Table of Contents

State/Territory Name: MN

State Plan Amendment (SPA) #: 09-025

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

APR 28 2010

Brian Osberg, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Mr. Osberg:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #09-025 - Miscellaneous Payment Rate Reductions for Various Providers
--Effective Date: July 1, 2009

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 442-9125 or by e-mail at Charles.Friedrich@cms.hhs.gov.

Sincerely,

acty ARA

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Lisa Knazan, MDHS

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: 09-25

2. STATE: Minnesota

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
July 1, 2009

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §440.20; §440.30§440.50(a); 440.60(a); §447.201(b)

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY '09: $ (6,388)
b. FFY '10: $ (28,925)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-A, pp. 33a, 34
Att. 3.1-B, pp. 32a, 33
Att. 4.19-B, pp 1a, 3, 6, 6a, 10,10a, 10b, 10c, 10d, 10e, 10f, 10g, 10h, 17, 19, 20, 20a, 23, 23a, 23.1, 27, 30, 30a, 31c, 39, 40

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Provider rate reduction

11. GOVERNOR'S REVIEW *(Check One)*:
X GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Ann Berg

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
September 15, 2009

16. RETURN TO:
Lisa Knazan
Minnesota Department of Human Services
Federal Relations Unit
PO Box 64983
St. Paul, MN 55164-0983

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 15, 2009

18. DATE APPROVED:
April 28, 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

7. Home health services. (continued)

- The following home health services are not covered under medical assistance:

  a) home health services that are the responsibility of the foster care provider;

  b) home health services when not medically necessary;

  c) services to other members of the recipient's household;

  d) any home care service included in the daily rate of the community-based residential facility in which the recipient resides;

  e) nursing and rehabilitation therapy services that can reasonably be obtained as outpatient services;

  f) any home health agency service that is performed in a place other than the recipient's residence;

  g) more than one home health aide visit per day; and

  h) more than two skilled nurse visits per day.

- Home health agencies that administer pediatric vaccines as noted in item 5.a., Physician's services within the scope if their licensure must enroll in the Minnesota Vaccines for Children Program.

- Influenza and pneumococcal immunizations for adults may be administered through a standing order ~~are an exception to the requirement that home health services be ordered by a physician~~. ~~If there is a standing order for these immunizations, they may be administered by a professional nurse per agency policy developed in consultation with a physician, and after an assessment for contraindications~~. The standing order includes an order from the physician, assessment criteria and contraindications for the immunizations. The professional nurse follows the standing order.

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area.

- Covered intermittent or part-time nursing services are those provided by a Medicare-certified home health agency that are:

  a) medically necessary;
  b) ordered by a physician;
  c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
  d) provided to the recipient at the recipient's own place of residence that is a place other than a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/MR in order to prevent an admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

- Homemaker services, social services, educational services, and services not prescribed by the physician are not paid by medical assistance.

- Home health agencies or registered nurses that administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

- Influenza and pneumococcal immunizations for adults may be administered through a standing order ~~are an exception to the requirement that home health services be ordered by a physician. If there is a standing order for these immunizations, they may be administered by a professional nurse per agency policy developed in consultation with a physician, and after an assessment for contraindications~~. The standing order includes an order from the physician, assessment criteria and contraindications for the immunizations. The professional nurse follows the standing order.

7. Home health services. (continued)

- The following home health services are not covered under medical assistance:

  a) home health services that are the responsibility of the foster care provider;

  b) home health services when not medically necessary;

  c) services to other members of the recipient's household;

  d) any home care service included in the daily rate of the community-based residential facility in which the recipient resides;

  e) nursing and rehabilitation therapy services that can reasonably be obtained as outpatient services;

  f) any home health agency service that is performed in a place other than the recipient's residence;

  g) more than one home health aide visit per day; and

  h) more than two skilled nurse visits per day.

- Home health agencies that administer pediatric vaccines as noted in item 5.a., Physician's services within the scope if their licensure must enroll in the Minnesota Vaccines for Children Program.

- Influenza and pneumococcal immunizations for adults may be administered through a standing order ~~are an exception to the requirement that home health services be ordered by a physician~~. ~~If there is a standing order for these immunizations, they may be administered by a professional nurse per agency policy developed in consultation with a physician, and after an assessment for contraindications~~. The standing order includes an order from the physician, assessment criteria and contraindications for the immunizations. The professional nurse follows the standing order.

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area.

