as a minimal office visit. The MassHealth agency does not pay separately for medication review if it is performed on the same day as another service.

(I) Case Consultation. The MassHealth agency pays for a consultation with another agency or person when the physician has accepted a patient for treatment and continues to assume primary responsibility for the patient's treatment, while the other agency continues to provide ancillary services.

(J) Family Consultation. The MassHealth agency pays for a preplanned meeting of at least one-half hour with the parent or parents or legal guardian of a child who is being treated by the physician, when the parent or parents or legal guardian are not clients of the physician.

(K) Crisis Intervention/Emergency Services. The MassHealth agency pays for an immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to members showing sudden, incapacitating emotional stress. The MassHealth agency pays only for face-to-face contact; telephone contacts are not payable. The MassHealth agency pays for no more than two hours of emergency services per member on a single date of service.

(L) Electroconvulsive Therapy. The MassHealth agency pays for electroconvulsive therapy only when it is provided in a hospital setting by a physician and only when both the physician

and the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(M) After-Hours Telephone Service. The physician must provide telephone coverage during the hours when the physician is unavailable, for members who are in a crisis state.

(N) Hospital Inpatient Visit. A visit to a hospitalized member is payable only as a hospital visit (see 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided.

Payment will be made for only one visit per member per day.

(O) Routine Inpatient Care. The MassHealth agency pays for a maximum of three weeks of routine inpatient care without prior authorization if the admission has received a preadmission screening number from the MassHealth agency or its agent in accordance with 130 CMR 433.415(A). Routine inpatient care includes the following services. The amounts of services listed are the maximum payable; fewer services may be provided.

(1) During the first week of hospitalization, the MassHealth agency pays for the following:

(a) for an initial evaluation:

(i) up to three hours for a member under 19 years of age; and

(ii) up to two hours for a member aged 19 or older;

(b) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:

(i) up to five hours for a member under 19 years of age; and

(ii) up to three hours for a member aged 19 or older; and

(c) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:

(i) up to one day for a member under 19 years of age; and

(ii) up to three days for a member aged 19 or older.

(2) During each of the second and third weeks of hospitalization, the MassHealth agency pays a psychiatrist for the following:

(a) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:

(i) up to five hours for a member under 19 years of age; and

(ii) up to three hours for a member aged 19 or older; and

(b) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:

(i) up to two days for a member under 19 years of age; and

(ii) up to four days for a member aged 19 years or older.

(3) The MassHealth agency pays for only one type of service a day.

(4) In order to be payable, individual psychotherapy, regulation of medication, and daily medical care must involve face-to-face contact between the psychiatrist and the member.

(5) For extended hospitalization, if the hospital has complied with the MassHealth agency's concurrent review process, the MassHealth agency pays a psychiatrist for the services described in 130 CMR 433.429(O)(2), that is, for the same amount of services payable in the second and third weeks.

433.472: Mental Health Services

130 CMR 433.472 describes the range of mental health services payable by the MassHealth agency.

(A) Mental Health Center Services. It is appropriate to refer members to a mental health center when they are no longer able to maintain their level of functioning and must seek professional help. Referral for treatment in a clinic setting is appropriate when the individuals

are not harmful to themselves or to others and can maintain themselves in the community even if at a diminished level of functioning.

(1) The MassHealth agency pays for mental health center services provided by freestanding mental health centers, community health centers, hospital-licensed health centers, or hospital outpatient departments only when the MassHealth agency has certified the provider to perform mental health center services.

(2) Mental health center services are payable only when provided by psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors (with a master's or doctoral degree in counseling education or rehabilitation counseling), or occupational therapists.

(3) Mental health center services include diagnosis and evaluation, case consultation, medication, psychological testing if done by a licensed psychologist, and individual, couple, family, and group psychotherapy.

(B) Mental Health Practitioner Services. A member may be referred to a private mental health practitioner (a licensed physician or a licensed psychologist) for the same reason that the member may be referred to a mental health center. Mental health practitioners provide services that are more specialized and less comprehensive than the treatment and support services provided in mental health centers.

(1) The only mental health practitioners who can receive direct payment by the MassHealth agency for diagnostic and treatment services are licensed physicians (see 130 CMR 433.428 and 433.429).

(2) The MassHealth agency pays licensed psychologists only for providing psychological testing. The MassHealth agency does not pay psychologists for providing psychotherapy, even under the supervision of a psychiatrist.

(C) Psychiatric Hospital Services. When psychiatric individuals require 24-hour management because they may be harmful to themselves or to others, or if they are unable to maintain themselves in the community, inpatient psychiatric services may be appropriate.

(1) The MassHealth agency pays for inpatient psychiatric hospitalization only when provided to:

(a) a member aged 65 years or older in a psychiatric hospital participating in MassHealth;

or

(b) a member of any age in a licensed and certified general hospital with or without an inpatient psychiatric unit.

(2) The services of an inpatient psychiatric unit include medication, individual and group therapy, milieu activities, and 24-hour observation provided by an interdisciplinary team.

(D) Psychiatric Day Treatment Services. Some members require the structure and support of a psychiatric treatment center, but do not require the overnight care provided by hospitalization. Accordingly, the member must have a suitable place to live while attending a psychiatric day treatment program. A psychiatric day treatment program may not adequately meet the needs of actively suicidal, homicidal, severely withdrawn, or grossly confused and disoriented individuals who cannot be maintained by family or friends and who are unable to travel to such a program. The MassHealth agency pays for psychiatric day treatment services provided by freestanding mental health centers, hospital-licensed health centers, hospital outpatient departments, or other facilities only when the MassHealth agency has certified the provider to perform psychiatric day treatment services.

(130 CMR 433.473 through 433.475 Reserved)

5. New Hampshire ⁷²

REIMBURSEMENT

Reimbursement for psychotherapy services is established by the Office of Medical Services. Payments are made only to licensed/certified practitioners listed above. Psychotherapy services shall not be separately billed when provided at or through a community mental health center. Psychotherapy services will be reimbursed for up to twelve (12) hours of service per State fiscal year.

NOTE: 0 to 30 minutes of service (procedure code 90843) equals 1 unit, 50 to 60 minutes of service (procedure code 90844) equals 1 unit, and 75 to 80 minutes of service (procedure code 90842) equals 1 unit.

PSYCHOTHERAPY SERVICES

Psychotherapy services are psychological evaluations or treatments provided by a licensed, certified practitioner.

LIST OF PROCEDURE CODES

All diagnostic evaluations are in bold print.

