UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

January 2017

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

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Additional Medicaid Information

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17-01 New Provider Enrollments and Modifications Now Online in PRISM

As of July 1, 2016, providers are able to enroll online and make modifications to their provider record using the Provider Reimbursement Information System for Medicaid (PRISM).

New Enrollments

To submit a new provider enrollment application, go to: https://medicaid.utah.gov/become-medicaid-provider and click *New Enrollment Application.*

Current Medicaid Providers

As part of the provider enrollment changes, we are asking existing providers to validate their information in PRISM. Each provider's current enrollment record has been converted to PRISM. This conversion will ease the transition between the MMIS and PRISM, allow providers to view historical data, and eliminate the need for providers to complete a new application.

As a Current Medicaid Provider, How Do I Access PRISM for the First Time?

Current Medicaid providers will receive a letter with instructions on how to login to PRISM to validate and modify information. If providers want to receive their validation letter before their scheduled timeframe, they can call Provider Enrollment at (801) 538-6155 or 1-800-662-9651, option 3, wait for the prompt, then option 4. Provider training for PRISM's provider enrollment and validation is available through the Medicaid website at https://medicaid.utah.gov/pe-training.

Some validation letters have been mailed to providers. The schedule for additional mailings is still being determined.

Can I Still Fax in Documents?

Uploading documents directly into PRISM is the most efficient way to send provider enrollment documents to Medicaid. However, providers will have the option to fax in documents, but must use a Provider Enrollment Cover Sheet. The cover sheet can be found on the Medicaid website at https://medicaid.utah.gov/utah-medicaid-forms and in PRISM in the *View Upload Attachment* Step, which is a step utilized when validating provider information, enrolling a new provider, or modifying current provider information. If providers do not use this cover sheet, their documents will not be processed because their documents cannot be properly matched to their provider account. Providers should fill out the cover sheet online and then print a separate cover sheet for each document to ensure that each document is correctly classified within the file.

Do I Need to Submit a Signed Provider User Security Agreement?

Yes. Each new enrollment and each provider validation requires submission of a signed (with a wet signature) provider user security agreement. It is important to review the provider user security agreement carefully so that no required fields are left blank. If a required field is left blank, it will be "returned for edit", which delays the approval process. Keep in mind, the first person to initiate the provider validation in PRISM automatically becomes the Account Administrator.

Furthermore, the provider user security agreement requires two signatures: one signature from the initial Account Administrator, which is referred to as the "user signature", and the other from the provider of services, which as the name suggests, is the "provider signature".

How Do I Register and Approve an Additional Account Administrator (User) in PRISM?

The first person to initiate the validation process automatically becomes the Account Administrator for that particular provider. However, providers often wish to have additional Account Administrators. In PRISM, these Account Administrators are called "users". Other staff members can register to become additional Account Administrators. Once registered, the initial Account Administrator can either approve or deny the request. The initial Account Administrator has full profile rights in PRISM. The initial Account Administrator can approve limited or full profile rights for additional Account Administrators in PRISM. For example, an additional user could be approved for only the "Provider Credentialing Specialist" profile, and thus would only be able to work on credentialing for that particular provider.

For instructions on how to register and approve an additional PRISM user (Account Administrator), view the training, "Managing Access to the Provider PRISM Account", at https://medicaid.utah.gov/pe-training.

How is Re-Credentialing Different from the Validation Process?

Re-credentialing is the federally mandated process providers must go through every 3-5 years to re-enroll as a Medicaid provider, as per the federal mandate as defined in 42 CFR 455.414. Validation for converted provider data is not a re-enrollment. It is a process in which current providers will need to access PRISM to validate that their converted provider enrollment information is correct after their enrollment record is converted to PRISM.

Does the Provider Enrollment Process in PRISM Change the Way I Submit Claims?

No. Providers should continue to submit claims as usual, as changes to claims are not part of PRISM's changes to provider enrollment.

We will continue to share updated information through future MIB articles, the Medicaid website, and information sent by email from Medicaid staff.

17-02 Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual Update

Effective January 1, 2017, the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated.

- Chapter 1-3, Medicaid Behavioral Health Service Delivery System, revisions have been made in the section on evaluations not covered by the Prepaid Mental Health Plan (PMHP).

