Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

Citation	4.19(i)	
1902 (a) (30) (A) 42 CFR 447.201 42 CFR 447.204 At – 78 - 90		The Medicaid agency provides methods and procedures relating to the utilization of, and the payment for, care and services available under the State plan as may be necessary to safeguard against unnecessary utilization of such care and services. The Medicaid agency's payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population in the geographic area. The rate methodologies are the same for both governmental and private providers, except as otherwise noted in the plan. The base rates for payments that are fixed across all providers are available on the agency's website http://www.dhs.state.mn.us in the Minnesota Health Care Program fee schedules. Methodologies for determining any adjustments to the base rates are ~~found through the Minnesota Health Care Program Provider Manual~~ available through the agency's website or through the Provider Help Desk at 1-800-366-5411 or 651-431-2700.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care

~~The following is a description of the policy and methods used in establishing payment rates for each type of care and services included in the State plan.~~

~~Medical Assistance payment for Medicare crossover claims is equal to the Medicare co-insurance and deductible.~~

~~IHS/638 Facilities: Except for child welfare-targeted case management services and relocation service coordination services, services provided by facilities of the Indian Health Service (which include, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as 638 facilities) are paid at the rates negotiated between the Indian Health Service and the Centers for Medicare & Medicaid Services and published by the Indian Health Service in the Federal Register. Child-welfare targeted case management services are paid in accordance with the methodology in item 19.b., child welfare-targeted case management services. Relocation service coordination services are paid in accordance with the methodology in item 19.c, relocation service coordination services.~~

~~Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Centers for Medicare & Medicaid Services) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.~~

~~Except in the case of critical access hospitals, for obstetric care the base rate is adjusted as follows:~~

- ~~outpatient hospital obstetric care (as defined by the Department) technical component (provided by outpatient hospital facilities) receives a 10% increase over the base rate.~~

- ~~all other obstetric care (as defined by the Department) receives a 26.5% increase over the base rate.~~

~~Pediatric care (as defined by the Department), except for the technical component provided by an outpatient hospital facility, receives a 15% increase over the base rate.~~

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, 2010, rates are reduced by an additional one and one half percent. Effective July 1, 2010, payment rates for these services rendered on or after July 1, 2010, are reduced by an additional seven 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 1c.~~

~~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.~~

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

~~**Rate Decrease Effective July 1, 2008:** Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2008, before third party liability and spenddown, is decreased by 3 percent. This decrease does not include psychiatric diagnostic categories or services provided by IHS or 638 facilities.~~

~~**Rate Decrease Effective January 1, 2009 for certain professional services and eyeglasses:** A $3.00 rate reduction is applicable to the following services provided to recipients for whom a copay had been required prior to January 1, 2009:~~

- ~~Eyeglass services;~~
- ~~Non-preventive services provided by the following:~~
  - ~~Physicians~~
  - ~~Public health nursing~~
  - ~~Optometrists~~
  - ~~Podiatrists~~
  - ~~Chiropractors~~
  - ~~Audiologists~~
  - ~~Opticians~~
  - ~~Nurse practitioners~~
  - ~~Nurse midwives~~
  - ~~Clinical nurse specialists~~
  - ~~Physician assistants~~

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

~~(4) The procedure code description has changed since the calendar year specified in the legislation governing maximum payment rates, therefore, the prevailing charge information reflects the same code but a different procedure description;~~
~~(5) The 50th percentile reflects a payment which is inequitable when compared with payment rates for procedures or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category; or~~
~~(6) The procedure code is for an unlisted service.~~

~~In these instances, the following methodology is used to reconstruct a rate comparable to the 50th percentile of charges submitted in the calendar year specified in legislation governing maximum payment rates:~~

~~(1) Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; and/or~~
~~(2) Refer to surrounding and/or comparable procedure codes; and/or~~
~~(3) Refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates; and "backdown" the amount by applying an appropriate CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI; and/or~~
~~(4) Refer to relative value indexes; and/or~~
~~(5) Refer to payment information from other third parties, such as Medicare; and/or~~
~~(6) Refer to a previous rate and add the aggregate increase to the previous rate; and/or~~
~~(7) Refer to the submitted charge and "backdown" the charge by the CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI.~~

~~If a procedure was authorized and approved prior to a reference file rate change, the approved authorized payment rate may be paid rather than the new reference file allowable.~~

~~HCPCS MODIFIERS~~

~~Medical Assistance pays more than the reference file allowable in the following areas:~~

~~20 microsurgery = 35% additional reimbursement.~~

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

~~22 unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered.~~

~~99 multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99.~~

~~In accordance with Minnesota Statutes, §256B.37, subdivision 5a: No Medical Assistance payment will be made when either covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.~~

~~Payment for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:~~

~~(1) the patient liability according to the provider/third party payer (insurer) agreement;~~

~~(2) covered charges minus the third party payment amount; or~~

~~(3) the Medical Assistance rate minus the third party payment amount.~~

~~IHS/638 FACILITIES:~~

~~An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.~~

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

~~Services included in the outpatient rate include:~~

- ~~outpatient hospital ambulatory surgical services~~
- ~~outpatient physician services~~
- ~~outpatient dental services~~
- ~~pharmacy services~~
- ~~home health agency/visiting nurse services~~
- ~~outpatient chemical dependency services~~
- ~~transportation services if the recipient is not admitted to an inpatient hospital within 24 hours of the ambulance trip~~

~~Services included in the inpatient rate include:~~

- ~~inpatient hospital services~~
- ~~transportation services if the recipient is admitted to an inpatient hospital within 24 hours of the ambulance trip~~

~~Inpatient physician services are paid in accordance with the methodology described in item 5.a., Physicians' services.~~

~~The ambulatory surgical center facility fee is paid in accordance with the methodology for the technical component of the surgical procedure described in item 2.a., Outpatient hospital services~~.

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

~~Total payment for services provided on or after January 1, 2004 is increased by two percent for the following Minnesota providers and services:~~

- ~~outpatient hospital services~~
- ~~x-ray services~~
- ~~EPSDT services, excluding rehabilitative services and services provided to a recipient with severe emotional disturbance residing in a children's residential treatment facility~~
- ~~physicians' services~~
- ~~medical and surgical services furnished by a dentist~~
- ~~podiatrists' services~~
- ~~optometrists' services~~
- ~~chiropractors' services~~
- ~~other practitioners' services: mental health, public health nursing, ambulatory surgical center, certified registered nurse anesthetist, nurse practitioner, case management services provided as a component of receiving clozapine, and clinical nurse specialist services~~
- ~~clinic services~~
- ~~dental services~~
- ~~physical therapy services~~
- ~~occupational therapy services~~
- ~~speech, language, and hearing therapy services~~
- ~~dentures~~
- ~~eyeglasses~~
- ~~diagnostic, screening, and preventive services~~
- ~~rehabilitative services: day treatment for mental illness, services for treating chemical abuse, rehabilitative restorative and specialized maintenance physical therapy, occupational therapy, and speech, language and hearing therapy services, and respiratory therapy services~~
- ~~services for individuals age 65 or older in institutions for mental diseases~~
- ~~inpatient psychiatric facility services for individuals under 22 years of age~~
- ~~nurse midwife services~~
- ~~pregnancy related and post partum services for 60 days after the pregnancy ends~~
- ~~services for any other medical condition that may complicate pregnancy~~
- ~~certified pediatric or family nurse practitioner services~~
- ~~licensed ambulance services, excluding volunteer ambulance services~~
- ~~emergency hospital services~~

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~~ $69.55 for adults and $45.36 for children.