FOR MD'S AND ARNP'S ONLY

<u>PROCEDURE CODE</u>	<u>TOS</u>	<u>DESCRIPTION</u>
90825	1	Psychiatric Evaluation of Hospital Records
90830	1	Psychological Testing by MD
90862	1	Pharmacologic Management
90870	9or1	Electroconvulsive Therapy, Single Seizure
90899	9	Unlisted Psychiatric Procedure

FOR ALL PRACTITIONERS

<u>PROCEDURE CODE</u>	<u>TOS</u>	<u>DESCRIPTION</u>
90801	9 or 1	Diagnostic Evaluation
90820	1	Psychiatric Diagnostic Interview Exam
90835	9	Narcosynthesis for Psychiatric Diagnostic and Therapeutic Purposes
90841	9	Psychotherapy with Medical Diagnostic Evaluation 15 minutes
90842	9or1	Psychotherapy 75 to 80 minutes
90843	9or1	Psychotherapy 20 to 30 minutes
90844	9or1	Psychotherapy 45 to 50 minutes
90845	1	Medical Psychoanalysis
90846	9or1	Family Medical Psychotherapy - without the patient

⁷² NH rules found at:

<http://www.nhmedicaid.com/Downloads/Manuals/Psychotherapy%20Provider%20Specific%20Billing%20Guidelines.doc>; Rates taken from NHAIM

<u>PROCEDURE CODE</u>	<u>TOS</u>	<u>DESCRIPTION</u>
90847	1	Family Psychoanalysis (conjoint psychotherapy)
90849	9or1	Multi-Family Group Psychotherapy
90853	9or1	Group Psychotherapy with Continuing Medical Diagnostic Evaluation, Other than Family Group
90855	1	Interactive Individual Medical Psychotherapy
90857	1	Interactive Group Medical Psychotherapy
90871	1	Multiple Seizures, per day
90880	9or1	Medical Hypnotherapy
90882	9or1	Environmental Intervention for Psychiatric Patient
90887	9or1	Interpretation Explanation Psychiatric Evaluation with Family or Others
X9172	9or1	Psychotherapy Verb/RX/other 15 min.
X9175	9or1	Group Therapy- 15 minutes
X9184	9	Psychological Testing 15 minutes units
X9185	9	Psychotherapy Team/Family 15 minutes
X9187	9	Psychotherapy Team Support Family Conference 15 minutes
X9190	9or1	General Clinical Psychiatric Diagnostic Evaluation Interview Process 15 minutes

Procedure codes that do not include a time specification but are referred to as a session or encounter are to be billed as one (1) unit. When the procedure code is billed with a time factor, the clinical progress notes of each session must identify the duration of service.

The following describes the differences in billing for some psychological services as related to Community Mental Health Centers (CMHCs):⁷³

CMHCs have a special relationship with the Department. They receive the large majority of their funds from NH Medicaid and have a legal obligation to provide certain mental health services to non-Medicaid patients with or without the ability to pay for care. This absence of other funding sources limits the CMHCs' ability to shift costs to other payers and in fact they may have difficulty covering the cost of the uninsured. CMHCs receive generous payment rate for MIMS services that has been estimated to substantially exceed costs. They also pay professional providers at rates that exceed standard Medicaid rates.

This has created a situation in which the same service, even when provided by the same provider, will be paid at very different rates depending on whether the patient is receiving services through a CMHC. For example, a psychiatric diagnostic visit, which would be paid \$65 in a private practice, would be paid \$143 if billed through a CMHC. CMHCs have generally received regular increases for their professional services, though MIMS services have not been increased since March of 2004. CMHC rates have been increased more regularly than rates for other providers. For

⁷³ The State of Acute Care Provider Payment In New Hampshire Medicaid, Draft August 22, 2007; T. Grannemann

example, rates for pharmacology management provided through CMHCs were increased most recently in July 2005 and July 2006, while the rate for the same service provided through a private practice has not been increased since 1997.

Services billed by independent practitioners. NH Medicaid payment for the most important psychology procedure, 90806 the 45-50 minute visit, is paid at \$65 and has not been increased since 1998. Psych testing rates were increased in January 2006. Psychologist and psychiatrists working through CMHCs receive much higher rates and that the state has less control over use in private settings. Private psychologists rates lag behind.

6. Rhode Island ⁷⁴

Adult/Children's Mental Health Services

Introduction

Community Mental Health services refers to those services provided with the primary purpose of diagnosis, treatment, and/or rehabilitation of a mental disorder, or a dysfunction related to a mental disorder. All services are reimbursable only when provided in accordance with a treatment plan approved by a licensed physician or other licensed practitioner of the healing arts.

Provider Participation

The Rhode Island Medical Assistance Program will reimburse qualified providers for those services provided to eligible recipients of the Medical Assistance Program who meet the criteria listed below.

Services are reimbursable only when provided in accordance with a treatment plan approved by a physician or other licensed practitioner of the healing arts.

A licensed practitioner of the healing arts is defined as a:

1. Physician
2. Licensed Psychologist
3. Registered Nurse licensed to practice under Rhode Island State Law
4. Certified Independent Social Worker (CISW) as defined in Rhode Island General Laws, Chapter 39.

Exclusions to this general rule include:

1. Crisis Intervention Services, which may be both recommended and delivered by the mental health professional on duty at the time of the crisis without the need for a treatment plan or approval by a licensed practitioner of the healing arts.

⁷⁴ RI rules found at: <http://www.dhs.state.ri.us/dhs/heacre/provsvcs/manuals/rehab/rehabpolicy.htm#1.1> and <http://www.dhs.state.ri.us/dhs/heacre/provsvcs/manuals/rehab/clinserv.htm>; Rates found at: http://www.dhs.state.ri.us/dhs/heacre/provsvcs/fee_schedule.htm

Mental Health Psychiatric Rehabilitative Residence services which require **physician authorization** on the treatment plan and must be **supervised by a registered nurse**.

Clinician's Services

Introduction

Clinical diagnostic and treatment services to individuals with mental or emotional disorders. Services include, but are not limited to: assessment and evaluation; psychological and neuropsychological assessment and evaluation; individual, family, couple, and group therapy; medication treatment and review. Except for medication treatment and review, clinician's services do not include those services that are part of another community mental health service, such as psychiatric rehabilitation program components and crisis intervention.

Covered Services

Services are covered for categorically and medically needy recipients. The following tables list all covered treatment and counseling services for the Adult/Children's Mental Health Program. The table shows the procedure code, service description, if the service requires prior authorization (Y=yes or N-no).

Provider Type(s)	PROCEDURE CODE	DESCRIPTION	PA
CHILD MENTAL HEALTH PHYSICIAN	X0101	CHILD MENTAL HEALTH PHYSICIAN - ASSESSMENT (1 1/2 HOURS)	N
CHILD MENTAL HEALTH PHYSICIAN	X0102	CHILD MENTAL HEALTH PHYSICIAN - INDIVIDUAL MINIMUM 40 - 50 MINUTE VISIT	N
CHILD MENTAL HEALTH PHYSICIAN	X0103	CHILD MENTAL HEALTH PHYSICIAN - INDIVIDUAL MINIMUM 15 -20 MINUTE VISIT	N
CHILD MENTAL HEALTH PHYSICIAN	X0104	CHILD MENTAL HEALTH PHYSICIAN - GROUP MINIMUM 40 - 50 MINUTE VISIT, PER CLIENT PER VISIT	N
CHILD MENTAL HEALTH PSYCHOLOGIST	X0105	CHILD MENTAL HEALTH PSYCHOLOGIST - ASSESSMENT, 1 1/2 HOURS	N
CHILD MENTAL HEALTH PSYCHOLOGIST	X0106	CHILD MENTAL HEALTH PSYCHOLOGIST - INDIVIDUAL, MINIMUM 40-50 MINUTE VISIT	N
CHILD MENTAL HEALTH PSYCHOLOGIST	X0107	CHILD MENTAL HEALTH PSYCHOLOGIST - INDIVIDUAL MINIMUM 15-20 MINUTE VISIT	N
CHILD MENTAL HEALTH PSYCHOLOGIST	X0108	CHILD MENTAL HEALTH PSYCHOLOGIST - GROUP MINIMUM 40-50 MINUTE VISIT, PER CLIENT PER VISIT	N
CHILD MENTAL HEALTH SOCIAL WORKER CHILD MENTAL HEALTH PSYCHIATRIC NURSE	X0109	CHILD MENTAL HEALTH SOCIAL WORKER/PSYCHIATRIC NURSE - ASSESSMENT, 1 1/2 HOURS	N
CHILD MENTAL HEALTH SOCIAL WORKER CHILD MENTAL HEALTH PSYCHIATRIC NURSE	X0110	CHILD MENTAL HEALTH SOCIAL WORKER/PSYCHIATRIC NURSE - INDIVIDUAL MINIMUM 40 - 50 MINUTE VISIT	N
CHILD MENTAL HEALTH SOCIAL WORKER CHILD MENTAL HEALTH PSYCHIATRIC NURSE	X0111	CHILD MENTAL HEALTH SOCIAL WORKER/PSYCHIATRIC NURSE, INDIVIDUAL MINIMUM 15-20 MINUTE VISIT	N

