DHCS

TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

MAR 29 2013

Gloria Nagle, PhD, MPA
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 13-003

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 13-003 for your review and approval. This SPA implements the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (H.R.) 4872–24, section 1202, for fee-for-service payments. SPA 13-003 will be effective for dates of service on or after January 1, 2013 through December 31, 2014.

PPACA provides an increase to Medi-Cal rates for calendar years 2013 and 2014 for specified primary care services provided by eligible physicians. Primary care services are defined in the H.R. 4872–24, section 1202, and include Healthcare Common Procedure Codes for evaluation and management (E&M) (99201 through 99499) and vaccine administration (90460, 90461, 90471, 90472, 90473, and 90474).

DHCS will be using the "Medicare Rate for Office Site of Service with all Geographic Adjustments" as provided by the Centers for Medicare & Medicaid Services (CMS). In addition, DHCS will be using the Los Angeles, CA (Locality 18) Medicare rate for all Los Angeles County as well. DHCS is also submitting crosswalks for various local codes to E&M codes and vaccine codes to vaccine administration codes that CMS has authorized for payment increase. The crosswalk for the Low Income Health Program will be sent to CMS under a separate cover.

Enclosed for your review are the following:

- SPA 13-003 - Attachment 4.19B, pages 78-80
- HCFA 179

Director's Office
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413
Telephone (916)440-7400 Fax (916) 440-7404
Internet Address: www.dhcs.ca.gov

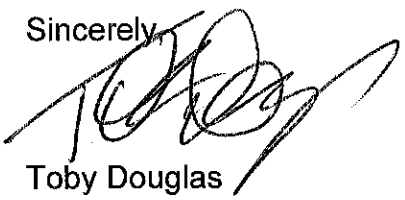
- Local codes crosswalked to E&M codes and vaccine codes crosswalked to vaccine administration codes.
- Public Notice
- Tribal Notice
- Managed Care Methodology

A public notice was published in the California Regulatory Notice Register on December 28, 2012, to notify Medi-Cal providers of the pending changes in payments to physician services to increase primary care services.

In addition, on February 22, 2013, DHCS notified the Indian Health Program and Urban Indian Organizations, of the PPACA payment increase. On February 27, 2013, DHCS held a Webinar to allow discussion and feedback. To date no comments have been received.

DHCS appreciates the guidance that CMS has provided in an effort to implement the PPACA payment increase to eligible physicians for specified primary care services. If you have questions or need additional information, please contact Mr. John Mendoza, Acting Chief, Fee-For-Service Rates Development Division at (916) 552-9639.

Sincerely,



Toby Douglas
Director

Enclosures

cc: Next Page

cc: Mari Cantwell
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Sacramento, CA 95899-7413

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-003**

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

X NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.405, 447.410, 447.415

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $227,600,000
b. FFY 2014 $303,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Pages 78-80

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None

10. SUBJECT OF AMENDMENT:
Increase Payments for Primary Care Services to Physician under Patient Protection and Affordable Care Act

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: MAR 29 2013

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

EDMUND G. BROWN, JR., GOVERNOR

OFFICE OF ADMINISTRATIVE LAW

California Regulatory Notice Register

REGISTER 2012, NO. 52–Z PUBLISHED WEEKLY BY THE OFFICE OF ADMINISTRATIVE LAW DECEMBER 28, 2012

PROPOSED ACTION ON REGULATIONS

TITLE 1. OFFICE OF ADMINISTRATIVE LAW
Determining "Good Cause" for Earlier Effective Date — Notice File No. Z2012–1218–07 1835

TITLE 2. VICTIM COMPENSATION AND GOVERNMENT CLAIMS BOARD
California Victims Compensation Program Regulations — Notice File No. Z2012–1218–01 1837

TITLE 8. OCCUPATIONAL SAFETY AND HEALTH STANDARDS BOARD
The Securing of Poles During Removal Operations; Aerosol Transmissible Diseases Respirator Exception — Notice File No. Z2012–1218–09 1839

TITLE 10. DEPARTMENT OF CORPORATIONS
Escrow Law Surety Bond Regulation — Notice File No. Z2012–1203–01 1845

TITLE 14. FISH AND GAME COMMISSION
Recreational Salmon Fishing — April Season — Notice File No. Z2012–1218–05 1847

TITLE 14. FISH AND GAME COMMISSION
Recreational Salmon Fishing — May to November Season — Notice File No. Z2012–1218–06 1850

TITLE 20. CALIFORNIA ENERGY COMMISSION
Conflict-of-Interest Code — Notice File No. Z2012–1218–02 1853

GENERAL PUBLIC INTEREST

DEPARTMENT OF FISH AND GAME
CESA Consistency Determination Request for Fruit Growers Supply Company, Multi–Species HCP (2080–2012–018–01), Siskiyou County 1855

DEPARTMENT OF FISH AND GAME
CESA Concurrence Request for San Joaquin River Restoration Project — Initial Broodstock Program (2080–2012–017–04) 1855

(Continued on next page)

Time-Dated Material

DEPARTMENT OF FISH AND GAME
Fish and Game Code section 2080.3 Concurrence No. 2080–2012–017–04 re: San Joaquin River Restoration Project Initial Broodstock Program 1856

DEPARTMENT OF HEALTH CARE SERVICES
Payments to Increase Primary Care Services 1861

DEPARTMENT OF HEALTH CARE SERVICES
Revise the Reimbursement Methodology for Durable Medical Equipment 1861

DECISION NOT TO PROCEED

OCCUPATIONAL SAFETY AND HEALTH STANDARDS BOARD
Concerning General Industry Safety Orders, Machinery and Equipment 1862

SUMMARY OF REGULATORY ACTIONS

Regulations filed with the Secretary of State 1862
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The *California Regulatory Notice Register* is an official state publication of the Office of Administrative Law containing notices of proposed regulatory actions by state regulatory agencies to adopt, amend or repeal regulations contained in the California Code of Regulations. The effective period of a notice of proposed regulatory action by a state agency in the *California Regulatory Notice Register* shall not exceed one year [Government Code § 11346.4(b)]. It is suggested, therefore, that issues of the *California Regulatory Notice Register* be retained for a minimum of 18 months.

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DEPARTMENT OF HEALTH CARE SERVICES

Health Care Reconciliation Act of 2010 (H.R.) 4872–24 Section 1202 Payments to Primary Care Services

This notice provides information of public interest with respect to the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (H.R.) 4872–24, section 1202, that requires the Department of Health Care Services to increase payments for primary care services furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, as specified in 77 Fed. Reg. 66,670. The increased payments would be at a rate not less than 100 percent of the Medicare rate in effect for calendar years 2013 and 2014, or if greater, the payment rates that would be applicable in those calendar years using the 2009 Medicare physician fee schedule conversion factor.

Primary care services are defined in the H.R. 4872–24, section 1202 as:

- Evaluation and management services that are procedure codes for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System as of December 31, 2009. The procedure codes are 99201 through 99499.
- Services related to immunization administration for vaccines and toxoids. The procedure codes are 90460, 90461, 90471, 90472, 90473, and 90474.

The H.R. 4872.24, section 1202 payment increase is effective for dates of service on or after January 1, 2013, through December 31, 2014.

Accordingly, DHCS is required to submit a State Plan Amendment to the Centers for Medicare & Medicaid Services on or before March 31, 2013, to obtain federal approval for the increased payments.

PUBLIC REVIEW AND COMMENTS

The federal law discussed above is available for public review at welfare offices in every county of the State. Written comments may be submitted within 45 days of the publication date of this notice to:

Arlene Sakazaki, Chief, Provider Rate Section
Fee–For–Service Rates Development
Department of Health Care Services; MS 4600
P.O. Box 997417
Sacramento, CA 95899–7417

DEPARTMENT OF HEALTH CARE SERVICES

THE DEPARTMENT OF HEALTH CARE SERVICES IS REVISING THE REIMBURSEMENT METHODOLOGY FOR DURABLE MEDICAL EQUIPMENT

This notice provides information of public interest about the California Department of Health Care Services (Department) revising the reimbursement methodology for durable medical equipment (DME) with no specified maximum allowable rate known as "by report". Senate Bill 728 (Chapter 451, Statutes of 2012) amends Welfare and Institutions (W&I) Code section 14105.48(d)(4) by revising the manufacturer's suggested retail purchase (MSRP) price date specified in the DME "by report" reimbursement methodology from June 1, 2006, to a date on or prior to the date of service.

Pursuant to subdivision (d) of section 14105.48 of the W&I Code, the Department reimburses DME "by report" the lesser of (1) the amount billed pursuant to section 51008.1 of Title 22 of California Code of Regulations, (2) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to section 14105.3 plus a percentage markup to be established by the Department, (3) the actual acquisition cost plus a markup to be established by Department, (4) the manufacturer's suggested retail purchase price on June 1, 2006, and documented by a printed catalog or hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 20 percent, or not to exceed 15 percent for wheelchairs and wheelchair accessories if the provider employs or contracts with a qualified rehabilitation professional, as defined in paragraph (3) of subdivision (c) of section 14105.485, or (5) a price established through targeted product–specific cost containment provisions developed with providers.

Effective for dates of service on or after January 1, 2013, the Department will require the MSRP price on or prior to date of service instead of on June 1, 2006, for DME "by report".

PUBLIC REVIEW AND COMMENTS

The California statutory provisions discussed above are available for public review at county welfare offices throughout the State. Written comments (or requests for copies of the statutes) may be submitted to: Arlene Sakazaki, Chief, Provider Rate Section; Fee–For–Service Rates Development; Department of Health Care Services; MS 4600; P.O. Box 997417; Sacramento, CA 95899–7417.

ACA Section 1202
Vaccinations

For several years, DHCS has reimbursed for non-Vaccines for Children (VFC) vaccinations by bundling the rate of the toxoid with the rate of vaccine administration. As a result the provider only needed to submit a bill using the CPT code for the vaccine. For VFC, the providers receive the vaccine toxoid free, and they are paid only for the administration fee. To track which vaccines are given (enabling CDPH to obtain and distribute the right amount of vaccine), VFC providers have billed for the administration fee using the toxoid code.

Under the Final Rule of ACA Section 1202 the increase in the reimbursement rate for vaccine administration in the non-VFC setting requires an unbundling of the toxoid and administration rates in order to appropriately reimburse for vaccines with multiple antigen components (highlighted vaccines in the spreadsheet below).

