

Chapter 8

Clinic Services

The following clinic services are included in this chapter:

1. Community Health Clinic (CHC)
2. Public Health Clinic
 - a. Community Health Worker (CHW) Patient Education
3. Health Care Homes
4. Tuberculosis Case Management and Directly Observed Therapy
5. Public Health Nursing Clinic
6. Federally Qualified Health Center (including FQHC dental) and Rural Health Clinic
7. Comprehensive Elder Health Evaluation (CEHE)

Provider Requirements

To enroll in PrimeWest Health, a clinic must have a Federal employer's identification number and must also be enrolled with the Minnesota Department of Human Services (DHS). Additional requirements may apply; refer to the specific clinic section in this chapter.

Covered/Non-Covered Services

For covered and non-covered services, refer to the individual services chapters, such as [Physician & Professional Services, Chapter 6](#), and [Dental Services, Chapter 19](#).

Community Health Clinic (CHC)

A community health clinic must meet the following requirements:

1. Have non-profit status as specified in applicable Minnesota Statutes
2. Have tax exempt status as provided for in the Internal Revenue Code 501(c)3
3. Be established to provide health services to low-income population groups
4. Have written clinic policies as required by the applicable provisions of Minnesota Rules
5. Ensure the facility meets the definitions of a CHC required by [MN Stat. sec. 256B.0625, subd. 30](#) and [MN Rules part 9505.0255 subp.4](#)

The following must be documented in the clinic files:

1. A description of health services provided
2. Policies concerning medical management of health problems including health conditions that require referral to physicians or other health professionals and provision of emergency health services
3. Policies for maintenance and review of health records by the physician

To enroll as a CHC, the facility must complete:

1. [MHCP Enrollment Application](#)
2. [CHC Applicant Assurance Statement](#)

Covered Services

1. Physician services
2. Preventive health services
3. Family planning services
4. Early periodic screening, diagnosis, and treatment services, also known as Child and Teen Checkups or C&TCs
5. Dental services
6. Prenatal care services

Eligible Providers

1. Physicians
2. Physician assistants (PAs)
3. Advanced practice registered nurses (APRNs). APRNs may contract with, be a volunteer of, or an employee of a CHC.
4. Nurse practitioners (NPs)
5. Certified nurse specialists (CNSs)
6. Certified nurse midwives (CNMs)

For physician extenders, see specific supervision and reporting requirements in the *Physician Extenders* section of [Physician & Professional Services, Chapter 6](#).

Public Health Clinic

Public health clinics must be a department of, or operate under the direct authority of, a unit of government. Examples of a unit of government include county and city.

Covered Services

1. Physician services
2. Preventive health services
3. Family planning services
4. Early periodic screening, diagnosis, and treatment services, also known as Child and Teen Checkups or C&TCs
5. Dental services
6. Prenatal care services
7. Tuberculosis case management and directly observed therapy

Eligible Providers

1. Physicians
2. PAs
3. APRNs
4. NPs
5. CNSs
6. CNMs

For physician extenders, see specific supervision and reporting requirements in the *Physician Extenders* section of [Physician & Professional Services, Chapter 6](#).

Community Health Worker (CHW) Patient Education

A CHW is a trained health educator who works with PrimeWest Health members who may have difficulty understanding providers due to cultural or language barriers. CHWs extend the reach of providers into underserved communities, reducing health disparities, enhancing provider communication, and improving health outcomes and overall quality measures. Working in conjunction with primary care providers, CHWs can bridge gaps in communication and instill lasting health knowledge.

CHW services are a diagnosis-related medical intervention, not a social service.

Eligible Providers

Eligible providers must meet the following criteria:

- Have a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demonstrating that the applicant has completed approved community health worker curriculum

Only CHWs with MnSCU certification will remain/be eligible to enroll and provide CHW services.

Enrolled CHWs are considered a non-pay provider and services must be billed as an eligible PrimeWest Health-enrolled billing provider to receive payment.