Provider Type(s)	PROCEDURE CODE	DESCRIPTION	PA
<i>PSYCHIATRIC NURSE</i>			
<i>CHILD MENTAL HEALTH SOCIAL WORKER CHILD MENTAL HEALTH PSYCHIATRIC NURSE</i>	X0112	CHILD MENTAL HEALTH SOCIAL WORKER/PSYCHIATRIC NURSE - GROUP MINIMUM 40-50 MINUTE VISIT, PER CLIENT	N
<i>REHABILITATIVE SERVICES: PHYSICIAN</i>	X0113	ADULT MENTAL HEALTH BY A PHYSICIAN - ASSESSMENT: MINIMUM 90 MINUTES	N
<i>REHABILITATIVE SERVICES: PHYSICIAN</i>	X0114	ADULT MENTAL HEALTH BY A PHYSICIAN - INDIVIDUAL: MINIMUM 40-50 MINUTES	N
<i>REHABILITATIVE SERVICES: PHYSICIAN</i>	X0115	ADULT MENTAL HEALTH BY A PHYSICIAN - INDIVIDUAL: MINIMUM 15-20 MINUTES	N
<i>REHABILITATIVE SERVICES: PHYSICIAN</i>	X0116	ADULT MENTAL HEALTH BY A PHYSICIAN - GROUP: MINIMUM 40-50 MINUTES, PER CLIENT, PER VISIT	N
<i>REGISTERED NURSE</i>	X0117	ADULT MENTAL HEALTH BY AN RN, ASSESSMENT: MINIMUM 90 MINUTES	N
<i>REGISTERED NURSE</i>	X0118	ADULT MENTAL HEALTH BY AN RN, INDIVIDUAL: MINIMUM 40 - 50 MINUTES	N
<i>REGISTERED NURSE</i>	X0119	ADULT MENTAL HEALTH BY AN RN, INDIVIDUAL: MINIMUM 15 - 20 MINUTES	N
<i>REGISTERED NURSE</i>	X0120	ADULT MENTAL HEALTH BY AN RN, GROUP: MINIMUM 40 - 50 MINUTES, PER CLIENT, PER VISIT	N
<i>CERTIFIED Ph.D. PSYCHOLOGIST</i>	X0121	ADULT MENTAL HEALTH BY A PSYCHOLOGIST, ASSESSMENT: MINIMUM 90 MINUTES	N
<i>CERTIFIED Ph.D. PSYCHOLOGIST</i>	X0122	ADULT MENTAL HEALTH BY A PSYCHOLOGIST, INDIVIDUAL: MINIMUM 40 - 50 MINUTES	N
<i>CERTIFIED Ph.D. PSYCHOLOGIST</i>	X0123	ADULT MENTAL HEALTH BY A PSYCHOLOGIST, INDIVIDUAL: MINIMUM 25 - 30 MINUTES	N
<i>CERTIFIED Ph.D. PSYCHOLOGIST</i>	X0124	ADULT MENTAL HEALTH BY A PSYCHOLOGIST, GROUP: MIN. 40-50 MINUTES, PER CLIENT, PER VISIT	N
<i>MSW SOCIAL WORKER; PRINCIPAL OCCUPATIONAL THERAPIST; PRINCIPAL REHABILITATION COUNSELOR</i>	X0125	ADULT MENTAL HEALTH BY A SOCIAL WORKER, ASSESSMENT: MINIMUM 90 MINUTES	N

Provider Type(s)	PROCEDURE CODE	DESCRIPTION	PA
<i>MSW SOCIAL WORKER; PRINCIPAL OCCUPATIONAL THERAPIST; PRINCIPAL REHABILITATION COUNSELOR</i>	X0126	ADULT MENTAL HEALTH BY A SOCIAL WORKER, INDIVIDUAL: MINIMUM 40-50 MINUTES	N
<i>MSW SOCIAL WORKER; PRINCIPAL OCCUPATIONAL THERAPIST; PRINCIPAL REHABILITATION COUNSELOR</i>	X0127	ADULT MENTAL HEALTH BY A SOCIAL WORKER, INDIVIDUAL: MINIMUM 25-30 MINUTES	N
<i>MSW SOCIAL WORKER; PRINCIPAL OCCUPATIONAL THERAPIST; PRINCIPAL REHABILITATION COUNSELOR</i>	X0128	ADULT MENTAL HEALTH BY A SOCIAL WORKER, GROUP: MINIMUM 40-50 MINUTES, PER CLIENT, PER VISIT	N
<i>MARRIAGE AND FAMILY THERAPIST</i>	X0129	ADULT MENTAL HEALTH BY MARRIAGE AND FAMILY THERAPIST - ASSESSMENT, MINIMUM 90 MINUTES	N
<i>MARRIAGE AND FAMILY THERAPIST</i>	X0130	ADULT MENTAL HEALTH BY MARRIAGE & FAMILY THERAPIST - INDIVIDUAL, MINIMUM 40-50 MINUTES	N
<i>MARRIAGE AND FAMILY THERAPIST</i>	X0131	ADULT MENTAL HEALTH BY MARRIAGE & FAMILY THERAPIST - INDIVIDUAL - MINIMUM 25-30 MINUTES	N
<i>MARRIAGE AND FAMILY THERAPIST</i>	X0132	ADULT MENTAL HEALTH BY MARRIAGE & FAMILY THERAPIST - GROUP, MINIMUM 40-50 MINUTES, PER CLIENT, PER VISIT	N
<i>REHABILITATIVE SERVICES: PHYSICIAN</i>	X0344	MEDICATION GROUP W/PHYSICIAN - MINIMUM 90 MINUTES, MAXIMUM 8 CLIENTS, PER CLIENT, PER VISIT	N
<i>REGISTERED NURSE</i>	X0345	MEDICATION GROUP W/RN, MINIMUM 90 MINUTES, MAXIMUM 8 CLIENTS	N
<i>TARGETED CASE MANAGEMENT</i>	X0371	NON-MEDICAL CASE MANAGEMENT - GROUP HOME PER DAY	N
<i>TARGETED CASE MANAGEMENT</i>	X0372	NON-MEDICAL CASE MANAGEMENT - COMMUNITY BASED PER 1/2 HOUR UNIT	N
<i>MENTAL HEALTH COUNSELOR</i>	X0540	ADULT MENTAL HEALTH COUNSELOR - ASSESSMENT - MINIMUM 90 MINUTES	N
<i>MENTAL HEALTH COUNSELOR</i>	X0542	ADULT MENTAL HEALTH COUNSELOR - INDIVIDUAL, MINIMUM 40-50 MINUTES	N