Examples: Adenovirus code 90476 (first vaccine in the spreadsheet below)

In the case of an adenovirus vaccination, a provider currently submits the bill using the CPT code 90476 then is reimbursed the bundled rate (the adenovirus toxoid plus 1 vaccine admin fee). According to Section 1202 the new process the provider is to submit the bill using the CPT code for the adenovirus toxoid and code 90460 for the administration of the vaccine to children ages 0 through 18. For adults CPT code 90473 is used for the administration of the vaccine (because it is oral).

For vaccines with 1 antigen component:

Billing for *children* ages 0-18 years
The appropriate CPT code (example 90476) is used to bill for the toxoid,
CPT code **90460** is to be used for billing for the administration of a vaccine with 1 antigen component.

Billing for *adults* ages over 18 years
The appropriate CPT code 90476 is for the toxoid,
CPT code **90473** is used for billing the **intranasal or oral administration** of a vaccine, which adenovirus is.
CPT code **90471** is used for billing the administration of a vaccine with 1 antigen component, intradermal, subcutaneous, or intramuscular.

For vaccines with multiple (2 or more) antigen components:

Billing for *children* ages 0-18 years
The appropriate CPT code (example 90644) is used to bill for the toxoid,
CPT code **90460** is to be used for billing the administration of a vaccine with 1 antigen component
CPT code **90461** is to be used for billing the administration for each additional antigen component contained in the vaccine.

For vaccines with multiple (2 or more) antigen components:

Billing for *adults* over 18 years of age
The appropriate CPT code (example 90696) is used to bill for the toxoid,
CPT code **90471** is to be used for billing the administration of a vaccine with 1 antigen component
CPT code **90472** is to be used for billing the administration for each additional antigen component contained in the vaccine.

OLD Bundled (Toxoid rate & admin rate included)	Rate	NEW (Section 1202)	Rate
90476 Adenovirus type 4, live, oral		**90476** Adenovirus type 4, live, oral	
		and	
		90460 vaccine administration, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90477 Adenovirus type 7, live, oral		**90477** Adenovirus type 7, live, oral	
		and	
		90460 vaccine administration, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90581 Anthrax, SQ or IM		90581 Anthrax, subcutaneous or IM	
		and	
		90460 vaccine administration, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90585 (BCG) for tuberculosis percutaneous		**90585** Tuberculosis, percutaneous	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90586 (BCG) for Bladder cancer, intravesical use		**90586** BCG for bladder cancer, IM	
		and	
		51720 vaccine admin. 1 component	
90632 Hepatitis A, adult dose, IM		**90632** Hepatitis A, adult dose, IM	
		and	
		90471 vaccine admin for adult	
90633 Hepatitis A, ped/adolescent, 2 dose schedule, IM		**90633** Hepatitis A, ped/adolescent, 2 dose schedule, IM,	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90634 Hepatitis A, ped/adolescent, 3 dose schedule, IM		**90634** Hepatitis A, ped/adolescent, 3 dose schedule, IM	
		and	
		90460 vaccine admin, 1 component	
90636 Hepatitis A and B (HepA-HepB), adult, IM		**90636** Hepatitis A and B (Hep A-Hep B), adult, IM	
		and	
		90471 vaccine admin for adult	

90644 Meningococcal & Hemophilus (Hib-MenCY), & 4 dose for children 2-15 months, IM **2 different antigen components**		**90644** Meningococcal & Hemophilus (Hib-MenCY), & 4 dose for children 2-15 months, IM ***2 antigen components:***	
		and	
		90460 vaccine admin, 1st component (through age 18);	
		and	
		90461 once for 1 additional component	
90645 Hemophilus influenza b (Hib), HbOC, 4 dose schedule, IM		**90645** Hemophilus influenza b (Hib), HbOC, 4 dose schedule, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90646 Hemophilus influenza b, (Hib), PRP-D, booster, IM		**90646** Hemophilus influenza b, (Hib), PRP-D, booster, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90647 Hemophilus influenza b (Hib),PRP-OMP, 3 dose schedule, IM		**90647** Hemophilus influenza b (Hib),PRP-OMP, 3 dose schedule, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90648 Hemophilus influenza b (Hib), PRP-T, 4 dose schedule, IM		**90648** Hemophilus influenza b (Hib), PRP-T, 4 dose schedule, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90649 (HPV) types 16, 11, 16, 18 (quadrivalent), 3 dose sch, IM 1 component		**90649** (HPV) types 16, 11, 16, 18 (quadrivalent), 3 dose, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90650 (HPV) types 16, 18, bivalent, 3 dose sch, IM 1 component		**90650** (HPV) types 16, 18, bivalent, 3 dose, IM	
		and	
		90460 vaccine admin, 1 component(through age 18)	
		or	
		90471 vaccine admin for adult	

90653 Influenza, IM		**90653** Influenza, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90654 Influenza, Intradermal		**90654** Influenza, Intradermal	
		and	
		90460 vaccine admin, 1 component(through age 18)	
		or	
		90471 vaccine admin for adult	
90655 Influenza, trivalent, when admin to children 6-35 months, IM		**90655** Influenza, trivalent, when admin to children 6-35 months, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
90656 Influenza, trivalent, when admin to individuals 3 and older, IM		**90656** Influenza, trivalent, when admin to individuals 3 and older, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90657 Influenza, trivalent, when admin to children 6-35 months, IM		**90657** Influenza, trivalent, when admin to children 6-35 months, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
90658 Influenza, trivalent, when admin to individuals 3 yrs and older, IM		**90658** Influenza, trivalent, when admin to individuals 3 yrs and older, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90660 Influenza, intranasal		**90660** Influenza, intranasal	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90672 Influenza, quadrivalent, intranasal		**90672** Influenza, quadrivalent, intranasal	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	

90661 Influenza, from cell cultures, IM		**90661** Influenza, from cell cultures, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90662 Influenza, enhanced immunogenicity, IM		**90662** Influenza, enhanced immunogenicity, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90664 Influenza, pandemic formulation, intranasal		**90664** Influenza, pandemic formulation, intranasal	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90666 Influenza, pandemic formulation, IM		**90666** Influenza, pandemic formulation, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90667 influenza, pandemic formulation, adjuvanted, IM		**90667** influenza, pandemic formulation, adjuvanted, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90668 Influenza, pandemic, IM		**90668** Influenza, pandemic, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90669 Pneumococcal, 7 valent, IM		**90669** Pneumococcal, 7 valent, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90670 Pneumococcal, 13 valent, IM		**90670** Pneumococcal, 13 valent, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	

90675 Rabies, IM		**90675** Rabies, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90676 Rabies, intradermal		**90676** Rabies, intradermal	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90680 Rotavirus, pentavalent, 3 dose, oral		**90680** Rotavirus, pentavalent, 3 dose, oral	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90681 Rotavirus, human, 2 dose, oral		**90681** Rotavirus, human, 2 dose, oral	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90690 Typhoid, oral		**90690** Typhoid, oral	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90691 Typhoid, Vi capsular, IM		**90691** Typhoid, Vi capsular, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90692 Typhoid, H-P, SubQ or intradermal		**90692** Typhoid, H-P, SubQ or intradermal	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90693 Typhoid, Acetone Killed, SQ		**90693** Typhoid, Acetone Killed, SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	

90696 Diphtheria, Tetanus, acellular Pertussis and Polio, 4-6 years, ((DTaP – IPV) IM ***4 different antigen components***		**90696** Diphtheria, Tetanus, Pertussis and Polio, 4-6 years, IM ***4 antigen components:***	
		and	
		90460 vaccine admin, 1st component, (use code **90471** for adults)	
		and	
		90461 (x 3) vaccine admin for each additional component , (use code **90472** for adults)	
90698 Diphtheria, Tetanus, Pertussis, H. Influenza, Poliovirus, (DTaP – Hib – IPV) IM ***5 different antigen components***		**90698** Diphtheria, Tetanus, Pertussis, H. Influenza, Poliovirus, (DTaP – Hib – IPV) IM	
		and	
		5 antigen components: **90460** vaccine admin, 1st component, (use code **90471** for adults),	
		and	
		90461 (x 4) vaccine admin for each additional component, (use code **90472** for adults)	
90700 Diphtheria, Tetanus, Pertussis, 0-7 years, IM ***3 different antigen components***		**90700** Diphtheria, Tetanus, Pertussis, 0-7 years, IM	
		and	
		3 antigen components: **90460** vaccine admin, 1st component	
		and	
		90461 (x 2) vaccine admin for each additional component	
90702 Diphtheria, Tetanus, 0-7years, IM ***2 different antigen components***		**90702** Diphtheria, Tetanus, 0-7years, IM	
		and	
		2 antigen components: **90460** vaccine admin, 1st component	
		and	
		90461 (x 2) vaccine admin for each additional component	
90703 Tetanus, IM		**90703** Tetanus, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90704 Mumps, SQ		**90704** Mumps, SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	

90705 Measles, SQ		**90705** Measles, SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90706 Rubella, SQ		**90706** Rubella, SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90707 Measles, Mumps, Rubella, (MMR), live, subcutaneous ***3 different antigen components***		**90707** MMR, live, subcutaneous	
		and	
		3 antigen components: **90460** vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 2) vaccine admin, for each additional component, (use **90472** for adults)	
90708 Measles and Rubella, SQ ***2 different antigen components***		**90708** Measles and Rubella, SQ	
		and	
		2 different antigen components: **90460** vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 1) vaccine admin, for each additional component, (use **90472** for adults)	
90710 Measles, Mumps, Rubella Varicella, (MMRV), SQ ***4 different antigen components***		**90710** MMRV, live, subcutaneous	
		and	
		4 antigen components: **90460** vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 3) vaccine admin, for each additional component, (use **90472** for adults)	
90712 Poliovirus, (OPV), oral		**90712** Poliovirus, (OPV), oral	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90473 vaccine admin for adults	
90713 Poliovirus, (IPV), SQ or IM		**90713** Poliovirus, (IPV), SQ or IM	
		and	
		90460 vaccine admin, 1 component	

90714 Tetanus, Diphtheria, (Td), 7 years or older, IM ***2 different antigen components***		**90714** Tetanus, Diphtheria, (Td), 7 years or older, IM	
		and	
		2 antigen components: **90460** vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 1) vaccine admin, for one additional component, (use **90472** for adults)	