Covered Services

PrimeWest Health will cover **diagnosis related** patient education services provided by a CHW with the following criteria:

1. The CHW is supervised by a physician or APRN, certified PHN, or dentist
2. A physician, APRN, dentist, or certified PHN must order the patient education service(s) and must order that they be provided by a CHW
3. The service involves teaching the member how to effectively self-manage his/her health or oral health in conjunction with the health care team
4. The service is provided face-to-face with the member (individually or in a group) in an outpatient, home or clinic, or other community setting
5. The content of the educational and training program is a standardized curriculum consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms, and health or dental literacy of the individual members.
6. Oral interpretation and sign language services are allowed when requirements are met

Required Documentation

This service is based on units of time and could include up to eight patients in a session. The following must be contained in the member's record:

1. A physician order for services signed by a PrimeWest Health-enrolled physician or an APRN specifying whether it is for group and/or individual services
2. Documentation of the date of service, start and end time for the service, and whether the service was group or individual. If a group service, documentation must show number of patients present, summary of the session's content, and the CHW's signature and printed name.

Billing

Refer to [Billing Policy, Chapter 4](#), for additional information. Submit claims electronically using the 837P format and include the following:

1. Hospital, clinic, physician, or APRN National Provider Identifier (NPI) as the billing provider

2. Use the following procedure codes:
 - a. 98960: self-management education and training, face to face, 1 patient
 - b. 98961: self-management education and training, face-to-face, 2 – 4 patients
 - c. 98962: self-management education and training, face-to-face, 5 – 8 patients
3. Bill in 30-minute units: limit four units per 24 hours; no more than eight units per calendar month, per member
4. Bill separate lines for each day service is provided
5. Enter appropriate diagnosis
6. Use CHW non-pay Unique Minnesota Provider Identifier (UMPI) as rendering or attending provider

Definitions

Community Health Representative (CHR): Community-based health care providers who provide health promotion and disease prevention services in their communities and have completed an Indian Health Service (IHS) funded, tribally contracted/granted and directed program of training.

Community Health Worker (CHW): Is a health worker who is a trusted member of and/or has an unusually close understanding of the community served that enables the provision of information about health issues that affect the community and link individuals with the health and social services they need to achieve wellness.

Health Care Homes (HCH)

Overview

Effective on or after July 1, 2010, the Health Care Homes (HCH) program, [authorized by the Minnesota Legislature in 2008](#), allows qualified providers to receive HCH reimbursement for the delivery of care coordination services to members who have complex and chronic medical conditions.

The development of the [HCH initiative](#) is a coordinated effort between the Minnesota Department of Health (MDH) and DHS and is driven by the Institute for Healthcare Improvement's Triple Aim, an initiative to simultaneously achieve the following goals:

1. Improve the individual experience of care
2. Improve the health of the population
3. Improve affordability by containing the per capita cost of providing care

Eligible Providers

The following provider types can bill for [eligible care coordination services](#): physician, nurse practitioner (NP), or physician assistant (PA). Refer to MHCP's *Primary Care Coordination (PCC): Provider Criteria* for complete certification details.

Providers must attest to PrimeWest Health that the facility and the PCC team members meet the Minnesota Administrative Rules statutory requirements of Chapter 4764, *Health Care Homes*, to provide services prior to submitting HCH claims to PrimeWest Health, including the following:

1. Patient-centered care coordination
2. Team
3. Communication
4. Access

5. Referral process
6. Care plan
7. Registry
8. Quality improvement

Clinics and clinicians must meet a set of standards and criteria in order to be certified as an HCH in Minnesota. Use the MDH [Health Care Homes certification process](#) to become a certified HCH provider. To receive reimbursement for HCH services, providers must do the following:

1. Receive HCH certification from MDH
2. Determine which of their patients are eligible HCH recipients
3. Provide HCH services to eligible PrimeWest Health members according to stated requirements
4. Claim HCH reimbursement once a month for each eligible member
5. Coordinate with PrimeWest Health to provide a continuum of care