Provider Type(s)	PROCEDURE CODE	DESCRIPTION	PA
MENTAL HEALTH COUNSELOR	X0544	ADULT MENTAL HEALTH COUNSELOR - INDIVIDUAL - MINIMUM 25-30 MINUTES	N
MENTAL HEALTH COUNSELOR	X0546	ADULT MENTAL HEALTH COUNSELOR - GROUP - MINIMUM 40-50 MINUTES	N
PRINCIPAL COUNSELOR	X0550	ADULT PRINCIPAL COUNSELOR - ASSESSMENT - MINIMUM 90 MINUTES	N
PRINCIPAL COUNSELOR	X0552	ADULT PRINCIPAL COUNSELOR - INDIVIDUAL - MINIMUM 40-50 MINUTES	N
PRINCIPAL COUNSELOR	X0554	ADULT PRINCIPAL COUNSELOR - INDIVIDUAL - MINIMUM 25-30 MINUTES	N
PRINCIPAL COUNSELOR	X0556	ADULT PRINCIPAL COUNSELOR - GROUP - MINIMUM 40-50 MINUTES	N
COUNSELOR	X0560	NON-MEDICAL CASE MANAGEMENT - GROUP HOME PER DAY	N
COUNSELOR	X0562	ADULT COUNSELOR - INDIVIDUAL - MINIMUM 40-50 MINUTES	N
COUNSELOR	X0564	ADULT COUNSELOR - INDIVIDUAL - MINIMUM 25-30 MINUTES	N
COUNSELOR	X0566	ADULT COUNSELOR - GROUP - MINIMUM 40-50 MINUTES	N
TARGETED CASE MANAGEMENT	X0660	MEDICAL CASE MANAGEMENT - MENTAL HEALTH, COMMUNITY BASED, PER 1/2 HOUR UNIT	N

Limitations

- Prior authorization is required for any clinician's services in excess of 20 visits in any one calendar year.
- Providers may request up to 26 additional visits at one time.
- 15-20 minute physician or nurse visits are generally used for medication maintenance and thus are needed on a more frequent basis. These visits, along with the 90 minute medication groups, should not be added in when counting visits.

7. Vermont ⁷⁵

PSYCHIATRY/PSYCHOLOGY

Procedure Codes and Units of Service

Psychiatrists - Individual psychotherapy is billed with the current CPT procedure codes.

The time period definitions of CPT psychotherapy procedure codes 90804–90829 are converted to the following for OVHA billing purposes:

20-30 minutes = 15–44 minutes

⁷⁵ VT Rules found at: <http://ovha.vermont.gov/for-providers/provider-manuals>, cms-15000-08-05-supplement-june2007.pdf; Rates found at: <http://ovha.vermont.gov/for-providers/claims-processing-1>

45-50 minutes = 45–74 minutes

75-80 minutes = 75–90 minutes

With family code 90847 - When billing this code for Psychiatrists, the patient must be present. One unit = 1 visit.

Drug Management In keeping with the federal guidelines for Medicare and Medicaid, the services of drug management and psychotherapy cannot be paid for the same beneficiary for the same date of service. Drug management is considered included within the psychotherapy service and is not to be billed separately as an additional charge. Medicaid is required to follow this policy and deny CPT code 90862 when it is billed in addition to individual psychotherapy.

Psychiatrists and Psychologists When therapy is given to the family members of a beneficiary as part of the individual therapy for that beneficiary, with or without the beneficiary present, providers must bill the appropriate procedure code (90846 or 90847).

Billing for Services Provided in Patient's Home Medicaid policy allows for payment of some psychotherapy services provided in the patient's home as well as in the office setting. Psychiatrists may bill for services provided in the home or office under codes 90846, 90847, and 90853.

Psychotherapy claims where the primary diagnosis is substance abuse or dependence (including alcohol or other drugs, excluding tobacco), are paid through the Office of Alcohol and Drug Programs to participants in their provider network of contracted substance abuse programs.

Accepted Procedure Codes

Psychologists/LCSW/LMHC/LMFT- Only the following procedure codes are allowed: Codes require a *modifier* of either: AJ = for MA, counselors, LCMHC, LSW, LMFT or AH = for Doctorate level Psychologist

Code	Description	Units
90806	Psychotherapy	1 unit = 45-50 min
90804	Psychotherapy - Less Than One Hour	1 unit = 20-30 min
90808	Psychotherapy - More Than One Hour	1 unit = 75-80 min
90801	Diagnosis and Evaluation	1 unit = 1 visit
90846	Family Psychotherapy without Patient present	1 unit = 1 day
90847	Family Psychotherapy	1 unit = 1 day
90853	Group Therapy Limited to 1 session per day, 3 sessions per week for each recipient	1 unit = 15 min 10 units/day max
96102	Psychological Testing with Qualified Hlth Care Prof Interpretation & Report , administered by technician	1 unit = 60 min
96103	Psychological Testing with Qualified Hlth Care Prof Interpretation & Report, administered by computer	1 unit = 60 min
96119	Neuropsychological Testing with Qualified Hlth Care Prof Interpretation & Report, administered by technician	1 unit = 60 min
96120	Neuropsychological Testing with Qualified Hlth Care Prof Interpretation & Report, administered by computer	1 unit = 60 min
The following codes must be billed with modifier AH when provided by a Doctorate level Ph.D:		
96101	Psychological Testing both face to face time with the patient & time interpreting test results and preparing the report	1 unit = 60 min
96116	Neurobehavioral status exam both face to face time with he patient & time interpreting test results and preparing the report test results	1 unit = 60 min
96118	Neuropsychological testing both face to face time with the Patient and time interpreting test results and preparing the	1 unit = 60 min

Code	Description	Units
	Report	
96150	Health and behavior assessment, clinical interview, Observation	1 unit = 15 min
96151	Health and behavior re-assessment	1 unit = 15 min
96152	Health and behavior intervention face to face individual	1 unit = 15 min
96153	Health and behavior assessment face to face group 2 or more patients	1 unit = 15 min

Allowed places of service codes: 11-Office, 03-School (when not part of an IEP), 12-Home, 21-Inpatient Hospital, and 53-Community Mental Health Clinic.

8. Medicare

Medicare pays for psychology codes from their Physician Fee Schedule. Please refer to section [H.8 Medicare](#) for more information on the Medicare Physician Fee Schedule.

Appendix E: Commercial Payment Rates for Benchmarks

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The New Hampshire Comprehensive Health Care Information System (NH CHIS) is a joint project between the New Hampshire Department of Health and Human Services (NH DHHS) and the New Hampshire Insurance Department (NHID). The NH CHIS was created by state statute (RSA 420-G:11-a) to make health care data “available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.” The system collects all medical and pharmacy eligibility and claims data from NH licensed insurance carriers and third party administrators for insurance policies issued in New Hampshire.