90715 Tetanus, diphtheria, pertussis, (Tdap), 7 years or older, IM ***3 different antigen components***		**90715** Tetanus, diphtheria, pertussis, (Tdap), 7 years or older, IM	
		and	
		3 different antigen components: **90460** vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 2) vaccine admin, for one additional component, (use **90472** for adults)	
90716 Varicella, SQ		**90716** Varicella, SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90717 Yellow Fever, SQ		**90717** Yellow Fever, SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90719 Diphtheria, IM		**90719** Diphtheria, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90720 Diphtheria, Tetanus. Pertussis. H. influenza B. (DTP-Hib), IM ***4 different antigen components:***		**90720** Diphtheria, Tetanus. Pertussis. H. influenza B. (DTP-Hib), IM	
		and	
		4 antigen components: **90460** vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 3) vaccine admin, for one additional component, (use **90472** for adults)	

90721 Diphtheria, tetanus, pertussis, H. influenza B, (DtaP-Hib), IM ***4 different antigen components***		**90721**Diphtheria, tetanus, pertussis, H. influenza B, (DtaP-Hib), IM	
		and	
		4 different antigen components: **90460** vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 3) vaccine admin, for one additional component, (use **90472** for adults)	
90723 Diphtheria, tetanus, pertussis, Hep B, poliovirus, (DtaP-HepB-IPV), IM ***5 different antigen components***		**90723** Diphtheria, tetanus, pertussis, Hep B, poliovirus, (DtaP-HepB-IPV), IM ***5 different antigen components:***	
		and	
		90460 vaccine administration, 1st component, , (use code **90471** for adults)	
		and	
		90461 (x 4) vaccine admin, for one additional component, (use **90472** for adults)	
90725 Cholera, Injectable		**90725** Cholera, Injectable	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90727 Plague, IM		**90727** Plague, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90732 Pneumococcal, 23-valent, adult or immunosuppressed patient dosage, individuals 2 years or older, SQ or IM		**90732** Pneumococcal, 23-valent, adult or immunosuppressed patient dosage, individuals 2 years or older, SQ or IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90733 Meningococcal, (any groups), SQ		**90733** Meningococcal, (any groups), SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	

90734 Meningococcal, serogroups A, C, Y and W-135 (tetravalent), IM		**90734** Meningococcal, serogroups A, C, Y and W-135 (tetravalent), IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90735 Japanese encephalitis, SQ		**90735** Japanese encephalitis, SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90736 Zoster (Shingles), SQ		**90736** Zoster (Shingles), SQ	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90738 Japanese encephalitis, inactivated, IM		**90738** Japanese encephalitis, inactivated, IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90739 Hepatitis B, adult dosage (2 dose schedule), IM		**90739** Hepatitis B, adult dosage (2 dose schedule), IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90740 Hepatitis B, dialysis or immunosuppressed patient (3 dose schedule), IM		**90740** Hepatitis B, dialysis or immunosuppressed patient (3 dose schedule), IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90743 Hepatitis B, adolescent (2 dose schedule), IM		**90743** Hepatitis B, adolescent (2 dose schedule), IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	

90744 Hepatitis B, pediatric/adolescent dosage (3 dose schedule), IM		**90744** Hepatitis B, pediatric/adolescent dosage (3 dose schedule), IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90746 Hepatitis B, adult (3 dose schedule), IM		**90746** Hepatitis B, adult (3 dose schedule), IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90747 Hepatitis B, dialysis or immunosuppressed patient (4 dose schedule), IM		**90747** Hepatitis B, dialysis or immunosuppressed patient (4 dose schedule), IM	
		and	
		90460 vaccine admin, 1 component (through age 18)	
		or	
		90471 vaccine admin for adult	
90748 Hepatitis B and H. influenza b (Hep B-Hib), IM		**90748** Hepatitis B and H. influenza b (Hep B-Hib), IM	
		and	
2 different antigen components		***2 different antigen components:*** **90460** vaccine administration, 1st component, (use code **90471** for adults)	
		and	
		90461 (x 1) vaccine admin, for one additional component, (use **90472** for adults)	
90749 Unlisted vaccine/toxoid		N/A – by report	

Consideration must be given regarding providers who do not qualify for the increase in administration rate. Unbundling the administration fee from the rate for the toxoid will require the establishment of a Medi-Cal rate for the administration.

DRAFT: Z Code Crosswalk, Conversion to CPT

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Local Z code	Rate	National CPT code (HIPAA compliant)	Rate
Z0100 - NICU and PICU Initial 24 hrs Admit		For Critically Ill Patients:	
		99468 - Initial neonatal critical care	
		99471 - Initial pediatric critical care (29d-24m)	
		99476 - Subsequent pediatric critical care (2-5 yrs)	
		99291 - Initial 1 hour Critical Care (> 5 years of age) **99292** - Additional 30 min Critical Care (> 5 years of age)	
		Newborns requiring Intensive Care, not Critically Ill:	
		99477 - Initial neonatal intensive care	
		For Initial Non-Critical (neonatal or pediatric):	
		99222 50 minutes – comprehensive history and exam, moderate-complexity	
		99223 70 minutes –comprehensive history and exam, high complexity	
Z0102 NICU and PICU Subseq CAT 1 [Vent., CPAP, Hyperal, IV drug support; metabolic change, invasive monitor]		For Critically Ill Patients:	
		99469 - Subsequent neonatal critical care	
		99472 - Subsequent pediatric critical care (29d-24m)	
		99476 - Subsequent pediatric critical care (2-5 yrs)	
		99291 – Initial Hour Critical Care (> 5 years of age) **99292** - Additional 30 min Critical Care (> 5 years of age)	
		For Newborns requiring Intensive Care, not Critically Ill:	
		99478 - Subseq intensive care, < 1500 gm	
		99479 - Subseq intensive care, 1500-2500 gm	
		99480 - Subseq intensive care, 2501-5000 gm	
		For Subsequent Non-Intensive neonate and pediatric	
		99232 25 minutes – expanded history and exam, moderate complexity	
		99233 35 minutes – detailed history and exam, high-complexity	
Z0104 NICU and PICU Subsequent CAT 2 [Supplemental oxygen; IV for meds/fluids; feeds via NG, OG, NJ, GTT]		For Critically Ill Patients	
		99469 - Subsequent neonatal critical care	
		99472 - Subsequent pediatric critical care (29d-24m)	
		99476 - Subsequent pediatric critical care (2-5 yrs)	
		99291 – Initial Hour Critical Care (> 5 years of age) **99292** - Additional 30 min Critical Care (> 5 years of age)	
		For Newborns requiring Intensive Care, not Critically Ill	
		99478 - Subseq intensive care, < 1500 gm	
		99479 - Subseq intensive care, 1500-2500 gm	
		99480 - Subseq intensive care, 2501-5000 gm	
		For Subsequent Non-Intensive neonate and pediatric	
		99232 25 minutes – expanded history and exam, mod-complexity	
		99233 35 minutes – detailed history and examination, high-complexity	
Z0106 NICU and PICU Subsequent CAT 3 [Frequency Monitor/Assessment; Cardiac Monitoring; Oximeter]		For Critically Ill Patients:	
		99469 - Subsequent neonatal critical care	
		99472 - Subsequent pediatric critical care (29d-24m)	
		99476 - Subsequent pediatric critical care (2-5 yrs)	
		99291 – Initial Hour Critical Care (> 5 years of age) **99292** - Additional 30 min Critical Care (> 5 years of age)	
		For Newborns requiring Intensive Care, not Critically Ill	
		99478 - Subseq intensive care, < 1500 gm	
		99479 - Subseq intensive care, 1500-2500 gm	
		99480 - Subseq intensive care, 2501-5000 gm	
		For Subsequent Non-Intensive neonate and pediatric	
		99232 25 minutes – expanded history and exam, mod-complexity	
		99233 35 minutes – detailed history and exam, high-complexity	

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DRAFT: Z Code Crosswalk, Conversion to CPT

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Local Z code	Rate	National CPT code (HIPAA compliant)	Rate
Z0108 NICU and PICU Subsequent CAT 4 [Stable Routine Day Prior to DC; Discharge Day]		For Critically Ill Patients	
		99469 - Subsequent neonatal critical care	
		99472 - Subsequent pediatric critical care (29d-24m)	
		99476 - Subsequent pediatric critical care (2-5 yrs)	
		99291 – Initial Hour Critical Care (> 5 years of age) **99292** - Additional 30 min Critical Care (> 5 years of age)	
		For Newborns requiring Intensive Care, not Critically Ill	
		99478 - Subseq intensive care, < 1500 gm	
		99479 - Subseq intensive care, 1500-2500 gm	
		99480 - Subseq intensive care, 2501-5000 gm	
		For Subsequent Non-Intensive neonate and pediatric	
		99232 25 minutes – expanded history and exam, moderate-complexity	
		99233 35 minutes – detailed history and exam, high-complexity	
		99239 (>30 min.) Hospital discharge day management	
		99238 (30 min. or less)	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Reimbursement - Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.
The Department will be using the Los Angeles, CA (Locality 18) Medicare rate for all Los Angeles County's.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐quarterly

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Primary Care Services Affected by this Payment Methodology

☒ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☐ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

☐ The State will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐Medicare Physician Fee Schedule rate

☐ State regional maximum administration fee set by the Vaccines for Children program

☒ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: .

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: Non-VFC $4.46 and VFC $9.00 .

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Documentation of Vaccine Administration Rates in Effect 7/1/09 (Continued)

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, to December 31, 2014.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, to December 31, 2014.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Reimbursement - Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments. The Department will be using the Los Angeles, CA (Locality 18) Medicare rate for all Los Angeles County's.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Primary Care Services Affected by this Payment Methodology

☒ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☐ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

☐ The State will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☐ State regional maximum administration fee set by the Vaccines for Children program

☒ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____.

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: Non-VFC $4.46 and VFC $9.00 .

_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Documentation of Vaccine Administration Rates in Effect 7/1/09 (Continued)

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, to December 31, 2014.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, to December 31, 2014.