Eligible Members

Providers can assess the overall complexity of members by grouping them into complexity tiers based on the number of major chronic condition groups that apply to them. Members with one or more major chronic condition are eligible for HCH. The [Care Coordination Tier Assignment Tool](#) developed by the Minnesota Department of Health and Human Services has been developed to support complexity assessments. Based on the above methodologies, members with major condition groups are scored as follows:

1. Tier 1: 1 – 3 major condition groups
2. Tier 2: 4 – 6 major condition groups
3. Tier 3: 7 – 9 major condition groups
4. Tier 4: 10 or more major condition groups

HCH reimbursement increases for care coordination when members (or caregivers of dependent members) have one of the following supplemental complexity factors:

1. Need sign or spoken language interpreter services
2. Have a serious and persistent mental illness

See the Care Coordination Tier Assignment Tool for how these factors are defined. There will be a 15 percent increase for each factor and a 30 percent increase when both apply. The corresponding procedure codes and modifiers for tier level and the presence of supplemental factors are described below.

HCH Provider Responsibilities

1. Providers wishing to bill for HCH services must follow and meet Minnesota Rules part 4764. 0040, Health Care Home Standards.
2. Reimbursement will be dependent on verification that both the pay-to provider and treating provider are eligible for HCH and the member is actively enrolled in PrimeWest Health at the time HCH services are rendered.
3. Providers must demonstrate collaboration with PrimeWest Health care coordinators and county case managers. This is especially important with members who are currently enrolled in PrimeWest Health's dual eligible programs—PrimeWest Senior Health Complete (HMO SNP)^{*} and Prime Health Complete (HMO SNP)^{**}—in order to avoid unnecessary duplication of care management expectations. For PrimeWest

^{*}PrimeWest Health's name for the Minnesota Senior Health Options (MSHO) program

^{**}PrimeWest Health's name for the Special Needs BasicCare (SNBC) program for members with Medicare

Health dual eligible members, providers agree to implement or use PrimeWest Health's assessment, care plan, Medication Therapy Management (MTM) program requirements, transition of care forms, and other stated requirements when indicated.

4. Providers wishing to provide HCH services will agree to actively cooperate with PrimeWest Health initiatives for reducing unnecessary emergency room visits and unnecessary inpatient admissions and readmissions.

Provider Procedure for HCH Services

1. Verify member eligibility.
2. Provide member education about HCH services and obtain necessary consent according to regulations.
3. Complete and submit [the *Medical Service Authorization Request Form*](#) to PrimeWest Health's Utilization Management department requesting HCH services.
4. Complete and submit the [Care Coordination Tier Assignment Tool](#).
5. Submit member's HCH comprehensive care plan and related documentation that ensures the member's health and social needs are met. This will include documentation of Interdisciplinary Care Team meetings; progress toward identified goals; and collaboration with other identified care coordinators, county case managers, and identified interdisciplinary team members. Include the member's HCH enrollment documentation.
6. Submit an HCH claim according to specifications above.

PrimeWest Health retains the right to periodically request HCH medical records to ensure providers are meeting and following stated HCH requirements. Should PrimeWest Health determine that a provider is submitting HCH claims without supporting documentation, PrimeWest Health may exercise its right to refuse such payment or future payments for HCH services.