The average payment rate data for commercially insured is based on NH resident 2007 incurred services, except for inpatient hospital which is based on 2006 services. Payments included health plan payments, member payments, and where applicable, fee for service equivalent payment if service was delivered under a capitated or prepaid arrangement. Commercial data was included in the benchmarking report when it could reliably be compared with Medicaid services.

⁷⁶ Source: NH Comprehensive Health Care Information System (NHCHIS), NH Department of Health and Human Services, 2008.

Appendix F: Public Hearing

A public hearing to review this report was held on Friday, September 19, 2008 at the Brown Building auditorium. The following pages include:

- The notification for the public hearing
- The list of attendees
- Written testimony read at the hearing
- Written testimony sent after the hearing



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

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Fax: 603-271-8431 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Director

To: Concerned Stakeholders

Date: September 4, 2008

From: Andrew Chalsma
Bureau of Data and Systems Management

Subject: Public Hearing Notice
RSA 126-A:18-b Medicaid Reimbursement Rates

Please be advised that on Friday, September 19th, at 10:00am, the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy, will host a public hearing as part of its obligations under RSA 126-A:18-b *Medicaid Reimbursement Rates*. This hearing will be held at the Department of Health & Human Services' Brown Building Auditorium, located at 129 Pleasant Street in Concord

This public hearing will provide an opportunity for providers, beneficiaries and their representatives, and other concerned residents, to provide information for consideration as part of the Department's biennial rate setting process. For your reference, the RSA can be found on the General Court's website at <http://www.gencourt.state.nh.us/rsa/html/X/126-A/126-A-18-b.htm>.

On or before September 12, a draft report containing information on the benchmarking of rates, and other information required under the statute, will be placed on the Department's website at www.dhhs.state.nh.us/dhhs/ombp/library. As this is the first year of this new process, we have focused our efforts primarily on select acute care services (see draft report for more information).

We welcome the opportunity to hear from those interested in the subject of the hearing. If you plan to attend, please arrive approximately five minutes early to allow time to check-in. If you are unable to attend the hearing, or are attending and have extensive comments, we are happy to accept written commentary via e-mail to achalsma@dhhs.state.nh.us or by mail at the address above.

Please submit any commentary by the close of business on September 24, 2008 to allow for review and consideration prior to the publication of the final report in October.

126-A:18(b)
BROWN AUDITORIUM
Friday, September 19, 2008

NAME	ORGANIZATION
Linda Steir	Sarah Care Adult Day Services
Richard E. Vachon	NH Dental Society
James Williamson	NH Dental Society
Angela Baja	NH Oral Health Coalition
Vanessa Santarelli	Bi-State Primary Care Associates
Janet Monahan	NH Medical Society
Cindy Robertson	Disabilities Rights Center
Stephen Norton	NHCPPS
Liz McConnell	Alzheimer's Association
Ann Larney	Planned Parenthood NNE
Leslie Melby	NH Hospital Association
Susan Young	Home Care Association
Sarah Burke	NH Legal Assistance
Susan Paschell	Dupont Group

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Medicaid Reimbursement Rate
Public Hearing, September 19, 2008

Statement by Linda Steir, Owner and Exec. Director, SarahCare Adult Day Services

Thank you for the opportunity to give my input on this important matter.

I am Linda Steir, owner and Executive Director of SarahCare Adult Day Services Center in Hampstead. We are a family owned business and do not have the financial support of a hospital, nursing home, assisted living facility or charitable organization.

We have been Medicaid approved since opening our business in November of 2006. SarahCare provides day services exclusively for senior adults who need assistance during the day. A day service program allows elders to live in their own homes or with their families rather than being institutionalized at far greater cost. We care for clients with physical disabilities as well as dementia issues. We provide 11 hours of service from 7am until 6pm to allow care givers to be able to work while their loved ones are safely cared for. We provide nurse care, breakfast, lunch, snacks, recreational and social activities.

We currently have about 40 clients enrolled with an average daily attendance of 23. We have the capacity to serve up to 50 clients per day. We would likely be near capacity today if it were not for the current Medicaid reimbursement rate of only \$50.22 per day. This is because we lose an average of \$15.00 per day on Medicaid clients. If we accepted all the Medicaid clients that have requested our services, we would be running at a significant loss which would cause us to close our doors. **BUT EVEN MORE IMPORTANTLY**, if day service programs stop accepting Medicaid clients, their only other options will include much more costly programs such as home health care or nursing homes. This is simple economics. The state could realize significant savings by incentivizing day care centers to open their doors to all Medicaid clients if we could at least recover our costs.

We accept as many Medicaid clients as possible out of compassion but at the expense of our personal family savings. We cannot continue on this path and we implore you to increase Medicaid reimbursement rates. Please keep in mind that the budgeted rate increase of 2% which was to take effect for 2008 was cancelled. We have Some Medicaid clients attending for only 4 or 5 hours during the day while others attend for up to 11 hours per day. To get the same reimbursement per day regardless of the hours is blatantly unfair.

We suggest that the State consider these options:

- 1 Raise the rate to not less than \$58.00 per day.
- 2 Allow day care centers to have the option of billing Medicaid on an hourly basis at the rate of \$10.00 dollars per hour up to a maximum of 8 hours per day.
- 3 Redefine the billable 'Unit' to be a maximum of four hours of service and allow day care centers to bill up to 2 Units per day for those participants attending for 8 hours or more.

It is difficult to compare other state rates because the formulas are different. Some have split rates for non-nurse care rates and intensive care rates, some reimburse by the hour, some have a flat rate that includes transportation. However, I did my best to find compare apples to apples and here are the current Medicaid day services reimbursement rates for in a number of other States:

The NH rate is 50.22 per day for not less than 4hrs. The average stay of our Medicaid clients is 8 hours with a minimum of 4 hours.

Maine – \$75.52 for 8 hour day @ \$2.36 for each 15 minutes

Massachusetts – \$47 and \$59 = avg of \$53

Pennsylvania - \$55

Ohio - \$42 and \$56 = avg of \$56

Illinois - \$56 @ \$7.02 per hr

Georgia - \$58.43 avg rate

Nebraska – total of \$68.98 for comparable services

New Mexico - \$65.28 @ \$8.16 per hr

Thank you for the opportunity to address this public hearing.
Linda Steir

**DHHS Public Hearing
Medicaid Reimbursement Rates
September 19, 2008**

Thank you for this opportunity to speak. I represent the New Hampshire Dental Society, which includes as its members over 750 dentists in NH, about 85% of dentists practicing in this state. The N.H. Dental Society has been very active over the last number of years in recruiting dentists to participate in Medicaid and have been generally successful. While Medicaid rates are not the only factor in why dentists become Medicaid providers, it is indeed a significant factor. Numerous studies have shown that when Medicaid rates are increased there is a proportionate increase in the number of dental Medicaid providers.

While benchmarking with other states is valuable, and I will comment on this in a moment, the real benchmarking must be with the other insurance programs in the state and with their level of reimbursement. Dentists will look at Medicaid rates and compare them with other reimbursement rates to determine how active a participant they might be. Rates are also important when new graduates are considering where to set up practice. This is especially true for Pediatric dentists because they see so many Medicaid children in their practices. In Connecticut, for instance, Medicaid rates are now near the commercial market rates, and combined with the fact that CT. has a dental school this is indeed an attractive place to practice. I don't think we want to lose prospective providers because our reimbursement rates do not compare: in fact, if we are to properly take care of all of our citizens, we cannot lose these individuals as providers.

