UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin
April 2014

Medicaid Information: 1-800-662-9651 | www.health.utah.gov/medicaid

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Additional Medicaid Information
Salt Lake City Area: (801) 538-6155
Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, Nevada: 1-800-662-9651
Other States: (801) 538-6155

Request a Medicaid Publication
Send a Publication Request form:
By Fax: (801) 536-0476
By Mail: Division of Medicaid and Health Financing
PO Box 143106, Salt Lake City, UT 84114

14-50 Utah Medicaid Provider Statistical and Reimbursement (PS&R) Report

Prior to State Fiscal Year 2014, the Utah State Plan Attachment 4.19-B, page 1, which is incorporated into Utah Administrative Rule R414-1-5 by reference stated, "In-state hospitals, beginning with the providers' fiscal year ending on or after January 1, 2012, shall complete the Title XIX sections of their Medicare Cost Report." The Medicaid-specific cost report information will be used to calculate a Medicaid CCR that will then be used in place of the Medicare CCR for outpatient hospital reimbursements as applicable.

Effective in State Fiscal Year 2014, the Utah State Plan Attachment 4.19B, page 1, was amended to remove the requirement for in-state hospitals to complete the Title XIX sections of the Medicare Cost Report. With this change, hospitals with fiscal reporting periods including June 30, 2013, are still required to complete this information; however, it would not be required for reporting periods beginning on or after July 1, 2013.

Upon request, Utah Medicaid will continue to provide a Provider Statistical and Reimbursement (PS&R) report for the fee-for-service claims data in order to accommodate Medicare Cost Report submissions as described above. The PS&R report provides summary statistical data including: total covered charges, units, and reimbursement (including supplemental payments) by fiscal period. This report provides data to aid in the provider cost reporting relative to Utah Medicaid reimbursement.

Please note that the data in this report only includes fee-for-service information. Any managed care plan claims data would need to be requested of the appropriate managed care organization.

To request a fee-for-service report, contact Andrew Ozmun at aozmun@utah.gov, or (801) 538-6733.

14-51 Physician and VFC Enhancement Payments

This update provides the latest information based on the most recent federal guidance and supersedes any previous communication.

The summaries of the enhancement payments made to date are posted on our website.

Group practices receiving quarterly lump-sum payments may find the breakout of these payments by servicing physician in these summaries.

The status of physician's eligibility based off self-attestation information is available on our website. We strongly encourage all physicians who have submitted the online self-attestation form to check their status on the list.

- Physicians on the list that are deemed eligible for the enhancement payments: Please do NOT fill out the online self-attestation form again. If the *Findings from Review* is noted as "Verified for 2013 only" and you have a valid board certification effective beyond 12/31/2013, please fax in the appropriate documentation in order to continue receiving enhancement payments for the services to be rendered in year 2014. However you do NOT need to re-submit the online self-attestation form.

- Physicians on the list that are NOT deemed eligible due to various attestation issues: Please take appropriate action. For example, when the *Findings from Review* is noted as "NPI Issue (e.g. invalid, group NPI, too short)" and *Provider Action* is "Re-Self-Attest, if not done already, and verify NPI is entered correctly", providers will need to re-submit the online self-attestation form and fax in any supporting documentation.

Following is a link to more program implementation details:

http://health.utah.gov/medicaid/stplan/PhysicianEnhancement.html

Physician and VFC Enhancement Payments

On November 6, 2012, the Centers for Medicare and Medicaid Services (CMS) published a final rule (CMS-2370-F) titled, *Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program*. In short, the rule, beginning January 1, 2013, and continuing through December 31, 2014, will allow the state to increase payments to qualifying physicians for E&M services up to the Medicare rates and also increase the VFC admin rate allowed.

The rule publication may be reviewed on the Federal Register page. The link is as follows:

http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf

On December 14, 2012, the Centers for Medicare and Medicaid Services (CMS) published a document that corrects technical errors (CMS-2370-CN) that appeared in the final rule published November 6, 2012 (CMS-2370-F) titled, *Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program; Correction*. A summary of the changes noted by CMS in the publication are as follows:

> In the November 6, 2012 final rule (77 FR 66670), we inadvertently published technical errors in § 447.400(a) and § 447.405 listed on page 66701. One correction ensures consistency between two sentences in the same paragraph and the other restores text inadvertently omitted from the final rule that had been included in the May 11, 2012 notice of proposed rulemaking (77 FR 27671) on pages 26789–90. Thus, we are correcting page 66701 to reflect the correct information…
>
> **IV. Correction of Errors**
>
> In FR Doc. 2012–26507 of November 6, 2012 (77 FR 66670), make the following corrections: 1. On page 66701, in the first column; in the last full sentence, in the first partial paragraph, the sentence reads, ''A physician self-attests that he/she:''. Correct the sentence to read, ''Such physician then attests that he/she:''.
>
> 2. On the same page, in the same column; in the last full paragraph, paragraph (a) reads, ''For CYs 2013 and 2014, a state must pay for physician services described in § 447.400 based on:''. Correct the sentence to read, ''For CYs 2013 and 2014, a state must pay for physician services described in § 447.400 based on the lower of:''.