Billing for HCH Services

To claim care coordination payment:

1. Document all care coordination services provided and justification for complexity tier assignment in the member's medical record
2. Use the 837P electronic claim transaction to submit all claims
3. Note that a single date of service represents the entire month. Bill on one claim transaction and enter one unit of Initial Care Coordination planning code S0280 for the first month. Enter Maintenance Care Coordination Planning code S0281 for each additional month. Bill the procedure code once a month with:
 - a. Modifier U1: Tier 1
 - b. Modifier TF: Tier 2
 - c. Modifier U2: Tier 3
 - d. Modifier TG: Tier 4

If necessary, include the following:

- a. Modifier U3: If primary language is non-English
- b. Modifier U4: If Severe and Persistent Mental Illness (SPMI)

For a provider to be eligible for reimbursement, the member must have an Evaluation and Management (E/M) visit with the care coordination provider within the last 12 months from the care coordination procedure code date of service. The appropriate E/M procedure code can occur on a different date of service and be billed separately from the care coordination procedure code. E/M visit procedure codes considered are 99201 – 99205,

99211 – 99215, 99324 – 99328, 99334 – 99337, 99339, 99340, 99341 – 99345, 99347 – 99350, 99381 – 99387, and 99391 – 99397.

Reimbursement is the lower of the submitted charge or, when the rendering enrolled provider is either a physician, nurse practitioner, or physician assistant, per the following tiers:

Physician	Nurse practitioner or physician assistant
Tier 1: \$10.14	Tier 1: \$ 9.81
Tier 2: \$20.27	Tier 2: \$ 19.61
Tier 3: \$40.54	Tier 3: \$ 39.22
Tier 4: \$60.81	Tier 4: \$ 58.83

Additional Resources

[Health Care Programs – Primary Care Coordination](#)

[Minnesota Department of Health – Health Care Homes](#)

Tuberculosis (TB) Case Management and Directly Observed Therapy

The DHS Omnibus Bill provides for coverage of case management and directly observed therapy services for PrimeWest Health members infected with TB. These services must be provided by certain people employed by a Community Health Board.

Community Health Board: A board of health established, operating, and eligible for a subsidy (from the Commissioner of Health). The board has general responsibility to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

Case Management Services: Face-to-face services furnished to assist persons infected with TB in gaining access to needed medical services.

Persons Infected with TB: Individuals infected with latent or active TB who have a positive TB skin test, or have a negative tuberculin skin test, but a positive sputum culture for the TB organism; an individual whose TB test is negative, but whose physician's certification indicates the individual requires TB-related drug and/or surgical therapy can be considered TB infected.

Directly Observed Therapy: Physically watching the member take the drugs prescribed for TB.

Covered Services

Case management services include the following, at a minimum:

1. Assessing the need for medical services to treat TB
2. Developing a plan of care addressing those needs
3. Assisting in accessing medical services identified in the care plan
4. Monitoring compliance with the care plan to ensure completion of TB therapy
5. Directly observed therapy

Eligible Providers

Case management services are covered if provided by a certified PHN employed by a community health board.

Directly observed therapy must be provided by a PHN employed by a community health board or by a community outreach worker, licensed practical nurse, or registered nurse trained and supervised by a PHN employed by a community health board.

Drugs for TB

PrimeWest Health covers drugs for TB and other communicable diseases if prescribed by a licensed practitioner and dispensed by a physician or certified nurse practitioner employed by, or under contract with, a community health board for purposes of communicable disease control.

Billing Requirements

Use code T1016 for case management and code H0033 for directly observed therapy. These two codes should not be billed on the same day, nor should office or home visits be billed on the same day as case management. Submit claims electronically using the 837P format. Please refer to the [Billing Policy, Chapter 4](#), for further information.

Public Health Nursing Clinic (PHNC)

PHNCs must meet the following requirements:

1. Be a department of, or operate under the direct authority of, a unit of government. Examples of a unit of government include county, city, or school district.
2. Be performed at a main clinic site, satellite clinics, mobile clinic sites that are open to the public, or the member's home