- #1 is revised for clarity as follows: 'Evaluations performed to evaluate intellectual disabilities, developmental disorders or related conditions.' #2 is revised to include 'evaluations required prior to certain surgical procedures.'

- Chapter 1-6, Evaluation, has been updated to include information on evaluations that may be used to qualify individuals for autism spectrum disorder (ASD) related services, pain management related evaluations and evaluations required prior to certain surgical procedures.

- Chapter 2-2, Psychiatric Diagnostic Evaluation, in the 'Limits' section, #4 has been revised and also includes reference to evaluations required prior to certain surgical procedures.

- Chapter 1-4, Scope of Services, has been updated to provide information on delivery of services via telemedicine.

- Chapter 1-5, Provider Qualifications, B. 2 g., and Chapter 2-3, Mental Health Assessment, #1 in the provider qualifications ('Who') section, have been updated to be consistent with other references in the manual to individuals working toward licensure as a social service worker to include 'in accordance with state law.'

- In Chapter 2-11, Psychosocial Rehabilitative Services, #7 in the provider qualifications ('Who') section, has been updated to include A.2 of Chapter 1-5 in order to allow supervision from the individuals included in A.2.

- In Chapter 2-11, Psychosocial Rehabilitative Services, in the 'Limits' section, item d. has been updated to include eating of meals as an example of routine activities. It also has been revised to clarify that the limitation on routine activities applies in any treatment setting, not just residential treatment settings.

- For Prepaid Mental Health Plans: Chapter 3-1, Personal Services, Chapter 3-3, Psychoeducational Services, and Chapter 3-4, Supportive Living, have been updated to replace the term serious and persistent mental illness (SPMI) with the term serious mental illness (SMI). This change aligns with the change nationally, thus promoting a recovery view of mental illness.

- Chapter 3-1, Chapter 3-2, Respite Care, Chapter 3-3, and Chapter 3-4, #4 in the provider qualifications ('Who') sections has been updated to include A.2 of Chapter 1-5 in order to allow supervision from the individuals included in A.2.

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

17-03 Access to Care

In an effort to ensure Utah Medicaid fee-for-service members can access medical services in a manner comparable to Utahns with other health insurance plans, and in accordance with 42 CFR 447.203, the Division of Medicaid and Health Financing (DMHF) has developed a Utah Access Monitoring Review Plan (UAMRP). The plan outlines the processes used to measure access to care related to the following services:

- Primary Care Services
- Physician Specialist Services
- Behavioral Health Services
- Pre- and Post-Natal Obstetric Services
- Home Health Services

The UAMRP includes a standardized, data-driven process by which DMHF documents and monitors access to care; taking into consideration the extent to which member needs are met, the availability of care and providers, utilization of Medicaid services, and a comparison of Medicaid rates to other payers in the market.

The plan was developed during the months of November 2015 through June 2016 and was posted from July 5, 2016, to August 5, 2016, to allow for public inspection and feedback. Both the full version of Utah's AMRP and responses to public comments can be found on the Medicaid website at https://medicaid.utah.gov/uamrp-utah-access-monitoring-review-plan.

17-04 Code Coverage and Changes

Codes Open, with PA, to EPSDT Eligible Members and Pregnant Women

V5160	Dispensing Fee, binaural
V5170	Hearing aid, CROS, in the ear
V5180	Hearing aid, CROS, behind the ear
V5200	Dispensing Fee, CROS
V5210	Hearing aid, BICROS, in the ear
V5220	Hearing aid BICROS, behind the ear
V5240	Dispensing Fee, BICROS
V5241	Dispensing Fee, monaural
V5244	Hearing aid, digitally programmable analog monaural, CIC
V5245	Hearing aid, digitally programmable, analog, monaural, ITC
V5246	Hearing aid, digitally programmable analog, monaural, ITE
V5247	Hearing aid, digitally programmable analog, monaural, BTE
V5250	Hearing aid, digitally programmable analog, binaural, CIC
V5251	Hearing aid, digitally programmable analog, binaural, ITC
V5252	Hearing aid, digitally programmable binaural, ITE