If there is no Ambulatory Payment Classification rate, outpatient hospital facility services are paid the lower of:

(1) Submitted; or
(2) 80% of the 1990 average submitted charge.

If there is no Ambulatory Payment Classification rate or an 80% of the 1990 average submitted charge, outpatient hospital facility services are paid at the consumer price index backdown.

~~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.~~

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

2.a. Outpatient hospital services (cont).

Vaccines are paid the lower of:
(1) submitted charge; or
(2) ~~the average wholesale price plus $1.50 for administration.~~
(2) Medicare's Average Sales Price (ASP) plus 6%; or
(3) (3) The Average Wholesale Price (AWP) minus 5%

Vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid the appropriate administration fee only.

Vaccine administration is paid the lower of:
(1) Submitted charge; or
~~(2) the $8.50 administration fee~~.
(2)

Vaccine Administration		
CPT Code	**MnVFC Rate**	**Non MnVFC Rate**
90460 (initial)	$14.69	$16.40
90461 (additional)	$0	$0
90471 (initial)	$14.69	$18.13
90472 (additional)	$7.35	$8.97
90473 (initial)	$14.69	$18.13
90474 (additional)	$7.35	$8.97
G0008 (flu)	$14.69	$18.13
G0009 (PPV)	$14.69	$18.13
G0010 (Hep B)	$14.69	$18.13

All other injectables are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price.

Additional payment adjustment for Hennepin County Medical Center and Regions Hospital Effective for services delivered on or after July 1, 2009, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment will be made annually, within two years of the close of the federal fiscal year, that is the difference between the Medicaid costs for outpatient
Costs for outpatient

2.a. Outpatient hospital services (cont).

hospital services and the Medicaid payments for outpatient hospital services for the non-state government-owned hospitals that are not critical access hospitals. Total additional payments shall be determined based on a comparison of Medicaid payments to the hospitals and the hospital's Medicaid costs for the most recent state plan rate year available as reported to DHS under 42 CFR §447.299 (10)and (9).

Payments will be distributed to the Hennepin County Medical Center and Regions Hospital as follows:

(1) Determine the difference between Medicaid costs and Medicaid payments for outpatient hospital services as reported under 42 CFR §447.299(10) and (9) for the most recent year, for each of the non-state government-owned hospitals that are not critical access hospitals.

(2) Calculate a ratio for each of the two hospitals receiving a payment under this section that is equal to:

the FFS Medicaid outpatient hospital payments to each of the two hospitals receiving payments under this section,

divided by the sum of the Medicaid payments for outpatient hospital services to the two hospitals receiving payments under this section.

(3) Apply the ratio computed in step (2) to the difference between the sum of the amounts computed in step (1) for all of the non-state government-owned hospitals that are not critical access hospitals.

Freestanding ambulatory surgical center facility services or facility components are paid in accordance with the methodology in item 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.

2.a. Outpatient hospital services (cont).

Outpatient chemical abuse programs services are paid using the same methodology in item 13.d., Rehabilitative services.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals paid on a cost-payment system
C TPL
D. MinnesotaCare tax rate adjustment
E. Modifiers subject to an increase in base payment rate
K. Copay converted to $2.50 provider rate reduction
M. Rate decrease effective 01/01/02
N. Rate decrease effective 03/01/03
R. Professional services rate decrease effective 7/1/09.
S. Professional services rate decrease effective 7/1/10.
U. Facility services decrease 07/01/09

3. Other laboratory and x-ray services.

X-ray services are paid using the same methodology as item 5.a., Physicians' services, or if provided in an outpatient hospital facility setting, item 2a.

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

6) the state agency established rate.

(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.~~

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment.

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
H. Medicare Cap
I. Exceptions to payment methodology and reconstructing a rate
U. Facility services 2009 rate decrease

4.b. Early and periodic screening, diagnosis, and treatment services:

EPSDT (in Minnesota, Child & Teen Checkup) services are paid the lower of the submitted charge or the 75th percentile of all screening charges submitted by providers of the service during the previous 12-month period of July 1 to June 30. The adjustment necessary to reflect the 75th percentile is effective annually on October 1.

Effective January 1, 2002, provider travel time is covered if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. Travel time is paid as a supplement to the payment for the associated covered service. Travel time is paid at the lower of the submitted charge or 45 cents per minute. This does not include travel time included in other billable services.

A. ~~IHS/638 facility providers of **children's therapeutic services and supports** are paid according to the encounter rate specified on page 1 of this Attachment for each face-to-face encounter.~~

~~B.~~ With the exceptions listed below, children's therapeutic services and supports not provided by IHS/638 facilities are paid the lower of the submitted charge or the Resource Based Relative Value Scale rate. ~~75.6% of the 50th percentile of 1999 charges.~~

The children's therapeutic services and supports below are paid the lower of the submitted charge or the listed rate.

90853 UA CTSS Group Psychotherapy: $42.52 per session

90857 UA CTSS Interactive Group Psychotherapy: $68.04 per session

H2012 UA CTSS Therapeutic Components of Preschool: $28.61 per 60 minute unit

H2014 UA CTSS Skills Training, Individual: $12.80 per 15 minute unit
H2014 UA HQ CTSS Skills Training, Group: $8.60 per 15 minute unit
H2014 UA HR CTSS Skills Training, Family: $16.67 per 15 minute unit
H2015 UA CTSS Crisis Assistance: $13.65 per 15 minute unit
H2019 UA CTSS Mental Health Behavioral Aide-level 1: $6.03 per 15 minute unit
H2019 UA HE CTSS Direction of Mental Health Behavioral Aide by Mental Health Professional or Mental Health Practitioner: $8.80 per 15 minute unit
H2019 UA HM CTSS Mental Health Behavioral Aide-level 2:$7.89 per 15 minute unit

~~Effective for services provided on or after October 1, 2007, the payment for all children's therapeutic services and supports not provided by IHS/638 facilities is the lower of the submitted charge or 2% over the rate in effect on September 30, 2007.~~
~~Effective for services provided on or after October 1, 2008, the payment for all children's therapeutic services and supports not provided by IHS/638 facilities is the lower of the submitted charge or 2% over the rate in effect on September 30, 2008.~~