The rule publication may be reviewed on the Federal Register page. The link is as follows:

http://www.gpo.gov/fdsys/pkg/FR-2012-12-14/pdf/2012-29640.pdf

Additionally, CMS has provided further guidance in recently published FAQ documents. The link to these documents is as follows:

http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

Physician Enhancement and Self-Attestation

The enhanced rate will be available during the program period as noted above. In order to qualify for the enhanced rate, a physician must:

1. Provide **self-attestation** that they have:
   a. A primary care designation in:
      i. family medicine,
      ii. general internal medicine, or
      iii. pediatric medicine
   b. **In addition**, they must be board certified in a sub-specialty recognized by:
      i. The American Board of Medical Specialties (ABMS),
      ii. The American Board of Physician Specialties (ABPS), or
      iii. The American Osteopathic Association (AOA).

      Or, if not board certified in a sub-specialty above,

      i. Self-attest to a specialty designation in family medicine, general internal medicine, or pediatric medicine and demonstrate that 60% or more of all Medicaid services they bill (including Medicaid managed care environments) are for the following codes: 99201 - 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474.

Providers qualifying with a board certification in one of the sub-specialties noted must also fax a copy of their board certification and any subspecialty certifications to (801) 536-0484 in order to complete the self-attestation. The fax cover sheet should include the provider's name, NPI, email address, and a contact phone number. Please be certain to submit the most current certification covering the calendar year 2013 and 2014 time periods.

Please note that self-attestation is subject to audit.

In order to validate the information that is submitted by physicians, Utah Medicaid will review all self-attestations to ensure, among other things, that: the NPI provided is valid, there is a current board certification for the submission, and that the attestation was a self-attestation submitted by the physician. The results for this review will then be posted on the Utah Medicaid website (http://health.utah.gov/medicaid/stplan/bcrp.htm) which will allow physicians to verify they have properly submitted, or where problems are identified, a list will be provided noting those problems. It is the provider's responsibility to submit all needed documentation to the agency. Providers should review this information to ensure that their self-attestation information is complete.

Clarification and guidance regarding eligible providers

First, further guidance has been provided to show the list of eligible sub-specialties. The list of these eligible sub-specialties is as follows:

ABMS

A. Family Medicine – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine.
B. Internal Medicine – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine: Transplant Hepatology.
C. Pediatrics – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities, Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology, Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

AOA

A. Family Physicians – No subspecialties.
B. Internal Medicine – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.
C. Pediatrics – Adolescent and Young Adult Medicine, Neonatology, Pediatric Allergy/Immunology, Pediatric Endocrinology, Pediatric Pulmonology.

ABPS

The ABPS does not certify subspecialists. Therefore, eligible certifications are:
American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no Board certification specific to Pediatrics.

Second, non-physician practitioners (e.g., nurse practitioner, physician assistant) should not participate in the self-attestation process. However, services rendered by such providers may be billed through an eligible physician if they are done under the direct supervision of that physician.

Third, these payments will be retroactive to the begin date of the quarter in which the self-attestation process is completed assuming that the board certification date spans the full period and is not expired. Also, for physicians attesting based on eligible board certification, continuing program eligibility is subject to continued board certification. Some examples are provided below:

Example 1
A provider who self-attests on 3/29/2013 and who is certified from 1/1/2013 to 12/31/2020 will be eligible for enhanced payments for service dates between 1/1/2013 and 12/31/2014.

Example 2
A provider who self-attests on 1/1/2013 and who is certified from 2/1/2013 to 12/31/2020 will be eligible for enhanced payments for service dates between 2/1/2013 and 12/31/2014.

Example 3
A provider who self-attests on 4/1/2013 and who is certified from 1/1/2013 to 12/31/2020 will be eligible for enhanced payments for service dates between 4/1/2013 and 12/31/2014.

Example 4
A provider who self-attests on 2/1/2013 and who is certified from 1/1/2006 to 12/31/2013 will be eligible for enhanced payments for service dates between 1/1/2013 and 12/31/2013.

Self-Attestation Form Link

The attestation form can be accessed through the following link:

https://docs.google.com/a/utah.gov/spreadsheet/viewform?formkey=dG0wVnVZMXh2bmh3bTdDNE9CNmoxVWc6MQ#gid=0

Please be sure to use the individual NPI in the self-attestation as group NPIs will not be accepted in the final determination of eligible physicians.

Utah Medicaid Fee-For-Service Enhanced Payments

These payments will be made as quarterly lump sum payment amounts to each qualifying provider based on the paid date of the claims data. These payments will be made to the billing provider based on the qualifying servicing provider(s)' applicable services rendered.

Details related to these payments (e.g. breakout of quarterly payments by servicing physician) can be found on the Utah Medicaid website. The link to this site is as follows:

http://health.utah.gov/medicaid/stplan/PhysicianEnhancement.htm

Utah Medicaid Accountable Care Organizations

Providers that only serve clients through an Accountable Care Organization (ACO) must still self-attest through the above process as Utah Medicaid will collect all of this information.