Eligible Providers

1. PHNs
2. Licensed registered nurses, supervised by a PHN, practicing in an PHNC

Covered Services

1. Clinic Visits – Clinic visits may include, but are not limited to, services in the following areas:
 - a. Health Promotion and Counseling: Education and counseling to alleviate or prevent health problems. This service does not include in-depth nutritional counseling normally performed by a licensed dietician, nor does it include structured diabetic education programs. Refer to the *Medical Nutritional Therapy and Diabetic Outpatient Self Management Training Services* sections of [Physician & Professional Services, Chapter 6](#), for coverage information and requirements.
 - b. Medication Management: Review of current medications and adherence to the prescribed medication regime. Education on proper medication use and contact with the prescribing physician when necessary.
 - c. Nursing Assessment Treatment and Diagnostic Testing: A health history or examination that includes an evaluation of health behaviors and risk factors and is performed within the scope of practice of a licensed registered nurse.
2. Home Visits – PHNC services that are typically provided in the clinic setting may also be performed in the member's home on an intermittent basis when necessary to ensure that the member receives the necessary care.

PHNC visits may not be used as a substitute for traditional home care, such as the type of home care that is reimbursable by Medicare. **If a member needs traditional home care, the member should be referred to a Medicare Certified Home Care Agency.**

Non-covered Services

1. Services covered by a primary insurance
2. Services that are part of the Women, Infants & Children Food Program (WIC) clinic package, such as height, weight, B/P, and client history
3. Services provided by a school-based PHNC, which are available at no cost to a non-MA recipient student

Billing for PHNC Services

Submit claims electronically using the 837P format. Please refer to the [Billing Policy, Chapter 4](#), for additional information.

New Code	Description	Qualifying Information
T1015	Clinic visit/encounter, all-inclusive	T1015 – one unit includes all clinic services, previously reported with codes X5546 through X5549, provided to a member in one day without regard to time. C & TC services may not be billed on the same day as a PHNC clinic visit. The administration of injections is included in the clinic visit. Bill HCPC code for drug.
S9446	Patient education, non-physician provider, group, per session	S9446, for group education and counseling, may be reported on the same day as T1015. Bill one unit per person for each class session. A session is one encounter; a class that meets four weeks has four sessions/encounters.
S9123	Nursing care, in the home, by PHN or registered nurse This code should be used by non-MC certified PHNC only. Medicare certified PHNC refer to (Billing Policy) Chapter 4 .	Although the S9123 code description indicates a <i>per-hour</i> service, PrimeWest Health reimbursement is limited to a <i>per-visit</i> rate. Report the number of hours/units actually spent on the home visit but report only one usual and customary visit charge. Report units in whole numbers. One unit equals one hour. C & TC services may not be billed on the same day as a PHNC home visit. The administration of injections is included in the home visit. Bill HCPC code for drug.

Federally Qualified Health Center (FQHCs) and Rural Health Clinic (RHC) Services

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) provide covered services to PrimeWest Health members in a manner similar to other physician clinics. However, federal mandates and guidelines apply specifically to FQHCs/RHCs. See [Billing Policy, Chapter 4](#).

Federally Qualified Health Center: A facility that meets one of the following:

1. Is receiving a grant under section 329, 330, or 340 of the Public Health Service (PHS) Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the PHS Act
2. Is, based on the recommendation of the PHS, determined by CMS to meet the requirements for receiving such a grant
3. Was treated by CMS, for purposes of Medicare Part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990
4. Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

Rural Health Clinic (RHC): A freestanding or provider based facility certified under Title 42 Code of Federal Regulations (CFR) Part 491.

Provider-Based Facility: A clinic that is an integral part of a hospital, skilled nursing facility (SNF), or home health agency that is participating in Medicare and is used, governed, and supervised with other departments of the facility.

Dental Encounter: Services provided during a dental visit.

Medical Encounter: Services provided during a medical visit, including but not limited to, the following:

1. Professional services
2. Supplies and pharmaceuticals incidental to professional services
3. Pharmaceuticals provided in compliance with pharmacy guidelines
4. Obstetrical and perinatal care
5. Clinic visits
6. FQHC or RHC professional services provided to FQHC or RHC members if covering inpatient hospital visits
7. FQHC or RHC professional services provided to FQHC or RHC members if surgical services are directly provided by the center or clinic
8. Mental health visits provided in compliance with mental health guidelines

Eligible Providers

Providers that meet the definition of an FQHC/RHC must enroll as an FQHC/RHC to receive consideration for payment under the Prospective Payment System (PPS) or Alternative Payment Methodology (APM).