- Covered intermittent or part-time nursing services are those provided by a Medicare-certified home health agency that are:

  a) medically necessary;
  b) ordered by a physician;
  c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
  d) provided to the recipient at the recipient's own place of residence that is a place other than a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/MR in order to prevent an admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

- Homemaker services, social services, educational services, and services not prescribed by the physician are not paid by medical assistance.

- Home health agencies or registered nurses that administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

- Influenza and pneumococcal immunizations for adults may be administered through a standing order ~~are an exception to the requirement that home health services be ordered by a physician~~. ~~If there is a standing order for these immunizations, they may be administered by a professional nurse per agency policy developed in consultation with a physician, and after an assessment for contraindications~~. The standing order includes an order from the physician, assessment criteria and contraindications for the immunizations. The professional nurse follows the standing order.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

Oral language interpreter services, provided by enrolled providers (except inpatient hospitals) to persons with limited English proficiency, are paid the lesser of charges or $12.50 per 15-minute unit of service. Effective July 1, 2009, payment rates for these services rendered on or after July 1, 2009, are reduced by five percent. Effective for these services rendered on or after July 1, 2009, and before July 1, 2011, rates are reduced by an additional one and one half percent.

Legislation governing maximum payment rates sets the calendar year at 1989, except that: (1) the calendar year for item 7, home health services, is set at 1982; and (2) the calendar year for outpatient mental health services is set at 1999 (payment is 75.6% of the 50th percentile of calendar year 1999 charges). Rates for services provided by community and public health clinics are increased by 20%, except for laboratory services.

Rate Decrease Effective July 1, 2002: Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2002, before third party liability and spenddown, is decreased by .5 percent from current rates.

Rate Decrease Effective March 1, 2003: Total payment paid to hospitals for outpatient hospital facility services provided on or after March 1, 2003 and through June 30, 2003, before third party liability and spenddown, is decreased by 5 percent from current rates.

Rate Decrease Effective July 1, 2003: Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2003, before third party liability and spenddown, is decreased by 5 percent from the rates in effect on February 28, 2003. This decrease does not include services provided by IHS or 638 facilities.

Rate Increase Effective January 1, 2004: Total payment for services provided on or after January 1, 2004 is increased by two percent if services are subject to outpatient hospital, surgical center, or health care provider taxes. The list of affected providers and services is found on page 1e.

Exceptions to the 50th percentile of the submitted charges occur in the following situations:

(1) There were less than 5 billings in the calendar year specified in legislation governing maximum payment rates;
(2) The service was not available in the calendar year specified in legislation governing maximum payment rates;
(3) The payment amount is the result of a provider appeal.

2.a. Outpatient hospital services.

Payments for outpatient hospital services may not exceed in aggregate the total payments that would have been paid under Medicare.

Outpatient hospital facility services are paid in accordance with the most recent Ambulatory Payment Classification system rates published by the Centers for Medicare & Medicaid Services in the Federal Register, listed in the column marked "Payment Rate," except that:

(1) end-stage renal disease hemodialysis for outpatient, per treatment is paid in accordance with composite rate methodology for the Medicare Program in effect prior to April 1, 2005.

(2) partial hospitalization is paid the lower of the submitted charge or an hourly rate that is 75.6% of the 50th percentile of 1999 charges.

For outpatient end stage renal disease hemodialysis and outpatient hospital facility services, except outpatient facility mental health services, rendered on or after July 1, 2009, payment is reduced by three percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2011, rates are reduced by an additional one and one half percent for outpatient end stage renal disease hemodialysis and outpatient hospital facility services services, except outpatient hospital facility mental health services.

Freestanding ambulatory surgical center facility services or facility components are paid in accordance with the methodology in item ~~6.d.C., Ambulatory surgical centers~~ 9, Clinic services.

Other outpatient hospital services as paid using the same methodology in item 5.a., Physicians' services.

Laboratory services are paid using the same methodology in item 3, Other laboratory and x-ray services.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the administration of vaccines.

Vaccines are paid the lower of:

(1) submitted charge; or

(2) the average wholesale price plus $1.50 for administration.

Vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid the lower of:

(1) submitted charge; or

(2) the $8.50 administration fee.

3. Other laboratory and x-ray services.

X-ray services are paid using the same methodology as item 5.a., Physicians' services.