Looking at Medicaid rates in surrounding states will also give us some indication of where we need to be with our own rates. Connecticut Medicaid rates are now approximately 30 – 35% higher than the rates in N.H.: looking at this and looking at

average claim data from Northeast Delta Dental, the major commercial provider in our state, the N.H. Dental Society feels that current N.H. rates must be raised 26-30% if we are to truly be competitive and attract the providers we need to service the needs in N.H. When rate increases are implemented these increases are targeted to specific procedures that are most used in delivering care. These procedures are determined by the Medicaid office in consultation with the Dental Society and this process has proven to be most effective. Currently there are 48 codes that fall into this category, and these 48 codes comprise about 95% of the procedures that are needed to deliver comprehensive care.

Of course, another major problem is that there is only very minimal dental coverage for adults on Medicaid in our state. In fact, it is almost non-existent. This needs to be corrected and a more comprehensive adult program must be implemented.

Thank you very much for this opportunity to present our concerns. I am happy to respond to any questions or if further information is needed you can contact the New Hampshire Dental Society through its Executive Director, James J. Williamson.

New Hampshire Dental Society
23 South State St.
Concord, NH 03301
225-5961
jwilliamson@nhds.org



TESTIMONY

NH Medicaid Provider Reimbursement Rate Benchmarks for Key Services RSA 126-A:18-b Biennial Report

September 19, 2008

Good morning. My name is Leslie Melby, and I am the Vice President for State Government Relations for the New Hampshire Hospital Association. I am here today on behalf of the state's 26 acute care and 5 specialty hospitals.

Thank you for the opportunity to comment on this important report on the Department's review of Medicaid payment rates as required under HB 43, Chapter 205 of the Laws of 2007.

My comments are limited to the sections of the Medicaid report on inpatient and outpatient hospital services. I first would like to correct a statement on page 13 of the report under Section B, Inpatient Hospital. The report states that "The NH payment method for inpatient hospital reimbursement mimics Medicare's method based on prospectively set rates ..." In fact, Medicare uses two different methods, depending on whether a hospital is a Critical Access Hospital (CAH) or a PPS (prospective payment system) hospital. The report's statement is correct for New Hampshire's thirteen PPS hospitals, but not for the state's thirteen CAH hospitals. With the introduction of critical access designation, Medicare now pays CAHs 101% of cost. In other words, no prospective payment method is applied to any CAHs under Medicare.

It is well known that Medicaid reimbursement for medical care has failed to keep pace with the rising costs of providing care. Costs attributable to the healthcare labor force, medical technology, pharmaceuticals, medical supplies, and the like are continually rising. New Hampshire's Medicaid reimbursement for hospital services is seriously inadequate when compared to the cost of providing services as well as when compared to the level of Medicaid reimbursement rates in other states. Hospitals in New Hampshire are paid on average 61 cents for each dollar of cost incurred in treating NH Medicaid patients. What's more, the percentage of Medicaid costs reimbursed has continuously declined year after year.

Hospitals in the state have increasingly been forced to cost-shift Medicaid underfunding or shortfalls to insured patients. In its recently released report on cost-shifting, the New Hampshire Center for Public Policy Studies reports that in 2007, Medicaid payments to

New Hampshire's hospitals were \$85 million short of paying for the actual cost of services. That's a 72% shortfall in Medicaid payments. The report states that in 2007, Medicaid paid on average only 61 percent of cost. (Medicare paid 86% of cost. Non-public payers paid 149% of cost to make up the difference.)¹ In short, as long as Medicaid payment rates are frozen at 2001 levels, as noted in the Department's report, the growing burden of paying for the Medicaid shortfall will be shifted to New Hampshire's consumers and businesses in the form of increased premiums.

Since 2001, the Medical Consumer Price Index for inpatient services has increased between 5.5% and 8.4% annually or an average over seven years of 6.5%. However, average Medicaid per diem payments have been flat. So with each year, NH Medicaid payments for inpatient hospital services have fallen further and further behind. Similarly, average outpatient payments per encounter have been relatively flat since 1999.

The Department's report on Medicaid rates and benchmarking states that rate information was not collected for inpatient and outpatient hospital services. Therefore, a comparison to other states' Medicaid payment rates was not performed. We disagree with the premise that differing payment methodologies prevented this analysis to be done. The state of Massachusetts, like New Hampshire, uses a DRG method of payment for inpatient hospital services. Massachusetts Medicaid pays hospitals \$7,947 per DRG point. New Hampshire pays \$3,147.

Another measure against which New Hampshire can be compared to other states' Medicaid programs is the payment to cost ratio. In 2007, Massachusetts' payment to cost ratio for hospital services was 81%; Vermont was 55%. New Hampshire was 61%. We believe that an analysis could have been performed by computing an average payment amount per discharge. NHHA would be happy to assist the Department in fulfilling the requirement to benchmark these services.

Finally, NHHA requests that the comment period be extended beyond the seven business days provided to continue our review and analysis of the Department's findings. From the date the report was published on the DHHS website – September 12th – until the deadline for comments – September 24 – is an inordinately brief period within which to review such a voluminous and important report.

As always, we appreciate the dedication, the time, and the effort by DHHS staff in preparing this important report. We are happy to work with the Department in any way we can to assist.

Thank you for this opportunity to comment on the draft report.

¹ NH Center for Public Policy Studies, *Driving Health Care Premiums: Cost-Shifting in New Hampshire*, September 2008, p.4.



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September 23, 2008

Andrew Chalsma
Bureau of Data and Systems Management
Office of Medicaid Business and Policy
Department of Health and Human Services

Dear Mr. Chalsma:

This letter will share the comments of Granite State Home Health Association on the draft report "NH Medicaid Provider Reimbursement Rate Benchmarks for Key Services," made available by the Office of Medicaid Business and Policy on September 12. We have reviewed only the sections of the report pertaining to home health and our comments are limited to that topic.

Summary by Service Group

In this section of the report, the information presented on home health carries several notations.

Notation #9 is accurate in its summary of the different payment methodologies used in the various New England states, that some use per visit rates and others pay per unit of time in the home. However, the report states "we are unable to provide a meaningful comparison for RN services at this time." I disagree. During the 2 ½ years of negotiations to establish a home health rate setting methodology for NH Medicaid services, which concluded with new rules adopted in March 2008, industry and DHHS representatives successfully tackled this issue. The Department should reflect the results of the analysis concluded just last winter in this report. I would be happy to assist the Department with accessing that data if it is not readily available in DHHS files.

The closing sentence of notation #9 reads "This report utilizes the home health aide rate for 8 or more units of direct care, as current utilization suggests that agencies submit one claim per month." This statement is very confusing. First, while many providers may submit one claim per month, all must report both the number of units billed for each date that care is rendered and the number of visits delivered (through a time of day modifier). Second, as a result of the negotiations referenced above, a two-tiered rate structure for home health aide visits was created. It is very important that this is reflected in the report, as the cost structure for delivering short, intermittent home health aide service is entirely different than that for longer, "block" time. We concluded that block time services, generally visits over 3 hours in length, are adequately reimbursed at this time; but shorter visits, those less than 2 hours in duration, are generally paid at about 50-70 cents on the dollar for most providers. The Department selected the two-hour mark as the threshold for use of the higher rate for short visits.

