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Agency with Choice - A New Member-Directed Service Option

On January 1, 2013, individuals who receive attendant care, personal care, habilitation or homemaker services in their own home through the Arizona Long Term Care System (ALTCS) will have the opportunity to choose a new member-directed option known as Agency with Choice. Agency with Choice is not a separate "service" but rather it is a different way of providing these specific services that offers members the ability to play a more active role in directing their own care. For all services provided as Agency with Choice, AHCCCS will receive a 6% enhanced Federal reimbursement match.

Under the new model, the member will enter into a co-employment relationship with the provider agency. The provider will serve as the legal employer of record - maintaining the authority for hiring and firing the caregiver and ensuring that the caregiver meets the minimum training qualifications. The member will serve as the day-to-day managing employer - taking on tasks such as selecting the caregiver and determining the worker's schedule and duties. Under Agency with Choice, if someone has been appointed to help the member direct their care, that person, called the "Individual Representative", is prohibited from also serving as a member's paid caregiver.

Services provided under the Agency with Choice option, will be authorized by the member's case manager. Agency with Choice services (listed below) will be authorized with the service modifier **U7** and therefore must be billed as such in order to be paid.

Certain additional services when provided to members getting one of the above services will also be authorized with the U7 service modifier in order to qualify for the enhanced Federal match. Those services are as follows:

Home Modifications	S5165
Community Transition	T2038
Home Delivered Meals	S5170
Emergency Alert System	S5160/S5161

The modifier allows AHCCCS to track utilization of Agency with Choice services and claim appropriate Federal reimbursement. More information on member-directed options is available on the AHCCCS website at: http://www.azahcccs.gov/shared/SDAC.aspx?ID=notices.

Enhanced Payments For Primary Care Providers

Background

Section 1202 of the Patient Protection and Affordable Care Act (ACA) requires state Medicaid programs to pay qualified primary care providers (PCPs) fees that are no less than the Medicare fee schedule in effect for 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare conversion factor, whichever is greater, for certain services designated by specific Current Procedural Terminology (CPT) codes. The enhanced payments apply only to services provided during calendar years 2013 and 2014 by qualified primary care providers, who self-attest as defined in the federal regulations. On November 6, 2012 the Centers for Medicare and Medicaid Services (CMS) published the Final Rule regarding these fee increases although CMS is still in the process of providing guidance to States regarding implementation of the Final Rule.

The information below outlines services eligible for the enhanced rates, providers who may be paid at those rates, steps providers must take to receive those increased fees, and timeframe for enhanced rate payment.

Services Eligible for Payment at the Enhanced Rates

Services eligible for the enhanced fees include Evaluation and Management (E/M) services (CPT codes 99201 – 99499) and vaccine administration procedures (CPT codes 90460, 90461, 90471, 90472, 90473 and 90474) provided to Medicaid members between January 1, 2013 and December 31, 2014. CMS is requiring changes in the way claims for vaccine administration services are submitted to state Medicaid programs. A separate memo outlining those changes will be issued and posted on the AHCCCS website.

Providers Eligible to Receive Enhanced Fees for Primary Care Services

CMS defines qualified providers for purposes of the enhanced fees for primary care services, as physicians who practice internal medicine, family practice medicine, or pediatric medicine, or any subspecialty of those three specialties recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties who meet one of the following criteria:

1) Physicians who are board certified in one of those specialties or subspecialties, or
2) Physicians who engage in the practice of one of the specialties or subspecialties described above, but are not board certified, who submit claims for services provided to Medicaid members during calendar year 2012 for which 60% of the CPT codes reported are E/M and/or vaccine administration codes described as eligible services. For newly eligible physicians, the 60% billing requirement will apply to Medicaid claims for the prior month.

Nurse practitioners (NPs) and physician assistants (PAs) who practice under the supervision of a qualifying physician will also be eligible for enhanced payments under these rules. However, in order for the NP or PA to receive the enhanced payment, the qualifying physician must submit forms to AHCCCS identifying these practitioners. CMS specifically notes that NPs who practice independently are not eligible for the enhanced fees under the ACA. CMS does not recognize other specialties, such as obstetrician/gynecologists, as primary care providers for purposes of the enhance fees.