Laboratory services are paid as follows:

(1) Services for which a Medicare upper payment limit applies are paid the lower of:

a) submitted charge; or

(b) the Medicare rate of the local carrier. If the local carrier does not have a current Medicare rate, then the previously established Medicare rate, if available, or according to the methodology below.

(2) Other services are paid the lower of:

(a) submitted charge; or

(b) one of the following:

1) 50th percentile of the charges submitted by all providers of the service (except dentists) in the calendar year specified in legislation governing maximum payment rates, less 25%;
2) 50th percentile of the charges submitted by all providers of the service (except dentists) in years subsequent to the calendar year specified in legislation governing maximum payment rates, down by the appropriate CPI formula, less 25%;
3) an average of a number of independent laboratory providers' charges, less 25%;
4) payment rates for comparable services; or
5) the Medicare rate.~~; or~~

(c) effective July 1, 2007, the sticker fee for laboratory specimens administered by the Department of Health is $25.00.

(d) effective July 1. 1997, the payment for newborn screening for metabolic disease administered by the Minnesota

3. Other laboratory and x-ray services (continued).

Department of Health is $21.00.

Effective for laboratory services rendered on or after July 1, 2009, payment is reduced by three percent. Effective for laboratory services rendered on or after July 1, 2009, and before July 1, 2011, rates are reduced by an additional one and one half percent.

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Except as noted, effective July 1, 2009, payment rates for services rendered on or after July 1, 2009, are reduced by five percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2011, the affected payment rates are reduced by an additional one and one half percent.

The rate reductions effective for services rendered on or after July 1, 2009, do **not** apply to HCPCS codes titled "office and other outpatient services", "preventive medicine new and established patient" and to "family planning services" when provided by primary care physicians and primary care advanced practice nurses.

With the exception listed below, for level one HCPCS codes titled "office and other outpatient services", "preventive medicine new and established patient", "delivery, antepartum and postpartum care", "critical care", "cesarean delivery" and, through June 30, 2001, "pharmacological management" provided to psychiatric patients; and HCPCS level three codes for enhanced services for prenatal high risk, payment is the lower of:

(1) submitted charges; or

(2) (a) 80% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

Effective July 1, 2007, "office and other outpatient services" and "preventive medicine new and established patient services"

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

are paid the lower of the submitted charge or 23.7% over the rates in effect on January 1, 2006, when provided by:
1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;
2) community mental health centers described in Attachment 3.1-A and 3.1-B at item 6.d.A; or
3) essential community providers as designated under Minnesota Statutes §62Q.19, in mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the performance payments described in the following two paragraphs.

Effective July 1, 2007, through June 30, 2009, eligible providers are paid an additional $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 130/80; and
- Lipids less than 100; and
- Patient is taking aspirin if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are physicians who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

With the exception noted below, for all other services the payment rate is the lower of:
(1) submitted charges; or
(2) (a) 75% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

Effective July 1, 2007, evaluation and management services" that are not "office and other outpatient services", "critical care services", or "preventive medicine new and established patient" services are paid the lower of the submitted charge or 23.7% over the rates in effect on January 1, 2006, when provided by:

1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;
2) community mental health centers described in Attachment 3.1-A and 3.1-B at item 6.d.A; or
3) essential community providers as designated under Minnesota Statutes §62Q.19, in mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to family planning services.

Effective for services provided on or after July 1, 2007, family planning services provided by family planning clinics, public health clinics and community health clinics are paid 25% over the rate in effect on June 30, 2007.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the performance payments described in the following two paragraphs.

Effective July 1, 2007, through June 30, 2009, eligible providers are paid an additional $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 130/80; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are physicians who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

complete clinical results per recipient that meet the criteria of optimal diabetic an/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

~~Effective January 1, 2000, the rate is increased by three percent.~~

Effective July 1, 2007, the State agency established rate is increased five percent for physical therapy services, occupational therapy services, speech-language therapy services, and respiratory therapy services.

Effective July 1, 1998, the rate is increased three percent for these services; effective January 1, 2000, the rate is increased another three percent; effective October 1, 2005, and October 1, 2006, the rate is increased by 2.2553 percent, excluding respiratory therapy services. Effective October 1, 2007, the rate is increased by two percent, excluding respiratory therapy services. Effective October 1, 2008, the rate is increased by two percent, excluding respiratory therapy services.

