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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

16-01 MyBenefits: Benefit Lookup Tool for Medicaid Members

The Division recently launched a new website called 'MyBenefits' (mybenefits.utah.gov). This website allows Medicaid members to view information about their eligibility status, health or dental plans, and co-pays online.

The website displays enrollment information for Medicaid, the Children's Health Insurance Program (CHIP), Primary Care Network (PCN), Utah's Premium Partnership for Health Insurance (UPP), and other Medicaid waiver program enrollees.

MyBenefits will also display each member's Form 1095-B online. This is an IRS document required for the 2015 federal tax season listing all individuals who have health coverage that qualified as "minimum essential coverage" in 2015.

Members can now access information about their case and benefits anytime! Please call the Medicaid Member Information Line at 1-844-238-3091 with questions or concerns.

16-02 Implementation of Fingerprint-Based Background Checks

Effective January 1, 2016, Provider Enrollment has implemented a new provider enrollment screening process for providers classified as "high risk". These new requirements are mandated by regulations that are published by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) and published in the State Medicaid Director's Letter #15-002.

"Section 6401 (b) of the Affordable Care Act amended section 1902 of the Act to require states to comply with the procedures established by the Secretary for screening providers and suppliers. CMS implemented these requirements with federal regulations at 42 CFR Part 455 subpart E. 42 CFR 455.410 (a) provides that a state Medicaid agency must require all enrolled providers to be screened according to the provisions of Part 455 subpart E. The state Medicaid agency is required to screen all applications, including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation, based on a categorical risk level or "limited", "moderate", or "high". Under 42 CFR 455.434, a state Medicaid agency must establish categorical risk levels for providers and provider categories who pose a financial risk of fraud, waste or abuse to the Medicaid program. When the agency determines that a provider's categorical risk level is "high", or when the agency is otherwise required to do so under State law, the agency must require providers to consent to criminal background checks, including fingerprinting. Under 42 CFR 455.434 (b), the requirement to submit fingerprints applies to both the "high" risk provider and any person with a 5 percent or more direct or indirect ownership interest in the provider, as those terms are defined in 455.101."

The instructions for "high risk" providers are available at <https://medicaid.utah.gov/become-medicaid-provider>.

Unless otherwise noted, all changes take effect on January 1, 2016

16-03 Fee-For-Service Network

As a reminder, State-paid Medicaid is now referred to as Fee-For-Service Network. Providers should note that the Eligibility Lookup Tool currently displays 'FFS Network', instead of 'Any Medicaid Provider'.

For questions or concerns, please call (801) 538-6155 or 1-800-662-9651, option 3, option 2.

16-04 Code Coverage

ICD Diagnosis Codes:

Covered ICD-9-CM Codes

89.19, effective March 12, 2015

43.82, effective January 1, 2015

Closed ICD-10-CM Codes

Effective October 1, 2015, ICD-10 codes D17.0, D17.1, D17.20, D17.21, D17.22, D17.23, D17.24, D17.30, D17.39, D17.4, D17.5, D17.6, D17.71, D17.72, D17.79, and D17.9, benign lipomas, were closed. Closure of these codes supports the Physician Manual policy which specifies benign lesions such as lipomas are not covered.

CPT and HCPCS Codes:

Manual Review Required

61782 Stereotactic computer-assisted (navigational) procedure; cranial, extradural. Limited to procedures requiring precision. Not covered for sinus surgery.

Non-Covered

94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination. A minor procedure considered part of the vital signs and included within the E&M visit.

Effective November 1, 2015

S0315 Disease management program; initial assessment and initiation of the program

S9810 Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour

These codes which were previously used for services rendered under the hemophilia contract, and having provider restrictions, are closed. Hemophilia contract providers should refer to the contract for current codes.