Actions Providers Must Take to Qualify for the Enhanced Fees

AHCCCS will post attestation forms on its website in January 2013. Physicians who practice internal medicine, family practice medicine, or pediatric medicine, or any subspecialty of those three specialties recognized by one of the professional bodies above who qualify for the enhanced fees by either being board certified in one of the qualifying specialties/ subspecialties or by meeting the 60% threshold for E/M and vaccine administration code submission rates must complete the attestation form in order to receive enhanced payments. In addition, in order for the NP or PA to receive the enhanced payment, the qualifying physician must submit forms identifying these practitioners.

Providers whose attestations are received by March 31, 2013 will qualify for enhanced payments for dates of service retroactive to January 1, 2013. For attestations received on or after April 1, 2013, enhanced payments will be available for dates of service that are prospective.

CMS requires that AHCCCS conduct random, statistically valid retrospective audits of the physicians who submit attestations to confirm that they meet either the board certification requirements or the 60% code requirements. Providers subjected to such audits that fail to show they meet the requirements to which they attested are subject to recoupment of funds paid at the enhanced rates and possible other sanctions.

Enhanced Fees

CMS is in the process of developing guidance for States to implement this final rule, which will not be available until January 2013, thus AHCCCS will provide additional information regarding the enhanced primary care payment process in the near future. The methodology and payment of the enhanced rate is predicated upon CMS approval, which could be delayed to March 31, 2013 or later. Therefore enhanced payments for qualifying claims with dates of service on or after January 1, 2013 will not begin January 1 but will be made retroactively once CMS approval is received. AHCCCS will continue to post information on its website at: www.azahcccs.gov as it becomes available

Error Code A622

Effective immediately edit A622 (CO-Pay Amount Different From Amount Assigned To Service), has been set to soft. Please note this change of edit status does not resolve Contractors from appropriate application of copays.

Code Change(s)

- The coverage code for the HCPCS code C9219 (Mycophenolic Acid, Oral) has changed to **04** (**Not Covered Service/Code Not Available**).

- Effective for the dates of service April 1, 2012 the coverage code has been changed to **01 (Covered Service/Code Available)** for the HCPCS codes:

  Q4118 - Matristem Micromatrix, 1 mg
  Q4119 - Matristem Wound Matrix, PSMX, RS, OR PSM, Per Square Centimeter

- Effective for dates of service beginning January 1, 2013 the CPT code 90460 (Immunization Administration Through 18 Years Of Age Via Any Route Of Administration, With Counseling By Physician Or Other Qualified Health Care Professional; First Or Only Component Of Each Vaccine Or Toxoid Administered) coverage code has been changed to 01 (Covered Service/Code Available).

- Effective for dates of service on or after **January 1, 2012** the following have been added to the CPT code 60210 (Partial Thyroid Lobectomy, Unilateral; With or Without Isthmusectomy):

  Modifier SG (Ambulatory Surgical Center)
  Place of Service 24 (Ambulatory Surgical Center)
  Provider Type 43 (Ambulatory Surgical Center)
  Revenue Code 0490 (Ambulatory Surgical Center)

- Effective for dates of service on or after **January 1, 2013** the following have been added to the following HCPCS codes below:

  Modifier SG (Ambulatory Surgical Center)
  Place of Service 24 (Ambulatory Surgical Center)
  Provider Type 43 (Ambulatory Surgical Center)
  Revenue Code 0490 (Ambulatory Surgical Center)

Code	Description
J0178	Injection, Aflibercept, 1 mg
J0485	Injection, Belatacept, 1 mg
J0716	Injection, Centruroides Immune F(AB)2, Up To 120 mg
J7178	Injection, Human Fibrinogen Concentrate, 1 mg
J7527	Everolimus, Oral, 0.25 mg
J9002	Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg
J9019	Injection, Asparaginase (Erwinaze), 1,000 IU
J9020	Injection, Asparaginase, Not Otherwise Specified, 10,000 Units
J9042	Injection, Brentuximab Vedotin, 1 mg
J9280	Injection, Mitomycin, 5 mg
Q4119	Matristem Wound Matrix, PSMX, RS, OR PSM, Per Square Centimeter
Q4131	Epiflix, Per Square Centimeter
Q4132	Grafix Core, Per Square Centimeter
Q4133	Grafix Prime, Per Square Centimeter

- Effective for dates of service on or after May 1, 2012 the CPT code 47490 (Cholecystostomy, Percutaneous, Complete Procedure, Including Imaging Guidance, Catheter Placement, Cholecystogram When Performed, And Radiological Supervision And Interpretation) can be reported with the following changes:

  Modifier SG (Ambulatory Surgical Center)
  Place of Service 24 (Ambulatory Surgical Center)
  Provider Type 43 (Ambulatory Surgical Center)
  Revenue Code 0490 (Ambulatory Surgical Center

Limits

- The limits for the HCPCS code V2624 have been changed to the following:
  Procedure daily maximum = 2
  Laboratory Limit 1: = 2
  Frequency 1: 1 y

- The Frequency limit for the CPT code 88280 (Chromosome Analysis; Additional Karyotypes, Each Study) have been changed to the following:
  Frequency 1: 1 y

Modifier(s)

- Effective for the dates of service on or after January 1, 2011 the modifier 51 (Multiple Procedures) has been added to the CPT code 20690 (Application of a Uniplane (Pins or Wires In 1 Plane), Unilateral, External Fixation System).

- Effective for the January 1, 2013 the modifier U2 (Self Directed Care/Unskilled) has been added to the following HCPCS codes:

Code	Description
S5108	Home Care Training To Home Care Client, Per 15 Minutes
S5110	Home Care Training, Family; Per 15 Minutes
S5115	Home Care Training, Non-Family; Per 15 Minutes

Modifier and Place of Service

Effective for the dates of service on or after October 1, 2012 the modifier SG (Ambulatory Surgical Center (ASC) Facility) and Place of Service 24 (Ambulatory Surgical Center (ASC)) has been added to the following CPT codes:

Code	Description
58150	Total Abdominal Hysterectomy (Corpus and Cervix), With or Without Removal of Tube(s), With or Without Removal of Ovary(s);
58260	Vaginal Hysterectomy, For Uterus 250 G or Less;
58262	Vaginal Hysterectomy, For Uterus 250 G or Less; With Removal of Tube(s), and/or Ovary(s)

- Effective for dates of service for January 1, 2013 the following modifiers (listed below) have been added to the HCPCS codes listed in the following table.

Modifier	Description	Modifier	Description
CH	0 Percent Impaired, Limited Or Restricted	CI	At Least 1 Percent But Less Than 20 Percent Impaired, Limited or Restricted
CJ	At Least 20 Percent But Less Than 40 Percent Impaired, Limited or Restricted	CK	At Least 40 Percent But Less Than 60 Percent Impaired, Limited or Restricted
CL	At Least 60 Percent But Less Than 80 Percent Impaired, Limited or Restricted	CM	At Least 80 Percent But Less Than 100 Percent Impaired, Limited or Restricted
CN	100 Percent Impaired, Limited Or Restricted		

Code	Description
G8978	Mobility: Walking & Moving Around Functional Limitation, Current Status, At Therapy Episode Outset And At Reporting Intervals
G8997	Swallowing Functional Limitation, Projected Goal Status, At Initial Therapy Treatment/Outset And At Discharge From Therapy
G8998	Swallowing Functional Limitation, Discharge Status, At Discharge From Therapy/End Of Reporting On Limitation
G8999	Motor Speech Functional Limitation, Current Status At Time Of Initial Therapy Treatment/Episode Outset And Reporting Intervals
G9157	Transesophageal Doppler Use For Cardiac Monitoring
G9158	Motor Speech Functional Limitation, Discharge Status At Discharge From Therapy/End Of Reporting On Limitation
G9159	Spoken Language Comprehension Functional Limitation, Current Status At Time Of Initial Therapy Treatment/Episode Outset And Reporting Intervals
G9160	Spoken Language Comprehension Functional Limitation, Projected Goal Status At Initial Therapy Treatment/Outset And At Discharge From Therapy
G9161	Spoken Language Comprehension Functional Limitation, Discharge Status At Discharge From Therapy/ End Of Reporting On Limitation
G9162	Spoken Language Expression Functional Limitation, Current Status At Time Of Initial Therapy Treatment/ Episode Outset And Reporting Intervals
G9163	Spoken Language Expression Functional Limitation, Projected Goal Status At Initial Therapy Treatment/ Outset And At Discharge From Therapy
G9164	Spoken Language Expression Functional Limitation, Discharge Status At Discharge From Therapy/End Of Reporting On Limitation
G9165	Attention Functional Limitation, Current Status At Time Of Initial Therapy Treatment/Episode Outset And Reporting Intervals
G9166	Attention Functional Limitation, Projected Goal Status At Initial Therapy Treatment/Outset And At Discharge From Therapy
G9167	Attention Functional Limitation, Discharge Status At Discharge From Therapy/End Of Reporting On Limitation
G9168	Memory Functional Limitation, Current Status At Time Of Initial Therapy Treatment/Episode Outset And Reporting Intervals
G9169	Memory Functional Limitation, Projected Goal Status At Initial Therapy Treatment/Outset And At Discharge From Therapy