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~1. Effective for group skills training and psychotherapy services provided on or after January 1, 2008, by providers of children's therapeutic services and supports, except those providers described in items 2a,b and c below, the payment is the lower of the submitted charge or 23.7% over the rate in effect on December 31, 2007.~~

~~2. Effective July 1, 2007, group skills training and psychotherapy services, when provided as components of children's therapeutic services and supports, are paid the lower of the submitted charge or 23.7% over the rates in effect on January 1, 2006, when provided by:~~

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

3. ~~Effective for individual skills training services provided on or after January 1, 2008, payment is the lower of the submitted charge or $12.55 per 15 minute unit.~~

~~4. Effective for family skills training services provided on or after January 1, 2008, payment is the lower of the submitted charge or $16.35 per 15 minute unit.~~

~~5. Effective for crisis assistance services provided on or after February 18, 2004, payment is the lower of the submitted charge or $13.13 per 15 minute unit.~~

~~6. Mental health behavioral aide services provided on or after January 1, 2008, are paid:~~

~~a. for Level I MHBAs, the lower of the submitted charge or $5.92 per 15 minutes unit;~~

~~b. for Level II MHBAs, the lower of the submitted charge or $7.74 per 15 minute unit; or~~

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~7. Effective January 1,2008, all mental health professional or mental health practitioner direction of MHBAs, except those described below in items 8, paragraphs 1, 2, and 3), are paid the lower of the submitted charge or 23.7 percent over the rate in effect on December 31, 2007.~~

~~8. Effective July 1, 2007, mental health practitioner direction of MHBA's is 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.~~

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~Mental health behavioral aide services provided as part of family community support services are paid:~~

~~For Level I MHBAs, the lower of the submitted charge or $4.70 per 15 minute unit;~~

~~For Level II MHBAs, the lower of the submitted charge of $6.14 per 15 minute unit; or~~

~~For mental health professional or mental health practitioner direction of MHBAs, the lower of the submitted charge or $6.85 per 15 minute unit.~~

~~Therapeutic components of preschool are paid the lower of the submitted charge or $27.50 per one hour unit.~~

Crisis response services are paid as follows:

Crisis assessment, intervention and crisis stabilization services are paid:

for doctoral prepared mental health professionals, the lower of the submitted charge or $87.00 per 60 minute unit;

for master's prepared mental health professionals, the lower of the submitted charge or $69.60 per 60 minute unit; or

for mental health practitioners supervised by mental health professionals, the lower of the submitted charge or $60.46 (effective February 18, 2004) per 60 minute unit and $43.50 (effective January 1, 2004) per 60 minute unit.

IHS/638 facility providers of crisis response services are paid according to the encounter rate specified ~~on page 8~~ in Supplement 2 of this Attachment for each face-to-face encounter.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Rate Formula:
The medical assistance payment is the computed percentage of the daily rate multiplied by the total facility daily rate.

All of the following conditions must be met in order for a claim to be made:

1) residents must be eligible for medical assistance
2) residents received rehabilitative services that day
3) all documentation requirements are met

A residential facility's daily medical assistance rate will be reviewed and updated quarterly for changes in the negotiated rate and annually for changes in time study or cost data.

Personal care assistant services identified in an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA) and provided by school districts during the school day to children with IFSPs/IEPs are paid pursuant to the methodology in item 13.d.V Rehabilitative services.

Other EPSDT providers are paid in accordance with the methodology set forth elsewhere in this Attachment for the provider type enrolled to provide the service.

The base rates as described in this item are adjusted by the following paragraphs of Supplement 2:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjusment effective for service dates beginning 01/01/04
E. Modifiers
G. Community and Public Health Clinics
I. Exceptions to payment methodology and reconstructing a rate
O. Rate increase effective 10/1/07 and 7/1/08.
P. Rate increase effective 07/01/07

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, 2010, the affected payment rates are reduced by an additional one and one half percent. Except as noted, effective July 1, 2010, payment rates for services rendered on or after July 1, 2010, are reduced by an additional seven percent.~~

~~Effective July 1, 2010, payment rates for services rendered by psychiatrists and advanced practice nurses with a specialty in mental health on or after July 1, 2010, are increased by one and one half percent.~~

~~Effective for services rendered on or after July 1, 2010, payment rates as otherwise calculated in this item, 5.a, shall not exceed the Medicare rate for the same service, except for payment rates for physicians' services provided by a psychiatrist or an advanced practice registered nurse with a specialty in mental health; optimal diabetic and/or cardiovascular care; and health care home services.~~

~~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" (except as listed in (2)(c) below), "critical care", "complicated 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~~ Effective for services provided on or after January 1, 2011, payment for physician services is the lowest 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~~

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

~~in legislation governing maximum payment rates;~~ the Resource Based Relative Value Scale calculated values (as published by the Centers for Medicare & Medicaid Services November 2010); or

(b) State agency established rate; or

(c) For delivery services, including cesarean delivery services that are not complicated:

59400, 59510, 59610:	~~$867.37~~	$1387.89
59409, 59514, 59612	~~$560.43~~	$540.00
59410, 59515, 59614	~~$585.15~~	$696.73

The Resource Based Relative Value Scale conversion factors are:

Evaluation and Management services: $27.10
Obstetric services: $27.10
Psychiatric services: $31.56
All other physician services: $24.52

~~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"~~

~~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 140/90; and
- Lipids less than 100; and

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

- 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~~

~~(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: Steve~~
~~—~~

~~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,~~

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

~~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 cla 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 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 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, 2010, payment rates for physical therapy services, occupational therapy services, and speech-language therapy services rendered on or after July 1, 2010, are increased by two percent.~~

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

~~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
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 on or after July 1, 2009, do **not** apply to the psychology services rates described above.~~

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

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~~ $18.59 per 30 minutes for an individual patient;
98961	~~4.16~~ $9.07 per 30 minutes for groups of 2-4 patients;
98962	~~1.92~~ $6.65 per 30 minutes for groups of 5-8 patients.

~~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),~~ the Resource Based Relative Value Scale calculated 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~~
~~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.~~

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

~~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), or (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~~ paid the lower of the submitted charge or as specified in item 4.b.

~~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

(2) (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

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

(2) the physician conversion factor multiplied by four.

*one time unit equals 15 minutes

~~**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~~

The State has established a rate for the following:

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

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

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

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

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

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 health care home rates that follow.~~

Effective July 1, 2010, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services, is the lower of:

- Submitted charge; or
- $10.14.

Effective July 1, 2010, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:

- Submitted charge; or
- $20.27.

