UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

April 2016

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16-32 PRISM's Release 3 Go-Live: July 1, 2016

The Provider Reimbursement Information System for Medicaid's (PRISM) Release 3 Go-Live is scheduled for July 1, 2016. Release 3 will focus on the Provider Enrollment component of the system, providing the ability for providers to complete online enrollment and changes.

As part of Release 3, we will ask existing providers to validate their information in PRISM. Their current enrollment record will be converted to PRISM in order to ease the transition between the MMIS and PRISM, as well as eliminate the need for providers to complete a new application. Providers will receive a letter specifying the provider portal URL web address with instructions on how to log in to PRISM to validate and modify information. The first steps providers will need to take once they receive their letter are:

1. Access the Converted Provider URL that is in the letter. (The first letters will be mailed in July 2016.)
2. Use the login information from the letter to log in through the initial PRISM access screen.

Subsequent steps to complete validation of provider information will be in the letter. The timeframe for validation in PRISM will also be included in the letter. Online training will be available to assist with navigating the steps, along with contact information in case providers encounter problems during the process.

Providers can prepare for Release 3 by doing the following:

1. Set up a Utah ID; instructions for doing so are found on Medicaid's Eligibility link at https://medicaid.utah.gov/eligibility.
2. Check your web browsers. The provider portal will be accessible via certain web browser versions. In order to ensure system security, the following are minimum web browser and OS requirements for PRISM to work adequately:
    - Chrome 29.0+ (Windows or Linux)
    - Firefox 23.0+ (Windows or Linux)
    - IE 9.0+ (Windows) – **Please note: IE 8.0 will not be supported**
    - **Please note: Safari will not be supported**

    All browsers must support:
    - HTML 4.01+
    - Enable Cookies
    - Enable JavaScript

As a reminder, provider training for all components of PRISM's Release 3 will be available through the Medicaid website in July 2016. Please bookmark the PRISM Training Home Page for providers, https://medicaid.utah.gov/prism-provider-training, for training specifics that will be added as the Release 3 Go-Live date nears.

We will continue to share updated information through future MIB articles, the Medicaid website, and information sent by email from Medicaid staff. Updated information can be found on the Medicaid website under the Administration & Publications tab by selecting "Medicaid Information System (PRISM)" or by clicking here. In addition, providers can email prism@utah.gov with PRISM questions.

16-33 Code Coverage

The following codes are effective January 1, 2016:

Discontinued

G0431 Drug screen, qualitative, multiple classes by high complexity test method
G0434 Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test

Covered

G0477 Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
G0478 Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
G0479 Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service
G0480 Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481 Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolites(s) if performed

Covered with Manual Review

G0482 Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483 Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or

quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

The following codes are effective April 1, 2016:

Non-Covered

C1782 Morcellator

Codes Removed from Prior Authorization

22328 Open treatment and/or reduction of vertebral fracture(s) or dislocation(s), posterior approach, each additional fractured vertebra or dislocated segment
44211 Laparoscopy, surgical; colectomy, total, abdominal with proctectomy with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed

16-34 Correct Coding vs. Unbundling Codes

According to CMS and Correct Coding Initiative (CCI), medical and surgical procedures should be reported with the CPT or Healthcare Common Procedure Coding System (HCPCS) codes that most comprehensively describe the services performed.

Unbundling is defined as billing separate procedure codes for a group of procedures that are covered by a single comprehensive code. An example of unbundling would be fragmenting one service into component parts and coding each component as if it were a separate service. Unbundling rules apply to all providers and facilities.

16-35 Dental Policy Updates

The *Utah Medicaid Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual* has been updated to reflect the changes noted in this article. To review the manual updates and for complete criteria and requirements, refer to the manual at https://medicaid.utah.gov and the Utah Medicaid Coverage and Reimbursement Code Lookup Tool at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

Code Closed

D2391 Resin-based composite, one surface, posterior

Diagnostic

EPSDT eligible members may have four periodic oral evaluations (D0120), or a one-time per provider comprehensive (D0150) and three periodic oral evaluations (D0120) per calendar year.

D0210 Intraoral complete series

- Allowed one every two years
- Allowed for ages 6 and older
- If more than 12 periapical (D0220, D0230) and more than two bitewing (D0270, D0272, D0274) radiographs are taken on the same date of service, it is considered a complete series (D0210)
- A panoramic x-ray (D0330) with more than two or four bitewing and two periapical radiographs is considered a complete series (D0210)
- No additional periapical or bitewing radiographs will be reimbursed with a complete series

D0270 Bitewing, single radiographic image. Allowed two times per calendar year.
D0272 Bitewing, two radiographic images. Allowed two times per calendar year.
D0274 Bitewing, four radiographic images. Allowed two times per calendar year.
D0330 Panoramic radiographic image. Allowed one every two years.