Modifiers

- Effective for dates of service January 1, 2013 the modifier SL (State Supplied Vaccine) has been added to the following CPT codes:

Code	Description
90471	Immunization Administration (Includes Percutaneous, Intradermal, Subcutaneous, Or Intramuscular Injec-
90472	Immunization Administration (Includes Percutaneous, Intradermal, Subcutaneous, Or Intramuscular Injections); Each Additional Vaccine (Single Or Combination Vaccine/Toxoid) (List Separately In Addition To Code For Primary Procedure)
90473	Immunization Administration By Intranasal Or Oral Route; 1 Vaccine (Single Or Combination Vaccine/
90474	Immunization Administration By Intranasal Or Oral Route; Each Additional Vaccine (Single Or Combina-
90460	Immunization Administration Through 18 Years Of Age Via Any Route Of Administration, With Counseling By Physician Or Other Qualified Health Care Professional; First Or Only Component Of Each Vaccine Or Toxoid Administered

- Effective for dates of service January 1, 2013 the modifiers GQ (VUA Asynchronous Telecommunications System) and GT (Telemedicine) have been added to the following codes:

Code	Description
90791	Psychiatric Diagnostic Evaluation
90792	Psychiatric Diagnostic Evaluation With Medical Services
90832	Psychotherapy, 30 Minutes With Patient And/Or Family Member
90833	Psychotherapy, 30 Minutes With Patient And/Or Family Member When Performed With An Evaluation
90834	Psychotherapy, 45 Minutes With Patient And/Or Family Member
90836	Psychotherapy, 45 Minutes With Patient And/Or Family Member When Performed With An Evaluation
90837	Psychotherapy, 60 Minutes With Patient And/Or Family Member
90838	Psychotherapy, 60 Minutes With Patient And/Or Family Member When Performed With An Evaluation
G0396	Alcohol And/Or Substance (Other Than Tobacco) Abuse Structured Assessment (e.g., Audit, Dast), And
G0397	Alcohol And/Or Substance (Other Than Tobacco) Abuse Structured Assessment (e.g., Audit, Dast), And
G0442	Annual Alcohol Misuse Screening, 15 Minutes
G0443	Brief Face-To-Face Behavioral Counseling For Alcohol Misuse, 15 Minutes
G0444	Annual Depression Screening, 15 Minutes
G0445	High Intensity Behavioral Counseling To Prevent Sexually Transmitted Infection; Face-To-Face, Individual, Includes: Education, Skills Training And Guidance On How To Change Sexual Behavior; Performed Semi-Annually, 30 Minutes
G0446	Annual, Face-To-Face Intensive Behavioral Therapy For Cardiovascular Disease, Individual, 15 Minutes
G0447	Face-To-Face Behavioral Counseling For Obesity, 15 Minutes

Place of Service (POS)

- Effective for dates of service January 1, 2013 the POS 03 (School) has been added to the following CPT codes:

Codes	Description
90832	Psychotherapy, 30 Minutes With Patient And/Or Family Member
90834	Psychotherapy, 45 Minutes With Patient And/Or Family Member
90837	Psychotherapy, 60 Minutes With Patient And/Or Family Member

- Effective for dates of service on or after July 1, 2011 the POS 23 (Emergency Room - Hospital) has been added to the CPT code 37195 (Thrombolysis, Cerebral, by Intravenous Infusion).

- Effective for dates of service on or after January 1, 2012 the POS 22 (Outpatient Hospital) has been added to the CPT code 51840 (Anterior Vesicourethropexy, Or Urethropexy (e.g., Marshall-Marchetti-Krantz,Burch); Simple).