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
Maternal Care Services	**Z6402**	Initial health education assessment and development of care plan first 30 minutes		**99401**- Preventive Medicine counseling, 15 minutes	$8.41 for each 15 minutes	Diagnosis is restricted to the following codes::(V22- V23.99; 640-676).
	and					
	Z6404	Initial health education assessment and development of care plan each subsequent 15 minutes				
	Z6406	Follow-up antepartum health education assessment, treatment, and/or intervention, group,per patient, each 15 minutes		**99401**- Preventive Medicine counseling, 15 minutes and modifier TS (follow-up service)	$8.41 for each 15 minutes	Diagnosis codes are restricted to the following:V22-V23.99 and 640-676.99. Frequency is restricted to eight in nine months without prior authorization.
	Z6414	Postpartum health education assessment treatment and/or intervention, including development of care plan individual, each 15 minutes		**99401**- Preventive Medicine counseling, 15 minutes and modifier TH (obstetrical treatment/services) prenatal or postpartum	$8.41 for each 15 minutes	Diagnosis codes are restricted to the following: V24.0-V24.2 Frequency is restricted four in six months without prior authorization for the same procedure, same recipient, same provider
Multi-Purpose Senior Citizens Program (No Rates Available)	**Z8584**	Therapeutic Counseling- Per hour		**Revenue Code: 0590**-Home Health Units of Service, General + **CPT Code: 99404** - Preventive medicine counseling and/or risk factor	Billing Instructions: Bill revenue code 0590 in conjunction with CPT code 99404 to indicate hourly Therapeutic Counseling services Reimbursement Rate; Amount billed on claim not to exceed the maximum allowable on the Provider Master File for the sevice as identified by the national code configuration.	Utilization: -Total expenditures for fiscal year 2005-06 were $105,579.57 with total claims count of 1,112.
Medical Services-Physician Subacute	**X9922**	Initial subacute care, per day, for the evaluation and management of a patient, which requires these three key components: • A detailed or comprehensive history; • A detailed or comprehensive examination; and • Medical decision making that is straightforward or of low complexity	Procedure Type N: $34.30 Procedure Type P: $30.60	**99221** -Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: • A detailed or comprehensive history; • A detailed or comprehensive examination; and . • Medical decision making that is straightforward or of low complexity *And* U2 - Medicaid Level of Care 2, as defined by each State	Procedure Type N: $34.30 Procedure Type P: $30.60	• Modifier U2 is used to identify Subacute level of care. • Where National Code rate differs from Interim Code rate, adopt National Code rate
	X9924	Initial subacute care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history; • A comprehensive examination; and • Medical decision making of moderate complexity	Procedure Type N: $73.20 Procedure Type P: $65.20	**99222**- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: • A comprehensive history; • A comprehensive examination; and • Medical decision making of moderate complexity	Procedure Type N: $73.20 Procedure Type P: $65.20	• Modifier U2 is used to identify Subacute level of care. • Where National .Code rate differs from Interim Code rate, adopt National Code rate.
Medical Services-Physician Subacute	**X9924**					

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
				And U2 - Medicaid Level of Care 2, as defined by each		
	X9926	Initial subacute care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history; • A comprehensive examination; and • Medical decision making of high complexity	Procedure Type N: $80.10 Procedure Type P: $71.40	**99223** -Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: • A comprehensive history; • A comprehensive examination; and • Medical decision making of high complexity *And* **U2** - Medicaid Level of Care 2, as defined by each State	Procedure Type N: $80.10 Procedure Type P: $71.40	• Modifier U2 is used to identify Subacute level of care. • Where National Code rate differs from Interim Code rate, adopt National Code rate.
Perinatal Services	**Z1032**	Initial comprehensive pregnancy-related office visit	$126.31	CPT Code (most applicable): **99205**- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: comprehensive history; comprehensive examination; medical decision making of high complexity **99215**- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: comprehensive history; comprehensive examination; medical decision making of high complexity *And* **Modifier** **TH** - Obstetrical treatment/services, prenatal or postpartum	$126.31 when either 99205 or 99215 are billed with modifier TH.	• Allow pregnancy diagnosis codes (V22-V23.9; V24-V24.2; 640-676.9) to be billed with 99205 and 99215 when also billed with modifier TH.
FAMILY PACT (No National Rates Available)	**Z9752**	Family PACT, Individual Family Planning Couseling 11-15 Minutes	$19.07	**CPT Codes: 99401 -** Preventive medicine counseling and/orrisk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes **Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for *this local code. The revenue* code *below is suggested to ensure compliance with HIPAA transaction. 0770 - Preventive Care Services, General***		• The national code is currently in use by Medi-Cal specific to the LEA program, but is not in use by Family PACT. LEA currently carries its own Procedure Type, Provider Type and Category of Service. Family PACT use and policy of the national code should remain separate from LEA use and policy. Existing Family PACT policy for the local code should be carried over and applied to the national code with the following exception: Termainate "S" codes and apply the identified ICD-9 diagnosis codes in the attached "S" Diagnosis Code crosswalk.

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
FAMILY PACT (No National Rates Available)	**Z9752**					Eliminate the requirement of submitting a specific diagnosis code in the primary diagnosis code position of the claim as this is not in accordance with ICD-9 guidelines which are covered under HIPAA. However, the primary focus of Family PACT is family planning. The terms and conditions from CMS state that services whose primary purpose is family planning, the Federal Financial Participation (FFP) will be available at 90%. This requires that procedures, office visits, labs and other tests carry a diagnosis code that specifically identifies them as family planning. For medical diagnosis or treatment services provided ancillary to a family planning service in a family planning setting and which carry a diagnosis code which indicate that they are related to family planning service, FFP will be available at tthe FMAP rate. In accordance with waiver requirements, current family Pact policy, billing instructions/claim form completion and claims processing (including MMIS 1700 table) require a specific diagnosis in the primary and secondary positions. Therefore, a solution must be developed that meets HIPPA compiance without impacting CMS 64 reporting to draw down FFP. In order to properly identify and route Family PACT claims, it is suggested that the system look for the specific HAP identification number in conjunction with the beneficiary AID code, 8H. Additionally, the system should also look . for ICD-9 "V" and numeric codes identified in the attached "S" diagnosis code crosswalk to indicate Family PACT benefits in accordance with the waiver. guidelines. The system should be able to look for the diagnosis code(s) in any position. It is recommended that edits be implemented to prevent the national code from being billed with other E&M codes (99201-99215 and 99381-99395 and 99402-99403) for the same recipient, same provider, same date of service. The Family PACT program will follow up with CMS for approval to use these codes in place of the current local codes, which have been approved by CMS to allow trained supervised non-clinician counselors to provide education and counseling services. If it is determined that 99401 - 99403 should not be used for non-clinician counselors. OHC recommends using HCPCS code H1010 (Non medical family planning education, per session) for those services provided by a non-clinician. If H1010 is implemented with this conversion, a rate analysis will need to be done on the appropriate. reimbursement methodology in order to maintain budget neutrality. OHC recommends defining a session as 15 minutes and applying the existing rates for local codes Z9752-Z9754 accordingly. In other words, one 15 minute session would equal one unit and be reimbursed at $19.07.
	Z9753	Family PACT, Individual Family Planning Counseling, 16-30 minutes	$31.79	**CPT Codes: 99402 -** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.		National code is not currently in use by Family PACT or Medi-Cal, therefore existing Family PACT policy for the local code should be carried over and applied to the national code with the following exception: Terminate current "S" diagnosis codes and apply the identified ICD-9 diagnosis codes in the attached "S" Diagnosis Code crosswalk.
FAMILY PACT (No National Rates Available)	**Z9753**			***Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for this local code. There venue code below is suggested to ensure compliance with HIPAA transactions. 0770- Preventive Care Services, General***		Eliminate the requirement of submitting a specific diagnosis code in the primary diagnosis code position of the claim as this is not in accordance with ICD-9 guidelines which are covered under HIPAA. However, the primary focus of Family PACT is family planning. The terms and conditions from CMS state that services whose primary purpose is family planning, the Federal Financial Participation (FFP) will be available at 90%. This requires that procedures, office visits, labs and other tests carry a diagnosis code that specifically identifies them as family planning. For medical diagnosis or planning setting and which carry a diagnosis code which indicate that they are related to a family planning service, FFP will be available at the FMAP rate. In accordance with waiver requirements, current Family PACT policy billing instructions/claim form completion and claims processing (including MMIS 1700 table) require a specific diagnosis in the primary and secondary positions. Therefore a solution must be developed that meets HIPPA compliance without impacting CMS 64 reporting to draw down FFP.

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
						In order to properly identify and route Family PACT claims, it is suggested that the system look for the specific HAP identification number in conjunction with the beneficiary AID code, BH. Additionally, the system should also look for ICD-9 "V" and numeric codes identified in the attached "S" diagnosis code crosswalk to indicate Family PACT benefits in accordance with the waiver guidelines. The system should be able to look for the diagnosis code(s) in any position. It is recommended that edits be implemented to prevent the national code from being billed with other E&M codes (99201-99215 and 99381-99395 and 99401 and 99403) for the same recipient, same provider, same date of service. The Family PACT program will follow up with CMS for approval to use these codes in place of the current local codes, which have been approved by CMS to allow trained supervised non-clinician counselors to provide education and counseling services. If it is determined that 99401 - 99403 should not be used for non-clinician counselors, OHC recommends using HCPCS code H1010 (Non-medical family planning education, per session) for those services provided by a non-clinician. If H1010 is implemented with this conversion, a rate analysis will need to be done on the appropriate reimbursement methodology in order to maintain budget neutrality. OHC recommends defining a session as 15 minutes and applying the existing rates for local codes Z9752-Z9754 accordingly. In other words, 16 - 30 minutes session would equal two units and be reimbursed at $31.79
FAMILY PACT (No National Rates Available)	**Z9754** **Z9754**	Family PACT, Individual Family Planning Counseling, 30-45 minutes	$44.51	**CPT Codes:** **99403 -** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes ***Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for this local code. The revenue code below is suggested to ensure compliance with HIPAA transactions. 0770- Preventive Care Services, General***		National code is not currently in use by Family PACT or Medi-Cal, therefore existing Family PACT policy for the local code should be carried over and applied to the national code with the following exception: Terminate current "S" diagnosis codes and apply the identified ICD-9 diagnosis codes in the attached "S" Diagnosis Code crosswalk Eliminate the requirement of submitting a specific diagnosis code in the primary diagnosis code position of the claim as this is not in accordance with ICD-9 guidelines which are covered under HIPAA. However, the primary focus of Family PACT is family planning. The terms and conditions from CMS state that services whose primary purpose is family planning, the Federal Financial Participation (FFP) will be available at 90%. This requires that procedures, office visits, labs and other tests carry a diagnosis code that specifically identifies them as family planning. For medical diagnosis or treatment services provided ancillary to a family planning service in a family planning setting and which carry a diagnosis code which indicate that they are related to a family planning service, FFP will be available at the FMAP rate. In accordance with waiver requirements, current Family PACT policy billing instructions/claim form completion and claims processing (including MMIS 1700 table} require a specific diagnosis in the primary and secondary positions. Therefore, a solution must be developed that meets HIPAA compliance without impacting CMS 64 reporting to draw down FFP. In order to properly identify and route Family PACT claims, it is suggested that the system look for the specific HAP identification number in conjunction with the beneficiary AID code, 8H. Additionally, the system should also look for ICD-9 "V" and numeric codes identified in the attached "S" diagnosis code crosswalk to indicate Family PACT benefits in accordance with the waiver guidelines. The system should be able to look for the diagnosis code(s) in any position. It is recommended that edits be implemented to prevent the national code from being billed with other E&M codes (99201-99215 and 99381-99395 and 99401-99402) for the same recipient, same provider, same date of service).