Preventative

D1510 Space maintainer, fixed, unilateral. Allowed one every three years.
D1515 Space maintainer, fixed, bilateral. Allowed one every three years.
D1520 Space maintainer, removable, unilateral. Allowed one every three years.
D1525 Space maintainer, removable, bilateral. Allowed one every three years.
D1550 Re-cement or re-bond space maintainer. Allowed one every six months, global if within six months of applying space maintainer.

Restorative

The following codes are allowed one every two years, per tooth, per surface. If more than one filling is applied on the same tooth/same date of service, use the appropriate restorative code for 2, 3, or 4 or more surfaces.

D2140 Amalgam, one surface, primary or permanent
D2150 Amalgam, two surfaces, primary or permanent
D2160 Amalgam, three surfaces, primary or permanent
D2161 Amalgam, four or more surfaces, primary or permanent
D2330 Resin based composite, one surface, anterior
D2331 Resin based composite, two surfaces, anterior
D2332 Resin based composite, three surfaces, anterior
D2335 Resin based composite, four or more surfaces, anterior

Additional restorative codes and coverage:
D2751 Crown, porcelain fused to predominantly base metal. Allowed one every five years, per tooth.
D2920 Re-cement or re-bond crown. Allowed one every six months, global if within six months of crown placement.
D2930 Prefabricated stainless steel crown, primary tooth. Allowed one every two years, per tooth.
D2931 Prefabricated stainless steel crown, permanent tooth. Allowed one every two years, per tooth.

Prosthodontics

D5110 Complete denture, maxillary. Allowed one every five years.
D5120 Complete denture, mandibular. Allowed one every five years.
D5130 Immediate denture, maxillary. Allowed one per lifetime.
D5140 Immediate denture, mandibular. Allowed one per lifetime.
D5211 Maxillary partial denture, resin base. Allowed one every five years.
D5212 Mandibular partial denture, resin base. Allowed one every five years.
D5213 Maxillary partial denture, cast metal framework with resin denture bases. Allowed one every five years.
D5214 Mandibular partial denture, cast metal framework with resin denture bases. Allowed one every five years.

16-36 Transition to InterQual Criteria for Wheelchair and Wheelchair Accessories

Effective April 1, 2016, many wheelchair and wheelchair accessory codes, previously reviewed using custom Department criteria from the Coverage and Reimbursement Lookup Tool notes (http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php), will be reviewed using InterQual criteria.

Utah Medicaid conducts medical necessity and appropriateness reviews utilizing McKesson's InterQual or Utah Department of Health criteria with precedence given to Department criteria. If either is silent, then Utah Medicaid's utilization review process is followed and requests are evaluated by a Medicaid staff physician or the appropriate Utah Medicaid Utilization Review Committee to determine the medical appropriateness of the services requested.

To access general prior authorization requirements at https://medicaid.utah.gov, select Health Care Providers > Prior Authorization > Medicaid Criteria. For general program policy, refer to the *Utah Medicaid Medical Supplies Provider Manual*.

For a copy of criteria that is not on the website, call the Prior Authorization Unit at (801) 538-6155, option 3, option 3, and choose the appropriate program, or email medicaidcriteria@utah.gov. Include the CPT/HCPCS codes; allow 24 hours for a response. Do not send any protected health information (PHI) through unsecured email.

For additional questions, contact adlucero@utah.gov.

16-37 Medical Supplies Provider Manual Update – Incontinence Products

Providers are no longer required to use the "U" modifier (U2 through U9) when submitting claims for incontinence products for members on an HCBS waiver program. All quantity limits remain the same.

The *Utah Medicaid Medical Supplies Provider Manual* has been updated and is available at https://medicaid.utah.gov.

16-38 Medical Supplies Update

E0277 Powered pressure-reducing air mattress as a rental

The Coverage and Reimbursement Lookup Tool was updated to show reimbursement at a daily rate. Providers should bill the number of units based on the number of days in the billing period. (One unit equals one day).

The Coverage and Reimbursement Lookup Tool is available on the Utah Medicaid website at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

16-39 Podiatry Services Update

The following code has been opened to podiatrists:

27685 Lengthening/shortening tendon, leg or ankle; single tendon

16-40 Hospital Services Manual Rehabilitation Services Attachment Update

The *Utah Medicaid Hospital Services Provider Manual* attachment, *Rehabilitation Services*, has undergone a complete revision, was reformatted, and renamed to *Inpatient Intensive Physical Rehabilitation Services*. This revision specifies the requirements and criteria for inpatient intensive physical rehabilitation services available for clients who meet the level of care criteria for admission to a distinct part rehabilitation unit of an acute-care general hospital or licensed rehabilitation specialty hospital.

