Interim December 2022

Utah Department of Health & Human Services
Integrated Healthcare

MEDICAID INFORMATION BULLETIN

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

22-105 PRISM General Information MIBs

The following MIB articles include changes that are coming with the new PRISM components. A comprehensive library of PRISM articles can be found at https://medicaid.utah.gov/prism/.

PRISM PROVIDER TRAINING

New PRISM Provider Training

To help providers with upcoming PRISM system changes, a comprehensive training program is being developed. This program will include live training sessions and on-demand eLearning materials. Both live training sessions and eLearning courses will be available February 2023 and will cover topics such as managed care processes, prior authorization, member eligibility, claim adjudication, and claim payment. To access the eLearnings, visit https://medicaid.utah.gov/prism-provider-training. To request a training, please contact PRISMtraining@utah.gov.

BILLING AND CLAIM CHANGES

Paper Claims Will No Longer Be Accepted

In PRISM, all paper claims processed by Medicaid will discontinue. To allow adequate time for Medicaid to process the remaining backlog of paper claims in the queue prior to the PRISM go-live in April 2023, Medicaid fee for service paper claims submission will no longer be accepted beginning February 23, 2023. Paper claims received on or after February 23, 2023, will be securely destroyed and no longer returned to providers nor their vendors. Providers will have options to submit electronic Medicaid claims for processing.

If providers are contracted with a clearinghouse to submit claims and the clearinghouse drops the claims to paper, providers must work directly with the clearinghouse to fix the issues and comply with submitting electronic claims.

Requirement for Providers to Choose a Specialty in PRISM

The PRISM system requires that all enrolled Medicaid providers select a specialty designation. To ensure proper claims adjudication, providers MUST choose at least one specialty upon enrollment or revalidation as a Medicaid provider. To choose a specialty, providers must go to the business process wizard step 3 "Specialties" in PRISM. This can be accessed at: https://medicaid.utah.gov/become-medicaid-provider/.

As of June 1, 2022, approximately 2,800 enrolled Medicaid providers have not added their specialties and are at risk of having their claims denied.

If there are questions regarding this process, providers may contact the Provider Enrollment Team at 1-800-662-9651; select option 3 and then option 4. Providers may also email the Provider Enrollment Team at providerenroll@utah.gov.

Mental Health and Substance Use Disorder Providers: Reporting of Servicing/Rendering Provider

Mental health and substance use disorder providers that are not enrolled as a group practice should begin including the servicing/rendering provider on claims, if not already doing so. With implementation of the new PRISM claims system on April 3, 2023, fee for service claims will be denied if the servicing/rendering provider is not included on the claim. The requirement to include the servicing/rendering provider has always been in effect for group practices.

Ordering/Referring Provider Requirement in PRISM

In PRISM, providers are required to provide the ordering/referring provider NPI on the following claim types:

- Home health
- Durable medical equipment
- Hospice
- Lab and x-ray

The ordering/referring provider must have a valid enrollment with Medicaid. Although this requirement goes into effect April 2023, providers are encouraged to implement this change immediately.

Group Practice Billing in PRISM

Providers billing as group practices must be aware of a change impacting payments in PRISM.

In the current MMIS system, if a procedure code is payable to a group practice (provider type 45) but is not payable to the servicing/rendering provider's provider type, the claim will sometimes pay.

In the PRISM system, editing for whether a code is payable to a provider will always be performed at the servicing/rendering provider level. Therefore, group practices may see a reduction of claims paid if they are billing for providers who are not authorized to perform the service based on Medicaid guidelines.

Provider Administered Drugs in PRISM

Claims for covered provider administered drugs adjudicated in the PRISM system are reimbursed under the same reimbursement logic for covered outpatient drugs billed through the pharmacy point of sale system, with the exception that no professional dispensing fee will be paid. Please refer to the Utah Medicaid State Plan 4.19-B Methods and Standards for Establishing Payment Rates - Other Types of Care, Prescribed Drugs for more information. "Effective for claims adjudicated on or after April 1, 2017, except as otherwise stated in this section and in addition to a reasonable professional dispensing fee as applicable, reimbursement for brand and generic covered outpatient drugs will be as follows: The lesser of the Utah Estimated Acquisition Cost

(UEAC), Federal Upper Limit, National Average Drug Acquisition Cost (NADAC), Utah Maximum Allowable Cost (UMAC), or the Ingredient Cost Submitted."