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
						The Family PACT program will follow up with CMS for approval to use these codes in place of the current local codes, which have been approved by CMS to allow trained supervised non-clinician counselors to provide education and counseling services. If it is determined that 99401 - 99403 should not be used for non-clinician counselors, OHC recommends using HCPCS code H1010 (Non-medical family planning education, per session) for those services provided by a non-clinician. If H1010 is implemented with this conversion, a rate analysis will need to be done on the appropriate reimbursement methodology in order to maintain budget neutrality. OHC recommends defining a session as 15 minutes and applying the existing rates for local codes Z9752-Z9754 accordingly. In other words, 31-45 minutes session would equal three units and be reimbursed at $44.51
Antigens	**Z0334**	Lead Screen/Counsel and Blood Draw	$17.50	**Revenue Codes**: 0305-Hematology and CPT Codes: **99429**- Unlisted preventive medicine service	$17.50	Reimbursement should be driven by the revenue/CPT code combination.
Audiology	**X4544**	Diagnostic evaluation for severely physically/mentally handicapped person over age seven	$84.75	**99241** – Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making *And* **Modifier** **TG** – Complex/high-tech level of care	$30.60	
Audiology	**X4544**			*Or* **99242** – Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making *And* **Modifier** **TG** – Complex/high-tech level of care	$47.20	
				Or **99243** – Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity *And* **Modifier** **TG** – Complex/high-tech level of care	$59.50	
				or **99244** – Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity *And* **Modifier** **TG** – Complex/high-tech level of care	$81.40	
				Or **99245** – Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity *And* **Modifier** **TG** – Complex/high-tech level of care	$102.20	

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
CHDP	**01**	History/Physical New/Extended **Birth thru 11 months**	Comprehensive Care Provider: $48.35 Health Assessment Only Provider: $40.55	**99381** -Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient, infant younger than 1 year.	Comprehensive Care Provider: $48.35 Health Assessment-Only Provider: $40.55	The national code alternatives do not differentiate between 'New' and 'Extended'. CPT codes 99381-99385 are for the initial visit which would correlate to new patient. If a visit is extended, recommend using modifier 22 for increased procedural services. However, if the visit is extended and the patient is established, providers would use CPT code 99391 - 99395 with modifier 22.The national codes will need to be priced differently based on provider type {i.e. comprehensive care provider or health assessment provider). Note that the local codes all carry the same age range in the system, however, there are more specific age restrictions built into the policy instructions. Recommend that the system implementation of the national codes for the purposes of CHOP screening services, incorporate the appropriate age/gender edits and restrictions with the national codes to ensure that the use of the national codes for the CHDP services are kept seperate from current Medi-cal; or other programs used. This will ensure that policy and budget neutrality are met
		History/Physical New/Extended **1 year thru 4 years, 11 months**	Comprehensive Care Provider: $51.46 Health Assessment Only Provider: $43.66	**99382** -Initial comprehensive an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1through 4 years)	Comprehensive Care Provider: $51.46 Health Assessment-Only Provider: $43.66	
		History/Physical New/Extended **5 years thru 11 years, 11 months**	Comprehensive Care Provider: $54.59 Health Assessment Only Provider: $46.79	**99383**- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	Comprehensive Care Provider: $54.59 Health Assessment-Only Provider: $46.79	
		History/Physical Routine **Birth thru 11 months**	Comprehensive Care Provider: $62.39 Health Assessment Only Provider: $54.59	**99391**-Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	Comprehensive Care Provider: $62.39 Health Assessment-Only Provider: $54.59	
CHDP	**01**	History/Physical Routine **1 yearthru 4years, 11 months**	Comprehensive Care Provider: $39.00 Health Assessment-Only Provider: $35.86	**99392** - Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4years)	Comprehensive Care Provider: $39.00 Health Assessment-Only Provider: $35.86	
		History/Physical Routine **5 years thru 11 years, 11 months**	Comprehensive Care Provider: $42.12 Health Assessment-Only Provider: $39.00	**99393** -Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age5 through 11 years)	Comprehensive Care Provider: $42.12 Health Assessment-Only Provider: $39.00	
		History/Physical Routine **12 years thru 20 years, 11 months**	Comprehensive Care Provider: $49.90 Health Assessment-Only Provider: $46.79	**99394** - Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years) **99395** - 18-39 years	Comprehensive Care Provider: $49.90 Health Assessment-Only Provider: $46.79	

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
EPSDT-CCS	**Z4302**	EPSDT ServicesCCS/SCC Medical Case Conference, Other-Allied Health Care Professionals, per quarter hour	$8.40	**CPT Code(s):** **99366-** Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family,30 minutes or more, participation by nonphysician qualified health care professional *or* **99368-** Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional *and* **HCPCS Modifier(s):** **EP-** Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program *and* **CPT odifier(s): 52** - Reduced services ***Note: A UB revenue code is required when billing on* a *UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for this local code. The revenue code below is suggested to ensure compliance with HIPAA transactions,do not deny claim if an alternative valid Revenue code is submitted* on *the claim.*** ***0515-*** Pediatric Clinic	$16.80 $8.40 (when billed with modifier 52)	**Policy Assessment:** •Convert Z4302 to 99366 and 99368 plus modifiers EP and 52, adopting all of the policy that belonged to Z4302 at the time of transfer. In other words, when the designated combination of national codes and modifiers are used in place of Z4302, use the policy currently in place for Z4302, but keep it separate from the policy for other uses of 99366, 99368 and 52 that currently are or will be active.•National modifier EP is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services.•Until SON 05071 (Multiple Modifiers) is implemented, the system is unable to process multiple modifiers and relies on the use of modifier -99 in the primary modifier field and the specific modifiers in the *Remarks* field of the claim. ***Rates Assessment:*** National code alternatives specify units as 30-minutes or more which is inconsistenlwith units for the current local codes.Out of 7,640 claims 5,826 were billed with 1 unit and 1,814 were billed 2 or more units. Given the majority of claims are billed for 15 minutes, modifier 52 is used to indicate reduced time. Carry over the existing reimbursement rate to the national codes.
	Z4302					Existing reimbursement rate should be applied as follows: 99366+EP = $16.80 99366+EP+ 52 = $8.40 99368+EP = $16.80 99368+EP+ 52 = $8.40
EPSDT-CCS	**Z4306**	EPSDT ServicesCCS/SCC Medical Case Conference, Physician/Dentist per case	$36.00	**CPT Code(s):** **99367** - Medical team conference with interdisciplinary team of health care professionals, patient and / or family not present, 30 minutes or more; participation by physician *Or* **HCPCS Level II Code(sl:** **S0220-** Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 30 minutes *or* **S0221** - Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 60 minutes. *And* **HCPCS <u>Mod</u>ifier(s): EP-** Service provided as part of Medicaid early ***Note: A UB revenue code is required when billing on* a *UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for this local code. The revenue code below is suggested to ensure compliance with HIPAA transactions, do not deny claim if an alternative valid Revenue code is submitted on the claim.*** ***0515-Pediatric Clinic***		**Policy Assessment**- Convert Z4306 to 99367, S0220 and S0221 plus modifier EP, adopting all of the policy that belonged to Z4306 at the time of transfer In other words, when the designated combination of national codes and modifiers are used in place of Z4306, use the policy currently in place for Z4306, but keep it separate from the policy for other uses of 99367, S0220 and S0221 that currently are or will be active. National modifier EP is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. EPSDT CCS SCC providers should be instructed to bill the appropriate code based on whether the patient is present or not. ***Rates Assessment:*** •Carry over existing reimbursement rate ($36.00) to the designated national code plus modifier combinations (99367+EP, S0220+EP, S0221+EP).Budget neutrality is anticipated.