Effective July 1, 2010, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- $40.54

Effective July 1, 2010, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply to the recipient:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their

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

health care; or

- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

Additional payment adjustment for physician practice groups at Hennepin County Medical Center and Regions Hospital Effective for services delivered on or after July 1, 2009, in recognition of the services provided by physicians and, effective for services delivered on or after January 1, 2011, non-physician practitioners affiliated with the two largest safety net hospitals, an additional adjustment, in total for the physician practice groups associated with Hennepin County Medical Center (Hennepin Faculty Associates) and with Regions Hospital (HealthPartners), will be made each calendar year, within two years following the close of the federal fiscal year, that equals the difference between average commercial payer rates for the hospital-based services delivered by physicians and practitioners affiliated with Hennepin County Medical Center and Regions Hospital and the rates paid to those physicians and practitioners under this section of Attachment 4.19-B using rates from the most recently complete calendar year available. ~~Non-physician practitioner services,~~ ~~a~~Anesthesia services and bundled radiology services are excluded from this payment. Total payments shall be based on data and calculated beginning in January of each year as follows:

1. For physician services delivered at Hennepin County Medical Center by physicians and practitioners practicing with Hennepin Faculty Associates, the set of services (by HCPCS code) delivered to Medicaid eligible individuals and billed on a fee-for-service basis shall be determined using MMIS data.

   For physician services delivered at Regions Hospital by physicians and practitioners practicing with HealthPartners, the set of services (by HCPCS code) delivered to Medicaid eligible individuals and billed on a fee-for-service basis shall be determined using a list of transaction control numbers from HealthPartners' billing system. DHS will use the supplied transaction control numbers to extract the relevant HCPCS codes from the MMIS system.

2. The payment rate for HCPCS code will be supplied, by the practice groups, for the top five commercial payers from the billing systems of the two physician practice groups.

3. The payment rates for each HCPCS code for each of the commercial

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

payers will be averaged to determine the average commercial payer rate for each HCPCS code.

4. For each of the two physician practice group data sets, the average commercial payer rate is multiplied by the Medicaid frequency for the HCPCS codes for that physician practice group.

5. For each of the two physician practice group data sets, the Medicaid payment amount is subtracted from the result in paragraph 4 for each HCPCS code.

6. The final payment amount for each of the two physician practice groups is equal to the sum of the amounts in paragraph 5.

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

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.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
F. Family Planning
G. Community and Public Health Clinics
H. Medicare Cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
P. Rate increase effective 07/01/07
R. Professional services decrease effective July 1, 2009.
S. Professional services decrease effective January 1, 2010
T. Rate increase July 1, 2010
V. Facility and professional services rate decrease 2010

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

6.d. Other practitioners' services.

A. With the exception listed below, **mental health services performed by a doctoral prepared mental health professional** are paid the lower of:

(1) submitted charge; 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 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;~~ the Resource Based Relative Value Scale calculated rate; or

(b) State agency established rate: or~~, except that psychotherapy services are paid using the same methodology as item 5.a., Physicians' services~~.

(c) provider travel time as specified in item 4.b.; or

(d) $65.01 per session for crisis assessment provided in a hospital outpatient department; or

(e) $37.80 per 60 minutes for cognitive remediation training.

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

~~Effective July 1, 2007, psychotherapy is paid the lower of the submitted charge or 23.7% over the rates in effect on January 1, 2006, when provided by:~~

~~1) 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.~~

Community health worker services are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

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

Mental health services performed by a master's prepared mental health professional are paid the lower of:

(1) submitted charge; or

(2) 80% of the reference file allowable established above for doctoral prepared mental health professionals.

Mental health services performed by a master's prepared mental health professional in a community mental health center are paid the lower of:

(1) submitted charge; or

(2) 100% of the reference file allowable established above for doctoral prepared mental health professionals.

Mental health services provided by a mental health practitioner who is supervised by an enrolled provider are paid to the supervising enrolled provider at the lower of:

(1) submitted charge; or

(2) 50% of the reference file allowable established above for mental health professionals.

~~A.~~ **Day treatment services for mental illness** provided on or after July 1, 2001 are paid the lower of:

(1) submitted charge; or

(2) ~~75.6% of the 50th percentile of 1999 charges~~ $20.41 per 60 minutes.

~~**Mental health services provided by rehabilitation agencies** are paid using the same methodology as item 7.d., Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.~~

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

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment.

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
G. Community and Public health Centers
I. Exceptions to payment methodology and reconstructing a rate
P. Rate Increase Effective July 1, 2007
T. Rate increase July 1, 2010

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, services provided by a community health worker, are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

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.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
F. Family Planning
G. Community and Public Health Clinic
H. Medicare Cap

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

I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
U. Facility services rate decrease 2009

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); or

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

~~f~~(relative base value units + time units*) x Medicare CRNA conversion factor x 0.632

- Pursuant to ~~page 1~~ Supplement 2 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)

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
I. Exceptions to payment methodology and reconstructing a rate.

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

E. Nurse Practitioner services

Effective July 1, 2007, through June 30, 2009, nurse practitioners and clinical nurse specialists 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 140/90; 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 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.

~~E.~~**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.~~

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

~~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 health care home services are paid using the same methodology as item 5.a., Physicians' Services.

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

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~~

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

~~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 separately bill for payment.

Laboratory, radiology, immunization, injection and allergy services are paid using the same methodology set forth elsewhere in this Attachment. EPSDT invoices are paid using the same methodology as item 4.b., Early and periodic screening, diagnosis, and treatment services.

With the exception noted below, mental health services are paid using the same methodology as item, 6.d.A, Mental Health services.

Nurse practitioners 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.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
F. Family Planning
G. Community and Public Health Clinics
H. Medicare cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
P. Rate increase effective July 1, 2007
R. Professional services rate decrease 2009
S. Professional services rate decrease 2010
T. Rate increase effective July 1, 2010

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

H. 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 140/90; 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.

~~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.~~

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

~~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

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~~

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

~~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.~~

Laboratory, radiology, immunization, injection and allergy services are paid using the same methodology set forth elsewhere in this Attachment. EPSDT invoices are paid using the same methodology as item 4.b., Early and periodic screening, diagnosis, and treatment services.

Clinical nurse specialists 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.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax
E. Modifiers
F. Family Planning
G. Community and Public Health Centers
H. Medicare cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
P. Rate increase effective July 1, 2007
R. Professional services rate decrease 2009
S. Professional services rate decrease 2010
T. Rate increase effective July 1, 2010

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. ~~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.~~

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:
A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
I. Exceptions to payment methodology and reconstructing a rate
R. Professional services rate decrease 2009
S. Professional services rate decrease 2010

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

Hearing aids, eyeglasses 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.

Effective for services provided on or after July 1, 2010, medical supplies and equipment manufactured for pediatric patients, medical supplies and equipment manufactured for bariatric patients, and HCPCS codes A7520, A7521, B4088, and E0202, are paid the lower of:

(1) submitted charge; or
(2) a payment amount determined by 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 items 12.a., Prescribed drugs, for drugs dispensed by a pharmacy.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

U. Facility Services rate decrease 2009

7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.