Prior Authorization Auto-Match Discontinued in PRISM

Providers need to be aware of a variance in how the PRISM system will process claims requiring prior authorization (PA). In the current MMIS system, a provider can submit a claim without the PA; and if a PA is already created, the system will auto match and allow the claim to be processed.

In PRISM, the process is different because the claim requires the PA information to be attached for the claim to process.

- If a provider submits a claim without a PA, the claim will be denied.
- If a provider submits a claim with a PA, the claim detail must match the information on the PA, or the claim will be denied. Examples of the claim detail include:
    - Member ID
    - Procedure Code
    - Diagnosis Code
    - DRG Code
    - Servicing Provider Number
    - Dates of Service

Providers must check the information carefully to avoid claim processing delays and payment denials.

Performing Claim Adjustment/Void

The process for adjustments and voids is changing with the PRISM system. Providers are encouraged to perform their own claim adjustments and voids.

In the current MMIS system, when an adjustment is received through submission of an electronic or paper claim, the system creates both a credit and debit claim.

- The credit claim takes back any payment made on the original claim. The debit claim is processed through as a new claim. This is called an "adjustment."
- If a provider wants to remove or take back a claim, a void must be submitted on the original claim. The system creates a credit claim only and the result is a straight take back of the original payment. This is called a "void."

In PRISM, a provider can submit an "adjustment" or "void" to a paid claim online. Providers can also use the current electronic claims adjustment process.

- An adjustment can only be done on a paid claim. When the adjustment is processed, it creates a debit and credit claim. If the new debit claim is denied, then the system does not process the credit claim to take back the payment. There will be no adjustment to the original claim and the status will remain as "Paid". A remittance advice (RA) is generated only for the denied debit claim.
- If the provider did not intend or expect the claim to be denied, an adjustment can be performed again after fixing the data on the claim.
- If the data on the claim is accurate and the status is denied, a void must be performed on the original claim that is being adjusted to have the funds recouped. A void can only be made on a paid claim and will be a straight take back of the original payment.

Credit Balance Changes

In the current MMIS system, when a provider adjusts and voids a claim and the amount paid is less than the amount paid on the original claim, MMIS places that provider in credit balance. The credit balance is automatically satisfied during the same or a future payment cycle by reducing the amount paid on other claims.

PRISM will function differently. PRISM will calculate the amount owed to the state in similar cases; however, the credit balance will not automatically be offset for a period of two weeks. This will allow providers to remit the difference to Medicaid if they do not want the credit balance to be offset against current or future claims.

Overpayments and PRISM Go-Live

As Medicaid transitions to PRISM, it is essential that providers pay any overpayments due to Medicaid prior to April 2023. Any credit balance still owed to the State will be adjusted off as a gross adjustment to clear the provider's account in the old MMIS system. Another gross adjustment will be made in PRISM to add the balance owed back into the system. If a provider is still in credit balance in April 2023, providers need to watch the remittance advice for reporting of these gross adjustments.

Member Cost Sharing and Copays

Medicaid requires certain members to pay for services or benefits, also known as cost sharing. Cost sharing amounts may include items such as premiums, deductibles, coinsurance, or copayments. The process of applying a cost share to the payment of a claim is changing with PRISM.

- In the current MMIS system, if a member is responsible for a cost share, it is applied based on the date of service and is reported on the remittance advice.
- In PRISM, a member's cost sharing is applied quarterly. Copays are applied to claims based on the member's cost share that is in place at the time of the claims adjudication. Copays are not applied based on the date of service but based on the member's copay requirements at the time of adjudication. The copay will be reported on the remittance advice. Before collecting a copayment at the time of service, providers must confirm the service requires a copayment and that the member has a copayment requirement. Providers must submit the claim as soon as possible so that the copayment requirements do not change between the date of service and the claim adjudication date. Providers are responsible for returning any collected copayments that are not applied to the claim at the time of adjudication.