Covered Services for MA Recipients

MA coverage for FQHCs/RHCs has been mandated for the following:

1. Physician's services and supplies furnished as incident to a physician's professional service
2. Vaccines (e.g., pneumococcal, influenza, and hepatitis B)
3. Services provided by a PA, nurse practitioner, clinical psychologist, or clinical social worker or chiropractor (effective July 15, 2009), and services and supplies furnished as incident to their services
4. In an area in which a shortage of home health agencies exists, part-time or intermittent nursing care by a registered nurse or licensed practical nurse to a homebound individual under a written plan of treatment, either established and reviewed by a physician every 60 days or established by a nurse practitioner or PA and reviewed at least every 60 days by a supervising physician
5. Services and supplies incident to a physician's professional services are covered if they are all of the following:

- a. Of a type commonly furnished in physicians' offices
- b. Of a type commonly rendered either without charge or included in the bill
- c. Furnished as an incidental, although integral, part of a physician's professional services
- d. Furnished under the direct, personal supervision of a physician
- e. Provided by a member of the clinic's health care staff who is an employee of the clinic
- f. Drugs and biologicals, furnished as "incidental to" a physician's professional service, only if they cannot be self-administered

In addition, MA coverage of services furnished by an FQHC/RHC includes all other ambulatory services covered under the Minnesota State Plan, which are furnished by the FQHC/RHC. With the exception of dental services, ambulatory services are considered part of the medical encounters and are included in the development of the medical encounter payment rate for both PPS and Minnesota's APMs (MAPMs).

FQHC/RHC Billing Requirements

Use the following guidelines when billing PrimeWest Health for services provided by an FQHC or RHC:

1. Bill medical claims using the 837P (Professional) claim format
2. Bill dental claims using the 837D (Dental) claim format and include tooth number, quadrant, or surface as appropriate
3. Use the NPI assigned to the FQHC/RHC location to bill all PrimeWest Health services
4. Use the NPI of the rendering/treating provider
5. Follow all frequency guidelines and request for authorization requirements
6. Enter time units according to the requirements for the services provided
7. Use applicable modifiers
8. For FQHCs using HCPCS codes T1017 and T2023, continue to use applicable code

PrimeWest Health covers one medical and/or one dental encounter per day, for federally-funded MA and MinnesotaCare members with MA benefits.

Note: the above claim format changes do not apply to Medicare crossover claims or [Global Procedure Service Date Reporting](#).

Pharmacy Copays

Pharmacy copay information will be provided to the pharmacist, and tracking of the monthly copay obligation will occur. As pharmacy services are part of the medical encounter, no separate pharmacy payment is made. For MA payments to reflect the applicable pharmacy copays, recognition of copay amounts that apply to FQHC/RHC services will occur during the payment cycle in which the pharmacy service occurred.

Collect copays at the time of the visit or bill the member, according to office policy.

Dentures/Partials

1. For appointments prior to the delivery of the denture/partial, utilize code D5899 and enter "Encounter in preparation for denture/partial" as the description.
2. Bill the appropriate code for the denture/partial when the appliance is delivered to the member.
3. For all adjustment appointments after the delivery of the appliance, utilize code D5899 and enter "Encounter for denture adjustment" as the description.

Billing

Bill services provided to PrimeWest Health members electronically using the 837P format for all services except Medicare covered services. For dual eligible Medicare/Medicaid (Minnesota Senior Health Options [MSHO])* program services, refer to your PrimeWest Health Participation Agreement for the payment terms. If you are reimbursed based on the CMS or DHS fee schedule, itemize all charges and submit electronically using the 837P format.