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
	Z4310	EPSDT ServicesCCS/SCC Medical Case Conference, Nurse Specialist, per quarter hour	$8.40	**CPT Code(s)**: **99366**- Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional or **99368** - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional and **HCPCSModifier(s**): **EP**- Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program and TD- Registered Nurse and **CPT Modifier(s)**: **52** - Reduced services Note: Modifier 52 should only be appended to 99366 or 99368 as a way to indicate 15 minutes of case conference time. **Note**: A UB revenue code is required when billing on a UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for this local code. The revenue code beloW is suggested to ensure compliance with HIPAA transactions, do not deny claim if an alternative valid Revenue code is submitted on the claim. **0515**-Pediatric Clinic		**Policy Assessment**: Convert Z4310 to 99366 and 99368 plus modifiers EP, TD and 52, adopting all of the policy that belonged to Z4302 at the time of transfer. In other words, when the designated combination of national codes and modifiers are used in place of Z4302, use the policy currently in place for Z4302, but keep it separate from the policy for other uses of 99366,99368 and TD and 52 that currently are or will be active. •National modifier EP is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. Until SON 05071 (Multiple Modifiers) is implemented, the system is unable to process multiple modifiers and relies on the use of modifier -99 in the primary modifier field and the specific modifiers in the Remarks field of the claim. **Rate Assessment**:•National code alternatives are based on 30-minutes or more which is inconsistent with the units specified in the local code. Additionally, the national code indicates 30-minutes or more which would negate the billing of units. In other words, the CPT code would be one rate per session or encounter. •Out of 13,885 claims 11,573 were billed with 1 unit and 2,312 were billed with 2 units. Given the majority of claims are billed for 15 minutes, recommend using modifier 52 to indicate reduced time. Because the majority of claims are billed as 15 minutes, budget neutrality is anticipated however further analysis will need to be done to assess the impact on claims billed for greater than 15 minutes. Existing reimbursement rate should be applied as follows: •99366+EP+TD = $16.80 •99366+ EP+ TD+52 = $8.40 •99368+EP = $16.80
EPSDT-CCS	**Z4311**	EPSDT Services-CCS/SCC Medical Case Conference, Medical Social Worker, per quarter hour	$8.40	**CPT Code(sl:** **99366** - Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional *or* **99368** - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional *and* **HCPCS Modifier(s):** **AJ** - Clinical Social Worker *and* **EP-** Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program *and* **CPT Modifier(s):** **52** - Reduced services *Note: Modifier 52 should only be appended to 99366* as *a*	$16.80 $8.40 (when billed with modifier 52)	**Policy Assessment**:•Convert Z4311 to 99366 and 99368 plus modifiers EP, AJ and 52, adopting all of the policy that belonged to Z4311 at the time of transfer. In other words, when the designated combination of national codes and modifiers are used in place of Z4311, use the policy currently in place for Z4311, but keep it separate from the policy for other uses of 99366, 99368, AJ and 52 that currently are or will be active. •National modifier EP is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. •Until SON 05071 (Multiple Modifiers) is implemented, the system is unable to process multiple modifiers and relies on the use of modifier -99 in the primary modifier field and the specific modifiers in the Remarks field of the claim.
				Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for this local code. The revenue code below is suggested to ensure compliance with HIPAA transactions, do not deny claim if an alternative valid Revenue code is submitted on the claim. **0515**-Pediatric Clinic		**Rate Analysis**:•National code alternatives are based on 3D-minutes or more which is inconsistent with the units specified in the local code. Additionally, the national code indicates 30-minutes or rnore which would negate the billing of units. In other words, the CPT code would be one rate per session or encounter. •Out of 24,174 claims 16,483 were billed with 1 unit and 7,691 were billed with 2 units. Given the majority of claims are billed for 15 minutes, recommend using modifier 52 to indicate reduced time. Because the majority of claims are billed as 15 minutes, budget neutrality is anticipated however further analysis will need to be done to assess the impact on claims billed for greater than 15 minutes.•Carry over existing rate as follows: 99366 + EP + AJ = $16.80 99366 + EP + AJ +52 = $8.40 99368 + EP + AJ = $16.80 99368 + EP + AJ +52= $8.40

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
	Z4312	EPSDT Services CCS/SCC Medical Case Conference Registered Dietician, per quarter hour	$8.40	**CPT Code(s**l: **99366**- Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family,30 minutes or more, participation by nonphysician qualified health care professional or **99368** - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional and **HCPCS Modifier(s**): **AE** - Registered Dietician and EP - Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program And **CPT Modifier(s):52** - Reduced services Note: Modifier 52 should only be appended to 99366 as a way to indicate 15 minutes of case conference time. **Note**: A UB revenue code is required when billing on a UB-04 claim form or the 837-1 transaction, but is not required in the conversion strategy for this local code. The revenue code below is suggested to ensure compliance with HIPAA transactions, do not deny claim if an alternative valid Revenue code is submitted on the claim. **0515**- Pediatric Clinic	$16.80 $8.40 (when billed with modifier 52)	**Policy Assessment***:* •Convert Z4312 to 99366 and 99368 plus modifiers EP, AE and 52, adopting all of the policy that belonged to Z4312 at the time of transfer. In other words, when the designated combination of national codes and modifiers are used in place of Z4312, use the policy currently in place for Z4312, but keep it separate from the policy for other uses of 99366,99368, AE and 52 that currently are or will be active.•National modifier EP is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services.•Until SDN 05071 (Multiple Modifiers) is implemented, the system is unable to process multiple modifiers and relies on the use of modifier -99 in the primary modifier field and the specific modifiers in the *Remarks* field of the claim. **Rate Analysis**:National code alternatives are based on 30-minutes or more which is inconsistent with the units specified in the local code. Additionally, the national code indicates 3D-minutes or more which would negate the billing of units. In other words, the CPT code would be one rate per session or encounter.•Out of 14,095 claims 13,483 were billed with 1 unit and 612 were billed with 2 units. Given the majority of claims are billed for 15 minutes, recommend using modifier 52 to indicate reduced time. Because the majority of claims are billed as 15 minutes, budget neutrality is anticipated however further analysis will need to be done to assess the impact on claims billed for greater than 15 minutes.•Carry over existing rate as follows: •99366 + EP + AE = $16.80 •99366 + EP + AE +52 = $8.40 •99368 + EP + AE = $16.80 •99368 + EP + AE +52 = $8.40
EPSDT-Audiology Services	**Z5908**	EPSDT Services – Subsequent audiology evaluation, 2-5 years of age	$36.40	**CPT Codes** **99242** – Office consultation for a new or established patient, which requires these 3 key components: □ An expanded problem focused history; □ An expanded problem focused examination; and □ Straightforward medical decision making or **99243** – Office consultation for a new or established patient, which requires these 3 key components: □ A detailed history; □ A detailed examination; and □ Medical decision making of low complexity And **Modifiers** **TS** – Follow-up services and **EP** – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program **Note**: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-	$33.37- 99242 $43.61 -99243	**Policy Assessment**: Convert Z5908 to the selected alternative national codes, adopting all of the policy that belonged to Z5908 at the time of transfer. In other words, when the alternative codes are used in place of Z5908, use the policy currently in place for Z5908, but keep it separate from the policy for other uses of the alternative codes that currently are or will be active. National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. Rates Assessment: National code reimbursement based on complexity of appointment and time spent, not age of patient. Proposed rates are based on the local code rates and estimates of how the codes would convert to time and using the number of claims billed in FY 08-09, taking into account need to remain budget neutral. Adopt new rates for the national code and modifier combination and apply the same maximum UVS edits. CCS concurs with this recommendation

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
	Z5910	EPSDT Services – Subsequent audiology evaluation, 6-20 years of age	$32.50	**CPT Code** **99242** – Office consultation for a new or established patient, which requires these 3 key components: □ An expanded problem focused history; □ An expanded problem focused examination; and □ Straightforward medical decision making □ Medical decision making of moderate complexity And Modifiers TS – Follow-up services and EP – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-04/387I claim that represents the room accommodation and or service	$33.37	**Policy Assessment:** • Convert Z5910 to 99242 plus modifiers TS and EP, adopting all of the policy that belonged to Z5910 at the time of transfer. In other words, when 99242 plus TS and EP are used in place of Z5910, use the policy currently in place for Z5910, but keep it separate from the policy for other uses of 99242 that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment**: • National code reimbursement based on complexity of appointment and time spent, not age of patient. Proposed rates are based on the local code rates and estimates of how the codes would convert to time and using the number of claims billed in FY 08-09, taking into account need to remain budget neutral. • Adopt new rates for the national code and modifier combination and apply the same maximum UVS edits. CCS concurs with this recommendation.
EPSDT-Audiology Services	**Z5904**	EPSDT Services – Initial audiology evaluation, 6-20 years of age	$58.50	**CPT Codes** **99243** – Office consultation for a new or established patient, which requires these 3 key components: □ A detailed history; □ A detailed examination; and □ Medical decision making of low complexity or **99244** – Office consultation for a new or established patient, which requires these 3 key components: □ A comprehensive history; □ A comprehensive examination; and □ Medical decision making of moderate complexity And **Modifier** EP – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-04/387I claim that represents the room accommodation and or service	$43.61 $60.96	**Policy Assessment**: • Convert Z5904 to the selected alternative national codes, adopting all of the policy that belonged to Z5904 at the time of transfer. In other words, when the alternative codes are used in place of Z5904, use the policy currently in place for Z5904, but keep it separate from the policy for other uses of the alternative codes that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment:** • National code reimbursement based on complexity of appointment and time spent, not age of patient. Proposed rates are based on the local code rates and estimates of how the codes would convert to time and using the number of claims billed in FY 08-09, taking into account need to remain budget neutral. • Adopt new rates for the national code and modifier combination and apply the same maximum UVS edits. • CCS concurs with this recommendation
	Z5906	EPSDT Services – Subsequent audiology evaluation, < 2 years of age	$39.00	**CPT Code** **99243** – Office consultation for a new or established patient, which requires these 3 key components: □ A detailed history; □ A detailed examination; and □ Medical decision making of low complexity **And** **Modifiers** **TS** – Follow-up services and **EP** – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program **Note**: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-04/387I claim that represents the room accommodation and or service.	$43.61	**Policy Assessment:** • Convert Z5906 to 99243 plus modifiers TS and EP, adopting all of the policy that belonged to Z5906 at the time of transfer. In other words, when 99243 plus TS and EP is used in place of Z5906, use the policy currently in place for Z5906, but keep it separate from the policy for other uses of 99243 that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment:** • National code reimbursement based on complexity of appointment and time spent, not age of patient. Proposed rates are based on the local code rates and estimates of how the codes would convert to time and using the number of claims billed in FY 08-09, taking into account need to remain budget neutral. • Adopt new rates for the national code and modifier combination and apply the same maximum UVS edits. • CCS concurs with this recommendation