Reporting Discharge Dates on Claims from Nursing Facilities, ICF/IDs, and Swing Beds

The process for determining day of discharge on claims will be changing in PRISM for nursing facilities, ICF/IDs, and swing beds.

- Currently, the day of discharge is determined by the discharge date on the claim submitted by the facility.
- In PRISM, Medicaid will utilize a Patient Status Code to determine if the resident has been discharged. Facilities will need to correctly identify the Patient Status Code on the claim and include a discharge date.
- As a reminder, Medicaid reimburses nursing facilities, ICF/IDs, and swing beds for day of admission, but does not reimburse for day of discharge.

Readmission after Hospitalization

- When a Medicaid resident is admitted to a hospital and returns to the original nursing facility no later than three consecutive days after the date of discharge from the nursing facility, do not report a discharge date on the claim. Report the hospital days as non-covered days using value code 81.
- If the readmission occurs four or more days after the date of discharge from the nursing facility, the facility must report a discharge date on their claims.

340B Billing and UD Modifier Discontinuation

Effective April 2023, claims billed to Medicaid under the 340B program will no longer utilize the UD modifier. Claims shall be submitted using modifiers TB and/or JG.

Trading Partner Association

Beginning April 2023, the mode of claims submission, which is part of the enrollment validation process in PRISM, will be utilized to determine whether a provider/billing agent/clearinghouse may submit claims through Direct Data Entry (DDE) or submit HIPAA transactions by Web Batch or UHIN. There are five (5) transactions available to exchange with Medicaid beginning April 2023:

- 837 (Claims)
- 270/271 (Eligibility)
- 276/277 (Claims Status)
- 278 (Prior Authorization)
- 835 (Remittance Advice)

These transactions may have multiple Trading Partner Numbers (TPNs), depending on the provider's business requirements with the exception of the transaction 835 (Remittance Advice) which may only be set for one trading partner number at a time.

All billing providers must complete their PRISM EDI enrollment in the business process wizard steps 8, 9, and 13 to ensure claims are accepted into the PRISM system for adjudication. Providers must mark the appropriate mode of submission for claims as well as any other EDI transactions they plan to submit. If PRISM is not updated with accurate trading partner information, the HIPAA transaction(s) that are not correctly associated will be rejected by the PRISM system. The

rejection(s) will be returned to the clearinghouse/billing agent or agency that owns the TPN that originally sent the claim.

MEDICAID ELIGIBILITY

Reminder to Check Medicaid Eligibility

Providers are encouraged to check Medicaid eligibility for members in the actual month of service or no earlier than 10 days prior to the first of the next month. Medicaid eligibility for a future month is not guaranteed if providers check eligibility earlier than 10 days prior to the end of the month. This is a friendly reminder to providers and not a change to the current process.

CHANGES TO PRIOR AUTHORIZATION

Changes to Medical Prior Authorization

Effective April 2023, medical prior authorization (PA) requests can be submitted through the PRISM system. Pharmacy PAs will not be processed through PRISM, including pharmacy-related HCPCS codes requiring PA.

PRISM eLearnings, including how to submit a medical PA request, will be available for providers at: https://medicaid.utah.gov/prism-provider-training/.

Hospice Admission Record

Effective April 2023, hospice care agencies are required to enter a Hospice Admission Record through the PRISM system for each Medicaid member admitted to the hospice agency. This will change the Program Enrollment Type (PET) in PRISM for the Medicaid member after being reviewed by a Medicaid Prior Authorization nurse reviewer. This applies to all hospice admissions and recertifications, including members who are receiving their hospice services through Medicare, as well as members only receiving room and board.

Providers will no longer have to request specific HCPCS codes with the exception of Service Intensity Add-on (SIA). An approved admission record allows for a provider to bill for hospice services.