Utah pays capitation rates without the ACA enhanced primary care payments. On a quarterly basis, Utah Medicaid will calculate the total non-risk reconciled payments for each ACO and distribute payments as noted below. The ACO or H.O.M.E will ensure that their eligible providers receive payments up to the Medicare rate (or the provider's billed charges if less), using a method of their choice, as required in 42 CFR 438.6.

This quarterly non-risk reconciled payment will ensure sufficient reimbursement to ACOs to in turn pay their qualified physicians at the Medicare rates for the applicable services provided in a given quarter.

On 7/1/2009, all Utah Medicaid health plans had a non-risk contract and payments were based on the prevailing Utah Medicaid rate at that time. The current risk-based, capitated ACO rates include a two percent increase to the 7/1/2009 rates.

In determining the enhancement amount for the ACOs, Utah Medicaid will compare the Medicare rate in effect as of January 1 of the calendar year in which the service was incurred to 102 percent of the 7/1/2009 rate to

determine the appropriate enhancement amount. Utah Medicaid will sum the enhancement amounts by ACO and make quarterly non-risk reconciled payments for the enhanced amounts. Each quarterly non-risk reconciled payment will be based upon the prior quarter's received encounter data with service end dates on or after 1/1/2013 and not later than 12/31/2014.

It is important to note that the amount Medicaid pays the ACOs does not necessarily equate to the amount the providers may expect to receive from the ACO. It is not a pass-through amount. The ACOs must calculate the amount needed to pay the providers to ensure that the provider is reimbursed in accordance with 42 CFR 447.405.

Questions related to an ACO's payment of this enhancement to eligible providers should be directed to the ACO.

Newly Enrolled Providers

For new providers that enroll over time, the process for the completion of the self-attestation process will need to be completed as explained above.

VFC Enhanced Payments

Qualifying providers, who meet the self-attestation requirements, may receive payments up to the new maximum allowed by the new rule.

Details related to these payments (e.g. breakout of quarterly payments by servicing physician) can be found on the Utah Medicaid website. The link to this site is as follows:

http://health.utah.gov/medicaid/stplan/PhysicianEnhancement.htm

14-52 Statewide Provider Training

Utah Medicaid providers are invited to attend the 2014 Medicaid Statewide Provider Training Seminar. This year's seminar will address common billing errors, tips on billing Utah Medicaid, prior authorizations, managed health care, and important changes regarding Medicaid. In addition, the Office of Inspector General will present information to help prevent and reduce fraud, waste, and abuse.

Each session will run approximately 2 to 2 ½ hours. This year, there will be additional locations and new session times to satisfy the requests received from last year's seminars. All office staff are invited to attend. Please RSVP either by e-mail at providertrainingsupport@utah.gov, or by phone at 1-800-662-9651 or (801) 538-6485 or (801) 538-6155, and select option 8. Please include your name, name of your group, how many will be in attendance, which session you plan to attend, and a contact name and phone number.

We look forward to seeing you! The schedule is as follows:

Statewide Provider Training Schedule 2014

CITY	DATE	PLACE	TIME
St. George	5/20/14	St. George Library 88 West 100 South Community Room B	10:30 a.m. - 12:30 p.m.
Cedar City	5/21/14	Iron County School District 2077 West Royal Hunt Drive Rooms A, B & C	9:30 a.m. - 11:30 a.m.
Panguitch	5/22/14	Garfield Memorial Hospital 200 North 400 East Administrative Conference Room	10:00 a.m. - 12:00 p.m.
Monticello	6/18/14	San Juan Hospital 380 West 100 North Administration Building	10:00 a.m. - 12:00 p.m.
Price	6/19/14	Southeastern Health Department 28 South 100 East Large Conference Room	10:00 a.m. - 12:00 p.m.
Richfield	7/14/14	EMS Building 50 West View Drive Conference Room	1:00 p.m. - 3:00 p.m.
Fillmore	7/15/14	Fillmore Community Medical Center 674 South Highway 99 Classroom	10:00 a.m. - 12:00 p.m.
Roosevelt	7/16/14	Northeastern Counseling Center 285 West 800 South Conference Room	10:00 a.m. - 12:00 p.m.

Tooele	7/31/14	Tooele County Health Department 151 North Main Street Room #180	10:00 a.m. - 12:00 p.m.
Park City	8/5/14	Park City Medical Center 900 Round Valley Drive Private Dining Room (Café)	10:00 a.m. - 12:00 p.m.
American Fork	8/6/14	American Fork Hospital 170 North 1100 East Education Center Classroom	11:00 a.m. - 1:00 p.m.
Salt Lake City	8/12/14	State Library for the Blind & Disabled 250 North 1950 West Multi-Purpose Room	10:00 a.m. - 12:00 p.m.
Salt Lake City	8/12/14	State Library for the Blind & Disabled 250 North 1950 West Multi-Purpose Room	1:30 p.m. - 3:30 p.m.
Logan	8/18/14	Bear River Health Department Baylee Building 655 East 1300 North Rooms #153 & #154	9:30 a.m. - 11:30 a.m.
Brigham City	8/18/14	Brigham City Hospital 950 South Medical Drive Boardroom	2:00 p.m. - 4:00 p.m.
Ogden	8/19/14	Ogden Regional Medical Center 5475 South 500 East Oak & Cedar Room	10:00 a.m. - 12:00 p.m.