The rates for respiratory therapy services are as follows:

Procedure Code	**Rate**
94640	$ 15.02
94642	19.02
94650	16.70
94651	14.48
94652	140.34
94656	100.24
94657	43.43
94660	100.24
94664	18.78
94665	12.93
94667	16.19
94668	16.19

If the service is provided by an **enrolled physician assistant**, the service is paid the lower of:

1) submitted charge; or

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

2) 90% of the reference file allowable.

If the service is provided by a **physician extender**, the service is paid the lower of:

1) submitted charge; or

2) 65% of the reference file allowable, except for psychology services that are provided by a non-enrolled mental health practitioner, in which case the service is paid the lower of the submitted charge or 50% of the reference file allowable.

The rate reductions affecting services rendered or after July 1, 2009, do **not** apply to the psychology services rates described above.

If the service is provided by a **community health worker**, the service is paid the lower of:

1) submitted charge; or

2)

Procedure Code	**Rate**	
98960	12.50	per 30 minutes for an individual patient;
98961	4.16	per 30 minutes for groups of 2-4 patients;
98962	1.92	per 30 minutes for groups of 5-8 patient.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the psychotherapy services rates that follow.

With the exception listed below, **psychotherapy services** provided on or after July 1, 2001 are paid the lower of:

(1) submitted charge; or

(2) (a) 75.6% of the 50th percentile of the 1999 charges submitted by all providers of the service (except for services provided by home and community-based waiver services providers, IEP providers and providers whose payment rate is based on a percentage of the physicians' payment rate); or

(b) State agency established rate; or

(c) Effective July 1, 2007, psychotherapy is paid 23.7% over the rates in effect on January 1, 2006, when provided by:

1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;
2) community mental health centers described in Attachment 3.1-A and 3.1-B at item 6.d.A; or

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

3) essential community providers as designated under Minnesota Statutes §62Q.19, in mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the mental health services rates that follow.

If the service is provided by a non-enrolled mental health practitioner, the supervising enrolled provider is paid the lower of:

(1) submitted charge; or

(2) 50% of item (2)(a), (2)(b), or 2(c) above, for psychotherapy services.

Effective January 1, 2002, provider travel time is covered if a recipient's individual treatment plan requires the provision of psychotherapy services outside of the provider's normal place of business.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to anesthesia services.

Anesthesia services personally performed by the anesthesiologist are paid the lower of:

(1) submitted charge; or

(2) the product of the physician conversion factor ($18.00) multiplied by the sum of the relative base value units and time units (one time unit equals fifteen minutes).

Anesthesia services provided by the anesthesiologist medically directing (supervising) one to four certified registered nurse anesthetists, student registered nurse anesthetists, or anesthesia residents are paid the lower of:

(1) submitted charge; or

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

(2) ~~$\left(\frac{(RBVUs + TUs)\ X\ Physician\ CF}{2}\right) X\ 1.86$~~

~~Where RBVU = Relative Base Value Units~~
~~TU = Time Units~~
~~CF = Conversion Factor~~

(relative base value unit + time units*) x
Medicare anesthesiologist conversion factor x 0.632

Anesthesia services provided by the anesthesiologist medically directing (supervising) five or more certified registered nurse anesthetists or anesthesia residents are paid the lower of:

(1) the submitted charge; or

(2) the physician conversion factor multiplied by four.

Laboratory services are paid using the same methodology as item 3, Other lab and x-ray services.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to vaccine or injectable services rates that follow.

With the exception of pediatric vaccines in item 2.a., Outpatient hospital services, covering the Minnesota Vaccines for Children program, **vaccines** are paid using the same methodology as item 2.a., Outpatient hospital services.

All other injectables are paid using the same methodology as item 2.a.

Payment for monitoring for identification and lateralization of cerebral seizure focus by attached electrodes; and combined electroencephalographic (EEG) and video recording and interpretation each 24 hours are paid the lower of:

(1) submitted charge; or

(2) $751.90

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

The State has established a rate for the following:

	Procedure Code	Rate
(1)	92340	$ 28.84
(2)	92341	33.99
(3)	V5090	182.15
(4)	V5110	273.23
(5)	V5160	273.23
(6)	V5200	182.15
(7)	V5240	273.23
(8)	V5241	182.15

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the rates paid to teaching sites that follow.