Open with Limits

86481 Tuberculosis testing by enumeration of gamma interferon-producing T-cells in cell suspension

Open with manual review to providers with appropriate CLIA certification. Use of this code is for high-risk populations from countries of origin with high incidence of TB and/or clients inoculated with BCG. Manual review is required on claims for clients not identified by eligibility as in a high-risk population. Claims deny if within 12 months of paid claim for 86480 (Tuberculosis testing, cell mediated immunity antigen response measurement; gamma interferon).

Billable as Outpatient for EPSDT

61500 Craniectomy, with excision of tumor or other bone lesion of skull. Effective September 24, 2015, per CMS approval. Billable as an outpatient service for EPSDT eligible clients only.

Covered

88341 Immunohistochemistry or immunocytochemistry, each additional single antibody stain procedure, professional component. Effective January 1, 2015.

Covered Effective August 8, 2015

- 75954 Endovascular repair of iliac artery aneurysm
- 75956 Endovascular repair of descending thoracic aorta
- 75957 Endovascular repair of descending thoracic aorta; not involving coverage of left subclavian artery
- 75958 Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta
- 75959 Placement of distal extension prosthesis after endovascular repair of descending thoracic aorta

16-05 Limited Abortion Services

Section I: General Information, Physician Services, and Hospital Services Manuals

Information on limited abortion services has been clarified and placed in Section I: General Information, Non-Covered Services and Limitations. This information has been removed from the Physician Services and Hospital Services manuals; they now refer the provider to Section I. The updated information below has been added to Section I:

9-1 Limited Abortion Services

Medicaid reimbursement for abortion services is limited to procedures consistent with the Hyde Amendment restrictions. The Hyde Amendment allows for the use of federal funds for abortions to terminate a pregnancy under two conditions:

- In the professional judgment of the pregnant woman’s attending physician, the abortion is necessary to save the pregnant woman’s life and all requirements of 42 CFR 441, Subpart E have been satisfied; or

Unless otherwise noted, all changes take effect on January 1, 2016

- The pregnancy is the result of rape or incest reported to law enforcement agencies, unless the woman was unable to report the crime for physical reasons or fear of retaliation.

In addition to the above conditions, Medicaid reimbursement for abortion service is allowed only when:

- Prior authorization is obtained,
- A properly executed and completed Utah Medicaid Abortion Acknowledgement and Certification Form is submitted, and
- A properly executed and completed Utah Medicaid Prohibition of Payment for Certain Abortion Services Provider Certification Form is on file with the Bureau of Medicaid Operations.

When circumstances occur that lead to a natural pregnancy loss or inevitable abortion, Medicaid will not reimburse any procedures or misoprostol when fetal heart tones are present. Ultrasound must confirm no fetal heart activity before procedures or misoprostol are initiated or administered.

16-06 Worker's Compensation Benefits for HCBS Workers Hired Through Participant Direction

Amendments made to House Bill 94 (2014 General Session), *Worker's Compensation and Home and Community Based Services*, became effective July 1, 2015. These amendments add Worker's Compensation benefits for employees hired by individuals participating in Home and Community-Based Service programs.

Medicaid will reimburse financial management agencies who facilitate payments to these employees for the added expense of providing Worker's Compensation benefits within the Home and Community-Based Service programs.

The manuals for the following Home and Community-Based Programs and Waivers have been updated to reflect this change:

Autism Waiver
Individuals Aged 65 and Over
New Choices Waiver
Technology Dependent Children
Medically Complex Children
Personal Care

16-07 Nurse Practitioner MIB Article Clarification

The May 2014 Interim Medicaid Information Bulletin, Article 14-72 Nurse Practitioners (NPs), has been clarified effective April 1, 2014, as follows:

A State Plan amendment previously approved by the Centers for Medicare and Medicaid Services, allows Licensed Nurse Practitioners (NP) in any specialty to enroll as a Medicaid provider and to bill independently for their service. This is in addition to the four NPs (e.g. pediatric, family, CRNM, CRNA) previously allowed to bill Medicaid independently.