Codes Closed

V5242 Hearing aid, analog, monaural, CIC
V5243 Hearing aid, analog, monaural, ITC
V5248 Hearing aid, analog, binaural, CIC
V5249 Hearing aid, analog, binaural, ITC

Codes Closed to Non-Traditional

L8512 Gel cap for trach voice pros
L8513 Trach pros cleaning device
L8514 Repl trach puncture dilator
L8515 Gel cap app device for trach

Codes Open to Provider Type 55- Ambulatory Surgery

57155 Insert uterine tandem and/or vaginal ovoids for clinical brachytherapy
63001 Laminectomy with exploration and/or decompression of spinal cord and/or decompression of spinal cord and /or cauda equina, without facetectomy, foraminotomy or discectomy, 1 or 2 vertebral segments; cervical
63003 . . . thoracic
63005 . . . lumbar, except for spondylolisthesis
63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, cervical
63030 . . . one interspace, lumbar
63042 Laminotomy single lumbar
63045 Laminectomy, facetectomy, and foraminotomy . . . single vertebral segment; cervical
63046 Laminectomy, facetectomy, and foraminotomy . . . single vertebral segment; thoracic
63047 Laminectomy, facetectomy, and foraminotomy . . . single vertebral segment; lumbar
63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

Code Open to Provider type 01 - Hospital

15777 Acellular matrix implant

Code Closed

83992 Phencyclidine (PCP)

New Codes, Non-Covered, Effective October 1, 2016

C9744 Ultrasound, abdominal, with contrast

G0490 Face-to-face home health nursing visit by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) in an area with a shortage of home health agencies. (Services limited to RN or LPN only.)

G0498 Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion

G9679 Onsite acute care treatment of a nursing facility resident with pneumonia. May only be billed once per day per beneficiary.

G9680 Onsite acute care treatment of a nursing facility resident with CHF. May only be billed once per day per beneficiary.

G9681 Onsite acute care treatment of a resident with COPD or asthma. May only be billed once per day per beneficiary.

G9682 Onsite acute care treatment a nursing facility resident with a skin infection. May only be billed once per day per beneficiary.

G9683 Onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration (similar pattern). May only be billed once per day per beneficiary.

G9684 Onsite acute care treatment of a nursing facility resident for a UTI. May only be billed once per day per beneficiary.

G9685 Evaluation and management of a beneficiary's acute change in condition in a nursing facility

G9686 Onsite nursing facility conference, that is separate and distinct from an Evaluation and Management visit, including qualified practitioner and at least one member of the nursing facility interdisciplinary care team

17-05 Tables of Authorized Emergency Diagnoses

The tables of authorized emergency inpatient diagnoses and authorized emergency department diagnoses are updated regularly. The current authorized diagnoses lists are available on the Medicaid website at http://health.utah.gov/medicaid/stplan/lookup/DXDownload.php.

17-06 Update to Telemedicine Policy in Section I: General Information

Providers must use the **GT** modifier to indicate that telemedicine was used as the service delivery mechanism.

The **GQ** modifier is used for transmission of data. This is not a covered service. No additional reimbursement is given to the provider at the originating site for the use of telemedicine.

Providers participating in telemedicine must comply with Utah Medicaid provider requirements as specified in the *Utah Medicaid Provider Manual, Section I: General Information*.

Covered services may be delivered by means of telemedicine, as clinically appropriate. Services include, but are not limited to, consultation services, evaluation and management services, mental health services, and substance use disorder services.

17-07 Laboratory Services Manual Update – Substance Abuse Screening

Substance abuse testing requires use of G codes. Documentation for manual review is required when a quantitative testing code exceeds 14 tests. The updated policy is below:

- Quantitative testing requires submission of presumptive drug testing results. The presumptive result must support the quantitative G code level reported.
- Documentation is required when additional quantitative tests such as spectrophotometry, quantitative mass spectrometry and quantitative column chromatography/mass spectrometry are reported on same date of service as the quantitative G code. Documentation must support completely different substances from the substances tested under quantitative G code drug test.
- Reimbursement is not available for the presumptive drug screen when the quantitative G code drug test is performed on the same date of service.