Medical Assistance provides for an additional annual payment to teaching sites providing physician services, including mental health services delivered by psychiatrists, community mental health centers and essential community providers. For each state fiscal year a Department medical education payment will be distributed by a sponsoring institution prior to October 1 of each year for the previous state fiscal year. Effective July 1, 2007 the payment will be increased in an amount equal to:

(1) $7,575,000 multiplied by a proportion equal to the physician's public program revenue divided by the total amount of public program revenue of all eligible training sites. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, general assistance medical care and, prepaid general assistance medical care.
(2) For physicians with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all eligible training sites, payments are increased by 20 percent.
(3) Payments to training sites with public program revenue less than 0.98 percent of the total public program revenue of all training eligible sites are reduced proportionately to fund the payment increases described in sub-item (2).
(4) Training sites with no public program revenue are not eligible for increased payments.

Psychiatric consultations provided on or after October 1, 2006, are paid through rates representing three levels of service complexity and substance, assigning a value to both the primary care physician and the psychiatrist's component of the consultation and combining them to create a single payment rate for each level of psychiatric consultation. Medical Assistance payment is made to the primary care physician who, in turn, is responsible for paying the consulting psychiatrist pursuant to a contract.

Medical Assistance will pay for this service at the lower of:
(1) the submitted charge; or the rate below in (2).

(2)(a) Primary care component is provided by a physician plus the psychiatrist component:

CPT code	99499 HE	$80.85
CPT code	99499 HE TF	$159.69
CPT code	99499 HE TG	$201.10

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

(b) Primary care component provided by a physician assistant, nurse practitioner, or clinical nurse specialist plus the psychiatrist component:

CPT code	99499 HE	$78.79
CPT code	99499 HE TF	$155.07
CPT code	99499 NE TG	$194.50

(c) Primary care component provided by a physician extender plus the psychiatrist component:

CPT code	99499 HE U7	$ 73.64
CPT code	99499 HE TF U7	$143.54
CPT code	99499 HE TG U7	$178.02

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the provider directed care coordination rates that follow.

Effective January 1, 2009, one six-month payment per recipient with 5-6 chronic diagnoses receiving Group 1 provider-directed care coordination, associated with an evaluation and management visit, is the lower of:

- Submitted charge; or
- $243.24

Effective January 1, 2009, one six-month payment per recipient with 7-~~8~~9 chronic diagnoses receiving Group 2 provider-directed coordination, associated with an evaluation and management visit, is the lower of:

- Submitted charge; or
- $ 316.20

Effective January 1, 2009, one six-month payment per recipient with 10 or more chronic diagnoses receiving Group 2 provider-directed coordination, associated with an evaluation and management visit, is the lower of:

- Submitted charge; or
- $458.52

For provider-directed care coordination payment based on services less than six months in duration, the payment rate listed above may be allocated to the time period served. Allocation can only occur in the case of a recipient's death, loss of eligibility or change of payer. Payment must be associated with the last evaluation and management visit occurring during the preceding six months.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services** are paid the lower of:

1) submitted charge; or

2) State agency established rates based on comparable rates for services provided by a nurse practitioner in an office setting, or by a home health nurse in a home setting or by a nurse providing perinatal high risk services under item 20, Extended services to pregnant women.

Effective for public health nursing services rendered on or after July 1, 2009, payment is reduced by three percent, except for pediatric vaccine administration by public health nurses as described in item 2.a. Effective for services rendered on or after July 1, 2009, and before July 1, 2011, payment rates for public health nursing services are reduced by an additional one and one half percent, except for pediatric vaccine administration by public health nurses as described in item 2.a.

Effective 7/1/08, ~~if the service is~~ services provided by a community health worker~~, the payment is the lower of:~~ are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

~~1) submitted charge; or~~

~~2) **Procedure Code Rate**~~

~~98960 12.50 per 30 minutes for an individual Medicaid eligible patient;~~

~~98961 4.16 per 30 minutes per patient for groups of 2-4 eligible patients~~

~~98962 1.92 per 30 minutes per patient for groups of 5-8 eligible patients.~~

Public health nurses who administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

6.d. Other practitioners' services. (continued)

D. **Administration of anesthesia by certified registered nurse anesthetists (CRNAs)** provided in an outpatient setting are paid the lower of:

(1) submitted charge; or

(2)(a) if the services are not provided under the medical direction of an anesthesiologist, effective July 1, 2009:

(relative base value units + time units*) x ($18.00 ~~Medicare CRNA conversion factor~~); or

(b) if the services are provided under the medical direction of an anesthesiologist, effective July 1, 2009:

~~[~~(relative base value units + time units*) x Medicare CRNA conversion factor x 0.632~~(Medicare CRNA conversion factor)/2] x 1.264~~

- Pursuant to page 1 of this Attachment, critical access hospitals are paid on a cost-based payment system for CRNA services based on the cost-finding methods and allowable costs of Medicare, if they apply and qualify for the CRNA direct billing exemption under Medicare Part B.