The following limitations apply:

- To participate in the Utah Medicaid Program, an NP must complete an enrollment application which is located at <https://medicaid.utah.gov/become-medicaid-provider>.
- The additional NP types may directly bill and be directly reimbursed for those services open to their provider type, as listed in the Medicaid Coverage and Reimbursement Lookup Tool located at <https://medicaid.utah.gov/health-care-providers>.
- The NP will bill with a National Provider Identifier (NPI), and the billed services must not appear on a facility cost report.
- Services provided by the NP and a physician on the same day to the same patient are not separately reimbursable.
- When service is provided by a NP working under the supervision of a physician, the supervising physician shall bill for the service according to their usual and customary fee schedule.
- When service is provided by a NP working in a private independent practice, the NP shall bill according to their usual and customary fee schedule.
- NPs will be reimbursed at 100 percent of the physician fee schedule with the exception of Certified Nurse Midwives which will continue to be reimbursed at 75 percent of the physician fee schedule.

16-08 Pharmacy Services Provider Manual Updated

The *Utah Medicaid Provider Manual for Pharmacy Services* has been updated to reflect the following clarifications:

Utah Medicaid Does Not Reimburse for Automatic Refills

This is a reminder that Utah Medicaid will not reimburse for prescriptions that are automatically refilled. Prescription refills must be requested by the Medicaid recipient or the recipient's agent based on a continued medical necessity.

340B Clarification

Medicaid providers using medications purchased through the 340B program to bill Medicaid ("carve-in") are reminded that claims must be submitted in the following manner to prevent duplicate discounts and to comply with Medicaid billing requirements:

- Outpatient pharmacy claims must be submitted with the Submission Clarification Code = "20", the Basis of Cost = "08" and the 340B acquisition cost submitted in the ingredient cost field.

Unless otherwise noted, all changes take effect on January 1, 2016

- 340B drugs administered in the outpatient setting and billed to Medicaid using a HCPCS code must be billed with the “UD” modifier and the 340B acquisition cost as the submitted charge.
- Outpatient pharmacy claims submitted to an Accountable Care Organization must contain the Submission Clarification Code = “20” and outpatient administered drugs must be submitted with the “UD” modifier; however, the billed charges will be based on the facilities contracted agreement with the Accountable Care Organization.

340B Clarification – Contract Pharmacies

340B covered entities may not utilize contract pharmacies to bill Utah Medicaid, unless the covered entity, the contract pharmacy, and the State Medicaid agency have established a written arrangement to prevent duplicate discounts. Any such arrangement shall be reported to the Office of Pharmacy Affairs (OPA) or Health Resources and Services Administration (HRSA) by the covered entity.

16-09 Recent Drug Utilization Review Board Activity

The Medicaid Drug Utilization Review (DUR) Board announces that prior authorization (PA) criteria have been changed or placed upon the following agents (see <https://medicaid.utah.gov/pharmacy/prior-authorization>):

- Androgens, PA criteria updated to include Aveed, Natesto and Vogelxo
- Grastek, PA criteria established
- Hyaluronic Acid Derivatives, PA criteria established
- Kalydeco, PA criteria established
- Oralair, PA criteria established
- Orkambi, PA criteria established
- Ragwitek, PA criteria established
- Skeletal Muscle Relaxants, quantity limits increased

16-10 Section I: General Information Provider Manual Revised

This provider manual has undergone a complete revision. The manual has a new format and organization. Policy information has also been updated. It is recommended that providers read the complete manual.

To access the revised manual, go to <https://medicaid.utah.gov>.