Ogden	8/19/14	Ogden Regional Medical Center 5475 South 500 East Oak & Cedar Room	1:30 p.m. - 3:30 p.m.

14-53 New Medicaid Management Information System (MMIS): New Medicaid Member Cards and Eligibility Lookup Tool

This spring, the first of five planned releases for the new Medicaid Management Information System will debut.

What will be in the first release of Medicaid's new system?
Providers will have a new online Medicaid Member Eligibility Lookup Tool that provides more complete eligibility and enrollment information than the current Medicaid card. The Eligibility Lookup Tool supports the new Medicaid Member Card. Starting July 2014, Medicaid and Primary Care Network (PCN) members will start receiving a different type of Medicaid card.

What will be different about the new Medicaid Eligibility card?
The new card will replace the current monthly color coded cards or 8.5x11" sheet of paper that shows the member's eligibility each month. The new wallet-sized cards will not have eligibility information listed on them. Instead, they will have the member's name, Medicaid ID number, and date of birth. Each member in a household will receive their own card.

The new Medicaid Member Card will be used for the duration of the member's enrollment in Medicaid. You will no longer see a card for each month of a Medicaid member's eligibility. New cards will be issued if the Medicaid member's case is closed and the member later re-applies. Replacement cards will also be issued in the event of loss or damage.

What is the Eligibility Lookup Tool?
The Eligibility Lookup Tool will help providers verify their patients' Medicaid eligibility. In addition to calling *AccessNow* at 1-800-662-9651, providers will be able to visit www.health.utah.gov/medicaid/providers to access this tool.

This website provides the ability for a provider to electronically view a member's Medicaid eligibility and plan enrollment information. The Eligibility Lookup Tool will also tell you if the patient is restricted to a specific provider and if the patient is responsible for co-pays.

A provider can select the current month and year of eligibility, or can look at past eligibility during the previous 36 months. The Eligibility Lookup Tool can also be used to verify PCN and Children's Health Insurance Program (CHIP) eligibility.

What do I need to do to get access to the Eligibility Lookup Tool?
In order to be in compliance with HIPAA, we must assure that only those that have the right to this information have access. A provider will have to register with the State of Utah Master Directory (UMD). A provider must have a valid NPI known to Medicaid to register.

What information will I need to verify my patient's eligibility?
To verify your patient's eligibility on the portal, you will need the member's name, Medicaid ID and date of birth.

Can I still call *AccessNow* after the new Eligibility Lookup Tool is available?
Yes, *AccessNow* will still be available at 1-800-662-9651; however, the Eligibility Lookup Tool will be faster, with more complete information that can be printed for your records.

When will the Eligibility Lookup Tool be available?
The Eligibility Lookup Tool will be available for use in May 2014.

Please watch for future updates in the MIB on the MMIS replacement project.

14-54 Physician Services Manual Update – Modifiers Added

The following changes regarding modifiers have been made in the Physicians Provider Manual:

D. Modifiers as defined in the CPT Manual have some limitations in Medicaid policy. Current edits are applicable and will remain. New limitations are implemented with the clinically-based auditing program.

- **Modifier 22:** (Unusual procedural services) Modifier 22 is suspended for manual review. If approved, it will be paid at an additional 10% of the established fee schedule. Exception: multiple gestation births. See article 14-55.
- **Modifier 24**: (Unrelated evaluation and management (E/M) service by the same physician during a postoperative period) Modifier 24 is only allowed for post-operative pain management as appropriate for anesthesia providers and is recognized for manual review. Otherwise, this modifier will not be recognized for manual review.
- **Modifier 25**: (Significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) Medicaid will ***not*** recognize modifier 25. The system will pay according to policy, the editing program, and correct coding initiative edits. Manual review has found an overwhelming number of claims submitted with modifier 25 when the E&M code is the only service, with a minor procedure such as drawing blood, or the services are those included within the procedure. Extensive review of provider documentation on manual review found claims warranting modifier 25 a rare occurrence.
- **Modifier 26** and **TC**: Certain procedures and services have both a professional and a technical component. In procedures having a recognized technical/professional split the following coding guidelines should be followed.
  - Append modifier 26 only for the professional (physician) component of a billed service.
  - Append modifier TC when only the technical component is being billed. In the event that the provider owns the radiology overhead and also reads the exam, then submit one line for the professional

component with modifier 26 and a second line for the technical component unmodified to ensure reimbursement for the global service.

Modifier 26 and TC have separate fees in the payment schedule and pay according to the established fee schedule.