Notes #4 and 6 assert that home health rates cannot be compared with other states or with Medicare “as payment methodologies are not the same.” As noted above, the Department and our Association successfully completed exactly such comparisons earlier this year, and this process is incorporated in the Medicaid home health rules adopted in March.

E. Home Health Service Group

This section of the report includes two tables comparing rates and payment methodologies from the New England states, Medicare and commercial payers, followed by copies of rules from the various New England states.

In the first table, Rate Information, an average is calculated for rates for RN services (GO 154) from other New England states. The numbers used to calculate the average include both visit rates and unit rates. Unit rates (the rate for ¼ hour of service) are between one quarter and one third of the cost of a visit, so the resulting average is invalid. The unit rates must first be converted to visit rates before calculating the average. During our rate negotiations, we converted NH’s unit rate to a visit rate based on actual utilization data to accomplish the comparison. The Vermont rate is listed at a unit level, but it is my understanding that Vermont pays for skilled nursing in visit rates, at 100% of Medicare rates.

The average home health aide rate for other New England states is calculated as an average of those states that pay unit rates, thus excluding the rate paid by Massachusetts. It may not be possible to convert the Massachusetts rate to a unit basis, unless utilization data can be obtained on the average length of a visit in that state. Again, I would refer the department to the detailed analysis conducted last winter by DHHS staff involved in the negotiations, which allowed us to compare NH rates with those in all the other New England states.

Thank you for the opportunity to share our comments.

Sincerely,

Susan M. Young
Executive Director



PSYCHOLOGICAL AND COUNSELING SERVICES

RECEIVED
SEP 22 2008



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9-18-08

Mr. Andrew Chalsma
Chief, Bureau of Data and
Systems Management
State of New Hampshire
Department of Health and Human Services
Office of Medicaid Business and Policy
129 Pleasant Street
Concord, NH 03301-3857

Dear Mr. Chalsma,

Thanks for the opportunity to communicate with you about the NH Medicaid rates. As I understand, the rates have not been changed since 1998. NH Medicaid's rates are now lower than any other major insurer we contract with. The Cost of Living Adjustment used by social security has been adjusted every year as follows since 1997:

Start	\$65.00
1. 1998- 1.3 %	\$65.85
2. 1999- 2.5%	67.49
3. 2000- 3.5%	69.85
4. 2001- 2.6%	71.66
5. 2002- 1.4%	72.66
6. 2003- 2.1%	74.19
7. 2004- 2.7%	75.75

8. 2005- 4.1%	77.79
9. 2006- 3.3%	80.98
10. 2007- 2.3 %	<u>83.65</u>
	\$85.57

Therefore, our rate should now be \$85.57.

As you can imagine, our costs both at work and at home do reflect the increases seen above. Mental health services are of increasing importance in today's world. I hope you will submit this letter for discussion of the long overdue need to increase our rates of reimbursement.



Rickey B. Silverman, Ph.D.
Licensed Psychologist, NH

cc Kathryn Saylor, New Hampshire Psychological Association



September 24, 2008

Andrew Chalsma
Bureau of Data and Systems Management
NEW HAMPSHIRE Department of Health and Human Services
Office of Medicaid and Business Policy
129 Pleasant Street
Concord, NH 03301-3857

RE: Testimony regarding the Report on New Hampshire Medicaid Provider Reimbursement Rates

Dear Mr. Chalsma:

Thank you for the opportunity to submit written testimony regarding the Department of Health and Human Services' draft report on New Hampshire Medicaid Provider Reimbursement Rates: Benchmarks for Key Services, as required by RSA 126 A: Chapter 18-b. Bi-State Primary Care Association is a statewide 501 c3 membership organization representing nonprofit providers of comprehensive primary care services and support programs that includes: community health centers (CHCs), including Federally Qualified Health Centers, Federally Qualified Health Center Look-Alikes, and Rural Health Centers; health care programs for the homeless; and community-based family planning programs. Our mission is to foster the delivery of primary and preventive health services to the people of New Hampshire and Vermont with special emphasis on the medically underserved.

New Hampshire's CHCs have a critical role in ensuring that all people, regardless of their health insurance status or ability to pay, have access to quality, primary and preventive health care services. The number of patients who are uninsured and those covered by Medicaid continues to grow. New Hampshire CHCs serve over 106,000 residents (or 1 in 12). Of those, approximately half of the patients are enrolled in Medicaid or without health insurance coverage. National studies have demonstrated that the CHCs save the state Medicaid programs approximately 30% per beneficiary per year.

Bi-State Primary Care Association appreciates the extensive work conducted by the Department to collect, benchmark, provide comparative analysis, and report on the eight service categories identified on page 3 of the report. We understand that the purpose of this report is to provide comparative data for New Hampshire in relation to the other New England states, and with other types of coverage, such as Medicare, and we applaud this work to be used in future decision making. We also appreciate the opportunity to offer the following comments as part of the Department's biennial rate setting process.

1. New Hampshire Medicaid provider rates should be adequate when compared to the benchmark data in the report, and the rates should keep pace with inflation in order to preserve an adequate provider network to support services to those who are on Medicaid.

Working for 100% Access to Health Care

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2. We are at a crisis situation in terms of recruiting and retaining primary care providers. The State's Medicaid Program must have competitive provider reimbursement rates because of the national shortage of primary care physicians, dentists, nurse practitioners, and other health professionals. Without adequate reimbursement for primary care and preventive services, New Hampshire is unable to successfully compete at the national level to recruit primary care providers to work here. This has a negative impact on all of the people of New Hampshire not only the Medicaid beneficiaries. In New Hampshire, there are currently more than 50 primary care vacancies reported to Bi-State Primary Care Association's Recruitment Center. If these positions remain unfilled, access to primary care will be limited for everyone, not just Medicaid beneficiaries.
3. The benchmarks and data in the report provide information for the Department to make recommendations to the Governor and Legislature to improve rate adequacy.

The Medicaid program impacts New Hampshire's overall health care system. When providers are inadequately reimbursed by Medicaid, it shifts costs onto those who have private insurance. This has a negative impact on the cost of health care to all consumers. It also negatively impacts the financial health of health care providers for all of the people of New Hampshire. We urge the Department, Governor and Legislature to consider these factors in its decision making on Medicaid provider rates and the Medicaid provider payment budget funding level for the next biennium.

The CHCs have a vision to provide 100% access to quality, affordable, comprehensive, and integrated primary care and preventive services to the people of New Hampshire. Yet, as the number of uninsured continues to rise, so too does the cost to provide care for all patients—resulting in a struggle to maintain current levels of service. The shortage of health care professionals adds another layer of complexity in finding solutions to these immediate challenges. Therefore, the adequacy of Medicaid rates is critical.

We look forward to working together to address these issues and to find ways to ensure provider reimbursement rates are adequate and developed with inflationary adjustments so that they can become competitive with the rest of the Northeast region.

Again, we want to take this opportunity to thank the Department for the hard work that went into producing the report. Please feel free to contact us if you have any questions or need any additional information.