For coordination of benefits (COB) crossover claims where PrimeWest Health is secondary, you may submit the claims in the same format used to bill the primary payer.

Follow any frequency guidelines or request for authorization requirements.

See the C&TC billing section of [Children Services, Chapter 9](#), for C&TC encounter billing instructions.

FQHC and RHC medical revenue codes effective July 1, 2006 (used for PPS/APM reimbursement)	
Revenue Code	Service
0521	Clinic visit by member to FQHC or RHC facility
0522	Home visit by FQHC or RHC practitioner
0524	Visit by FQHC or RHC practitioner to a member in a covered Part A stay at an SNF
0525	Visit by FQHC or RHC practitioner to a member in an SNF (not in a covered Part A stay), Nursing Facility (NF), ICF-MR, or other residential facility
0527	Visit by FQHC or RHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
0528	Visit by FQHC or RHC practitioner to other non-FQHC/RHC site (e.g., scene of accident)

Comprehensive Elder Health Evaluation (CEHE) Incentive

DHS recently announced the implementation of a Comprehensive Elder Health Evaluation (CEHE) incentive payment for primary care providers.

PrimeWest Health would like to ensure that primary care providers who are currently contracted with us and working in our communities are aware of the CEHE incentive payment opportunity for primary care providers.

CEHE allows caregivers to do a comprehensive preventive health evaluation on an annual basis and receive an additional \$15 above the usual reimbursement for CPT codes 99387 or 99397. If the provider performs and documents an evaluation of influenza and pneumococcal immunization status, mental health status, presence or absence of urinary incontinence, and visual function during the preventive health evaluation, the provider will receive a \$40 reimbursement.

CEHE Service	CPT Code(s)	CPT Code(s) Description	Provider Incentive Payment	Comment
New or established patient annual CEHE visit	99387 or 99397	Initial comprehensive preventive medicine evaluation; 65 years or over	\$15.00	The provider will also receive the established PrimeWest Health reimbursement rate for this code

CEHE Service	CPT Code(s)	CPT Code(s) Description	Provider Incentive Payment	Comment
New or established patient annual CEHE visit along with the following (all five items must be assessed):	99387 or 99397	Initial comprehensive preventive medicine evaluation; 65 years and over	\$40.00	The provider will also receive the established PrimeWest Health reimbursement rate for this code
1. Pneumococcal immunization status	1022F	Pneumococcal immunization status assessed		
2. Influenza immunization status	1030F	Influenza immunization status assessed		
3. Visual functional status	1055F	Visual functional status assessed		
4. Urinary incontinence status	1090F	Presence or absence of urinary incontinence assessed		
5. Mental status	2014F	Mental status assessed		

Non-covered Preventive Services

The following services are not covered as a preventive service:

1. Services that are only for vocational or educational purposes that are not health related
2. Services that deal with external, social, or environmental factors that do not directly address the member's physical or mental health

Preventive Medicine Services/Counseling and/or Risk Factor Reduction

Preventive health counseling to promote health and prevent illness or injury is a covered service. These services should be billed with the appropriate E/M code for preventive medicine, individual counseling, and group counseling.

Legal References

- Minnesota Rules [9505.0250](#) (physician clinic)
 MS [256B.0625](#), subd. 4 (physician clinic)
 MS [256B.0625](#), subd. 30 (community clinic)

MS [256B.0625](#), subd. 49

Minnesota Rules [9505.0255](#) (community clinic)

Minnesota Rules [9505.0380](#) (PH clinic)

MS [256B.0625](#), subd. 40 (TB tx in PH clinic)

42 CFR 491 (RHC)

42 USC 1396d (RHC)

MS [256B.0625](#), subd. 29 (FQHC)

MN Stat. sec. [256B.0625, subd. 51](#) (provider-directed care coordination services)

42 CFR 491 (FQHC)

[Title XIX, Section 1905\(l\)](#) of the Social Security Act