- **Modifier 27:** (Multiple Outpatient Hospital Evaluation and Management Encounters on the Same Day) Medicaid will not recognize Modifier 27. Modifier 27 is only appended to facility based services performed in the hospital outpatient setting. Medicaid does not reimburse for services attached to Modifier 27.
- **Modifier 50:** (Bilateral Procedures) Medicaid will ***not*** recognize modifier 50.
- **Modifier 51:** (Multiple Procedures) When more than one procedure is performed during an operative session the surgeries are subject to the multiple surgery rules and are ranked in descending order by the Medicaid fee schedule allowed amount.
- **Modifier 52**: (Reduced Service) Modifier 52 is paid at 50% of the established fee schedule.
- **Modifier 53**: (Discontinued Procedure) Modifier 53 is paid at 50% of the established fee schedule.
- **Modifier 54**: (Surgical Care Only) Modifier 54 is paid at 70% of the established fee schedule.
- **Modifier 55**: (Post-Operative Management Only) Modifier 55 is paid at 20% of the established fee schedule.
- **Modifier 56:** (Pre-Operative Management Only) Modifier 56 is paid at 10% of the established fee schedule.
- **Modifier 57**: (Decision for surgery) Medicaid will ***not*** recognize modifier 57. Decision for surgery performed for the purposes of hospital accreditation requirements that indicate every patient must have an initial hospital history and physical, is not a covered service and is integral to the surgical global fee.
- **Modifier 58:** (Staged or related procedure or service by the same physician during the postoperative period) Modifier 58 is suspended for manual review.

  Submit CPT modifier 58 to indicate that the performance of a procedure or service during the postoperative period was either:
  - Planned prospectively at the time of the original procedure (staged)
  - More extensive than the original procedure
  - For the therapy following a surgical procedure
- **Modifier 59:** (Distinct Procedure Service) Modifier 59 is used to describe distinct unrelated service from the other submitted procedures. Modifier 59 should not be used to circumvent correct coding initiative edits. The purpose of this modifier is to identify procedures or services that are not usually reported together, but appropriate under the circumstances. This may represent the following:
  - Different surgical session
  - Different surgeon
  - Different site or organ system
  - Separate incision or excision (this excludes multiple port sites integral to endoscopy surgery)
  - Separate lesion
  - Separate injury (or area of injury in extensive injuries)

  These circumstances are not usually encountered or performed on the same day by the same individual.

  Modifier 59 is the modifier of “last resort” and should only be used if there is no other appropriate modifier.

Modifier 59 is reserved for non E/M services per CPT and should not be appended to an E/M service.

The submission of modifier 59 appended to a procedure code will be processed through the system and a denial will occur based on Medicaid's editing program. Providers may then submit appropriate medical records for review that will support the distinct or independent identifiable nature of the service submitted with modifier 59. Modifier 59 will only be considered for manual review after editing program denial.

- **Modifier 62**: (Two surgeons of a different specialty are required to perform a specific procedure) Modifier 62 is suspended for manual review and requires each co-surgeon to submit a separate operative report clearly describing the separate portions of the procedure that each surgeon completed. Modifier 62 is paid at 62.5% of the established fee schedule.
- **Modifier 66:** (Surgical Team) Modifier 66 is suspended for manual review and is priced by Medicaid physician consultants.
- **Modifier 73**: (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure prior to the administration of anesthesia) Modifier 73 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.
- **Modifier 74:** (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure after the administration of anesthesia) Modifier 74 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.
- **Modifier 76**: (Repeat Procedure by Same Physician) Modifier 76 is paid at 100% of the established fee schedule.
- **Modifier 77:** (Repeated Procedure(s)) Modifier 77 is paid at 100% of the established fee schedule.
- **Modifier 78:** (Unplanned return to the operating room by the same physician following initial procedure for a related procedure during the postoperative period) Modifier 78 is suspended for manual review.
- **Modifier 80:** (Assistant at Surgery) Modifier 80 for assistant surgeon is limited to 20% of the established fee schedule.
- **Modifier 81:** (Minimal assistant at surgery) Medicaid does not reimburse for services attached to Modifier 81.
- **Modifier 91:** (Repeat clinical diagnostic laboratory test) Modifier 91 is suspended for manual review. Used to report laboratory tests performed more than once on the same date to obtain subsequent, multiple test results. Submit documentation supporting the claim that separate services were provided for a distinct medical purpose.

  Inappropriate usages of Modifier 91 include, but are not limited to:
  - Used for a rerun of a laboratory test to confirm results
  - Due to testing problems for the specimen
  - Due to testing problems of the equipment
  - When another procedure code describes a series test
  - When the procedure code describes a series of tests

- For any reason when a normal one time result is required
- Repeat a test for quality control purposes

14-55 Modifier 22 and Multiple Gestation Births

Medicaid covers multiple birth deliveries, in the same delivery setting, when two or more infants from one pregnancy are delivered in the same delivery setting for vaginal, cesarean, or combination of vaginal and cesarean.

Vaginal delivery
Each vaginal delivery is reimbursed a percentage of the Medicaid established fee schedule.

- First delivery: 100%
- Second delivery: 50%
- Each additional delivery: 25%

Vaginal with cesarean section delivery
One infant of a multiple pregnancy delivered vaginally followed by one or more infants delivered by cesarean section. The deliveries are reimbursed at these percentages of the Medicaid established fee schedule.

- Cesarean section: 100%
- Second delivery: 50%
- Each additional delivery: 25%

Cesarean section delivery
When two or more infants from one pregnancy are delivered by cesarean section in the same operative setting, delivery is reimbursed at 100% of the established fee schedule.

