## CHAPTER 247: UNIFORM REPORTING SYSTEM FOR NON-CLAIMS-BASED PAYMENTS

**SUMMARY**: This Chapter contains the provisions for filing non-claims-based payment information related to the delivery of health care services.

### 1. Definitions

Unless the context indicates otherwise, the following words and phrases shall have the following meanings:

A. **Capitation Payments**. "Capitation payments" means per capita payments to providers to provide services needed by designated patients over a defined period.

B. **Care Management/Care Coordination/Population Health Payments**. "Care management/care coordination/population health payments" means payments to fund a care manager, care coordinator, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, patient navigators, or nurse care managers) who help providers organize clinics to function better and help patients take charge of their health.

C. **Carrier**. "Carrier" means an insurance company licensed in accordance with 24-A M.R.S., including a health maintenance organization, a multiple employer welfare arrangement licensed pursuant to 24-A M.R.S., chapter 81, a preferred provider organization, a fraternal benefit society, or a nonprofit hospital or medical service organization or health plan licensed pursuant to 24 M.R.S. An employer exempted from the applicability of 24-A M.R.S., chapter 56-A under the federal *Employee Retirement Income Security Act of 1974*, 29 *United States Code*, Sections 1001 to 1461 (1988) ("ERISA") is not considered a carrier.

D. **Designee**. "Designee" means an entity with which the MHDO has entered into an agreement under which the entity performs data collection, validation and management functions for the MHDO and is strictly prohibited from releasing information obtained in such a capacity.

E. **Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments**. "Electronic health records/health information technology infrastructure and other data analytics payments" means payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs outside of the electronic health records and/or the cost of a data analyst to support practices.

F. **Global Budget Payments**. "Global budget payments" means payments made to providers for either a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain services such as behavioral health or pharmacy are carved out. Services typically include primary care clinician services, specialty care physician services, inpatient hospital services, and outpatient hospital services, at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, though this is not widespread.

G. **Medicare Health Plan Sponsor**. “Medicare health plan sponsor” means a health insurance carrier or other private company authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to administer Medicare Part C and Part D benefits under a health plan or prescription drug plan.

H. **Medication Reconciliation**. “Medication reconciliation” means payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

I. **MHDO**. "MHDO" means the Maine Health Data Organization.

J. **M.R.S.** “M.R.S.” means *Maine Revised Statutes*.

K. **Non-Claims Based Payments.** “Non-claims-based” means payments that are for something other than a fee-for-service claim. These payments include but are not limited to Capitation Payments, Care Management/Care Coordination/Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions.

L. **Patient-centered Medical Home Payments**. “Patient-centered medical home payments” means Practice-level payments such as payments to Patient-Centered Medical Homes (PCMH), Health Homes for provision of comprehensive services; payments based upon PCMH recognition; or payments for participation in proprietary or other multi-payer medical -home or specialty care practice initiative.

M. **Pay-for-performance Payments**. “Pay-for-performance payments” means payments to reward providers for achieving a set target (absolute, relative, or improvement-based) for quality or efficiency metrics. Payments could include the return of a withhold if not attached to a claim payment.

N. **Pay-for-reporting Payments**. “Pay-for-reporting payments” means payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for future pay-for-performance incentives.

O. **Payor.** "Payor" means a carrier, third-party payor, third-party administrator, Medicare health plan sponsor or Medicaid.

P. **Primary Care**. "Primary care" is defined as regular check-ups, wellness and general health care provided by a provider with a primary care specialty/ taxonomy as specified in Appendix A. It does not include urgent care or emergency health.

Q. **Primary Care and Behavioral Health Integration Payments**: “Primary care and behavioral health integration payments” means payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting), such as: a) substance abuse or depression screening; b) performing assessment, referral, and warm hand-off to a behavioral health clinician; and/or c) supporting health behavior change,

such as diet and exercise for managing prediabetes risk). This excludes payments for mental health or substance use counseling.

R. **Prospective Case Rate Payments**. "Prospective case rate payments" means payments received by providers in a given provider organization for a patient receiving a defined set of services for a specific period.

