UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

July 2017

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

TABLE OF CONTENTS

17-37 MEDICAID DENTAL MANAGED CARE UPDATE 2
17-38 DENTAL BENEFITS FOR PEOPLE WHO ARE VISUALLY IMPAIRED OR THOSE WITH DISABILITIES 2
17-39 PRIVACY AND SECURITY REMINDER ON MINIMUM NECESSARY PHI 3
17-40 UTAH MEDICAID PROVIDER MANUAL UPDATES 3
17-41 UTAH MEDICAID UPDATES AND REMINDERS 4
17-42 UTAH ADMINISTRATIVE RULE R414-10 PHYSICIAN SERVICES UPDATED 5
17-43 PHYSICIAN PROVIDER MANUAL UPDATED 5
17-44 NEONATAL AND PEDIATRIC INTENSIVE CARE AND CRITICAL CARE SERVICES 6
17-45 SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) MEDICAID REIMBURSEMENT 7
17-46 UTAH MEDICAID PHARMACY PROGRAM UPDATES 7
17-47 PREFERRED DRUG LIST 8
17-48 DRUG CRITERIA UPDATE 8
17-49 DRUG UTILIZATION REVIEW BOARD UPDATE 8
17-50 PHARMACY MANUAL ATTACHMENTS UPDATED 9
17-51 SMOKING CESSATION 9
17-52 HEALTH AND BEHAVIOR ASSESSMENT 9
17-53 NEW PRIOR AUTHORIZATION REQUEST FORMS 10
17-54 PERSONAL CARE SERVICES AND HOME HEALTH SERVICES MANUAL UPDATES 10
17-55 NEW CHOICES WAIVER MANUAL UPDATED 11
17-56 SECTION I: GENERAL INFORMATION UPDATED 11
17-57 COST SHARING 11
17-58 HOSPITAL SERVICES PROVIDER MANUAL UPDATED 12
17-59 ANESTHESIOLOGY SERVICES PROVIDER MANUAL UPDATED 13
17-60 WOMEN'S SERVICES PROVIDER MANUAL UPDATED 13
17-61 LABORATORY SERVICES MANUAL UPDATED 13
17-62 AMBULATORY SURGICAL CENTERS (ASC) PROVIDER TYPE 55 14
17-63 HOME HEALTH SERVICES AND MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT (DME) MANUALS REVISED 14
17-64 MEDICAL TRANSPORTATION MANUAL UPDATED 14
17-65 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS SERVICES MANUAL UPDATED 14
17-66 REHABILITATIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES PROVIDER MANUAL UPDATED 15
17-67 NON-TRADITIONAL MEDICAID INCOME ELIGIBILITY INCREASE - IMPACT TO PCN MEMBERS 16
17-68 CODE UPDATES 16

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

17-37 Medicaid Dental Managed Care Update

Based on an agreement between members of the Utah State Legislature, the Utah Dental Association, and Utah Medicaid's dental managed care plans, the following changes will be made to the administration of Medicaid dental through our Managed Care Programs (Delta Dental and Premier Access) no later than July 1, 2017:

- Reimbursement to network providers will be based on the Utah Department of Health Medicaid fee schedule. Providers will receive a 5% increase for all preventive dental services.
- All providers will be paid fee for service and will no longer be offered a sub-capitation payment arrangement.
- Any licensed and credentialed Utah Medicaid dental provider will be allowed to enroll as a network provider with Delta Dental and Premier Access. Please contact the plan(s) directly for more information about participating in their network(s).
- Delta Dental and Premier Access can only require prior authorization on the services that require prior authorization under the Utah Medicaid fee for service program.
- Members assigned to a dental plan will be allowed to see any provider on the assigned plan's network.
- Members will not be assigned to a primary dental provider.
- Members may seek services from a dentist or specialist on their dental plan's network without referral or prior approval from the plan.

For questions about individual provider agreements with Premier Access and Delta Dental, please contact your local provider relations representative for each of the plans.