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
EPSDT-Audiology Services	**Z5902**	EPSDT Services – Initial audiology evaluation, 2-5 years of age	$65.00	**CPT Codes** **99243** – Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity or **99244** – Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity **or** **99245** – Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity And **Modifier** **EP** – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-	$43.61-**99243** $60.96-**99244** $72.28-**99245**	**Policy Assessment:** • Convert Z5902 to the selected alternative national codes, adopting all of the policy that belonged to Z5902 at the time of transfer. In other words, when the alternative codes are used in place of Z5902, use the policy currently in place for Z5902, but keep it separate from the policy for other uses of the alternative codes that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment**: • National code reimbursement based on complexity of appointment and time spent, not age of patient. Proposed rates are based on the local code rates and estimates of how the codes would convert to time and using the number of claims billed in FY 08-09, taking into account need to remain budget neutral. • Adopt new rates for the national code and modifier combination and apply the same maximum UVS edits. • CCS concurs with this recommendation.
	Z5900	EPSDT Services – Initial audiology evaluation, < 2 years of age	$71.50	**CPT Code** **99245** – Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity And **Modifier** **EP** – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program **Note**: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-04/387I claim that represents the room accommodation and or service.	$72.28	**Policy Assessment:** • Convert Z5900 to 99245 plus modifier EP, adopting all of the policy that belonged to Z5900 at the time of transfer. In other words, when 99245 plus EP is used in place of Z5900, use the policy currently in place for Z5900, but keep it separate from the policy for other uses of 99245 that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment**: • National code reimbursement based on complexity of appointment and time spent, not age of patient. Proposed rates are based on the local code rates and estimates of how the codes would convert to time and using the number of claims billed in FY 08-09, taking into account need to remain budget neutral. • Adopt new rate of $72.28 for the national code and modifier combination and apply the same maximum UVS edits. • CCS concurs with this recommendation

Program	Local Code	Local Code Description	Local Code Rate	National Proposed Codes	National Proposed Code Rate and Billing Instructions	Business Considerations/Issues Currently CA-MMIS system does not have logic to process revenue codes for outpt. services
EPSDT-Audiology Services	**Z5912**	EPSDT Services – Evaluation of difficult-to-test (due to physical or mental handicap) patient, < 7 years of age	$84.75	**CPT Code** **99245 –** Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity And **Modifier** **EP** – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program Note: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-04/387I claim that represents the room accommodation and or service.	$72.28	**Policy Assessment**: • Convert Z5912 to 99245 plus modifier EP, adopting all of the policy that belonged to Z5912 at the time of transfer. In other words, when 99245 plus EP is used in place of Z5912, use the policy currently in place for Z5912, but keep it separate from the policy for other uses of 99245 that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment**: • National code reimbursement based on complexity of appointment and time spent, not age of patient. Proposed rates are based on the local code rates and estimates of how the codes would convert to time and using the number of claims billed in FY 08-09, taking into account need to remain budget neutral. • Adopt new rates for the national code and modifier combination and apply the same maximum UVS edits. • CCS concurs with this recommendation
	Z5950	EPSDT Services – Counseling by audiologist of patient and family regarding cochlear implantation including benefits and risks of the procedure, and obtaining commitment to follow-up care, per hour	$112.32	**CPT Codes** **99354** – Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour **or** **99355** - …each additional 30 minutes **Note**: 99354 and 99355 are added to 99241-99245 as appropriate to indicate longer-than-usual office visits. **And** **Modifier** **EP** – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program **Note**: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-04/387I claim that represents the room accommodation and or service.	$112.32 $56.16	**Policy Assessment:** • Convert Z5950 to the selected alternative national codes, adopting all of the policy that belonged to Z5950 at the time of transfer. In other words, when the alternative codes are used in place of Z5950, use the policy currently in place for Z5950, but keep it separate from the policy for other uses of the alternative codes that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment**: • Carry over existing rate to the designated national code and modifier combination and apply the same maximum UVS edits.
	Z5966	EPSDT Services – Patient and caregiver cochlear implant orientation, per hour	$112.32	**CPT Codes** **99354** – Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour **99355** - …each additional 30 minutes **Note**: 99354 and 99355 are added to 99241-99245 as appropriate to indicate longer-than-usual office visits. **And** **Modifier** **EP** – Service provided as part of a Medicaid early periodic screening diagnosis and treatment (EPSDT) program **Note**: A UB revenue code is required when billing on a UB-04 claim form or the 837-I transaction. The provider must include the most appropriate revenue on the UB-	$112.32 $56.16	**Policy Assessment:** • Convert Z5966 to the selected alternative national codes, adopting all of the policy that belonged to Z5966 at the time of transfer. In other words, when the alternative codes are used in place of Z5966, use the policy currently in place for Z5966, but keep it separate from the policy for other uses of the alternative codes that currently are or will be active. • National modifier is not currently in use by Medi-Cal. Instruct providers to use EP to indicate expanded EPSDT services. No policy or rates should be driven by the use of the modifier unless otherwise specified. The use of EP is consistent with the code conversion strategy for EPSDT Supplemental Services. **Rates Assessment**: • Carry over existing rate to the designated national code and modifier combination and apply the same maximum UVS edits.

State of California – Medi-Cal Managed Care
Proposal for Implementation of Affordable Care Act (ACA) Section 1202: Increased Payments for Medicaid Primary Care Services

Section 1902(a)(13)(C) of the Social Security Act (SSA) as amended by the Affordable Care Act (ACA) requires that state Medicaid programs incorporate the requirement for increased payment to primary care providers for years 2013 and 2014 into contracts with managed care organizations and the corresponding capitation payments. In technical guidance provided by the Centers for Medicare and Medicaid (CMS) States were provided flexibility to implement this provision using methodologies consistent with current rate-setting practices. The options provided in CMS' technical guidance include Model 1: Full risk prospective capitation; Model 2: prospective capitation with risk sharing that incorporates retrospective reconciliation; and Model 3: non-risk reconciled payments for enhanced rates.

This document details the methodology for how future payments will be made from the State of California (State) through our contracted Managed Care Plans (MCPs) to primary care providers (PCPs). The methodology encompasses all of the pieces of the Affordable Care Act (ACA) Section 1202 PCP rule compliance, including:

- Compliance with the Centers for Medicare and Medicaid Services (CMS) regulations regarding the needed contractor payment increases for computed 2013/2014 Medicare rates.
- Certification of the actuarial soundness of Medicaid managed care capitation rates under the contract per 42 CFR 438.6(c)(2).
- Explanation of the State's methodology to CMS in a manner consistent with risk payments, compliance with all relevant CMS regulations, including required documentation, and the State's chosen payment option.
- Explanation of the State's claiming for the federal matching funds utilizing the July 2009 baseline Medicaid capitation payment amounts.

The methodology encompasses all required elements of the two methodologies as required by CMS, including:

- Determining the July 1, 2009 "base" in managed care capitation payments (i.e., a reasonable methodology, based on rational and documented data and assumptions, for identifying the payments that would have been made by the contractor for eligible primary care furnished as of July 1, 2009).
- Determining the difference between the July 1, 2009 base amount and the 2013/2014 increases (i.e., a reasonable methodology, based on rational and documented data and assumptions, for identifying the differential in payment between the provider payments that would have been made by the contractor on July 1, 2009, and the amount needed to make payments at the required Medicare levels).

This methodology is being submitted to CMS by March 31, 2013, and once approved by CMS, will be inserted into the MCP provider agreement and reflected in the actuarial certification of the final additional rates.

Summary of Methodology
The State has opted to utilize the prospective capitation risk model with a retrospective "100% true-up" reconciliation (Model 2). Under this approach, the higher costs associated with complying with the PCP rule will be reflected in separate additional MCP-specific capitation payments through a programmatic change adjustment and certified by the State's actuary. The State will pay the required capitation payment to the contractor prospectively, and there will be reconciliation retrospectively.[1] Thus, the separate additional MCP-specific capitation rates paid would be inclusive of the enhanced rates and expected utilization, with actual data being used to reconcile the expected utilization with actual utilization for the specified primary care services. Based on the difference in utilization actually experienced, the State and CMS would reimburse or recoup from MCPs the unit cost differential for amounts differing between original (Medicaid) 2013/2014 and updated (reflecting Medicare fees) 2013/2014 aggregate unit costs, multiplied by the differing utilization. This is at 100% federal match.

Provider Attestation
The State will develop an online registry for providers to self- attest their qualification for the higher payment. MCPs will be given the option of using the online registry or they may utilize their own methodology. MCPs using their own methodology may utilize the State's online registry for out of network providers.

All physicians must self-attest to practicing in a specialty/sub-specialty of family medicine, general internal medicine, or pediatric medicine recognized by the American Board of Physician Specialties, the American Board of Medical Specialties, or the American Osteopathic Association; AND, that they are either:

- Board certified with a specialty or subspecialty from the boards above
  OR
- Billing at least 60% of services rendered of the specified evaluation and management (E&M) or vaccine administration (VFC) codes.

Providers need to self-attest regardless of how they qualify. California will verify provider attestations in accordance with the approved fee for service (FFS) State Plan process.

The implementation considerations below describe the relevant and available sources of data, as well as the material assumptions, methods, and processes by which the separate additional MCP-specific capitation rates will be calculated. Each step references the applicable CMS Technical Guidance (TG) section.

[1] Note that the separate additional MCP-specific ACA Section 1202 capitation rates are effective January 1, 2013, and the State will make retroactive payment adjustments.

Data Sources (CMS TG Section 4.1)

Data Request — Requirements for the Data Each MCP Will Send to the State

The State and the State's actuary, Mercer, have determined that data to determine the amount of the 2009 and calendar year (CY) 2013/2014 capitation rates associated with the qualified codes being provided by qualified PCPs under this regulation is not available in the necessary detail required and/or excessively costly and burdensome to the State to gather. Because of multiple difficulties and impossibilities of breaking down the base data in the level of detail desired, and then tracing it through the capitation rate development process, the most appropriate, comprehensive, and practical data approach (Actuarial Standard of Practice No. 23 — Data Quality http://www.actuarialstandardsboard.org/pdf/asops/asop023_141.pdf) for determining provider payments that would have been made by the MCO, PIHP, or PAHP for specified primary care services [See 42 CFR 438.804 (a)(1)] is through a detailed data request (with review and potential adjustment) to the MCPs.

The State will gather utilization and unit cost data through an ad hoc data request of the MCPs to determine how much PCPs were paid in 2012 and how much the PCPs were paid in 2009 for the prescribed codes and appropriate providers. This will require the MCPs to do additional analysis in determining and including the utilization and unit cost structure of any sub-capitated arrangements they may have with providers. Comparative reports between MCPs and to existing reports will also be developed in order to determine the reasonableness of results. The ad hoc MCP 2009 and 2012 data may be adjusted, if necessary, to improve consistency with more aggregate known claim cost components of the 2009 and 2013/2014 capitation rates. This overall approach should produce a reliable and accurate result to the fullest extent possible.

For Medicaid beneficiaries dually eligible for Medicare, the State will ensure that the 100% FFP match will only be claimed where it exceeds the amount that would have been payable under the state plan in effect on July 1, 2009. The State will estimate the amount eligible for FFP utilizing the methodology discussed in this document.