S. **Prospective Episode-based Payments.** "Prospective episode-based payments" means payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care by multiple providers, including providers, or care for a specific condition over a specific time.

T. **Provider**. "Provider" means a health care facility, health care practitioner, health product manufacturer or health product vendor but does not include a retail pharmacy.

U. **Provider Salary Payments**. "Provider salary payments" means payments for salaries of providers who provide care. This category may only be applicable for closed health systems.

V. **Recoveries**. "Recoveries" means payments received by a provider from a payor and then later recouped due to a review, audit, or investigation. Recoveries not reported in claims payments should be netted out of the total non-claims based payments reported.

W. **Retrospective/Prospective Incentive Payments**. "Retrospective/prospective incentive payments" means payments to reward providers for achieving quality and/or efficiency goals. The two main subcategories of incentive payments are pay-for-performance and pay-for-reporting.

X. **Risk-based Payments**. "Risk-based payments" means payments received by providers (or recouped from providers) based on performance relative to a defined spending target. Risk-based payment methodologies can be applied to different types of budgets, including but not limited to episode of care and total cost of care. The two main subcategories of risk-based payments are shared savings and shared risk.

Y. **Shared-risk Recoupments**. "Shared-risk recoupments" means payments payors recoup from providers if costs of services are above a predetermined, risk-adjusted target. Shared-risk arrangements are typically calculated on a total cost of care basis and typically exclude high-cost outliers. Recoupment should be netted out of the total non-claims-based payments reported.

Z. **Shared-savings Distributions**. "Shared-savings distributions" means payments received by providers if costs of services are below a predetermined and risk-adjusted target. The amount of savings the provider can receive is often linked to performance on quality measures.

AA. **Third-party Administrator.** "Third-party administrator" means any person licensed by the Maine Bureau of Insurance under 24-A M.R.S., chapter 18 who, on behalf of a plan sponsor, health care service plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State.

BB. **Third-party Payor**. "Third-party payor" means a state agency that pays for health care services or a health insurer, carrier, including a carrier that provides only administrative services for plan

sponsors, nonprofit hospital, medical services organization, or managed care organization licensed in the State.

## 2. Non-Claims-Based Payments Filing Description

### A. General Requirements

(1) Payors that: a) provide medical benefits to Maine residents; and b) are not excluded from submitting health care claims data sets under 90-590 Chapter 243 Sec 2(A)(9)(a-b); and c) reimburse providers by means other than a Fee-for-Service model shall submit to the MHDO or its designee complete non-claims-based payment information and in accordance with the requirements of this section. Non-claims based payments are payments from carriers to providers based on definitions above.

(2) The above payors shall report non-claims-based payments or certify that these are not applicable via the annual registration update at https://mhdo.maine.gov/portal by February 28th of each year. It is the responsibility of the payor to amend the information, as needed, and to have an authorized user electronically sign to confirm/attest that the information provided is complete and accurate.

(3) Each payor is responsible for the submission of all information related to non-claims-based payments made by any sub-contractor on its behalf.

(4) Any self-funded employee benefit plan regulated by ERISA that submits claims data under 90-590 CMR Chapter 243 Section 5, may voluntarily submit completed data sets for Maine residents regarding non-claims-based payments in accordance with the provisions of this rule. Any such data shall be subject to the same laws and regulations as other MHDO data.

### B. Data Elements and Attributes

**Header Record**

| Data Element # | Data Element Name | Type | Maximum Length | Definition/Description |
|---|---|---|---|---|
| **HD001** | **Record Type** | Text | 2 | HD |
| **HD002** | **Submitter** | Text | 8 | MHDO-assigned identifier of payor submitting data. Do not leave blank. |
| **HD003** | **Payor** | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
| **HD004** | **Type of File** | Text | 2 | NC Non-Claims-Based Payments |

| | | | | |
|---|---|---|---|---|
| **HD005** | **Period Beginning Date** | Text | 6 | CCYYMM<br><br>Beginning of paid period for payments |
| **HD006** | **Period Ending Date** | Text | 6 | CCYYMM<br>End of paid period |
| **HD007** | **Record Count** | Number | 10 | Total number of records submitted in this file<br>Exclude header record in count |
| **HD008** | **Comments** | Text | 80 | Submitter may use to document this submission by assigning a filename, system source, etc. |