Physical therapist, occupational therapist, speech pathologist and audiologist services provided by a **home health agency** are paid the lower of:

(1) submitted charge; or

(2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in calendar year 1982.

Physical therapy assistant and occupational therapy assistant services provided by a **home health agency** are paid using the same methodology as items 11.a., Physical therapy and 11.b., Occupational therapy.

Effective for therapy visits on or after July 1, 1998, payment is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	7/1/98	7/1/99	7/1/00	7/1/01	7/1/02	10/1/05	10/1/06	10/1/07	10/1/08	7/1/09
Physical Therapy Visit (PT)	$51.00/ visit	$53.04/ visit	$56.22/ visit	$57.91/ visit	$59.65 /visit	$64.05/ visit	$65.49	$66.80	$68.14	$66.38
Physical Therapy Visit (Ass't.)				$37.64/ visit	$38.77 /visit	$41.63/ visit	$42.57	$43.42	$44.29	$43.15
Speech Therapy Visit	$51.78/ visit	$53.85/ visit	$57.08/ visit	$58.79/ visit	$60.55 /visit	$65.01/ visit	$66.48	$67.81	$69.17	$67.39
Occupational Therapy Visit (OT)	$52.05/ visit	$54.13/ visit	$57.38/ visit	$59.10/ visit	$60.87 /visit	$65.35/ visit	$66.83	$68.17	$69.53	$67.74
Occupational Therapy Visit (Ass't.)				$38.42/ visit	$39.57 /visit	$42.49/ visit	$43.44	$44.31	$45.20	$44.08
Respiratory Therapy Visit	$37.85/ visit	$39.36/ visit	$41.72/ visit	$42.97/ visit	$44.26 /visit	$45.26/ visit	$46.28	$47.21	$48.15	$46.91

Services provided by **rehabilitation agencies** are paid using the same methodology as item 5.a, Physicians' services., ~~except that payments are increased by 38% for physical therapy, occupational therapy, and speech pathology and mental health services provided by an entity that:~~

7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.

~~(1) is licensed under Minnesota Rules, parts 9570.2000 to 9570.3400 that operate residential programs and services for the physically handicapped;~~

~~(2) is Medicare certified as a comprehensive outpatient rehabilitation facility as of January 1, 1993; and~~

~~(3) for which at least 33% of the patients receiving rehabilitation services in the most recent calendar year are recipients of medical assistance, general assistance medical care, and MinnesotaCare.~~

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
E. Modifiers
I. Exceptions to payment methodology and reconstructing a rate
L. Rehabilitation Agency Rate Increase Effective July 1, 1993

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,charge; or

9. Clinic services continued.

(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.~~

The base rate as described in the item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax 2 percent increase effective service date 01/01/04
E. Modifiers subject to an increase in base payment rate
U. Facility services decrease effective July 1, 2009

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.~~

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

U. Facility Services rate decrease 2009

12.d. Eyeglasses.

Effective March 2, 2010, payment for eyeglasses is based on volume purchase contracting established through the competitive bidding process.

For ophthalmic materials not covered by the volume purchase contract, ~~Effective for services provided on or after January 15, 2002,~~ payment ~~for 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.

Ophthalmologists, optometrists and opticians are paid for dispensing eyeglasses using the same methodology as item 5.a, Physicians' services.

~~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.~~

The base rate as described in this item for non-volume purchase contract materials is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
C. TPL
D. MinnesotaCare Tax Rate Adjustment e
E. Modifiers
H. Medicare Cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
U. Facility Services rate decrease 2009

13.d. Rehabilitative services.

Rehabilitative services are paid using the same methodology in item 5.a., Physicians' services, except as listed below.

Physical therapy assistants are paid using the same methodology as item 11.a., Physical therapy.

Occupational therapy assistants are paid using the same methodology as item 11.b., Occupational therapy.

~~Effective for~~ With the exceptions below, **Mental health services** ~~provided on or after July 1, 2001, payment is the lower of the submitted charge or 75.6% of the 50th percentile of 1999 charges~~ are paid the lower of the submitted charge or the Resource Based Relative Value Scale calculated rate.

This rate includes mental health services provided by community mental health centers. For partial hospitalization services provided by community mental health centers, the hourly rate is based on outpatient hospital charges for partial hospitalization.

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; and 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, to Medical Assistance-enrolled community mental health centers. The Medical Assistance payment is increased according to the sum of subitems (1) through (3):

(1) (Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, divided by the state matching rate) minus $4,850,000, multiplied by .9, multiplied by .67, multiplied by [(the number of full-time equivalent trainees at the site multiplied by the average cost per trainee for all sites) divided by (the total

13.d. Rehabilitative services. (continued)

training costs across all sites)], for each type of graduate trainee at the clinical site.

(2) graduate trainee at the clinical site.

(Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, divided by the state matching rate) minus $4,850,000, multiplied by .9, multiplied by .33, multiplied by the ratio of the site's public program revenue to the public program revenue for all teaching sites.

(3) A portion of: [(the total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, divided by the state matching rate) minus $4,850,000, multiplied by .10, multiplied by the provider's sponsoring institution's ratio of the amounts in subitems (1) and (2) to the total dollars available under subitems (1) and (2)], in the amount the sponsoring institution determines is necessary to offset clinical costs at the site.

Community health worker services are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

Effective October 1, 2008, **basic living and social skills** provided as part of mental health community support services are paid:

for mental health professionals or mental health practitioners, the lower of the submitted charge or $13.01 per 15 minute unit;

for mental health rehabilitation workers, the lower of the submitted charge or $9.75 per 15 minute unit; or

in a group setting, regardless of the provider, the lower of the submitted charge or $5.72 per 15 minute unit. For the purposes of mental health community support services, "group" is defined as two to 10 recipients.

13.d. Rehabilitative services. (continued)

Effective October 1, 2008, **consultation with significant people,** including relatives, guardians, friends, employers, and treatment providers, provided as part of mental health community support services is paid:

for mental health professionals or mental health practitioners, the lower of the submitted charge or ~~$13.01~~ $36.88 per ~~15 minute unit~~ session;

for mental health rehabilitation workers, the lower of the submitted charge or ~~$9.75~~ $27.66 per ~~15 minute unit~~ session.~~, or~~

~~for mental health professionals, practitioners and rehabilitation workers, in a group setting, the lower of the submitted charge or $5.72 per 15 minute unit.~~

Effective for **medication education** provided as part of mental health community support services on or after October 1, 2008, payment is:

the lower of the submitted charge or $12.86 per 15 minute unit;

in a group setting, the lower of the submitted charge or $8.36 per 15 minute unit.