- Hospitals continue to be paid for CRNA services as part of the prospective payment system specified for inpatient hospital services in Attachment 4.19-A, unless CRNA services were not in the hospital's base rate. If CRNA services are not part of the hospitals' base rate, they are paid as specified in items (1) and (2), above.

Certified registered nurse anesthetist services that are not administration of anesthesia are paid as specified in item 5.a., Physicians' services.

* one time unit equals 15 minutes

6.d. Other practitioners' services. (continued)

E. With the exception noted below for the provision of optimal diabetic and/or cardiovascular care, **nurse practitioner services** (independently enrolled)are paid the lower of:

1) submitted charge; or

2) 90% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 130/80; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those nurse practitioners who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

Nurse practitioners who provide provider-directed care coordination are paid using the same methodology as item 5.a., Physicians' Services.

Nurse practitioner services (physician extenders) are paid the lower of:

6.d. Other practitioners' services. (continued)

1) submitted charge; or

2) 65% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

Effective July 1, 2007, evaluation and management services are paid the lower of the submitted charge or 23.7% over the rates established above, when provided by a nurse practitioner with a psychiatric specialty.

Effective July 1, 2007, through June 30, 2009, eligible providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 130/80; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those nurse practitioners who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

If the services are paid through the payment for inpatient services, the nurse practitioner cannot

6.d. Other practitioners' services. (continued)

H. With the exception noted below, **clinical nurse specialist** services (independently enrolled) are paid the lower of:

1) submitted charge; or

2) 90% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 130/80; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those clinical nurse specialists who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

With the exception noted below, **clinical nurse specialist** services (physician extenders) are paid the lower of:

1) submitted charge; or

6.d. Other practitioners' services. (continued)

2) 65% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

Clinical nurse specialist services provided by a **masters prepared nurse with American Nurses Association certification as a clinical specialist in psychiatric or mental health** are paid as provided in item 6.d.A and as follows:

- Effective July 1, 2007, evaluation and management services are paid the lower of the submitted charge or 23.7% over the applicable rate established above for independently enrolled or physician extender clinical nurse specialists.

Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 130/80; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those clinical nurse specialists who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

6.d. Other practitioners' services. (continued)

I. **Medication therapy management services.**

Medication therapy management services are paid the lower of submitted charges or:

A. for the first encounter, $52.00 for the first 15 minutes, then $24,00 for each additional 15-minute unit

1. for each provider a recipient visits, the first encounter is limited to one every 365 days

2. for each additional 15-minute unit, a maximum of four per encounter

B. for subsequent encounters, $34.00 for the first 15 minutes, then $24.00 for each additional 15-minute unit

1. for each subsequent encounter, a maximum of seven per recipient, every 365 days

2. for each additional 15-minute unit, a maximum of four per encounter.

Effective July 1, 2009, payment rates for services rendered on or after July 1, 2009, are reduced by five percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2011, rates are reduced by an additional one and one half percent.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

Hearing aids and oxygen are purchased on a volume basis through competitive bidding.

Effective for all of the following medical supplies, equipment and appliances provided on or after July 1, 2009, payment is reduced by three percent. Effective for medical supplies, equipment and appliances provided on or after July 1, 2009, and before July 1, 2011, rates are reduced by an additional one and one half percent.

Medical supplies and equipment that are not purchased on a volume basis are paid the lower of:

(1) submitted charge;
(2) Medicare fee schedule amount for medical supplies and equipment; or
(3) if Medicare has not established a payment amount for the medical supply or equipment, an amount determined using one of the following methodologies:
    (a) 50th percentile of the usual and customary charges submitted for the previous two calendar years minus 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment;
    (b) if no information about usual and customary charges exists, payment is based upon the manufacturer's suggested retail price minus 20 percent; or
    (c) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

Augmentative and alternative communication device manufacturers and vendors are paid the manufacturers's suggested retail price.

Enteral products are paid the lower of:

(1) submitted charge; or
(2) Medicare fee schedule amount for enteral products.
    • Pediatric enteral products may be paid at the average wholesale price.