**Trailer Record**

| Data Element # | Data Element Name | Type | Maximum Length | Definition/Description |
|---|---|---|---|---|
| **TR001** | **Record Type** | Text | 2 | TR |
| **TR002** | **Submitter** | Text | 8 | MHDO-assigned identifier of payor submitting data. Do not leave blank. |
| **TR003** | **Payor** | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
| **TR004** | **Type of File** | Text | 2 | NC Non-Claims-Based Payments |
| **TR005** | **Period Beginning Date** | Text | 6 | CCYYMM<br><br>Beginning of paid period for payments |
| **TR006** | **Period Ending Date** | Text | 6 | CCYYMM<br><br>End of paid period |
| **TR007** | **Data Processed** | Text | 8 | CCYYMMDD<br>Date file was created |

**Annual Non-Claims Based Payment Information**

| Data Element # | Data Element Name | Type | Maximum Length | Definition/Description |
|---|---|---|---|---|
| **NC001** | **Submitter** | Text | 8 | MHDO-assigned identifier of payor submitting data. Do not leave blank. |
| **NC002** | **Payor** | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
| **NC003** | **Insurance Type/Product Code** | Text | 2 | Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix B for standard code list. Coding should match MHDO Chapter 243 Data Element ME003. In addition, MHDO uses the following non-standard codes:<br><br>HN Medicare Part C<br>MD Medicare Part D<br>. |
| **NC004** | **Performance Period Start Date** | Text | 6 | CCYYMM<br><br>Effective date of performance period for reported Insurance Type/Product Code. |
| **NC005** | **Performance Period End Date** | Text | 6 | CCYYMM<br><br>End date of performance period for reported Insurance Type/Product Code. |
| **NC006** | **Total Number of Members** | Number | 10 | Total, de-duplicated members<br><br>No decimal places; round to nearest integer Example: 12345 |
| **NC007** | **Total Member Months** | Number | 10 | Total, member months<br><br>No decimal places; round to nearest integer Example: 12345 |

| | | | | |
|---|---|---|---|---|
| **NC008** | **Total Dollars Non-Claims-Based Payments** | Number | 10 | Do not code decimal point. Two decimal places implied. |
| **NC009** | **Total Dollars Non-Claims-Based Payments (Primary Care Only/Portion)** | Number | 10 | Do not code decimal point. Two decimal places implied. See definition of Primary Care above (1P) for reporting Primary Care Only. |
| **NC010** | **Payor Notes** | Text | 80 | Clarification about the population the payments apply to, limitations in ability to report the measure, and/or explanation of why the data is not reported |

C. **File Specifications**

(1) **Header and Trailer Records**. Each file submission shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last.

(2) **File Format**. Each data file submission shall be an encrypted (AES-256) ASCII file, variable field length, and asterisk delimited.

(3) **Filled Fields**. All required fields shall be filled where applicable. Non-required-text and number fields shall be left blank when unavailable.

(4) **Position**. All text fields are to be left justified. All numeric fields are to be right justified.

(5) **Signs**. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all numeric fields.

**3. Submission Requirements**

A. **File Organization.** Each file shall be submitted to the MHDO or its designee as separate ASCII file. Each record shall be terminated with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

B. **Filing Method**. Data files must be submitted to the MHDO's Payor Data Portal via secure FTP or secure web upload interface at https://mhdo.maine.gov/portal. E-mail attachments shall not be accepted.

C. **Testing of Files**. File testing shall be completed within one hundred and eighty days of the adoption of any changes to the data element content or format of the files described in Section 2(B) or at least sixty days prior to the initial submission of production files.

D. **Rejection of Files**. Failure to conform to the requirements subsections A, B, or C of this Section shall result in the rejection of the applicable data file(s). All rejected files must be resubmitted in the appropriate, corrected form to the MHDO or its designee within 15 days.

E. **Filing Period**. The annual filing for each submission shall cover the previous completed calendar year and shall be due by August 31.