Entering a Hospice Admission Record is distinct and different from requesting a prior authorization for other services, such as home health or personal care. All hospice agencies are strongly encouraged to attend the Medicaid Provider PRISM Trainings and review the PRISM eLearnings available regarding Hospice Admission Records. Beginning February 2023, eLearnings will be available at https://medicaid.utah.gov/prism-provider-training. More information on additional Medicaid Provider PRISM Trainings will also be available in February 2023 at https://medicaid.utah.gov/prism/.

Prior Authorizations for Long Term Acute Care in PRISM

Effective April 2023, Long Term Acute Care (LTAC) Hospitals will be required to report claims with a prior authorization (PA) tracking number in the PRISM system. The tracking number will populate once providers submit a PA request through PRISM.

For members who have been admitted prior to April 2023, and whose admissions continue past this effective date, a correspondence from the Medicaid Prior Authorization team will notify providers of the members' PA tracking numbers.

Prior Authorization for Sterilization

Effective April 2023, Medicaid will no longer require prior authorization for sterilization. For claims processing, the sterilization consent form must be submitted by fax to (801) 237-0745.

IVR AND PROVIDER PORTAL

Clearinghouse/Billing Agent Access to IVR and Provider Portal

Clearinghouse/billing agents can inquire about member eligibility and benefit information by accessing the Medicaid Interactive Voice Response (IVR) phone system or the PRISM Provider Portal. This includes information regarding managed care organizations, other insurance, provider restrictions, and copay requirements.

To access these systems, the clearinghouse/billing agents need to be enrolled in PRISM, have a seven-digit PRISM ID number, and be associated with a provider. Login information is based on the system that is being accessed.

IVR

The clearinghouse/billing agents must have an active enrollment with Medicaid on the date of inquiry. When utilizing the Medicaid (IVR) system, the clearinghouse/billing agents should utilize their Medicaid Provider ID for access. Upon validation, the Provider Main Menu options are provided to access member eligibility and benefit information.

PRISM Provider Portal

When utilizing the PRISM Provider Portal for a member eligibility inquiry, clearinghouse/billing agents must utilize their domain for access. When utilizing the PRISM Provider Portal for claim status inquiry, clearinghouse/billing agents must obtain access from the provider to the provider's domain. They must log into the provider portal using the provider's domain. Claims access will be based on the profile given by the provider.

22-106 Dental Hygienists – Billing Independently

Beginning January 1, 2023, the following policy regarding dental hygienists performing authorized dental services, independently in a public health setting, under a written agreement or general supervision of a dentist, as detailed in Utah Administrative Code 58-69-801 – *Dentist and Dental Hygienist Practice Act*, will be implemented. Due to the change in Medicaid's claims processing system, the following services performed by dental hygienists (provider type 169) from January 1, 2023, through April 2, 2023, in order to be reimbursed, must be reported after April 3, 2023:

D0190 – *Screening of a patient; A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis.*
D0191 - *Assessment of a patient; A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.*
D0701 – *Panoramic radiographic image - image capture only*
D0707 – *Intraoral - periapical radiographic image*
D0708 – *Intraoral - bitewing radiographic image - image capture only*
D0709 – *Intraoral - complete series of radiographic images - image capture only*
D1110 - *Prophylaxis - adult; Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.*

D1120 - *Prophylaxis - child; Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.*
D1206 – *Topical application of fluoride varnish*
D1351 - *Sealant - per tooth*
D4341 – *Periodontal scaling and root planing - four or more teeth per quadrant*
D4342 – *Periodontal scaling and root planing - one to three teeth per quadrant*

The following additional CDT code will also be opened for coverage for dental providers (provider types 7 – Maxillofacial Surgery, 28 – Dental, and 115 – Group Practice) beginning January 1, 2023, for the interpretation of radiographic images performed by a dental hygienist in a public health setting:

D0391 - *Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report*

22-107 Prefabricated Stainless Steel Crown Rates

On July 1, 2022, Medicaid increased rates for porcelain crowns to $501.12. As part of this update, the rates for prefabricated stainless steel crowns were changed in error. To address this issue, Medicaid has adjusted the rates for the prefabricated stainless steel crowns back to the established rates prior to the July 1, 2022, rate adjustment. The rate change will be implemented December 1, 2022.