Premier Access
Carrie Campbell
(916) 388-3055
carrieC@premierlife.com

Delta Dental
Jamie Diaz
(801) 298-0606
Jdiaz2@ddic.delta.org

17-38 Dental Benefits for People who are Visually Impaired or those with Disabilities

Beginning July 1, dental services are available to Utah Medicaid members who are visually impaired or those with disabilities, who are 21 years of age or older. Visual impairment or disability is as defined in Subsection 1614 (a) of the Social Security Act. Current coverage for other members already receiving dental benefits will remain unchanged.

"Dental services" whether furnished in the office, a hospital, a skilled nursing facility, or elsewhere, means covered services performed within the scope of the Medicaid dental provider's license as defined in Title 58, Occupations and Professions.

In accordance with UCA 26-18-413(2)(b), *to the extent possible, services delivered in Salt Lake County shall be provided through the University of Utah School of Dentistry.*

For Medicaid members who are visually impaired or those with disabilities and who reside within a nursing home and are 21 years of age or older, covered dental services are not allowed to reduce the nursing home liability. Covered dental services must be rendered by a Medicaid provider and billed directly to Medicaid.

Program coverage and limitations have been updated and are available in the Dental, Oral Maxillofacial, and Orthodontia Services provider manual and the Utah Medicaid Coverage and Reimbursement Code Lookup.

17-39 Privacy and Security Reminder on Minimum Necessary PHI

Remember to use and disclose only the minimum necessary Protected Health Information (PHI). To lessen the risk to patient privacy, be sure to access only the information you need to do your job. For example, if you only need to look up a mailing address, do not look at other screens containing other information.

If you are authorized to disclose or release PHI to someone else, be sure that you give out only the information needed to satisfy the purpose of the release. For example, if information about a single provider visit is all that is needed, do not release the full billing record. Note that the organization releasing PHI is responsible for following the principle of minimum necessary.

For more information, ask your organization's HIPAA Privacy Officer.

17-40 Utah Medicaid Provider Manual Updates

Utah Medicaid will be making substantial changes to the provider manuals. Beginning July 1, 2017, Medicaid will start moving policy from the provider manuals to the appropriate Utah Administrative Rule within R414, Health, Health Care Financing, Coverage and Reimbursement Policy. Providers will notice this move taking place over the next several quarters.

Moving Medicaid policy to the Administrative Rules will allow providers the opportunity to review and comment on rule updates. Providers are encouraged to become familiar with the Administrative Rule, because Medicaid coverage policy will be relocated to the appropriate rule based on service coverage.

The manuals will also be streamlined. For example, ancillary services such as laboratory services and women's services information will be in the *Utah Medicaid Physician Services Provider Manual* effective July 1, 2017.

As part of the manual revision process, information regarding specific code coverage will be moved from the provider manuals to the Utah Medicaid Coverage and Reimbursement Lookup Tool. The provider manuals will continue to be a reference for criteria and reporting instructions.

Providers are encouraged to become familiar with the updated rules and manuals noting changes in the structure, formatting, and content of the manuals. Providers are still required to follow coverage policy, criteria, and prior authorization (PA) requirements.

17-41 Utah Medicaid Updates and Reminders

- Utah Medicaid coverage policy is found in the Utah Administrative Rule Title R414. Health, Health Care Financing, Coverage and Reimbursement Policy
- Physician Services coverage and limitation policy information is found in the Utah Administrative Rule R414-10 Physician Services
- Specific coverage on CPT or HCPCS codes is found in the Utah Medicaid Coverage and Reimbursement Code Lookup
- The Coverage and Reimbursement Code Lookup allows providers to search for coverage and reimbursement information by procedure code, date of service, and provider type
- Information regarding CPT modifiers has been removed from the Physician Manual and Utah Administrative Rule R414-10-5 Physician Services, Service Coverage and Limitations
    - Information regarding these modifiers is found in the Utah Medicaid Provider Manual Section I: General Information
- Information removed from the Physician Manual and Utah Administrative Rule R414-10-5 Physician Services, Service Coverage and Limitations are:
    - Limiting magnetic resonance imaging (MRI) to coverage only for service to the brain, spinal cord, hip, thigh, and abdomen
    - Physical examinations
    - Limitations regarding after hours service codes
    - Limitations regarding the technical and professional component or radiology

17-42 Utah Administrative Rule R414-10 Physician Services Updated

The Utah Administrative Rule R414-10 Physician Services has been updated and is undergoing major revisions. With this update, providers will notice a change in the structure, formatting, and content of the Administrative Rule. The specific changes are detailed in the State Bulletin as the changes go through the rule-making process.