F. **Update/Replacement of Data**. A payor may update or replace a data file submission up to one year after its original due date. Any updates or replacements after this period must be approved by the MHDO.

**4. Data Validation; Notification; Response**

A. **Attestation**. The MHDO or its designee shall require an authorized user for each payor to electronically sign an attestation that the payor is compliant with the requirements outlined in this rule. The annual attestation shall be due by August 31.

B. **Notification**. Within 15 days, the MHDO or its designee will complete the evaluation of any data file submissions and notify any payors whose data submissions for any filing period do not satisfy the requirements of Section 2(B). This notification will identify the specific file(s) and the data elements within the file(s) that do not satisfy the requirements.

C. **Response**. Each payor notified under subsection 4(B) shall respond in writing within 15 days of notification and make the necessary changes within 30 days to satisfy the requirements.

**5. Public Access**

Information collected, processed and/or analyzed under this rule shall be subject to release to the public or retained as confidential information in accordance with 22 M.R.S. Chapter 1683 and *Code of Maine Rules* 90-590, Chapter 120, unless prohibited by state or federal law.

**6. Extensions or Waivers to Data Submission Requirements**

If a payor, due to circumstances beyond its control, is temporarily unable to meet the terms and conditions of this rule, a written request must be made within 30 days of the filing deadline of August 31 to the Compliance Officer of the MHDO. The written request shall include: the specific requirement to be extended or waived; an explanation of the cause; the methodology proposed to eliminate the necessity of the extension or waiver; and the time frame required to come into compliance. If the Compliance Officer does not approve the requested extension or waiver, the payor may submit a written request appealing the decision to the MHDO Board. The appeal shall be heard by the MHDO Board at the next regularly scheduled meeting following receipt of the request at the MHDO.

**7. Compliance**

The failure to file, report, or correct non-claims-based payment data sets when required under the provisions of this rule may be considered a violation under 22 M.R.S. Sec. 8705-A and Code of Maine Rules 90-590, Chapter 100: *Enforcement Procedures*.

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STATUTORY AUTHORITY: 22 M.R.S. §§ 8703(1); 8704(1) & (4)

EFFECTIVE DATE: December 12, 2021

## Appendix A
## Primary Care Provider Type Taxonomy Codes and Description

| **Primary Care** | |
|---|---|
| 261QF0400X | Federally Qualified Health Center |
| 261QP2300X | Primary Care Clinic |
| 261QR1300X | Rural Health Clinic |
| 207Q00000X | Physician, Family Medicine |
| 207R00000X | Physician, General Internal Medicine |
| 175F00000X | Naturopathic Medicine |
| 208000000X | Physician, Pediatrics |
| 208D00000X | Physician, General Practice |
| 363L00000X | Nurse Practitioner |
| 363LA2200X | Nurse Practitioner, Adult Health |
| 363LF0000X | Nurse Practitioner, Family |
| 363LP0200X | Nurse Practitioner, Pediatrics |
| 363LP2300X | Nurse Practitioner, Primary Care |
| 363A00000X | Physician Assistants |
| 363AM0700X | Physician Assistants, Medical |
| 207RG0300X | Physician, Geriatric Medicine |
| 207QG0300X | Family Practice Geriatrics |
| 207QA0505X | Family Practice Adult |
| 207QA0000X | Family Practice Adolescent |
| 175L00000X | Homeopathic Medicine |
| 2083P0500X | Physician, Preventive Medicine |
| 364S00000X | Certified Clinical Nurse Specialist |
| 163W00000X | Registered Nurse, Non-Practitioner |
| **OB/GYN Codes**[1] | |
| 207V00000X | Physician, Obstetrics and Gynecology |
| 207VG0400X | Physician, Gynecology |
| 363LW0102X | Nurse Practitioner, Women's Health |
| 363LX0001X | Nurse Practitioner, Obstetrics and Gynecology |

[1] For OB/GYN practitioners only include non-claims payments for primary care services as defined by HCPCS codes in Appendix C