17-08 Coverage and Reimbursement Code Lookup Tool Search Results Look Modified

To make the Coverage and Reimbursement Code Lookup tool search results more clear, the system now gives a specific message for the following circumstances:

- A code and type of service is not billable by the provider type entered.
  Example, enter code L8512 with provider type 35 - Physical Therapist
  Search results message: "*Code L8512 Type of Service Global NOT Billable for Provider Type 35."*

- A discontinued code is entered.
  Example, enter discontinued code 92506 with any provider type.
  Search results message: "*Your search did not return any information. Please try again.*"

- A DME code not billable by the provider type is entered.
  Example, enter DME code V5299 with provider type 01 – General Hospital.
  Search results message:
  "Code V5299 Type of Service DME - Rental NOT Billable for Provider Type 01" and
  "Code V5299 Type of Service DME - Purchase NOT Billable for Provider Type 01"

Refer to Utah Medicaid website Coverage and Reimbursement Code Lookup tool http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

17-09 CHEC Manual Updated

Utah Medicaid is updating blood lead level reporting requirements based on recommendations from the Utah Department of Health, Bureau of Environmental Epidemiology. We are also adding a question to the verbal risk assessment located in the CHEC manual. Utah Medicaid continues to encourage providers to screen children for lead exposure.

To review the changes in the *Utah Medicaid CHEC Provider Manual*, refer to the Medicaid website at https://medicaid.utah.gov. If you have further questions, please contact Julie Olson at (801) 538-6764 or julieolson@utah.gov.

17-10 Opioid Quantity Limits and Prior Authorization Requirements

Reimbursable quantities of short-acting opioids, long-acting opioids, and opioid/acetaminophen combination products ("opioids", collectively) have been revised.

Patients continuing previous opioid treatment exceeding the new limits will be given a three-month authorization to reduce their dose to the reimbursable amount. The prescriber may call Utah Medicaid prior authorization staff to request the three-month authorization. If after three months, doses cannot be sufficiently reduced, the prescriber can request a quantity override prior authorization. Criteria is posted on the Utah Medicaid Pharmacy website.

For updated quantity limits for specific opioids and for the Quantity Override Prior Authorization Form, see the Utah Medicaid Pharmacy website at *https://medicaid.utah.gov/pharmacy/pharmacy-program*.

The *Utah Medicaid Provider Manual Drug Criteria and Limits* attachment has been updated to reflect these new limitations. To review the changes, refer to the Medicaid website at https://medicaid.utah.gov.

17-11 Preferred Drug List Updates

Psychotropic Drugs

In accordance with HB 437, psychotropic drugs are being added to the Utah Medicaid Preferred Drug List (PDL). The following drug classes will be added to the PDL:

- Tricyclic Antidepressant
- Monoamine Oxidase Inhibitor
- Anti-Anxiety Benzodiazepine

As with other psychotropic drug classes, prescribers may bypass the non-preferred drug prior authorization requirement by writing "Dispense as Written" on the prescription. The pharmacy must submit a Dispense as Written code of "1" on the claim. In accordance with UCA 58-17b-606 (4) and (5), the Dispense as Written code will not allow claims for the brand-name version of multisource drugs to bypass the prior authorization requirement if the generic version is preferred, or vice versa. Additionally, if both the brand name version and generic version of a drug are non-preferred, the Dispense as Written code will only override the non-preferred prior authorization edit for the least costly version of the drug (i.e., either the brand or generic, but not both).

Annual Update

Due to changes in pricing, rebates, and drug utilization, all PDL classes are reviewed and updated as part of the annual PDL review process.

17-12 Long Acting Reversible Contraceptives (LARC) Placed Immediately Following an Inpatient Delivery

Hospitals that are paid using a Diagnosis Related Group (DRG) are reimbursed for all services as a bundled payment under the DRG. Rule R414-2A-6 (4) and (5) clarifies all drugs administered to a member during a hospital stay, reimbursed using a DRG, are included in the DRG payment:

> *(4) Medical supplies, appliances, drugs, and equipment required for the care and treatment of a client during an inpatient stay are reimbursed as part of payment under the DRG.*
>
> *(5) Services associated with pregnancy, labor, and vaginal or C-section delivery are reimbursed as inpatient service as part of payment under the DRG, even if the stay is less than 24 hours.*

A LARC, including an IUD (intra-uterine device) or subcutaneous implantable contraceptive, placed during an inpatient hospital stay for a delivery (vaginal or C-section) would be reimbursed through the DRG. As with other drugs, the hospital would bill the LARC on the claim and it would get rolled into the DRG payment.