~~**Crisis assessment** provided as part of mental health crisis response services are paid:~~

~~for doctoral prepared mental health professionals, the lower of the submitted charge or $32.50 per 15 minute unit;~~

~~for master's prepared mental health professionals, the lower of the submitted charge or $26.00 per 15 minute unit; or~~

~~for mental health practitioners supervised by mental health professionals, the lower of the submitted charge or $22.58 (effective February 18, 2004) per 15 minute unit~~

~~**Crisis intervention** provided as part of mental health crisis response services are paid:~~

13.d. Rehabilitative services. (continued)

~~lower of the submitted charge or $23.75 per 15 minute unit;~~

~~for master's prepared mental health professionals, the lower of the submitted charge or $19.00 per 15 minute unit; or~~

~~for mental health practitioners supervised by mental health professionals, the lower of the submitted charge or $16.49 (effective February 18, 2004) per 15 minute unit (effective January 1, 2004).~~

Crisis assessment, crisis intervention, and ~~C~~crisis stabilization provided as part of mental health crisis response services are paid:

for mental health professionals or mental health practitioners, ~~the lower of the submitted charge or $54.21 (effective February 18, 2004) per 60 minute unit (effective January 1, 2004)~~ are paid as provided in item 4.b.;

for mental health rehabilitation workers, the lower of the submitted charge or $40.64 (effective February 18, 2004) per 60 minute unit (effective January 1, 2004);

in a group setting (which does not include short-term services provided in a supervised, licensed residential setting that is not an IMD), regardless of the provider, the lower of the submitted charge or ~~$11.00~~ $22.00 per ~~30~~ 60 minute unit. For the purposes of mental health crisis response services, "group" is defined as two to 10 recipients;

in a supervised, licensed residential setting that is not an IMD that provides short-term services but does not provide intensive residential rehabilitative mental health services, combining individual and group modalities and the individual provider's qualifications, and including consultation with significant people, the lower of the submitted charge or $262.00 per day; or

in a supervised, licensed residential setting that is

13.d. Rehabilitative services. (continued)

not an IMD that provides short-term services, including intensive residential rehabilitative mental health services, combining individual and group modalities and the individual provider's qualifications, and including consultation with significant people, the rate is the rate for residential rehabilitative services, below.

When not provided in a supervised, licensed residential setting that is not an IMD that provides short-term services, **consultation with significant people** including relatives, guardians, friends, employers, and treatment providers provided as part of mental health crisis response services on or after October 1, 2008, are paid:

for mental health professionals or mental health practitioners, the lower of the submitted charge or ~~$13.01~~ $36.88 per ~~15 minute unit~~ session;

for mental health rehabilitation workers, the lower of the submitted charge or ~~$9.75~~ $27.66 per ~~15 minute unit~~ session ~~per 15 minute unit; or~~

~~the lower of the submitted charge or $5.72 per 15 minute unit if provided by mental health professionals, mental health practitioners or mental health rehabilitation workers in a group setting.~~

Effective July 1, 2009, **Certified Peer Specialist** support provided as part of mental health community support services or mental health crisis response services are paid:

for Certified Peer Specialists Level I, the lower of the submitted charge or $11.38 per 15 minute unit;

for Certified Peer Specialists Level II (qualified at the mental health practitioner level), the lower of the submitted charge or $13.01 per 15 minute unit;

in a group setting, the lower of the submitted charge or $5.72 per 15 minute unit.

13.d. Rehabilitative services (continued)

Effective October 1, 2010, dialectical behavior therapy services are paid:

for individual dialectical behavior therapy, the lower of the submitted charge or $40.00 per 15 minute unit;

for group dialectical behavior therapy skills training, the lower of the submitted charge or $18.16 per 15 minute unit.

Assertive community treatment (ACT) services and **residential rehabilitative services** provided by entities with host county contracts are paid a per diem, per provider, county negotiated rate inclusive of all ACT or residential rehabilitative services, staff travel time to provide ACT or residential rehabilitative services, and crisis stabilization services provided as a component of mental health crisis response services. To determine the rate, each host county must consider and document the:

1. cost for similar services in the local trade area;
2. actual costs incurred by entities providing the services;
3. intensity and frequency of services to be provided to each recipient;
4. degree to which recipients will receive services other than ACT or residential rehabilitative services;
5. costs of other services that will be paid separately; and
6. input from county or regional mental health planning initiatives regarding recipients' service needs.

Assertive community treatment (ACT) services and **residential rehabilitative services** provided by county entities and entities furnishing specialized ACT or residential rehabilitative services to a subpopulation of recipients are paid a per diem rate negotiated between the Department and a county or between the Department and the provider of services to a subpopulation, based on the Department's consideration of the six factors, above.

13.d. Rehabilitative services. (continued)

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
G. Community and Public health Clinics
I. Exceptions to payment methodology and reconstructing a rate
P. Rate Increase Effective July 1, 2007
T. Rate increase July 1, 2010

20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

Payment was derived from the additional costs of delivering these services above and beyond the global prenatal care package.

~~In order to establish rates comparable to the 50th percentile of charges, base rates were determined by referring to surrounding and/or comparable procedure codes. The base rates are increased by 26.5% pursuant to page 1 of this Attachment.~~

Procedure Code(s)	Component	Base Rate: 1/1/02
H1001	At Risk Antepartum Management	$64.89
H1002	Care Coordination	$25.95
H1003	Prenatal Education	$38.92
H1004	At Risk Post Partum Follow-Up Home Visit	$52.79

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
G. Community and Public Health Clinics increase
I. Exceptions to payment methodology and reconstructing a rate
R. Professional Services Rate Decrease July 2009
S. Professional Services Rate Decrease 2010

A. **IHS/638 Facilities**

Except for child welfare-targeted case management services and relocation service coordination services, services provided by facilities of the Indian Health Service (which include, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as 638 facilities) are paid at the rates negotiated between the Indian Health Service and the Centers for Medicare & Medicaid Services and published by the Indian Health Service in the Federal Register. Child-welfare targeted case management services are paid in accordance with the methodology in item 19.b., child welfare-targeted case management services. Relocation service coordination services are paid in accordance with the methodology in item 19.c, relocation service coordination services.

An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.

B. **Critical Access Hospitals**

Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Centers for Medicare & Medicaid Services) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.

C. **Third Party Liability**

In accordance with Minnesota Statutes, §256B.37, subdivision 5a: No Medical Assistance payment will be made when covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.

Payment for services for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:

(1) the patient liability according to the provider/third party payer (insurer) agreement;

(2) covered charges minus the third party payment amount; or

(3) the Medical Assistance rate minus the third party payment amount.

D. **MinnesotaCare Tax Rate Adjustment**

Total payment for services provided on or after January 1, 2004, is **increased by two percen**t for the following Minnesota providers and services. This is an increase to the rate methodology described elsewhere in this Attachment for the following Minnesota providers and services. This rate increase is applied after all other payment rate increases or decreases described below in paragraphs N-W have been made.