17-43 Physician Provider Manual Updated

The Physician Manual is updated and renamed *Utah Medicaid Physician Services Manual*.

The manual has undergone a major revision, noting a change in the structure, formatting, and content of the manual.

Policy coverage information has been moved to the Administrative Rule R414-10 Physician Services.

As part of the Physician Services Manual revision, information regarding specific code coverage has been removed from this provider manual. The provider manual will continue to be a reference for criteria and reporting instructions.

Providers are encouraged to become familiar with the updated manual noting:

- The Laboratory Services and Women Services Manuals have been incorporated into the Physician Services Manual
- The following services no longer require prior authorization:
  - Physician Home Visit E/M CPT codes 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, and 99350
- The following services have been removed from manual review:
  - Fetal biophysical profile
  - Removal of benign skin lesions
  - Destruction, premalignant lesions
  - Facet joint radiofrequency neurotomy
  - Neurobehavioral status exam – CPT code 96116
    - Members are allowed 3 units per a 12-month period. Prior authorization will be required when the unit limit is exceeded.
  - Neuropsychological testing - CPT code 96118
    - Members are allowed 10 units per a 12-month period. Prior authorization will be required when the unit limit is exceeded.
- Polysomnography coverage has been updated to reflect a limitation of 1 per rolling year without prior authorization.

- Information regarding medications has been removed from the manual, please refer to Utah Administrative Code. R414-60. Medicaid Policy for Pharmacy Program and the Utah Medicaid Provider Manual Pharmacy Services.
- Cosmetic – Reconstructive Surgery

  The reconstruction and cosmetic procedures policy is changed to the following:
  Reconstructive or restorative services are only covered when medically necessary and performed on abnormal structures of the body to improve or restore bodily function or to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

  Cosmetic procedures performed solely for the purpose of improving appearance are not covered services, including non-medically necessary procedures that are performed in the same episode as a covered procedure when there was more than one purpose for the cosmetic procedure.

  Reconstructive breast procedures related to cancer:
  Coverage includes reconstruction of the breast on which the procedure was performed, reconstruction of the breast on which the procedure was not performed to produce a symmetrical appearance, and prostheses. Reconstructive surgeries require prior authorization and are limited to initial occurrences including multi-step procedures to achieve the final result. Repeat procedures may only be approved based on medical necessity.

Additional coverage information is found on the Coverage and Reimbursement Code Lookup.

Providers are still required to follow coverage policy, criteria, and Prior Authorization (PA) requirements.

Utah Medicaid policy coverage is found in the Utah Administrative Rule R414-10 Physician Services. Updates to Medicaid Policy may be found at Utah State Bulletin.

Coverage criteria requirements are found in the Utah Medicaid Coverage and Reimbursement Code Lookup, InterQual®, the Physician Services Manual, All Providers General Information Section I and/or the Utah Medicaid Prior Authorization website.