- Effective for the dates of service on or after January 1, 2012 the following CPT codes can be reported with the POS 11 (Office):

Code	Description
22900	Excision, Tumor, Soft Tissue Of Abdominal Wall, Subfascial (e.g., Intramuscular); Less Than 5 cm
27339	Excision, Tumor, Soft Tissue Of Thigh Or Knee Area, Subfascial (e.g., Intramuscular); 5 cm Or Greater
21931	Excision, Tumor, Soft Tissue Of Back Or Flank, Subcutaneous; 3 cm Or Greater
21932	Excision, Tumor, Soft Tissue Of Back Or Flank, Subfascial (e.g., Intramuscular); Less Than 5 cm
21933	Excision, Tumor, Soft Tissue Of Back Or Flank, Subfascial (e.g., Intramuscular); 5 cm Or Greater
27328	Excision, Tumor, Soft Tissue Of Thigh Or Knee Area, Subfascial (e.g., Intramuscular); Less Than 5 cm

Revenue Code

- Effective for dates of service on or after July 1, 2012 the following revenue codes can be reported with the CPT code 83631 (Lactoferrin, Fecal; Quantitative):

  0300 Laboratory

  0301 Laboratory/Chemistry

  0309 Laboratory/Other

- Effective for dates of service on or after January 1, 2012 the revenue code 0323 (DX X-Ray/Artery) can be reported with the CPT code 75791 (Angiography, Arteriovenous Shunt (e.g., Dialysis Patient Fistula/Graft), Complete Evaluation Of Dialysis Access, Including Fluoroscopy, Image Documentation And Report (Includes Injections Of Contrast And All Necessary Imaging From The Arterial Anastomosis And Adjacent Artery Through Entire Venous Outflow Including The Inferior Or Superior Vena Cava), Radiological Supervision And Interpretation).

- Effective for dates of service January 1, 2012 the revenue code 0323 (DX X-Ray/Arter) has been added to the CPT code 75791 (Angiography, Arteriovenous Shunt (e.g., Dialysis Patient Fistula/ Graft), Complete Evaluation Of Dialysis Access, Including Fluoroscopy, Image Documentation And Report (Includes Injections Of Contrast And All Necessary Imaging From The Arterial Anastomosis And Adjacent Artery Through Entire Venous Outflow Including The Inferior Or Superior Vena Cava), Radiological Supervision And Interpretation).

G9170	Memory Functional Limitation, Discharge Status At Discharge From Therapy/End Of Reporting On
G9171	Voice Functional Limitation, Current Status At Time Of Initial Therapy Treatment/Episode Outset And Reporting Intervals
G9172	Voice Functional Limitation, Projected Goal Status At Initial Therapy Treatment/Outset And At Discharge From Therapy
G9173	Voice Functional Limitation, Discharge Status At Discharge From Therapy/End Of Reporting On Limitation
G9174	Other Speech Language Pathology Functional Limitation, Current Status At Time Of Initial Therapy Treatment/Episode Outset And Reporting Intervals
G9175	Other Speech Language Pathology Functional Limitation, Projected Goal Status At Initial Therapy Treatment/Outset And At Discharge From Therapy
G9176	Other Speech Language Pathology Functional Limitation, Discharge Status At Discharge From Therapy/End Of Reporting On Limitation
G9186	Motor Speech Functional Limitation, Projected Goal Status At Initial Therapy Treatment/Outset And At Discharge From Therapy

- Effective for dates of service on or after January 1, 2011 the modifier JW (Drug Amount Discarded/No) has been added to the HCPCS codes J9263 (Injection, Oxaliplatin, 0.5 mg) and J9041 (Injection, Bortezomib, 0.1 mg).

Provider Type (PT)

Effective for the dates of service on or after January 1, 2011 the PT 19 (Registered Nurse Practitioner) can report the CPT codes listed below with the modifier 80 (Assistant Surgeon).

Code	Description
24545	Open Treatment Of Humeral Supracondylar Or Transcondylar Fracture, Includes Internal Fixation, When Performed; Without Intercondylar Extension
27245	Treatment Of Intertrochanteric, Peritrochanteric, Or Subtrochanteric Femoral Fracture; With Intramedullary Implant, With Or Without Interlocking Screws And/Or Cerclage
27418	Anterior Tibial Tubercleplasty (e.g., Maquet Type Procedure)
27422	Reconstruction Of Dislocating Patella; With Extensor Realignment
27428	Ligamentous Reconstruction (Augmentation), Knee; Intra-Articular (Open)
27486	Revision Of Total Knee Arthroplasty, With Or Without Allograft; 1 Component
27487	Revision Of Total Knee Arthroplasty, With Or Without Allograft; Femoral And Entire Tibial Component
29880	Arthroscopy, Knee, Surgical; With Meniscectomy (Medial And Lateral, Including Any Meniscal Shaving) Including Debridement/Shaving Of Articular Cartilage (Chondroplasty), Same Or Separate Compartment(s), When Performed