This change will affect the following CDT codes:

D2930 - *Prefabricated stainless steel crown - primary tooth*
D2931 - *Prefabricated stainless steel crown - permanent tooth*

22-108 Laboratory Services Amendment

The Physicians Services Manual, Chapter 8-12.7 *Billing* has been updated to add additional clarification regarding the reporting and billing of laboratory services. The manual now states:

Providers must submit laboratory claims on a CMS-1500 form with the CLIA certification number appended. Failure to submit a CMS-1500 claim form with the CLIA certification number will result in denial of the service. Facilities billing laboratory services on a UB-04 form are not required to append their CLIA certification number. In addition, laboratories must only submit laboratory codes whose level of complexity is permitted within their level of certification. Submission of a laboratory code that a facility is not certified to perform will result in the denial of the service.

22-109 Qualifying Clinical Trials

To help providers and members better understand Medicaid policy surrounding qualifying clinical trials, an FAQ has been created titled *Qualifying Clinical Trials and Medicaid*, which is now available for reference on the Medicaid website at the Health Care Providers, Prior Authorization, or Provider Resources and Information links.

The Section I: General Information Provider Manual, Chapter 9-3.3.1 *Qualifying Clinical Trials* has been updated to include the following information:

4. Providers and the principal investigator (entity conducting the qualifying clinical trial) must validate the appropriateness of the trial by using the National Clinical Trial Number found at https://clinicaltrials.gov/. The National Clinical Trial Number must be placed on the Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form. This form is found on the Medicaid.gov website page Medicaid SPA Processing Tools for States under the "Benefits and Coverage SPA Tools" section. Coverage determinations are not restricted to the location of the trial.
5. Not all services that are a part of the clinical trial may require prior authorization. However, when they do, providers must include the completed Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form along with the completed Prior Authorization Request Form. Fax both forms to (801) 536-0162, or email both completed forms to fax_allotherauth_prior@utah.gov.
6. Please review the Qualifying Clinical Trials and Medicaid FAQ for more information regarding qualifying clinical trials.

22-110 Code Updates

The content for MIB Article 22-102 *Code Updates* regarding code G0315 has been retracted from publication in the November 2022 MIB. This is a closed code at present and is under review.

The following codes are updated to allow for provider types (PT) 51 - Public Health Department Clinic to bill for these services:

H1000- *Prenatal care, at-risk assessment*
H1001- *Prenatal care, at-risk enhanced service; antepartum management*
H1004- *Prenatal care, at-risk enhanced; follow-up home visit*

The following laboratory service code is covered, effective July 1, 2022:

87798- *Infectious agent detection by nucleic acid [DNA or RNA], not otherwise specified; amplified probe technique, each organism*

22-111 Refugee Medicaid

In accordance with 45 CFR 400.105 - Refugee Medicaid, Medicaid has added *Chapter 8-2.12 Refugee Medicaid* to *Chapter 8-2 Medicaid Programs* of the Section I: General Information Provider Manual to clarify the services provided to refugees in Utah.

22-112 Self-Administered Hormonal Contraceptives

Beginning January 1, 2023, Utah Medicaid will reimburse $20.00 for an annual consultation fee for services provided by pharmacists who furnish self-administered hormonal contraceptives by either prescription or by standing order in accordance with Utah Administrative Code R156-17b-621b. This reimbursement will be provided for pharmacy point of sale claims that include one of the following diagnosis codes when submitted with a claim for self-administered hormonal contraceptive:

Z30.011 *Encounter for initial prescription of contraceptive pills*

Z30.015 *Encounter for initial prescription of vaginal ring hormonal contraceptive*

Z30.016 *Encounter for initial prescription of transdermal patch hormonal contraceptive device*

22-113 Brand Pristiq Preferred on PDL

Beginning October 1, 2022, Utah Medicaid included brand Pristiq as a preferred medication in the Antidepressants – SSRI/SNRI Preferred Drug List (PDL) Category. More information can be found at https://medicaid.utah.gov/pharmacy/preferred-drug-list/.