Parental products are paid using the methodology in tems 12.a., Prescribed drugs, for drugs dispensed by a pharmacy.

9. Clinic services

Clinic services are paid using the same methodology as item 5.a., Physicians' services, except:

- dental services provided by clinics are paid using the same methodology as item 10, Dental services
- end-stage renal disease hemodialysis provided by renal dialysis clinics is paid using the same methodology as item 2.a., Outpatient hospital services

As provided for in item 5.a., Medical Assistance provides for an additional annual payment for: 1) State Fiscal Year 2006 (July 1, 2005 through June 30, 2006), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2006; 2) State Fiscal Year 2007 (July 1, 2006 through June 30, 2007), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2007; and 3) for state fiscal year 2008 and thereafter, which includes a Department medical education payment for each state fiscal year and distributed by a sponsoring institution prior to October 1 of each year for the previous state fiscal year, to Medical Assistance-enrolled physician and chiropractic clinics. In accordance with Code of Federal Regulations, title 42, section 447.321(b)(2), this payment will not exceed the Medicare upper payment and charge limits.

Freestanding ambulatory surgical centers:

Payment for facility services or facility component is the lower of:

(1) submitted charge; or

(2) (a) Medicare rates; or

(b) if there is not a Medicare rate, effective October 1, 1992, payment is at 105.6% of the 1990 average submitted,

9. Clinic services.

charge; or

(c) if there is not a Medicare rate and there is not a 105.6% of the 1990 average submitted charge, effective October 1, 1992, payment is at the State agency established rate, which is derived by backing down the submitted charge to 1990 (by using the CPI) and increasing this amount by 5.6%.

Effective for freestanding ambulatory surgical center facility services or facility component rendered on or after July 1, 2009, payment is reduced by three percent. Effective for these services rendered on or after July 1, 2009, and before July 1, 2011, these payment rates are reduced by an additional one and one half percent.

10. Dental services (continued):

- **X-ray services** are paid according to the dental services methodology listed above. Effective January 1, 2002, payment for x-ray services provided to recipients under age 21 are paid the lower of:

  (1) the submitted charge; or
  (2) 85% of the median charges submitted in 1999.

- **Diagnostic examinations** are paid according to the dental services methodology listed above. Effective January 1, 2002, payment for diagnostic examinations provided to recipients under age 21 are paid the lower of:

  (1) the submitted charge; or
  (2) 85% of the median charges submitted in 1999.

- **Tooth sealants** and **fluoride treatments** are paid at the lower of:

  (1) submitted charge; or
  (2) 80% of the median charges submitted in 1997.

  Effective January 1, 2000, the rate is increased by three percent.

- **Medical and surgical services** (as defined by the Department) furnished by dentists are paid using the same methodology as item 5.a., Physicians' services.

- Community health worker services educating patients to promote good oral health and self-management of dental conditions when supervised by a dentist ~~is~~ are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services. ~~the lower of:~~
  ~~1) submitted charge; or~~
  ~~2) **Procedure Code** **Rate**~~
  ~~98960 12.50 per 30 minutes for an individual Medicaid eligible patient;~~
  ~~98961 4.16 per 30 minutes per patient for groups of 2-4 eligible patients~~
  ~~98962 1.92 per 30 minutes per patient for groups of 5-8 eligible patients.~~

12.c. Prosthetic devices.

Payment the lower of:

(1) submitted charge;

(2) Medicare fee schedule amount; or

(3) if Medicare has not established a payment amount for the prosthetic or orthotic device, an amount determined using one of the following methodologies:

(a) 50th percentile of the usual and customary charges submitted for the prosthetic or orthotic device for the previous calendar year minus 20 percent;

(b) if no information about usual and customary charges exists for the previous calendar year, payment is based upon the manufacturer's suggested retail price minus 20 percent; or

(c) if no information exists about the manufacturer's suggested retail price, payment is based upon the wholesale cost plus 20 percent.

Effective for services rendered on or after July 1, 2009, payment is reduced by three percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2011, these payment rates are reduced by an additional one and one half percent.

12.d. Eyeglasses.

Effective for services provided on or after January 15, 2002, payment for eyeglasses and ophthalmic materials is the lower of:

1) submitted charge; or

2) a) .481 of the July 2001 Medicare rate; or

b) state agency established rate.

Effective for services rendered on or after July 1, 2009, payment is reduced by three percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2011, these payment rates are reduced by an additional one and one half percent.