- outpatient hospital services (Item 2.a)
- x-ray services (Item 3)
- EPSDT services, excluding rehabilitative services and services provided to a recipient with severe emotional disturbance residing in a children's residential treatment facility (Item 4.b)
- physicians' services (Item 5.a)
- medical and surgical services furnished by a dentist (Item 5.b)
- podiatrists' services (Item 6.a)
- optometrists' services (Item 6.b)
- chiropractors' services (Item 6.c)
- other practitioners' services: mental health, public health nursing, ambulatory surgical center, certified registered nurse anesthetist, nurse practitioner, case management services provided as a component of receiving clozapine, and clinical nurse specialist services (Item 6.d)
- clinic services (Item 9)
- dental services (Item 10)
- physical therapy services (Item 11.a)
- occupational therapy services (item 11.b)
- speech, language, and hearing therapy services (Item 11.c)
- dentures (Item 12.b)
- eyeglasses (Item 12.d)
- diagnostic, screening, and preventive services (Items 13.a, 13.b, and 13.c)
- rehabilitative services: day treatment for mental illness, services for treating chemical abuse, rehabilitative restorative

and specialized maintenance physical therapy, occupational therapy, and speech, language and hearing therapy services, and respiratory therapy services (Item 13.d)

- services for individuals age 65 or older in institutions for mental diseases (Item 14)
- inpatient psychiatric facility services for individuals under 22 years of age (Item 16)
- nurse midwife services (Item 17)
- pregnancy-related and postpartum services for 60 days after the pregnancy ends (Item 20.a)
- services for any other medical condition that may complicate pregnancy (Item 20.b)
- certified pediatric or family nurse practitioner services (Item 23)
- licensed ambulance services, excluding volunteer ambulance services (Item 24.a)
- emergency hospital services (Item 24.e)

E. **Modifiers**

22 modifier: unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered. (Item 5.a)

99 modifier: multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99. (Item 5.a)

F. **Family Planning**

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. (Item 5.a.)

Effective for services provided on or after January 1, 2011, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 25% over the rate in effect on January 1, 2011. (Item 5.a.)

G. **Community and Public Health Clinic**

Effective July 1, 1989, rates for services provided by **community and public health** clinics are increased by 20%, except for laboratory services.

H. **Medicare Cap**

Effective for services provided on or after July 1, 2010, payment rates as otherwise calculated in Item, 5.a, shall not exceed the **Medicare rate** for the same service, except for payment rates for physicians' services provided by a psychiatrist or an advanced practice registered nurse with a specialty in mental health; optimal diabetic and/or cardiovascular care; and health care home services. (Item 5.a.)

I. **Exceptions to payment methodology and reconstructing a rate**

Exceptions to payment methodology stated elsewhere in this Attachment result in a reconstructed rate when:

(1) the service was not available in the calendar year specified in law governing maximum payment rates;
(2) the payment amount is the result of a provider appeal;
(3) the procedure code description has changed since law governing maximum payment rates, therefore, the payment rate reflects the same code but a different procedure description;
(4) the payment rate reflects a payment which is inequitable when compared with payment rates for procedures or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category;
(5) the procedure code is for an unlisted service; or
(6) there is no Resource Based Relative Value Scale relative value.

The following methodology is used to reconstruct a rate comparable to the payment methodology specified in law when 1-6 above occur:

(1)Refer to surrounding and/or comparable procedure codes; and/or
(2)Refer to relative value indexes from other sources such as Ingenix; and/or
(3)Refer to payment information from other third parties, such as Medicare; and/or
(4) Refer to a previous rate and add the aggregate increase to the previous rate; and/or
(5) Refer to the submitted charge and "backdown" the charge by the CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI.

If a procedure was authorized and approved prior to a reference file rate change, the approved authorized payment rate may be paid rather than the new reference file allowable.

J. **Copay converted to $3.00 provider rate reduction**
A $3.00 rate reduction is applicable to the following services provided to recipients for whom **copays** had been required prior to January 1, 2009:

Eyeglass services; (Item 12.d)
Non-preventive services within the following categories;
Physicians (Item 5.a)
Public health nursing (Item 6.d.B)
Optometry (Item 6.b)
Podiatry (Item 6.a)
Chiropractic (Item 6.c)
Audiology (Item 11.c)
Opticians (Item 12.d)
Nurse practitioners (Item 6.d.E)
Nurse midwives (Item 17)
Traditional midwives (Item 28)
Clinical nurse specialists (Item 6.d.H)
Physician assistants (Item 5.a)

K. **Copay converted to $2.50 provider rate reduction**
A $2.50 rate reduction is applicable to outpatient hospital facility services provided to recipients for whom **copays** for non-emergency visits to hospital-based emergency rooms had been required prior to January 1, 2011. (Item 2.a.)

L. **Rehabilitation Agency Rate Increase Effective July 1, 1993**
Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency are paid using the same methodology as item 5.a, Physicians' services. Effective July 1, 1993, payments are increased by 38% for physical therapy, occupational therapy, and speech pathology and mental health services provided by an entity that:

(1) is licensed under Minnesota Rules, parts 9570.2000 to 9570.3400 that operate residential programs and services for the physically handicapped;

(2) is Medicare certified as a comprehensive outpatient rehabilitation facility as of January 1, 1993; and

(3) for which at least 33% of the patients receiving rehabilitation services in the most recent calendar year are recipients of medical assistance, general assistance medical care, and MinnesotaCare. (Item 7.d)

Ratable Increases and Decreases

The following rate increases or decreases are cumulative. They do not apply to cost based Federally Qualified Health Centers, Rural Health Centers, 638 facilities, Indian Health Services, or Medicare crossover claims.

M. **Rate Decrease Effective July 1, 2002:** Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2002, is decreased by .5 percent from current rates. (Item 2.a)

N. **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, is decreased by 5 percent from current rates. (Item 2.a).

O.Rate Increase Effective October 1 2007 and July 1, 2008: Payment rates for the psychotherapy components of children's therapeutic services and supports are increased by 2% effective with service date October 1, 2007, and an additional 2% effective with service date July 1, 2008. (item 4.b)

P.Rate Increase Effective July 1, 2007: Effective July 1, 2007, rates for the services below are increased 23.7% 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 and other providers of children's therapeutic services and supports.