Sincerely,



Tess Stack Kuenning
Executive Director
Bi-State Primary Care Association



Vanessa Santarelli
Director of New Hampshire Public Policy
Bi-State Primary Care Association

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COALITION FOR NEW HAMPSHIRE ORAL HEALTH ACTION

September 24, 2008

Andrew Chaslma
Office of Medicaid Business and Policy
Department of Health and Human Service
129 Pleasant Street
Concord, NH 03301

Subject: NH Medicaid Provider Reimbursement Rate Biennial Report

Dear Mr. Chalsma,

The Coalition for New Hampshire Oral Health Action (Coalition) would like to commend the Department on a well compiled report and acknowledge the dedication and the time spent on drafting the biennial report. The Coalition is pleased with the Department's willingness to include dental as one of the eight service categories identified for the first benchmarking project.

The Coalition is a diverse group of dental and non-dental stakeholders who continuously feel the impact of oral health issues within their organizations. In 2007, the Coalition secured an administrative home under Bi-State Primary Care Association (Bi-State). Bi-State and the Coalition have an ongoing partnership that continues to work collaboratively in addressing oral health issues as it relates to preventive and primary care for the underserved populations of New Hampshire. It is the vision of the Coalition that New Hampshire residents will have the opportunity to achieve and maintain oral health through access to an effective system of health services.

Removing known barriers between people and oral health services is an important principle outlined in the NH Oral Health Plan. Barriers to oral health services undoubtedly exist in New Hampshire. Attracting and increasing the number of dental providers willing to care for Medicaid patients has been negatively impacted by an inadequate reimbursement rate for New Hampshire's practicing dentists. The importance of New Hampshire's ability to provide dental care services is connected to the fact that reimbursement rates must be increased in order to encourage dental provider participation. The Coalition suggests that the Department support a dental reimbursement rate comparable to that of other New England states in order to remove a well known barrier to care.

COALITION FOR NEW HAMPSHIRE ORAL HEALTH ACTION

Numerous studies indicate that oral health is linked to overall health. The Coalition admires the Department's long standing effort of working with the dental community to ensure that the oral health needs of New Hampshire's children are addressed comprehensively. Unfortunately, the parents of those children have not been given the same opportunity to access oral health on a preventive or restorative level. Many suffer day to day with chronic dental infection and limited avenues of care. Trips to the emergency room for temporary relief of pain and infection or removal of the infected tooth are the only options currently addressing the need. The Coalition encourages the Department to consider the importance of preventive and restorative dental care for the adult Medicaid population, including pregnant women, in order to improve the overall health of adult Medicaid recipients. The emphasis on primary prevention can only be underscored, but the opportunity to reduce expensive unnecessary trips to the emergency room for dental care is imperative. Dental disease is preventable. The Coalition welcomes the opportunity to work collaboratively with the Department on exploring dental care models.

The Coalition for NH Oral Health Action is grateful for the opportunity to submit written testimony and welcomes the Department response on any of the above mentioned content. We sincerely appreciate the Department's transparency around the report.

Respectfully submitted,

The Coalition for NH Oral Health Action
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September 24, 2008

Andrew Chalsma
Bureau of Data & Systems Management
Office of Medicaid & Business Policy
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

RE: RSA 126-A:18-b, Medicaid Reimbursement Rates

Dear Mr. Chalsma:

Dartmouth-Hitchcock welcomes the opportunity to comment on the Department's recently issued *DRAFT NH Medicaid Provider Reimbursement Rate Benchmarks for Key Services* report.

As the State's largest Medicaid provider, Dartmouth-Hitchcock served more than 40,000 NH Medicaid patients at our sites in Lebanon, Manchester, Nashua, Concord and Keene in our FY 2006. We are New Hampshire's "safety net" for Medicaid and uninsured patients and we serve as an important resource for critical access hospitals and community health centers. The volume of Medicaid patients that we serve, combined with the acuity level of many of those patients – especially children served in our neonatal and pediatric intensive care units – means that Dartmouth-Hitchcock is disproportionately impacted by the inadequacy of NH Medicaid's rates. In FY 2006, the cost of care provided by Dartmouth-Hitchcock to NH Medicaid patients totaled \$48.6 million, for which we received payments totaling \$29.1 million, resulting in a Medicaid shortfall of \$19.5 million. Dartmouth-Hitchcock's 5-year loss on NH Medicaid payments is over \$65 million.

We appreciate the Department's efforts to compile such an extensive report. At the same time, we are disappointed that the Department was unable to gather comparative data from other New England states in regard to Hospital Inpatient and Hospital Outpatient rates. Here are some observations on information that was detailed in the report:

- **Page 13: Inpatient Hospital**

"In most cases in NH Medicaid, the payment is determined by multiplying the DRG relative weight by the base rate for the average service, referred to as the Price Per Point. The NH price per point has been \$3147.61 for general hospitals since 2001."

Even without comparative data, the statement above gets to the root cause of NH Medicaid's inadequate reimbursement. New Hampshire's current Price Per Point, (which was low to begin with) has not kept pace with the increasing costs of providing health care. Between 2001 and 2008, the Medicare "market basket" index increased an average of 3.4% a year. If the actual market basket rates were compounded annually and the increases applied to NH Medicaid rates, the DRG Price Per Point would be \$4116.83. If DHHS applied the Medical Consumer Price Index increases, as suggested by testimony offered by the NH Hospital Association, the Price Per Point would be even higher. **Dartmouth-Hitchcock urges DHHS to increase the Price Per Point to better reflect the true cost of medical care.**

- **Page 13: Neonatal rates**

Neonatal DRG 789 through 794 are reimbursed on a per diem basis of 65% of the full outlier amount.

Infants treated in DHMC's Neonatal Intensive Care Unit frequently have medical needs that require significant resources. Neonatal rates have traditionally been extremely low. Based on data provided by DHHS to the legislative fiscal committee for consideration for pediatric specialty rates, per diem rates have been as low as 12% of the 2007 Medicare Equivalent Rate. In the past, DHHS has relied on the "Catastrophic Pool" to improve payment for high cost cases. However, changes made to the catastrophic pool payment formula in 2004 have resulted in a decrease in payments to hospitals with high cost cases. **Dartmouth-Hitchcock urges DHHS to increase the per diem rates for neonatal DRGs. We also recommend that DHHS revise the catastrophic payment formula by introducing a "case mix index" threshold so that the catastrophic pool supplements payment for high-cost, high-acuity, truly "catastrophic" care.**

- **Page 14: Outpatient Hospital**

The current final payment rates are 91.27% of costs for critical access hospitals and rehabilitation hospitals and 81.24% of costs for all other hospitals.

A rate structure that does not cover the full cost of providing care to patients results in cost-shifting to other payers. The extent of the cost-shift has been well-documented by policy analysts. Hospital outpatient payment rate reductions are frequently offered by DHHS as potential "savings" in the Medicaid budget. Further reductions in outpatient rates will only exacerbate the existing cost-shift. **Dartmouth-Hitchcock urges DHHS to develop an outpatient payment formula that pays hospitals for the true cost of care.**

NH Medicaid's hospital rate structure is inadequate and has been for many years. Unless significant changes are made to the payment methodologies, safety net institutions such as Dartmouth-Hitchcock will be challenged to continue to provide the full range of

services we currently provide to NH Medicaid patients. We welcome the opportunity to work with DHHS to develop payment formulas that sustain safety net providers.

Thank you for the opportunity to comment.

Respectfully,

A handwritten signature in black ink, appearing to read "Gina Balkus".

Gina Balkus
Director of Government Relations