17-44 Neonatal and Pediatric Intensive Care and Critical Care Services

Medicaid no longer requires providers to submit the Requisition for Privileges: Neonatal and Pediatric Intensive Care and Critical Care Services Form or a Physician Privilege Checklist to Provider Enrollment to bill the following codes:

99464 Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn
99468 Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger

99469 Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99471 Initial inpatient pediatric critical care, per day, for the E&M of a critically ill infant or young child, 29 days through 24 months of age
99472 Subsequent inpatient pediatric critical care, per day, for the E&M of a critically ill infant or young child, 29 days through 24 months of age
99478 Subsequent intensive care, per day, for the E&M of the recovering very low birth weight infant (present body weight less than 1500 grams)
99479 Subsequent intensive care, per day, for the E&M of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99480 Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)

17-45 Screening, Brief Intervention, and Referral to Treatment (SBIRT) Medicaid Reimbursement

In accordance with UCA 26-18-22, Medicaid will now reimburse certain health care providers for SBIRT services. Effective July 1, 2017, Medicaid will reimburse a Medicaid enrolled, controlled substance prescriber who has completed a nationally recognized opioid abuse screening training for SBIRT services provided to an eligible Medicaid member who is 13 years of age or older for SBIRT services.

If the Medicaid member is enrolled in an ACO, reimbursement to the provider will be made by the ACO. Providers must comply with all requirements of UCA-26-18-22, as well as all other pertinent laws, rules, and regulations prior to submitting a claim for reimbursement to Utah Medicaid. Qualified Medicaid enrolled providers should report the following codes for SBIRT services:

99408 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes

99409 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

---

17-46 Utah Medicaid Pharmacy Program Updates

UCA 26-18-2.4(3)(c)(i), amended in the 2016 General Session of the Utah State Legislature, requires the Utah Department of Health to *establish a system to:*

(A) track health care provider prescribing patterns for psychotropic drugs;
(B) educate health care providers who are not complying with the preferred drug list; and
(C) implement peer to peer education for health care providers whose prescribing practices continue to not comply with the preferred drug list.

Beginning July 1, 2017, the Utah Medicaid Pharmacy Program will launch two new programs that will specifically address these prescriber monitoring requirements established in statute.

The first project is a confidential prescriber feedback report. This reporting compares a health care provider's prescribing patterns to an average, such as that of his/her peers. Specifically, individual feedback reports will be generated and confidentially emailed to Medicaid prescribers. These feedback reports will illustrate how often the provider follows the PDL compared to his/her peers.

The second project involves prescriber medical education including electronic materials and peer to peer education. Initially, education and information on best practices will be placed on the Utah Medicaid Pharmacy Preferred Drug List web page with hyperlinks to articles that will provide brief answers, evidence-based treatment guidelines, and related information.

17-47 Preferred Drug List

The Pharmacy and Therapeutics (P&T) Committee reviewed five classes of treatments for HIV in March 2017. These drug classes will be added to the Utah Medicaid Preferred Drug List (PDL), effective July 1, 2017.

Information regarding the P&T Committee and PDL can be found on the Utah Medicaid Pharmacy website at https://medicaid.utah.gov/pharmacy/pharmacy-program.

17-48 Drug Criteria Update

Prior authorization (PA) criteria have been modified for Buprenorphine and Buprenorphine/Naloxone containing medications for the treatment of opiate dependence. The PA criteria is available online at: https://medicaid.utah.gov/pharmacy/prior-authorization.

17-49 Drug Utilization Review Board Update

Buprenorphine products for the treatment of opioid dependence and long-acting blood factors were recently discussed by the Drug Utilization Review Board. Meeting minutes are available on the Utah Medicaid Pharmacy website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board.

17-50 Pharmacy Manual Attachments Updated

The Drug Criteria and Limits and the Over the Counter (OTC) Drug List have been updated to reflect changes in coverage.

17-51 Smoking Cessation

Tobacco cessation counseling is covered with a maximum of four intermediate sessions and three intensive sessions per 12-month period. HCPCS code S9453 will be closed, CPT codes 99406 and 99407 are open with quantity limits as stated above. For more detailed coverage information see the Coverage and Reimbursement Code Lookup.

- Utah Tobacco Quit Line (1-800-QUIT-NOW) provides free and confidential phone-based counseling to Utah callers. Eligible callers may receive nicotine replacement therapy (patch or gum) at no cost.
- Utah's Way-To-Quit website provides information about free quitting resources, including a text-to-quit program and online coaching.

17-52 Health and Behavior Assessment

Nurse practitioners and social workers are not allowed to bill codes 96150-96155.