16-11 Rural Health Clinics and Federally Qualified Health Centers (RHC/FQHC) Services

Provider manual updates include, among other items:

- Clarification of the general information introductory material
 - Clarification of the fee-for-service/managed care information
 - Addition of the eligibility tools
 - Definitions update
 - Clarification and differentiation RHC and FQHC coverage responsibilities
 - Co-payment requirement and exemptions update
 - Addition of United States Code 42 § 254b as a reference
-

16-12 RHC and FQHC Co-pays

Beginning January 1, 2016, the Division of Medicaid and Health Financing (DMHF) will deduct a \$3 co-payment from claims paid at the encounter rate for Medicaid Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers that collect co-payments from clients. Regarding FQHCs on the Alternative Payment Method (APM), the Department will have them self-report any co-pays collected from clients. The co-pay amounts will be factored into their annual cost settlements.

16-13 Personal Care Services Manual Updates

The *Utah Medicaid Personal Care Services Provider Manual* has been revised to include updates and provide policy clarification. The revision includes additions to the definition section and clarification of Utah Medicaid policy that only one Nurse Assessment Visit (T1001) is billable every 60 days and is subject to post payment review. Reassessment visits may take place no more than five days prior to, or two days after, the previous certification period expires. When the nurse assessment is performed, related to State Plan Personal Care services, the SE modifier must be submitted on the claim. As with all Utah Medicaid services provided, submitted claims are subject to post payment review and must be billed appropriately and according to policy.

16-14 Home Health Services Manual Updates

The *Utah Medicaid Home Health Services Provider Manual* has been updated to include post payment review verbiage in “Limitations for Assessment/Reassessment Visits” section. Utah Medicaid policy states that only one Nurse Assessment Visit (T1001) is billable every 60 days. Reassessment visits may take place no more than five days prior to, or two days after, the previous certification period expires. As with all Utah Medicaid services

Unless otherwise noted, all changes take effect on January 1, 2016

provided, submitted claims are subject to post payment review and must be billed appropriately and according to policy.

16-15 CLIA List Updated

The CLIA Certification for Laboratory Services List has been updated. See the CLIA attachment to the *Utah Medicaid Laboratory Services Provider Manual*.

16-16 Hysterectomy Acknowledgement Form Requirement for Anesthesia Codes

Effective October 20, 2015, the following anesthesia codes have been added to the list of codes that require a completed Utah Medicaid Hysterectomy Acknowledgement Form:

01963 Cesarean hysterectomy without any labor analgesia/anesthesia care

01969 Cesarean hysterectomy following neuraxial labor analgesia/anesthesia

Access the required form at <https://medicaid.utah.gov> by selecting Health Care Providers > Prior Authorization > General PA Forms > Hysterectomy Acknowledgement Form. For hysterectomy procedures performed in a life-threatening emergency, refer to Section B of the Instructions for Completing the Hysterectomy Acknowledgement Form.

For questions, please contact adlucero@utah.gov.

16-17 Chiropractic Services

Effective October 1, 2015, Medicaid members eligible for chiropractic services are allowed 12 visits in a 12-month period when medically appropriate. If the needed number of visits exceeds the limit, prior authorization must be received prior to providing the additional services.

16-18 Medical Supplies Update

The following code has been repriced:

B4100 Food thickener, administered orally, per ounce

16-19 Attention Licensed Psychologists

Effective January 1, 2016, the *Utah Medicaid Provider Manual for Psychology Services* will be archived. For information on evaluations and psychological testing for individuals with an intellectual disability, developmental disorder or related condition, please refer to the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

For information on requirements for evaluations for individuals with autism spectrum disorder (ASD), please refer to the *Utah Medicaid Provider Manual for Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals*.

For information on evaluations for individuals with chronic pain, please refer to Chapter 2 of the *Utah Medicaid Provider Manual for Physician Services*.

16-20 Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual Updates

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

- Clarifications and revisions have been made to Chapters 1-1, 1-2, 1-3, 1-6, 1-7, 2-1, and 2-2.
- Chapter 2-5, Psychotherapy, under group psychotherapy and multi-family group psychotherapy, in the Limits section, limits have been added regarding size of multi-family psychotherapy groups.