The revised attachment is available on the Utah Medicaid website at https://medicaid.utah.gov.

16-41 Documentation of Medication Administration

In a recent review of submitted medical records, it was noted that medication administration was not consistently documented in the member's record. The administration of medications is an important part of the plan of care and should be consistently documented.

Evaluation and Management Documentation Guidelines, developed jointly by the American Medical Association and the Centers for Medicare and Medicaid Services (CMS), states that physicians should include documentation that contains the plan of care, as well as progress and response to changes in treatment.

Refer to the *Utah Medicaid Section I: General Information Provider Manual*, Documentation Requirements, for further information on documentation requirements.

16-42 Pharmacy Reimbursement: New Federal Upper Limit

In accordance with the new requirements of 42 CFR 447.512 and 42 CFR 447.514, Utah Medicaid is required to begin using the new Federal Upper Limits published by the Centers for Medicare and Medicaid Services on May 1, 2016.

Effective May 1, 2016, Utah Medicaid will pay the lesser of the Federal Upper Limit, Utah Maximum Allowable Cost, Estimated Acquisition Cost, or Submitted Charges.

The *Utah Medicaid Pharmacy Services Provider Manual* has been updated to reflect this and other minimal changes. The updated manual is available on the Utah Medicaid website at https://medicaid.utah.gov.

16-43 Drug Utilization Review (DUR) Board Activity

Prior authorization (PA) criteria have been place upon the following agents:

- PCSK9 inhibitors
- Lidocaine preparations
- Movantic

For more information on the Drug Utilization Review (DUR) Board activity, refer to the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/prior-authorization.

16-44 Hospital Services – End Stage Renal Disease (Dialysis Services)

The *Utah Medicaid Provider Manual, Hospital Services – End Stage Renal Disease (Section 4)*, addressing dialysis services has been updated. Providers are reminded that Utah Medicaid pays a composite rate per dialysis session that includes payment for all training services, evaluations, laboratory tests, items, supplies, medications, and equipment necessary to perform dialysis.

Providers can access the revised provider manual at https://medicaid.utah.gov.

16-45 Non-Traditional Medicaid (NTM) Provider Manual Updated

The *Utah Medicaid Provider Manual for the Non-Traditional Medicaid (NTM) Plan* has been updated for April 1, 2016. Providers can access the revised provider manual at https://medicaid.utah.gov.

The NTM manual has been simplified; only the limitations and reduced benefits under NTM are described. If the benefits are the same for both NTM and Traditional Medicaid, this is stated under each type of service listed in the NTM manual. If there is a limitation or reduced benefit for NTM this is described under each type of service. In both instances, providers are referred to the appropriate provider manual.

16-46 Primary Care Network (PCN) Provider Manual Updated

The *Utah Medicaid Provider Manual for the Primary Care Network* has been updated for April 1, 2016. Providers can access the revised provider manual at https://medicaid.utah.gov.

Chapter 2-8, Preventive Services and Health Education; Chapter 2-10, Family Planning Services; and Chapter 2-12, Dental Services, have been revised to accurately reflect coverage under the PCN program. The changes from the prior publication of the PCN manual are as follows:

- Under Preventive Services and Health Education, Nutrition Counseling and Tobacco Cessation Training have been added because they had been inadvertently left out.
- Under Family Planning Services, it has been clarified that birth control patches, surgical and non-surgical sterilizations are not covered under the PCN program.
- Under Dental Services, D1206 (topical application of fluoride varnish) has been deleted because it is covered only for children; and D2140 (amalgam-one surface) has been added because it had been inadvertently left out.

16-47 New Choices Waiver Provider Manual Updated

The *New Choices Waiver Provider Manual* has been updated with an effective date of April 1, 2016. The updates clarify the following policies:

- The majority of enrollment capacity will be reserved for individuals applying from hospitals and nursing facilities.
- Waiver case management services must be provided free from conflict in accordance with federal regulations.
- All new providers or new owners of provider agencies that have had changes in ownership must complete the New Choices Waiver New Provider Training.

If you have any questions, contact Trecia Hansen at (801) 538-6861 or Treciah@utah.gov.

Providers can access the revised provider manual at https://medicaid.utah.gov.

16-48 Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual Update

Effective April 1, 2016, the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated.

