



**pennsylvania**

DEPARTMENT OF PUBLIC WELFARE

# Office of Medical Assistance Programs

Medical Assistance Program Fee Increase for Select Primary Care Services  
Physician Attestation Form

## Attestation Form Completion Tutorial

## General Information

- Section 1202 of the Patient Protection and Affordable Care Act (ACA), requires state Medicaid programs to pay increased fees for primary care services to qualifying physicians.
- The Department has a website dedicated to this mandate which includes shortcuts to other helpful resources:  
<http://www.dpw.state.pa.us/provider/acaphysicianfeeincreasesforpcs/index.htm>
  - MAB 31-13-11 contains specific information on this form.
- You may submit questions to: [RA-FFS\\_ACA@pa.gov](mailto:RA-FFS_ACA@pa.gov)

## Are You Ready to Complete the Form? Do you Qualify?

- Are you enrolled as a Provider Type 31 with a Specialty of 316, 322, or 345?
  
- Can you self attest to a specialty or subspecialty designation of family medicine, general internal medicine or pediatric medicine recognized by the American Board of Physician Specialties (ABPS), the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA)?
  
- Can you attest that
  - You are board certified in the specialties/subspecialties from the above boards and will be providing documentation of your certification?
  - OR
  - At least 60% of Medicaid-billed codes are the qualifying E&M and vaccine administration codes for the past year if you were enrolled for at least a year prior to the day you attest, or from the time you were enrolled (at least one month of billing) if you are newly enrolled?
  
- If you are attesting to board certification, do you have your certification begin and end date readily available? You will need these dates to complete the form.

## Attestation Form Highlights

Sections I, II, III, and IV – to be completed by *individual providers*.

- Section I: Physician Information (every individual fills this part out)
- Section II: Information Only
- Section III: American Board of Medical Certification (only complete if Board certified)
- Section IV: 60% Threshold Attestation( complete this part if you are not board certified and cannot complete section III)

The attestation is a legally binding document. The information will be part of your provider record.

## Section I: Physician Information

- Every individual provider attesting must complete all required information in Section I.
- Required Information (all parts of Section I that pertains to the individual provider):
  - First Name, Middle Initial, Last Name, NPI#, 13-digit Provider ID(s), Designated Contact Name, Designated Contact Phone Number, Designated Contact E-mail Address, and AT LEAST ONE CHECK BOX for the specialties that apply. If Subspecialty is selected, you must indicate description of the subspecialty
  - One form may be filled out for multiple service locations, but each service location must be listed.

### Medical Assistance Program Fee Increase for Select Primary Care Services Physician Attestation Form for Calendar Years 2013-2014

Please complete the information in the sections I and III or IV, sign and return per the instructions NOTE: EACH physician must complete an Attestation Form to be considered to meet eligibility requirements. PRINT CLEARLY.			
<b>SECTION I: PHYSICIAN INFORMATION</b>			
FIRST NAME	MIDDLE INITIAL	LAST NAME	
PRACTICE NAME	NPI#	13-DIGIT PROVIDER ID	FEIN#
DESIGNATED CONTACT NAME	DESIGNATED CONTACT PHONE NUMBER		DESIGNATED CONTACT E-MAIL ADDRESS
Check specialty(s) that apply: <input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatric Medicine AND			
<input type="checkbox"/> Subspecialty (if applicable) _____			

## Section I: Physician Information (cont'd)

- Optional Information:
  - Practice Name
  - FEIN#

### Medical Assistance Program Fee Increase for Select Primary Care Services Physician Attestation Form for Calendar Years 2013-2014

Please complete the information in the sections I and III or IV, sign and return per the instructions

**NOTE: EACH physician must complete an Attestation Form to be considered to meet eligibility requirements. PRINT CLEARLY.**

#### SECTION I: PHYSICIAN INFORMATION

FIRST NAME				MIDDLE INITIAL		LAST NAME	
PRACTICE NAME			NPI#		13-DIGIT PROVIDER ID		FEIN#
DESIGNATED CONTACT NAME				DESIGNATED CONTACT PHONE NUMBER		DESIGNATED CONTACT E-MAIL ADDRESS	
<p><b>Check specialty(s) that apply:</b></p> <p> <input type="checkbox"/> Family Medicine                 <input type="checkbox"/> Internal Medicine                 <input type="checkbox"/> Pediatric Medicine <b>AND</b> </p> <p> <input type="checkbox"/> Subspecialty (if applicable) _____                 </p>							



## Before Completing the Rest of the Form: Are you eligible? How will you attest?

### SECTION II: INFORMATION – ELIGIBILITY FOR PRIMARY CARE RATE INCREASE

Section 1202 of the ACA and the implementing regulations require states to increase fees for specified primary care services to at least the Medicare Physician Fee Schedule rate in effect for calendar years (CYs) 2013 and 2014, or if higher, the CY 2009 Medicare conversion from January 1, 2013 through December 31, 2014. The regulation at 42 CFR § 447.400, provides that in order to be eligible for the increased payment the services must be provided by a physician as defined in 42 CFR § 440.50, or under the personal supervision of a physician with specialty designation in family practice, general internal medicine and pediatrics or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA); and the physician self-attests that the physician

- Is board certified with such a specialty or subspecialty as set forth above; or
- has furnished evaluation and management (E&M) and vaccines services that equal at least 60% of the Medicaid codes billed during the most recently completed Calendar Year or, for newly enrolled physicians the prior month plus a partial year or, the prior month if newly enrolled the current year.

- This is information that:
  - will help you determine if you qualify, and
  - provides the two options for attesting.
- If you need more information, or still aren't sure if and how you may qualify, you should re-review MAB 31-13-11, the attestation instructions, and if necessary, the final rule.
- All parts of either **Section III (Board Certified)** OR **Section IV (60%)** must be completed.