Rural hospitals that are not paid using a DRG receive 89 percent, currently, of allowable charges; therefore, LARCs placed during an inpatient hospital stay for a delivery (vaginal or C-section) would be reimbursed at 89 percent, currently, of allowable charges.

Utah Medicaid providers can verify the coverage status of an individual LARC by searching the Coverage and Reimbursement Lookup Tool at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php, by entering their provider type, the Health Care Common Procedure Coding System (HCPCS) code, and the date of service.

17-13 Update to Audiology Manual and Hearing Aid Codes

Dispensing fee codes V5160, V5200, V5240, and V5241 are now open, with prior authorization, for eligible Medicaid members.

A dispensing fee may be reported once per hearing aid for the operational lifetime of that hearing aid. Dispensing fee is to include:

- Adjusting the hearing aid to the recipient, including necessary programming on digital and digitally programmable hearing aids.
- Instructing and counseling the recipient on use and care of the hearing aid.
- Fitting and modifications of the hearing aid.
- Freight, postage, delivery of the hearing aid.
- Maintenance, cleaning, and servicing for the first year of ownership.

Requirements for hearing aid prior authorization now require a final unaltered purchase invoice. Prior authorization for hearing aids will no longer require proof of MSRP.

The hearing aid fee schedule is updated. Specific codes are found on the Utah Medicaid website Coverage and Reimbursement Code Lookup Tool at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

17-14 Medicaid Face-to-Face Requirement

Due to changes in federal regulations, Utah Medicaid will implement the face-to-face encounter requirements for home health services and durable medical equipment (DME) on July 1, 2017. Qualified Medicaid providers ordering home health services or DME will be required to meet the face-to-face encounter requirements for all

Medicaid members in accordance with 42 CFR Part 440.70. Additional information related to this change in federal policy will be provided in the coming months.

17-15 Oxygen Concentrator Contract

Alpine Home Medical will continue as the contracted vendor for oxygen concentrators for fee-for-service Medicaid members and for Medicaid members enrolled in an Accountable Care Organization (ACO) residing in a voluntary county (see ACO county chart in article 17-17).
Effective January 1, 2017, members enrolled in an ACO living in a mandatory county must receive oxygen concentrator services through their ACO.

17-16 Accountable Care Organization (ACO) County Update

Effective January 1, 2017, Healthy U and Health Choice ACO plans will expand to additional voluntary ACO enrollment counties. Health Choice will be a new option for Medicaid members living in Beaver, Juab, Millard, Sanpete, and Sevier counties. Healthy U will be expanding state-wide, to all mandatory and voluntary counties. Medicaid members living in voluntary counties have the option to choose an ACO health plan or use the fee-for-service network, while those living in mandatory counties must choose an ACO health plan or be assigned to one. An updated county chart, effective January 1, 2017, is listed on the following page containing the available ACO plans in each county.

County*	Health Choice Utah	Healthy U	Molina	SelectHealth Community Care	Fee for Service Network
Beaver	•	•	•		•
Box Elder	•	•	•	•	
Cache	•	•	•	•	
Carbon		•	•		•
Daggett		•	•		•
Davis	•	•	•	•	
Duchesne		•	•		•
Emery		•	•		•
Garfield		•	•		•
Grand		•	•		•
Iron	•	•	•	•	
Juab	•	•	•		•
Kane		•	•		•
Millard	•	•	•		•
Morgan	•	•	•		
Piute		•	•		•
Rich	•	•	•		
Salt Lake	•	•	•	•	
San Juan		•	•		•
Sanpete	•	•	•		•
Sevier	•	•	•		•
Summit	•	•	•	•	
Tooele	•	•	•		
Uintah		•	•		•
Utah	•	•	•	•	
Wasatch	•	•	•	•	
Washington	•	•	•	•	
Wayne		•	•		•
Weber	•	•	•	•	

***Effective January 1, 2017**
Members living in highlighted counties
must **have a health plan.**
Members living in counties not highlighted can choose a health plan (ACO) or use the Fee for Service Network.