Registered AHCCCS providers elected to participate in the Primary Care Services Program for increased payments. This program, described in Sections 1902(a) (13), 1902 (jj), 1905 (dd) and 1932(f) of the Social Security Act, authorizes increased (also referred to as "enhanced") payments for certain E&M and vaccine codes furnished by or under the personal supervision of certain qualifying physicians for dates of service January 1, 2013 through December 31, 2014.

In order to qualify for the increased reimbursement for primary care services, the physician must attest to meeting one of the following requirements. The physician must attest to being:

Option 1) Board certified with a specialty designation of family medicine, general internal medicine, or pediatric medicine, or a subspecialty of family medicine, general internal medicine, or pediatric medicine recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS).

OR

Option 2) A primary care physician or subspecialist who works in one or more of the above specialty designations but who does not have a certification specified in 1 but has billed at least 60% of Medicaid services provided, using the E&M and vaccine administration codes list at
http://www.azahcccs.gov/commercial/ProviderRegistration/pcpattestation.aspx
during the calendar year 2012.

As required by federal law, the AHCCCS Administration conducted an audit of the claims and encounters for AHCCCS services provided in calendar year 2012 for physicians attesting as Option 2.

The 60% billing threshold is calculated using the following formula:

$$\frac{\text{\# of billed Primary Care Eligible Services (PCES)}}{\text{Total \# of billed services for all CPT and HCPCS codes}} \times 100\%$$

Claims and encounters for 2012 services have been audited to verify the physician met the 60% threshold requirement for enhanced fees paid for 2013 and 2014 services.

Data Capture Parameters

The 2012 claims data was compiled from AHCCCS Fee-For-Service claims and health plan encounters, as identified by the following data query parameters:

PROCEDURE CODE LOGIC:

EMCODE COUNT = E&M codes 99201 through 99499;
Vaccine administration codes 90460, 90461, 90471, 90472, 90473, 90474 and 90476-90749; with an SL modifier

NOT EMCODE COUNT = All other procedures

NO ELIMINATED PROCEDURE

DATE RANGE SELECTED: between Jan 1, 2012 and Dec 31, 2012, inclusive

Paid, Denied and Administrative Denial Status'

Provider List includes all Option 2 attestation providers (attest type = 6 on PMMIS)

The data capture and reporting of the 2012 services was completed on November 6, 2013. Data verification and auditing commenced November 11, 2013.

PCS Option 2 Audit Process - Summary

Reported threshold less than 60% requirement
All physicians resulting with less than 60% of the Option 2 threshold were identified and audited.

The audit process, as outlined below, was followed for each physician reported with less than the 60% threshold.

The provider detail report listed claims and encounters; random sampling verified the code capture was valid based on the criteria for service date, EM code set and nonEM code set when compared to the PMMIS claim and encounter systems.

The provider procedure code count report listed each procedure code billed for the 2012 time period with a count of how many times each code was billed.

- A random sampling of codes was verified against the provider detail report (above) to verify the count was accurate.

- Whenever a code was reported with a count in both EM code and nonEM code counts, the claims and encounters were reviewed to verify the appropriate count/category
  (in all cases identified, the nonEM code counts were vaccine admin codes billed without the SL modifier; some were correctly re-billed with the SL modifier and accurately counted as EM code).

The provider summary report calculated the EM code count, the nonEM code count, total code count and the percentage of valid program EM codes, using the formula:

$$\frac{\text{\# of billed Primary Care Eligible Services (PCES)}}{\text{Total \# of billed services for all CPT and HCPCS codes}} \times 100\%$$

Additional reports were run to identify any physician failing to meet the 60% criteria who attested for their practitioners (PA/NP). A second set of queries were run to report the combined code counts and calculate the combined percentage of valid program EM codes.

Letters were sent to each physician who failed to meet the Option 2 threshold advising the regulations, program criteria, the audit finding and possible remedies. Enclosed with the letter was the provider's summary report.

Online web searches of American Osteopathic Association (AOA) and American Board of Medical Specialists (ABMS) were conducted for each of the failed physicians.

Follow up contacts were made to those physicians who had not responded.

This page will go into Exhibits for those doctors who do not meet 60% threshold and did not re-attest @ Opt 1

PCS Option 2 Audit Process - Summary

Practicing in non-qualifying specialty

The physicians who attested as Option 2 and *met* the 60% threshold, but did not list a qualifying specialty/subspecialty were identified for audit.

Online web searches of American Osteopathic Association (AOA) and American Board of Medical Specialists (ABMS) were conducted for each physician identified.

CMS 2370-F (Set IV) Question #2 asks "If a physician is board certified in a non-eligible specialty but practices within the community as, for example, a family practitioner and attests to meeting the 60 % claims threshold, are we expected to audit his or her practice and, if so, how?

CMS answer: Since the only evidence of eligibility is the self-attestation and claims history, the state would need to take steps to verify the practice characteristics of the physician. This could be done by determining that the physician represents himself in the community as a family practitioner, as evidenced by medical directory listings, billings to other insurers, advertisements, etc."

Each physician was researched online to determine how the doctor represents her/himself in the medical community and to the public.

If the web research did not verify the physician's practice characteristics as a qualifying specialty/subspecialty, a letter was sent to each physician advising the regulations, program criteria, the audit finding and possible remedies.

Follow up contacts were made during August, September and October to those physicians who had not responded.

This page will go into Exhibits ONLY for 2 specific physicans