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

16-21 Payment Adjustment Request Form

The electronic Payment Adjustment Request Form for fee-for-service Medicaid claims is available for issues regarding overpayments and credit balance. The form must accompany a payment in order to allow proper allocation of funds. To view the form, go to <https://medicaid.utah.gov/utah-medicaid-forms>. From the list choose the form named: Payment Adjustment Form.

This form may be filled out on the computer before printing. One form is required per claim. The form must have all required fields appropriately filled out or it will be returned to the provider for corrections.

Do not use this form for changes to a claim that is less than three years old. If a payment adjustment is required on a claim that is less than three years old, a replacement claim must be submitted. Refer to your internal practice management policies on the procedure to submit a replacement claim. Additional information regarding how to submit a replacement claim can be found at the end of this article.

Unless otherwise noted, all changes take effect on January 1, 2016

**Make all checks payable to: Bureau of Medicaid Operations
Mail checks for Credit Balance, Third Party Liability for Crossover Claim Payments, and Overpayments older than three years to:**

Bureau of Medicaid Operations: Payment Adjustments
PO Box 143106
Salt Lake City, UT 84114-3106

Payment Adjustments refer to Credit Balance Payments, Third Party Liability for Crossover Claim Payments, and Overpayments due to coding adjustments older than three years.

Information regarding the Credit Balance is found on the letter sent to the provider, or you may call (801) 538-6513 for additional help.

**Make all checks payable to: Bureau of Medicaid Operations
Mail checks for Third Party Liability payments (TPL) excluding Crossover Claim (TPL) adjustments to:**

Office of Recovery Services
Medicaid Section, Team 85
PO Box 45025
Salt Lake City, UT 84145-0005

For questions regarding payments sent to ORS, call (801) 536-8798.

A replacement claim will correct units, charges including Third Party Liability (TPL) and client information. Check the 5010 companion guide for electronic claims submission requirements: <http://health.utah.gov/hipaa/guides.htm>. If you have additional questions how to submit a replacement claim, refer to your internal practice management procedure or your clearinghouse support services.

If using paper, the explanation for the CMS-1500 Claim Form is available from the insurance commissioner through the Utah Health Information Network (UHIN) website: <http://uhin.org>. Therefore, Utah Medicaid no longer provides an explanation for the CMS-1500 Claim Form. Providers who use the paper claim form should access the UHIN website (<http://uhin.org>) for CMS 1500 Paper Claim Form Standard Version 3.3.

For help with either the UHINt tool or paper submission questions, please contact UHIN for assistance at (801) 716-5901.

Please do not send checks intended for a Medicaid ACO (Health Choice Utah, Healthy U, Molina Healthcare of Utah, SelectHealth Community Care, DentaQuest, or Premier Dental) to Utah Medicaid. To ensure proper reimbursement, follow each ACO's guideline for returning payment adjustments.

16-22 Publication of 2016 Codes

The 2016 HCPCS and CPT codes will be published in the coming January 2016 Interim MIB. This is due to the delayed release of the codes by the Centers for Medicare and Medicaid Services (CMS).

16-23 PRISM's New Release 3 Go-Live Date: July 1, 2016

The Provider Reimbursement Information System for Medicaid's (PRISM) Release 3 Go-Live date has been rescheduled for July 1, 2016. We identified areas in the system that need more extensive testing to assure greater readiness for both Medicaid staff and providers. We also want to ensure providers have a quality experience when they use PRISM. Release 3 will focus on the Provider Enrollment component of this system, providing the ability to complete online enrollment and changes.

Providers can prepare for Release 3 by doing the following:

1. Set up a Utah Master Directory (UMD) account that will provide a Utah ID and password; 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

Various providers statewide have already signed up to test PRISM's Release 3. Provider testing will be rescheduled. Additional information will be forthcoming in a future MIB and we will be in touch to schedule testing times with providers who have signed up to test. If you are interested in testing PRISM's Release 3 but have not signed up, you can still do so by emailing prism@utah.gov.

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 submit PRISM questions to prism@utah.gov.