An ACOG guideline does not allow additional reimbursement for additional births when all babies are delivered by cesarean section. If there is increased physician work involvement for delivery of the second baby, modifier 22 is added to the global cesarean code (CPT codes 59510 or 59618). Claims submitted with modifier 22 must include medical record documentation which supports use of the modifier.

14-56 Rural Health Clinics and Federally Qualified Health Centers

Effective April 1, 2014, the *Utah Medicaid Rural Health Clinics and Federally Qualified Health Centers Services Provider Manual* has been reformatted and includes updated content. The new manual and associated information is available on the Medicaid website at www.health.utah.gov/medicaid.

FQHCs and RHCs Billing and Reimbursement

FQHCs and RHCs are required to list each procedure code on separate lines, in addition to the encounter code, on the claim form. Payment will continue to be made by encounter under code T1015.

Mobile FQHC Units

In accordance with Medicare requirements, each permanent FQHC requires a separate agreement. Mobile units of a FQHC approved site are not required to enroll or bill separately, but must comply with Medicare health and safety standards.

14-57 Diagnoses Lists Updated

Effective April 1, 2014, the following attachments will be updated in the *Utah Medicaid Hospital Services Provider Manual*:

- Authorized Emergency Inpatient Diagnoses List
- Authorized Emergency Diagnoses List

The lists are available on the Medicaid website at www.health.utah.gov/medicaid.

14-58 Home Health Agencies Provider Manual

Effective April 1, 2014, the *Utah Medicaid Home Health Agencies Provider Manual* has been reformatted and includes updated content. The new manual and associated information is available on the Medicaid website at www.health.utah.gov/medicaid.

14-59 Speech-Language Services Clarification

Speech therapy services and speech augmentative communication devices are not a covered benefit for Non-Traditional Medicaid beneficiaries. Codes that incorrectly indicated the services were covered have been corrected to show the service is not allowed for Non-Traditional Medicaid beneficiaries.

14-60 Code Updates

The following CPT codes will require prior authorization:

36475 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated. Refer to criteria for chronic vein insufficiency or varicose veins.

36476 . . . second and subsequent veins treated in a single extremity, each through separate access sites. Refer to criteria for chronic vein insufficiency or varicose veins.

37500 Vascular endoscopy, surgical with ligation of perforator veins, subfascial (SEPS). Refer to criteria for chronic venous insufficiency or varicose veins.

The following CPT code is opened, effective January 1, 2014, to provider types 20, 24, 45, 91:

15777 Implantation of biologic implant for soft tissue reinforcement

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14-61 Nutritional Counseling for Obesity

Effective April 1, 2014, non-pregnant adults, in addition to pregnant adults, may receive one hour of code 97802 and code 97803 with documentation which meets criteria under manual review.

97802 Initial nutritional therapy, 15 minute unit (4 units) up to 1 hour, allowed for pregnant adults, EPSDT, and non-pregnant adults. Criteria: EPSDT and pregnant women are covered for one hour of nutritional counseling for obesity or malnutrition. A non-pregnant adult is eligible for one hour of nutritional counseling if BMI $\geq$ 30. See Coverage & Reimbursement Lookup Tool.

97803 Subsequent nutritional therapy, 15 minute unit (4 units) up to 1 hour. Criteria: pregnant women are allowed one hour of nutritional counseling for malnutrition or obesity (BMI > 30). Non-pregnant adults are allowed one hour of nutritional counseling for obesity (BMI > 30). EPSDT clients with malnutrition or BMI $\geq$ 27 are covered with supportive documentation of medical necessity and progress. See Coverage & Reimbursement Lookup Tool.

Nutritional counseling and an evaluation and management (E&M) are not covered for the same provider on the same date of service. Medicaid does not pay two E&M codes on the same date of service. The E&M service may be billed with a prolonged service code to include the time for nutritional counseling.

Note: Current coverage of code S9470, dietician nutritional counseling for pregnant adults (14 visits) and EPSDT eligible, will continue. The codes 97802 and 97803 have both been opened for EPSDT and pregnant women for up to one hour of time.

14-62 Utah Pharmacy Provider Portal

Utah Medicaid has a secure, HIPAA-compliant, prior authorization (PA) web portal for prescribers, pharmacies, and clients. The portal has resources for Medicaid providers from the physician's office to the pharmacy. Please visit the web portal at www.utahrxportal.org.

Tools for Pharmacies:

- Look-ups for reimbursable NDCs
- Preferred Drug List (PDL) status of drugs
- Beneficiary coverage look-up, including ACO information
- Ability to receive and validate electronic fax prescriptions

Tools for Prescribers:

- View the beneficiary's medication profile for drugs reimbursed by Utah Medicaid
- Electronic prescribing via electronic fax
- Electronic PA submission and monitoring
- Look-ups for reimbursable NDCs, diagnosis codes, and pharmacies
- Ability to add permissions for office staff to submit prescriptions and PAs on behalf of the prescriber
- Customized response to the prescriber via e-mail, text message, or fax concerning updates to the PA status

New tools added for 2014:

- Ability to upload documents related to the PA by the prescriber
- Uploaded documentation is thoroughly inspected for malware or viruses to keep information secure

All Utah Medicaid prescribers, once registered with the portal, may submit and manage PAs within the Utah Pharmacy Provider Portal interface. Until recently, any attachments to a PA had to be faxed to Medicaid. A recent update to the portal now allows prescribers to electronically attach documents.