For any populations that are new to managed care, e.g. aged, blind or disabled (ABD) children that will be mandatorily enrolled in managed care, they did not have managed care experience in 2009 and/or 2012. Therefore, the State and Mercer will determine the utilization and unit cost amounts assumed within the 2013/2014 capitation rates to similarly calculate the claim cost component for these additional payments. In order to determine the claim for enhanced match, the State will use the FFS schedule in effect in July 2009 to establish the baseline to compare to the Medicare levels.

Rate Setting and Reporting Analysis and Development

In order to calculate the additional payment, the State and Mercer will develop a process to:

- Determine the utilization and unit cost amounts for the additional capitation rates covering CY 2013/2014. When compared to the applicable CY 2013/2014 Medicare unit costs, this analysis will develop the claim cost component for the proposed payments for each MCP.
- Determine appropriate amounts and percentages for any MCP administration, underwriting gain, taxes, fees, and any other applicable non-claim load to the additional payment (not subject to enhanced claiming).
- Identify the necessary documentation of the services provided.
- Confirm and validate the applicable procedure codes on the submitted files.
- Develop and implement the required reporting mechanism with one of the objectives being to verify MCP compliance with the regulation.
- Produce payments to the MCPs for the correct amount.

Establish the 2009 Base Rate (CMS TG Section 4)

The State and Mercer will analyze the ad hoc data request from the MCPs. The State and Mercer will analyze FFS utilization and unit cost for any new populations. Mercer will multiply the July 1, 2009 unit cost (described above) by individual procedure code by the expected 2013/2014 utilization and will divide by the total 2013/2014 utilization to establish the 2009 base unit costs in aggregate. These aggregate unit cost levels will represent the 2009 base rate levels reflective of 2013/2014 utilization. For any procedure code with expected utilization in 2013/2014 where there was no unit cost rate assumed in the 2009 capitation rate even though it was a covered procedure, the unit cost and associated 2013/2014 utilization included in the calculations described above will be excluded from this weighting calculation (this exclusion is anticipated to have immaterial impact on the final aggregate unit costs). For any procedure code that was not a covered procedure in 2009, the 2009 unit cost is considered to be zero. This same 2013/2014 utilization will also be applied to the Medicare fee schedule to establish a similar aggregate unit cost level. The difference of the July 1, 2009 and Medicare aggregate unit cost levels, when multiplied by the anticipated utilization in the separate additional 2013/2014 capitation rate, will determine the base for the 100% federal match.

Calculate the 2013/2014 Capitation Rate (CMS TG Section 5)

Capitation rates will be developed in accordance with the requirement that the MCP pay PCPs at least 100% of the 2013/2014 computed Medicare fee schedule (in accordance with the State Plan amendment for the PCP increase) for eligible primary care service codes furnished by a qualified physician. The development of the claim cost components is discussed further below.

To calculate the capitation rate attributed to qualifying PCP services in CY 2013/2014, Mercer will first establish the estimated utilization for applicable providers and services. Mercer will then also determine the unit cost levels associated with this utilization with particular attention to unit cost levels relative to the Medicare fee schedule. Only base utilization below the Medicare fee schedule will be considered in the rate adjustment. The unit cost levels will then be compared to the Medicare fee schedule at the procedure code level to determine the needed rate that will compensate the MCPs to be able to pay the qualifying providers at least the Medicare fee schedule. The

development of the 2013 Medicare fee schedule rates and 2013 utilization is described below.

2013 Medicare Fee Schedule Rates

The 2013 Medicare fee schedule rates are based on the 2009 conversion factor and 2013 relative value units (RVUs), consistent with the geographic practice cost index (GPCI) schedule published by CMS in January 2013. The 2013 Medicare rates utilized will conform to the approach used in California's FFS program for each of the specified evaluation and management and vaccine billing codes.

Note that the increased payment is not applicable to services provided by a physician delivering services under the federally qualified health center (FQHC) or rural health clinic (RHC) benefits because, in those instances, payment is made on a facility basis and is not made according to the physician fee schedule.

2013 PCP Utilization

Mercer will base the expected utilization of eligible primary care services on the base data utilization in 2012, with adjustments as necessary. These data will be trended forward to 2013 using rate setting trend assumptions.

In addition to the typical utilization trend, Mercer will work with the State and MCPs to evaluate the need for additional PCP utilization increases to reflect any impact of the increased payment levels. The magnitude of such a utilization adjustment depends on several factors, including the size and timing of the PCP fee increases, provider self-attestation levels, whether access issues exist in the California Medicaid managed care program, and whether the higher fees will attract more providers or expand current provider capacity for California Medicaid managed care recipients. In addition, Mercer may assess whether increased PCP utilization may result in decreased utilization of other higher cost services such as inpatient admissions and emergency room visits.

Non-Claim Cost Components

Any applicable, non-claim cost amounts and percentages for MCP administration, underwriting gain, taxes, fees, or any other non-claim load to the additional capitation payment (not subject to enhanced claiming) should be considered, and if appropriate be accounted for and quantified.

Actuarial Certification (CMS TG Section 7)

The State will submit rate package documentation that will include an actuarial certification demonstrating compliance with 42 CFR 438.6(c). This documentation will include a description and certification of the process used to establish the CY 2013/2014 additional capitation rate, an indication of the risk model selected by the State, and a description and certification of the process used to establish the amount that is eligible for 100% federal financial participation (as described herein), and a

description of the retrospective reconciliation for Model 2 (as described herein). The PCP capitation increase amount will not be risk-adjusted.

State Payment to Contractor through Capitation Rates

The State will pay the MCPs capitation rates under the newly certified rates once rate approval is received from CMS. The State will pay the contractor retroactively for any payments due from January 1, 2013 to the date of CMS approval.

Contractor Requirements for PCP Payment, Including FFS PCP Payments, and Requirements for Contractor PCP Subcapitation Arrangements (CMS TG Section 8)

MCP requirements for PCP payment: MCPs pay PCPs at least 100% of the 2013 computed Medicare fee schedule. The State contract with the MCPs will reflect this requirement. MCPs and their association will work with the State and Mercer to establish a uniform understanding of the change and its implementation. The State has decided to pay the office-setting rate, using the January 2013 Medicare published rate adjustments. The enhanced payment requirement is effective retrospective to January 1, 2013 for all units rendered by a qualified provider, as indicated by the State above under the provider attestation section, billed using a qualified billing code under an MCP contract.

Each MCP must provide the State with the MCP's plan for compliance with ACA Section 1202 and how payments to the PCPs will be made. MCPs will pay the PCPs at least 100% of the 2013 computed Medicare rate promptly (after the MCP has received payment from the State) before receiving any reconciliation payment from the State. The MCO contracts will reflect this requirement, and the submission from the MCP will outline how each MCO will accomplish this.

Contractor Documentation of PCP Payments — Requirements for Ongoing Contractor Reporting (CMS TG Section 8)

MCP documentation of PCP payments: MCPs will continue to submit encounter data reflecting actual payments. MCPs will also submit an annual report documenting payments for all encounters (FFS and sub-capitated). This documentation will include the utilization and payments for applicable PCP services. The State will require each MCP to attest compliance with these elements to ensure accuracy and compliance with the PCP rate increase rule.

Model 2 Additional Payments or Recoupments Made through Annual Reconciliation

The State will reconcile the capitated payments in 2013/2014 for primary care made under this provision to each MCP utilizing the utilization data submitted by the MCP in their annual report. The unit cost differential between the Medicare level and the 2013/2014 Medicaid level will already be known as part of the MCP-specific additional

capitation rate. This approach reduces duplicate payment concerns to the extent possible.

CMS TG Section 2.2 100% true up: The run-out period will be six months, so reconciliation will take place in July 2014 for CY 2013 and July 2015 for CY 2014.

Once the State receives the annual report documenting aggregate payments to the PCPs in the form of an Excel spreadsheet from the MCPs, the State will pay MCPs for the amount that the Medicare rate paid exceeds the rate differential in the capitation rates based on actual utilization. This step will include detailed instructions to the MCPs on how to document to the State the utilization and unit cost rate paid for PCPs.

Per revised CMS-64 reporting, the E&M and VFC components of the capitation and their reconciliation will be analyzed separately.

On an annual basis, the State will reconcile the amounts paid to the plan against the managed care plan's actual reported experience. Amounts due to or from the plans will be made through the reconciliation payment process. The State will be reconciling based on utilization and will not re-price unit costs. Utilization will be reconciled as follows:

Reconciliation to Actual:	**Under**	**Over**
Difference between base rate unit cost and Medicare unit cost	$ 4	$ 4
Multiply by 2013 utilization built into capitation	10	10
Sum (capitation amount to comply with policy)	$ 40	$ 40
Rate Differential based on capitation	$ 4	$ 4
Multiply by Actual utilization	8	12
Sum	$ 32	$ 48
Difference to be recouped/paid:	$ (8)	$ 8

Please note that if actual unit cost varies, there will be no re-pricing of unit costs. The reconciliation will be based on the unit costs built into the capitation rate. Additionally, the State will not be collecting or paying the base Medicaid payment amount if utilization is lower or higher than what is projected in the capitation. As shown above, reconciliation would only apply to the difference between the base Medicaid rate and the Medicare rate ($4 per unit in the above examples)

Calculate the Differential that Qualifies for 100% Federal Financial Participation (CMS TG Section 6)

As the State is opting to use Risk Model 2, the amount of the 2013/2014 capitation payment that is eligible for 100% Federal financial participation is determined by

calculating the difference between the base 2009 aggregate unit cost calculation and the aggregate Medicare unit cost in the 2013/2014 capitation rates, multiplied by the anticipated utilization within the updated 2013/2014 capitation rates described above, plus any additional payments (or recoupments) made through annual utilization reconciliation at the unit cost differential amount only.

State Claiming — The State's Plan for Claiming

The State will claim the amount of the capitation rate identified above, as well as any payments (or recoupments) made through the annual reconciliation at 100% Federal Medical assistance percentages (FMAP). The State will claim the remainder of the calendar year 2013/2014 capitation rate, minus the portion of the capitation rate identified, as the rate differential at the State's regular FMAP percentage. These amounts may include, for example, MCO administration, underwriting gain, taxes, or fees.