## Section III: Board Certification Attestation

- If completing Section III, you must
  - complete all fields (all are required), sign and print your name, and date the form.
  - also submit documentation of your board certification.

SECTION III: AMERICAN BOARD OF MEDICAL CERTIFICATION - (COMPLETE THIS SECTION IF PHYSICIAN IS BOARD CERTIFIED)		
Complete this section <b>only</b> if you have a certification from American Board of Medical Specialties (ABMS), American Board of Pediatric Specialties (ABPS), or American Osteopathic Association (AOA).		
CERTIFICATION BOARD NAME:	CERT BEGIN DATE:	CERT END DATE:
I attest that I am an eligible primary care physician or subspecialist and have a certification issued by the ABMS, ABPS, or AOA. I attest that the information submitted in this attestation is true and accurate. I understand that any false statements made herein are subject to the penalties contained in 18 PA. C.S. § 4904, relating to any unsworn falsifications to authorities.		
SIGNATURE	PRINTED NAME	DATE

- This section should be completed **ONLY** if you have a certification from American Board of Physician Specialties (ABPS), the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or a subspecialty board recognized by these three boards;
  - If your certification is does not expire at any time, please indicate “lifetime” in the cert end date box.
- If, you need not attest each year if your are board certification is current through December 31, 2014, and attest as such. The attestation will qualify you for both years.
- If you qualify based on the requirements in Section III, you do not need to fill out section IV.

## Section IV: 60% Attestation

- Complete Section IV **only** if you are NOT board certified for the duration of the period.
- Remember to exclude the toxoid vaccine procedure codes currently under the MA Program in calculations determining whether you meet the 60% threshold. These codes are not included in the Centers for Medicare & Medicaid Services' (CMS) list of qualifying primary care services procedure codes.
- If you qualify under the 60% criteria, sign, print you name, and date the attestation section that describes how long you have been enrolled. Have been enrolled:
  - ❖ since January 1, 2012 or before?
  - ❖ for more than 1 month, and part of the previous year?
  - ❖ For more than 1 month in the current year?

### SECTION IV: 60% ATTESTATION - ( COMPLETE THIS SECTION IF PHYSICIAN IS NOT BOARD CERTIFIED)

Complete this section **only** if you are NOT board certified as described above, but at least 60% of the Medicaid codes that you billed are Evaluation and Management (E&M) Codes: 99201 through 99499 and/or Current Procedural Terminology (CPT) Vaccine Administration Codes: 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

**CURRENT PA MA PHYSICIAN PROVIDERS enrolled for at least 1 full calendar year:** I attest that I am an eligible primary care physician or subspecialist but I do not have a certification recognized by the ABMS, ABPS, or AOA. I attest that at least 60% of the procedure codes billed to Medicaid in the previous calendar year (as of the signature date of this attestation form) were for the E&M and/or vaccine administration codes set forth above. I attest that the information submitted in this attestation is true and accurate. I understand that any false statements made herein are subject to the penalties contained in 18 PA. C.S. § 4904, relating to any unsworn falsifications to authorities.

SIGNATURE

PRINTED NAME

DATE

**PA MA PHYSICIAN PROVIDERS enrolled 1 full calendar month or more but less than the full previous calendar year ( more than 31 days billing history and enrolled in the previous calendar year):**

I attest that I am an eligible primary care physician or subspecialist but I do not have a certification recognized by the ABMS, ABPS, or AOA. I attest that at least 60% of the procedure codes billed to Medicaid in the prior calendar year's billings (as of the signature date of this attestation form), through the current CY month were for the E&M and/or vaccine administration codes set forth above. I attest that the information submitted in this attestation is true and accurate. I understand that any false statements made herein are subject to the penalties contained in 18 PA. C.S. § 4904, relating to any unsworn falsifications to authorities.

SIGNATURE

PRINTED NAME

DATE

**NEWLY ENROLLED PA MA PHYSICIAN PROVIDERS ( more than 31 days billing history not enrolled in the previous calendar year):**

I attest that I am an eligible primary care physician or subspecialist but I do not have a certification recognized by the ABMS, ABPS, or AOA. I attest that at least 60% of the procedure codes billed to Medicaid in the prior full calendar month (as of the signature date of this attestation form), were for the E&M and/or vaccine administration codes set forth above. I attest that the information submitted in this attestation is true and accurate. I understand that any false statements made herein are subject to the penalties contained in 18 PA. C.S. § 4904, relating to any unsworn falsifications to authorities.

SIGNATURE

PRINTED NAME

DATE

## How do You Submit Attestation and Board Certification Documents?

Several options are available for submission of Attestation Forms and board certifications

- ePEAP: Upload your board certification and/or attestation forms via the PROMISe provider portal's new upload feature. To upload documents, please select the "Upload PDF" entry in the ePEAP menu of your provider profile, browse for your pdf file, and select the appropriate document description.
- Email: [Ra-ProvApp@pa.gov](mailto:Ra-ProvApp@pa.gov) (Indicate subject as "PCP")
- Fax: 717-265-8284 (Indicate "PCP" in fax cover sheet subject line)
- Mail: DPW/OMAP/BFFSP  
Attention: Provider Enrollment Unit/PCP  
PO Box 8045  
Harrisburg, PA 17105-8045

## Final Checklist

- Did you complete all of the required sections of the form for the attestation method you chose and qualify for?
- Did you complete an attestation for every service location/site of service (or include several on one form)?
- Did you sign, print you name, and date the form?
- Did you send your board certification documentation (copy of the certificate or verification from the certifying board) if you attested to board certification?
- Did you send the attestation and/or board certification documentation via one of the specified submission options?