- In Chapter 2-11, under the 'Limits' section, requirements for intensive psychosocial rehabilitative services groups have been updated.
- In Chapters 3-2 and 3-3, a correction has been made to #4 of the 'Who' sections.

Providers can access the revised provider manual at https://medicaid.utah.gov.

16-49 Inpatient Hospital Psychiatric Admissions for Individuals with Hospital Presumptive Medicaid Eligibility

Presumptive Medicaid eligibility provides temporary Medicaid coverage for qualified low income individuals prior to establishing eligibility for ongoing Medicaid.

For individuals with hospital presumptive eligibility, inpatient psychiatric admissions may be reimbursed by Medicaid when care is provided in a psychiatric unit of a general hospital.

However, federal law limits when Medicaid payment can be made to psychiatric specialty hospitals. Medicaid payment may only be made to a psychiatric hospital if the individual is under age 21, or in certain circumstances,

under age 22, or age 65 or older. Therefore, Medicaid payment is not available to psychiatric hospitals for individuals between age 22 and 64.

For individuals under age 21 with hospital presumptive Medicaid eligibility, prior authorization is required and may be granted if the following is documented in the medical record:

- an emergency admission is required for active treatment;
- the services required are of an intensity that can only be provided in an inpatient hospital setting; and
- that the referring emergency department was unable to locate a placement in a psychiatric unit of a general hospital.

Psychiatric hospitals must fax the following information for the prior authorization review:

- Current prior authorization request form;
- Documentation that alternative placement in a psychiatric unit of a general hospital was not available; and
- Documentation that supports the emergency admission (e.g. psychiatric admission evaluation, admission history and physical, and psychiatric discharge summary and lab work as applicable, etc.).

This information must be faxed to Medicaid's Bureau of Authorization and Community Based Services Prior Authorization Unit within 24 hours of admission. For admissions that occur after hours, on weekends or holidays, the information must be faxed during the next business day. Fax information to: (801) 536-0490.

16-50 Personal Care Services Manual Updates

The *Utah Medicaid Personal Care Services Provider Manual* has been revised to include updates and policy clarification.

Sections regarding *Employment-Related Personal Care Services* have been amended to include information to describe when participants may be residing in a facility or participating on a 1915 (c) waiver program.

In addition, clarification has been provided on when it may be appropriate to suspend or disenroll a participant, along with details surrounding the appropriate use of transportation to visit banks/financial institutions to support employment activities.

16-51 1915(C) HCBS Physical Disabilities Waiver Renewal

The Home and Community-Based Services Physical Disabilities Waiver Program has a current expiration date of June 30, 2016. The State submitted a renewal application for this waiver to CMS by the March 31, 2016, deadline.

A copy of the final draft and a summary of changes may be found at http://health.utah.gov/ltc.

16-52 New Professional, Outpatient, and Dental Claims Editing Modules Released on April 1, 2016

Beginning April 1, 2016, Utah Medicaid, along with Verisk Health, will implement improved technology in software editing to assess and evaluate the coding of professional, outpatient, and dental claims. The new editing modules are intended to reduce and prevent fraud, waste, and abuse, as well as accurately track over-utilization of codes billed to Utah Medicaid.

Professional and Outpatient Claims Editing Modules

Based upon guidelines from authorities such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), Utah State-specific Medicaid policies, and other specialty societies, professional and outpatient claims will be processed through a clinically robust and technically advanced claims editing software program.

Utah Medicaid's current claims editing system contains many customized edits, which over time have become NCCI edits. These edits will be carried over and programmed into the Verisk Health editing software program, along with other correct coding initiatives and state policies.

Medical billers and providers should be aware that claims processed on or after April 1, 2016, may adjudicate with new edits and messages in accordance with these standards, regardless if the date of service is before April 1, 2016.

Dental Claims Editing Module

Utah Medicaid will be enforcing industry standard rules and guidelines, as published and defined in CDT, and providing more consistent and logical dental claims processing. Payment of dental claims is based upon Utah Medicaid policy, CDT coding, and common reimbursement methodologies and guidelines.

The improved software editing system will identify unbundled, fragmented, and global dental-related services and correctly deny payment.

Dental billers and providers should be aware that claims processed on or after April 1, 2016, may adjudicate with new edits and messages in accordance with these standards, regardless if the date of service is before April 1, 2016.

We are aware that these improvements may impact claims payments for providers on and after April 1, 2016. For questions regarding your claims, claims processing, or the new claims editing modules, please call Medicaid Customer Service at (801) 538-6155, or 1-800-662-9651, option 3, option 2.