**Appendix B**
**Maine Health Data Organization**
**Source Codes**

# Accredited Standards Committee (ASC)

**ASC X12 Directories**
**(MHDO Data Elements: NC003)**

SOURCE: Complete ASC X12 005010 Standard

AVAILABLE FROM:
https://www.nex12.org/
Data Interchange Standards Association, Inc. (DISA)
7600 Leesburg Pike Ste 430
Falls Church, VA 22043

ABSTRACT: The complete standard includes design rules and guidelines, control standards, transaction set tables, data element dictionary, segment directory and code sources. The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

Several Definitions are adapted from the Milbank Memorial Fund Report, available from:

https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_7-1.pdf

## Appendix C
## Narrow Definition Primary Care Service Procedural Terminology (HCPCS) Codes and Description

| Procedure Codes included in the Narrow Primary Care Definition | |
|---|---|
| **Procedure Codes** | **Description** |
| **Immunizations and Injections** | |
| **90281** | Immune Globulin |
| **90287** | Botulinum antitoxin, equine, any route |
| **90288** | Botulism immune globulin, human, for intravenous use |
| **90291** | Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use |
| **90296** | Diphtheria antitoxin, equine, any route |
| **90371** | Hepatitis B immune globulin |
| **90375 - 90376** | Rabies immune globulin |
| **90384 - 90386** | Rho(D) immune globulin |
| **90389** | Tetanus immune globulin |
| **90393** | Vaccinia immune globulin |
| **90396** | Varicella-zoster immune globulin |
| **90399** | Unlisted immune globulin |
| **90460 - 90461** | Immunization through age 18, including provider consult |
| **90465 - 90466** | Immunization administration younger than 8 years of age |
| **90467 - 90468** | Immunization administration younger than age 8 years |
| **90471 - 90472** | Immunization by injection/oral/intranasal route |
| **90473 - 90474** | Immunization administration by intranasal or oral route |
| **90476 - 90477** | Adenovirus vaccine |
| **90581** | Anthrax vaccine |
| **90585** | Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis |
| **90586** | Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, |
| **90587** | Dengue vaccine |
| **90620** | Meningococcal recombinant protein and outer membrane vesicle vaccine |
| **90621** | Meningococcal recombinant lipoprotein vaccine |
| **90625** | Cholera vaccine |
| **90630** | Influenza virus vaccine |
| **90632 - 90633** | Hepatitis A vaccine, pediatric/adolescent dosage-2 |
| **90634** | Hepatitis A vaccine, pediatric/adolescent dosage |
| **90636** | Hepatitis A and hepatitis B vaccine |
| **90644** | Meningococcal conjugate vaccine |
| **90645 - 90648** | Hemophilus influenza b vaccine |
| **90649 - 90650** | Human Papilloma virus (HPV) vaccine |
| **90651** | Human Papilloma virus vaccine |
| **90653 - 90661** | Influenza virus vaccine |
| **90662** | Flu |

| Procedure Codes included in the Narrow Primary Care Definition | |
|---|---|
| **Procedure Codes** | **Description** |
| **90663 - 90664** | Influenza virus vaccine |
| **90665** | Lyme disease vaccine |
| **90666 - 90668** | Influenza virus vaccine |
| **90669 - 90670** | Pneumococcal conjugate vaccine |
| **90672 - 90674** | Influenza virus vaccine |
| **90675 - 90676** | Rabies vaccine |
| **90680 - 90681** | Rotavirus vaccine |
| **90682** | Influenza virus vaccine |
| **90685 - 90689** | Influenza virus vaccine |
| **90691** | Typhoid vaccine |
| **90696** | DtaP-IPV |
| **90697** | DTaP-IPV-Hib-HepB |
| **90698** | Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, |
| **90700** | DTaP |
| **90701** | DTP |
| **90702** | Diphtheria and tetanus toxoids (DT) |
| **90703** | Tetanus toxoid adsorbed |
| **90704** | Mumps virus vaccine |
| **90705** | Measles virus vaccine |
| **90706** | Rubella virus vaccine |
| **90707** | Measles, mumps and rubella virus vaccine (MMR) |
| **90708** | Measles and rubella virus vaccine |
| **90710** | Measles, mumps, rubella, and varicella vaccine (MMRV) |
| **90712 - 90713** | Poliovirus vaccine |
| **90714 - 90715** | Tetanus, diphtheria toxoids adsorbed |
| **90716** | Varicella virus vaccine |
| **90717** | Yellow fever vaccine |
| **90718** | Tetanus and diphtheria toxoids (Td) adsorbed |
| **90719** | Diphtheria toxoid, |
| **90720** | Diphtheria, tetanus toxoids |
| **90721** | Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib) |
| **90723** | Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV) |
| **90725** | Cholera vaccine |
| **90727** | Plague vaccine, |
| **90732** | Pneumococcal polysaccharide vaccine |
| **90733** | Meningococcal polysaccharide vaccine |
| **90734** | Meningococcal conjugate vaccine |