Once logged into the portal, the prescriber can select the web PA option on the site. The physician can then select the patient name, drug, diagnosis code, and pharmacy. If the drug requires a PA, the prescriber can either fax or submit the PA online to obtain a PA tracking number. Once the PA has a tracking number, documents (including .doc, .pdf, .jpg, and other formats) pertaining to the PA can be uploaded to the portal. In addition, providers can choose how they wish to be contacted concerning updates on the status of the submitted PA, including e-mail, fax, or even text message.

In the event that a PA is denied or incomplete, additional documentation can be submitted to the existing PA using the tracking found in the patient profile in the portal. All attachments are thoroughly inspected for malware or viruses to ensure data security of Utah Medicaid's computer systems and Personal Health Information (PHI) is secure.

The portal is designed to improve patient care and can be accessed via any device that can run a web browser, including iPads, tablets, smartphones, and blackberry devices. We hope that these new features will encourage prescribers to take advantage of the online portal, and will improve patient care through more efficient and accurate healthcare.

14-63 DUR Board and P&T Committee Update

The Drug Utilization Review Board (DUR) meets on the second Thursday of each month. Topics of discussion in the past meetings include thiazolidinedione (TZD) class, SGLT-2 inhibitors, Tudorza, a review of insulin pen criteria, roflumilast, and COPD. Other topics that are scheduled to be discussed in future meetings include the pulmonary embolism and deep vein thrombosis agent, Eliquis, and the multiple sclerosis agent, Tecfidera. Recent decisions from the DUR meetings have resulted in the establishment of consistent PA criteria for anti-diabetic drugs.

The Pharmacy and Therapeutics (P&T) Committee meets on the third Thursday of each month. Topics of past discussion include IBS agents, phosphate binding agents and topical immune modulators, topical anesthetics, pediculosides, short acting opioid agents, antiemetics, and appetite stimulants. Future topics include epinephrine formulations and antihistamine agents.

Please visit the website at http://www.health.utah.gov/medicaid/pharmacy for more detailed information including agendas, past meeting minutes, locations and times, as well as future topics for discussion. All interested persons are welcome to attend these public meetings.

14-64 Non-Preferred vs. Clinical Prior Authorizations

Utah Medicaid employs both non-preferred and clinical prior authorizations (PAs). A non-preferred PA is requested when a medication is not a Utah Medicaid preferred product. The medication is requested by using the *Non-Preferred Drug PA Form*. Preferred and non-preferred products are determined by Utah Medicaid's Pharmacy and Therapeutics Committee and Utah Medicaid's Pharmacy Team. Preferred and non-preferred products are listed on Utah Medicaid's Preferred Drug List (PDL), which is updated regularly. The PDL and the *Non-Preferred Drug PA Form* can be found at http://www.health.utah.gov/medicaid/pharmacy/PDL/directory.php.

A clinical PA is requested when a medication must meet certain clinical requirements. Clinical requirements are developed and reviewed by Utah Medicaid's Drug Utilization Review Board and Utah Medicaid's Pharmacy Team. Drugs requiring clinical PAs, and their specific criteria, can be found at http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/allentries.php.

Please note that a particular drug may require a clinical PA **and** be non-preferred. In these cases, the *Clinical PA Form* and supporting documentation should be submitted to Utah Medicaid, rather than the *Non-Preferred Drug PA Form*.

PAs may be submitted by fax at (855) 828-4992, or via the online Pharmacy Provider Portal at https://www.utahrxportal.org/upp/application/login.joi.

14-65 Preferred Drug List 2014

The new Preferred Drug List (PDL) has been published for 2014. New subclasses, added to the PDL for 2014, include GLP-1 agents and oral anticoagulant agents. Some of the changes include Coumadin being preferred, while warfarin is non-preferred. A 45-day look-back (grandfather clause) will be in effect for patients who are stabilized on warfarin.

Another change is in the Proton Pump Inhibitor (PPI) class, where Nexium has changed from a preferred to non-preferred product. Aciphex, omeprazole, pantoprazole, Protonix Packets, and Dexilant will be preferred PPI agents for 2014.

14-66 Mental Health and Substance Use Disorder Treatment Providers

Effective January 1, 2014, the Medicaid provider manual, *Rehabilitative Mental Health and Substance Use Disorder Services*, has been updated as follows:

- Chapter 2-2, Psychiatric Diagnostic Evaluation, clarifications have been made regarding documentation of reassessments.
- Chapter 2-5, Psychotherapy, and Chapter 2-7, Psychotherapy with Evaluation and Management (E/M) Services, minor wording changes have been made in the sections on documentation. Also, in Chapter 2-5, under group psychotherapy, the procedure code referenced for psychotherapy groups has been corrected.
- Chapter 2-9, updates and clarifications have been made to add procedure code 96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
- Chapter 4, Procedure Codes and Modifiers, procedure code 96372 has been added to the table.

Providers may access the current and revised provider manual at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions about this article, contact Merrila Erickson at (801) 538-6501 or e-mail at merickson@utah.gov.