The rate increases for providers identified in clauses 1-3 above, are applied to the following procedure codes:

90801 - 90829
90846 - 90847
90849
90853
90857
90862
90875 - 90876
90887
96101 - 96103
96116
96118 - 96120
97535 HE

99201 - 99285
99304 - 99364
99381 - 99412
H2012 HK
H2014 UA HQ
H2019 UA HE
M0064
(See items 4.b, 5.a, 6.d, 13.d)

Q.Rate Decrease Effective July 1, 2008: Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2008, before third party liability and spenddown, is decreased by 3 percent. This decrease does not include psychiatric diagnostic categories. (item 2.a)

R. Professional Services Rate Decrease 2009
Effective for services, except as noted in **R.1**, provided on or after July 1, 2009, the following services payment rates are reduced by 5 percent. Effective for services provided on or after July 1, 2009 and before July 1, 2010, the following services payment rates are reduced an additional one and one half percent:

Radiology (Item 3)
Physician (Item 5.a)
Physician assistant (Item 5.a)
Podiatry (Item 6.a)
Vision (Item 6.b)
Chiropractic (Item 6.c)
Nurse practitioner (Item 6.d.E.)
Clinical nurse specialist (6.d.H)
Medication therapy management (Item 6.d.I)
Physical therapy (Item 11.a.)
Speech therapy (Item 11.c)
Occupational therapy (Item 11.b)
Audiology (Item 11.c.)
Nurse midwife (Item 17)
Traditional midwife (Item 28)

R.1. Noted exceptions to clause R:
1. Procedure code 99000-99999 when performed by treating providers physician, nurse practitioner, nurse midwife, clinical nurse specialist, physician assistant and the pay-to-provider is a family planning agency.
2, Procedure code 99201-99215, 99381-99412 when performed by treating provider specialties general practitioner, geriatric nurse practitioner, family nurse practitioner, geriatrician, family practitioner, or primary care.
3. 90281-90399, 90476-90749, G9142 (vaccines), 90465-90474 when provided with MN Vaccines for Children, 96372-96379 when provided with MN vaccines for Children, G9141 (administration), A4641-A4642,

A9500-A9700, C9113-C9253, J0120-J9999, Q0144-Q0181, Q2004, Q2009, Q2017, Q3025-Q3026, Q4080-Q4099, Q9951-Q9967, S0012-S0197, S8085 (injections), S4989, S4993

4. G9002 (coordinated care fee)
5. S0280-S0281 (health care home)
6. Teaching sites
7. Performance based payments
8. Vaccine administration
9. Mental health services provided through physicians
10. Anesthesia services

S. Professional Services rate decrease 2010

Effective for services, except as noted in **S.1**, provided on or after July 1, 2010, the following services payment rates are reduced an additional 7 percent (cumulative 12 percent (5 percent from 07/01/09 and 7 percent from 07/01/10)):

Radiology (Item 3.),
Physician (Item 5.a.),
Physician assistant (Item 5a),
Podiatry (Item 6.a.),
Vision (Item 6.b.),
Chiropractic (Item 6.c.),
Nurse practitioner (Item 6.d.E.),
Clinical nurse specialist (Item 6.d.H),
Medication therapy management (Item 6.d.I)
Audiology (Item 11.c.),
Nurse midwife (Item 17.).
Traditional midwife (Item 28)

S.1. Noted exceptions to clause S:

1. Procedure code 99000-99999 when performed by treating providers physician, nurse practitioner, nurse midwife, clinical nurse specialist, physician assistant and the pay-to-provider is a family planning agency
2. Procedure code 99201-99215, 99381-99412 when performed by treating provider specialties general practitioner, geriatric nurse practitioner, family nurse practitioner, geriatrician, family practitioner, or primary care.
3. 90281-90399, 90476-90749, G9142 (vaccines), 90465-90474 when provided with MN Vaccines for Children, 96372-96379 when provided with MN vaccines for Children, G9141 (administration), A4641-A4642, A9500-A9700, C9113-C9253, J0120-J9999, Q0144-Q0181, Q2004, Q2009, Q2017, Q3025-Q3026, Q4080-Q4099, Q9951-Q9967, S0012-S0197, S8085 (injections), S4989, S4993
4. G9002 (coordinated care fee),
5. S0280-S0281 (health care home)
6. S9441 UA, T1028 UA (asthma demo)

7. Teaching sites
8. Performance based payments
9. Administration of vaccines
10. Psychiatrist
11. Advanced practice nurses with a specialty in mental health
12. Mental health services provided through physicians
13. Anesthesia services

T. Rate increase July 1, 2010

Effective for services provided on or after July 1, 2010, the following provider payment rates for physicians' services are increased by one and one half percent:

Psychiatrists
Advanced practice nurses with a specialty in mental health (Items 5.a. and 6.d.)

U. Facility Services rate decrease 2009

Effective for services, except as noted in **U.1**, provided on or after July 1, 2009, the following services payment rates are reduced by 3 percent. Effective for services provided on or after July 1, 2009 and before July 1, 2011, the following services payment rates are reduced an additional one and one half percent:

Outpatient hospital (Item 2.a),
Renal dialysis (Item 2.a),
Laboratory (Item 3),
Public health nursing (except for pediatric vaccine administration as described in item 2.a.) (item 6.d.B),
Medical supplies and durable medical equipment (Item 7.c),
Ambulatory surgery (Item 9.),
Noncontract eyeglasses and contact lenses (Item 12.d.),
Noncontract hearing aids.
Prosthetics and orthotics (Item 12.c.)

U.1. Noted exceptions to clause U:

1. For outpatient hospital exclude claim lines with [mental health] procedure codes 90800-90899, 96101-96103, 96118-96120, 97535 HE.
2. For medical supplies and durable medical equipment exclude procedure codes E0424, E0431, E0434, E0439, E1390, S8120, S8121, K0738 (volume purchase oxygen) and E1399 with modifier QH. Effective 02/01/10, E0441-E0444, E1392
3. For hearing aids, excluding claim lines priced using rates data and excluding procedure codes V5030, V5040, V5050, V5060, V5120, V5140, V5170, V5180, V5210, V5220, V5246, V5247, V5252,V5253, V5256, V5257, V5260, V5261 accompanied by a RB modifier.
4. Teaching sites

V. Facility and Professional Services rate increase 2010

Effective for services, except as noted in V.1, provided on or after July 1, 2010, the following services payment rates are increased by two percent:

Physical therapy (Item 11.a.),
Speech therapy (Item 11.c.),
Occupational therapy (Item 11.b.),

V.1. Noted exceptions to clause V:

1. For outpatient hospital exclude claim lines with [mental health] procedure codes 90800-90899, 96101-96103, 96118-96120, 97535 HE.
2. For medical supplies and durable medical equipment exclude procedure codes E0424, E0431, E0434, E0439, E1390, S8120, S8121, K0738 (volume purchase oxygen) and E1399 with modifier QH. Effective 02/01/10, E0441-E0444, E1392
3. For hearing aids, excluding claim lines priced using rates data and excluding procedure codes V5030, V5040, V5050, V5060, V5120, V5140, V5170, V5180, V5210, V5220, V5246, V5247, V5252,V5253, V5256, V5257, V5260, V5261 accompanied by a RB modifier.
4. Teaching sites