| Procedure Codes included in the Narrow Primary Care Definition | |
|---|---|
| **Procedure Codes** | **Description** |
| **90735** | Japanese encephalitis virus vaccine |
| **90736** | Zoster (shingles) vaccine |
| **90738** | Japanese encephalitis virus vaccine, |
| **90739 - 90740** | Hepatitis B vaccine (HepB) |
| **90743 - 90744** | Hepatitis B vaccine |
| **90746 - 90747** | Hepatitis B vaccine |
| **90748** | Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib) |
| **90749** | Unlisted vaccine/toxoid |
| **90750** | Zoster (shingles) vaccine |
| **90756** | Influenza virus vaccine |
| **90785** | add-on code specific for psychiatric service |
| **Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes chemotherapy and other highly complex drug or highly complex biologic agent administration)** | |
| **96160 - 96161** | Administration of health risk assessment (replaces 99420 as of 1/1/2017) |
| **96372 - 96374** | Therapeutic, prophylactic, or diagnostic injection |
| **Non-face-to-Face Non-Physician Services** | |
| **98966 - 98968** | Non-physician telephone services |
| **98969** | Online assessment, mgmt. services by non-physician |
| **Evaluation and Management Services** | |
| **Office Visits** | |
| **99201 - 99205** | Office or outpatient visit for a new patient |
| **99211 - 99215** | Office or outpatient visit for an established patient |
| **99241 - 99245** | Office or other outpatient consultations |
| **Home/NH Visits** | |
| **99304 - 99310** | Nursing Facility Care |
| **99315 - 99316** | Nursing Facility Care |
| **99318** | Nursing Facility Care |
| **99324 - 99328** | Domiciliary or rest home Custodial Care |
| **99334 - 99337** | Domiciliary or rest home Custodial Care |
| **99339 - 99340** | Domiciliary or rest home multidisciplinary care planning |
| **99341 - 99346** | Home visit for a new patient |
| **99347 - 99350** | Home visit for an established patient |
| **99354 - 99360** | Prolonged Service Office Visit |
| **99360** | Standby service |
| **99367** | Medical team conference |
| **Preventive Visits** | |
| **96110** | Developmental screen |
| **99381 - 99385** | Preventive medicine initial evaluation |
| **99386 - 99387** | Initial preventive medicine evaluation |
| **99391 - 99397** | Preventive medicine periodic reevaluation |