14-67 Timely Billing Procedures and Hearings

Certain Medicaid rules require action to be taken within a specified time frame. They include submitting claims within one year of the date of service, and filing a fair hearing request within 30 days of a denial. Speaking to a customer service representative or other Medicaid employee, exchanging e-mails, or having any other contact with Medicaid about the claim or issue cannot extend or fulfil this requirement.

A claim must be submitted to Medicaid for payment, and a hearing request form must be submitted to the Office of Formal Hearings in a timely manner. These rules are explained in the *Utah Medicaid Provider Manual, General Information – Section I*, in Chapter 11-10 and Chapter 6-15.

A claim meeting the definition found in 42 CFR 447.45 must be submitted within 365 days of the date of service. A completed *Request for Hearing/Agency Action Form*, or a document otherwise meeting the requirements of Utah Administrative Code R410, must be received by the hearing office within 30 days of the denial or other action being appealed. The hearing form is available on the Utah Medicaid website at http://health.utah.gov/medicaid.

Providers are encouraged to use the resources found on the Utah Medicaid website, including the Coverage and Reimbursement Lookup Tool, in addition to calling Medicaid. The website also contains provider manuals and current and past Medicaid Information Bulletins (MIBs).

14-68 Renewal of Utah's Acquired Brain Injury Waiver

Utah Medicaid is in the process of submitting a 5-year renewal of the Acquired Brain Injury Home and Community-Based Services 1915 (c) waiver. The current waiver is set to expire on June 30, 2014. The state must supply its renewal request 90 days prior to this date to allow CMS time to review.

There are no substantive changes to the waiver in terms of its operation or services delivered. All other administrative changes may be viewed online at http://health.utah.gov/ltc. In addition, comments from the public are being accepted for review and consideration at http://health.utah.gov/ltc/publiccomment.html.

14-69 Radiology/Oncology Worksheet

Effective April 1, 2014, a new form for the submission of radiation therapy documentation will be available for download at www.health.utah.gov/medicaid, forms. Per Medicaid policy (Physician Provider Manual, Radiology, item 3), radiation therapy that includes more than four plans per one anatomical area or that employs intensity modulated radiation therapy (IMRT) must undergo manual review.

Documentation of all treatment plans must be submitted for review. To guide submission of the appropriate records and to facilitate timely review, the *Radiation Therapy Dosimetry Documentation Form* has been created. This form should be completed by the ordering physician and submitted along with the specified medical records.

Below is an example of the form:

Radiation Therapy Dosimetry Documentation

Please have the physician complete all sections of this sheet marked by a * and submit all relevant medical documentation, using the guidelines below.

*Please state site(s)/type(s) of cancer being treated & identify primary vs secondary sites.

_____

*Please check one or make a brief statement as to the reason/intent for treatment –
☐ Initial primary treatment ☐ Pre-operative radiation ☐ Extension into Viscera
☐ Isolated local recurrence at local or adjacent site ☐ Spinal Cord Compression
☐ Palliation: primary site ☐ Palliation: metastatic site
☐ Other _____

Medical Documentation Submission Guidelines:

For Simple, Intermediate or Complex Radiation Delivery Technique
For each separate dose calculation, please provide the following documentation:

- Date of plan
- Target site
- Particle type
- Energy type
- Number of Fractions
- Port/angle
- Radiation delivery technique
- Whether a boost is planned.
  - If so, also provide the following documentation:
    - Boost delivery technique
    - Boost site(s)
    - Particle type
    - Energy dose
    - Number of Fractions
    - Port/angle

Submission of treatment plan documents will suffice, so long as all requested information is included for each individual plan.

For IMRT Radiation Delivery Technique
For each separate dose calculation please provide the following documentation:

- Date of plan
- Target site
- *Please identify which one of the following critical structures/functions will be spared by using IMRT:
  ☐ brain stem ☐ optic nerve ☐ sensorineural hearing ☐ carotid artery
  ☐ mandible ☐ salivary glands ☐ parotid glands ☐ cervical spinal cord
  ☐ other_____
- Please include the following documents, as applicable:
  - All relevant CT or MRI reports that verify the dose limited structures are adjacent to but outside of planned treatment volume area
  - Documentation that immediately adjacent areas have been irradiated and the planned treatment area must be targeted with high precision
  - Documentation that gross tumor is concave, convex or irregular and in close proximity to critical structures

*Name of the physician completing this form: _____

*Signature: _____ *Date: _____

14-70 Nurse Practitioners (NPs)

Currently, Medicaid allows the following NPs to bill directly for their services:

Certified Nurse Midwife

Certified Nurse Anesthetist

Family Nurse Practitioner

Pediatric Nurse Practitioner

Recently, Medicaid submitted a State Plan amendment to the Centers for Medicare and Medicaid Services (CMS) requesting that all licensed nurse practitioners be allowed to directly bill Medicaid for payment of approved services. If and when Medicaid receives CMS approval of the amendment, nurse practitioners may begin enrollment and direct billing for their covered services. Reimbursement if anticipated at 100% of the Medicaid established fee schedule and this is also pending CMS approval of the State Plan amendment.

Future MIB articles will provide updates.