| Procedure Codes included in the Narrow Primary Care Definition | |
|---|---|
| **Procedure Codes** | **Description** |
| **99401 - 99404** | Preventive medicine counseling and/or risk reduction intervention |
| **99406 - 99409** | Smoking and tobacco use cessation counseling visit (Alcohol/Substance Abuse Screening) |
| **99411 - 99412** | Group preventive medicine counseling and/or risk reduction intervention |
| **99420** | Administration and interpretation of health risk assessments |
| **99429** | Unlisted preventive medicine service |
| **99441 - 99443** | Telephone calls for patient mgmt. |
| **99444** | Non-face-to-face on-line Medical Evaluation |
| **99487** | Chronic Care Management |
| **99490 - 99491** | Chronic Care Management |
| **99495 - 99496** | Transitional care management service |
| **99497 - 99498** | Advance Care Planning |
| **G0102** | Prostate cancer screening; digital rectal examination |
| **G0108 – G0109** | Diabetes outpatient self-management training services |
| **G0472** | Hepatitis C antibody screening |
| **G0475** | HIV antigen/antibody, combination assay, screening |
| **G0476** | Pap test add-on |
| **G8420** | BMI is documented within normal parameters |
| **G8427** | Med review |
| **G8482** | Influenza immunization administered or previously received |
| **G8709** | Patient prescribed antibiotic |
| **G8711** | Patient prescribed antibiotic for documented medical reason |
| **G8730 – G8731** | Pain assessment documented |
| **G8950** | BP reading documented |
| **G9903** | Patient screened for tobacco use and identified as a non-user |
| **G9964** | Patient received at least one well-child visit with a pcp during the performance period |
| **G9965** | Patient did not receive at least one well-child visit with a pcp during the performance Period |
| **G9966** | Children who were screened for risk of developmental, behavioral and social delays |
| **G9967** | Children who were NOT screened for risk of developmental, behavioral and social delays |
| **S0610** | Annual gynecological exam, established patient |
| **S0612** | Annual gynecological exam, new patient |
| **S0613** | Annual gynecological exam; clinical breast exam without pelvic |
| **Other Primary Care HCPCS Codes (Medicaid/Medicare)** | |
| **G0008** | Administration of influenza virus vaccine |
| **G0009** | Administration of influenza virus vaccine |
| **G0103** | PSA screening |
| **G0101** | CA screen;pelvic/breast exam |
| **G0123** | Screen cerv/vag thin layer |
| **G0145** | Scr c/v cyto,thinlayer,rescr |
| **G0151** | Hhcp-serv of pt,ea 15 min |

| Procedure Codes included in the Narrow Primary Care Definition | |
|---|---|
| **Procedure Codes** | **Description** |
| **G0166** | Extrnl counterpulse, per tx |
| **G0202** | Screening mammography digital |
| **G0249** | Provide inr test mater/equip |
| **G0279** | Tomosynthesis, mammo |
| **G0283** | Elec stim other than wound |
| **G0299** | Hhs/hospice of rn ea 15 min |
| **G0399** | Home sleep test/type 3 porta |
| **G0402** | Welcome to Medicare visit |
| **G0438** | Annual wellness visit |
| **G0439** | Annual wellness visit |
| **G0424** | Pulmonary rehab w exer |
| **G0442** | Annual alcohol screening |
| **G0443** | Brief alcohol misuse counsel |
| **G0444** | Annual depression screening |
| **G0447** | Face to face Behavioral Counseling for Obesity |
| **G0454** | Md document visit by npp |
| **G0463** | Hospital Outpatient Clinic Visit (Medicare) |
| **G0466** | FQHC Visit, new patient |
| **G0467** | FQHC Visit, established patient |
| **G0468** | FQHC Preventive visit |
| **G0480** | Drug test def 1-7 classes |
| **G0481** | Drug test def 8-14 classes |
| **G0483** | Drug test def 22+ classes |
| **G0498** | Chemo extend iv infus w/pump |
| **G0500** | Mod sedat endo service >5yrs |
| **G8400** | Pt w/dxa no results doc |
| **G8978** | Mobility current status |
| **G8979** | Mobility goal status |
| **G9162** | Lang express current status |
| **G9163** | Lang express goal status |
| **G9197** | Order for ceph |
| **G9551** | Abd imag no les,kid/livr/adr |
| **G9557** | Ct/cta/mri/a no thyr <1.0cm |
| **G9655** | Toc tool incl key elem |
| **G9656** | Pt trans from anest to pacu |
| **G9771** | Anes end, 1 temp >35.5(95.9) |
| **G9775** | Recd 2 anti-emet pre/intraop |
| **G9968** | Pt refrd 2 pvdr/spclst in pp |
| **G9969** | Pvdr rfrd pt rprt rcvd |

| Procedure Codes included in the Narrow Primary Care Definition | |
|---|---|
| **Procedure Codes** | **Description** |
| **G9970** | Pvdr rfrd pt no rprt rcvd |
| **T1015** | Clinic visit, all-inclusive (FQHC) |