CPT codes 96150-96155 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions.

Nurse practitioners (and any qualified provider who may report evaluation and management services) are instructed to bill an Evaluation and Management code. Per 58-60-202 (3) of the Utah Code, the practice of clinical social work includes services for the purpose of preventing, treating, or eliminating mental or emotional illness or dysfunction, the symptoms of any of these, or maladaptive behavior.

17-53 New Prior Authorization Request Forms

Effective July 1, 2017, there will be four new Prior Authorization Request Forms posted in the Prior Authorization Section of the Medicaid website. The following forms will be posted and are required after October 1, 2017. The general Request for Prior Authorization Form should only be used when there is not a specific form for the service(s) being requested. For pharmacy prior authorization forms, please visit the Pharmacy Section of the Medicaid website.

- Request for Prior Authorization
- Enteral Formula PA Request Form
- Applied Behavior Analysis (ABA) Services Prior Authorization Request Form
- Genetic Testing Prior Authorization Request Form

Requests received after October 1, 2017, that have been submitted using an outdated or inappropriate request form will be returned. The PA request must be sent with complete documentation or the request will be returned with a letter indicating what is missing. The date in which a complete request, with all necessary supporting documentation, is received will be the date posted for the PA request. This includes using a current prior authorization request form.

*All requests must be submitted to the correct fax number listed on the form or in the instructions that are attached to the specific form.

17-54 Personal Care Services and Home Health Services Manual Updates

PART 1 TRADITIONAL PERSONAL CARE SERVICES – has been modified to include general updates and to provide policy clarification. The revision includes updates to references in the Social Security Act and CFR, additions to the Limitations sections and clarification regarding appropriate use of the TN and SE modifiers on claims submitted for personal care services.

PART 2 EMPLOYMENT-RELATED PERSONAL CARE SERVICES – has been updated to add clarification on the following items:

- Duplication of same day personal care services
- Financial Management Agency paperwork requirements for Self-Administered Service workers
- Inappropriate use of personal assistant services

17-55 New Choices Waiver Manual Updated

The New Choices Waiver provider manual is updated. The following list details the substantive changes being made effective July 1, 2017:

1. Section 4-1 describes conflict free case management guidelines and the process of utilizing a financial transaction services contractor to pay for waiver goods and services purchased from retail stores, general contractors, or other entities not directly enrolled as Medicaid providers.
2. Section 5-1 instructs providers to use the PRISM Provider Portal for provider enrollment, applications, validations and changes.
3. All New Choices Waiver forms that were previously included in the provider manual have been removed and can now be accessed online at http://health.utah.gov/ltc/NC/NCProviders.htm.
4. Other non-substantive clarifications have been made throughout the manual where strengthening of policy language was needed.

For questions, please contact Trecia Hansen at (801) 538-6861 or TreciaH@utah.gov.

17-56 Section I: General Information Updated

The Section I: General Information Provider Manual has been updated.

Providers are encouraged to read and become familiar with the manual noting:

- Information regarding coverage for CPT modifiers will now be in the Utah Medicaid Provider Manual Section I: General Information.
- Updates have been made to the Prior Authorization chapter of the Utah Medicaid Provider Manual Section I: General Information.
- A definition has been added:
    - Years: Any 12-month period of time unless specified as a calendar year.

17-57 Cost Sharing

Utah Medicaid submitted a State Plan amendment to the Centers for Medicare and Medicaid Services (CMS) to update cost sharing amounts with a proposed effective date of July 1, 2017. CMS must approve the State Plan amendment prior to Utah Medicaid making the changes to its claims adjudication. Should CMS approve the proposed changes, Utah Medicaid will readjudicate previously paid claims with service dates on or after the proposed effective date to reflect the updated cost sharing amounts.

The Utah Medicaid proposed State Plan change will be to update cost sharing amounts to align with requirements in 42 CFR §447.50, Sections 1902(a)(14), 1916, and 1916A of the Act.

The proposed cost sharing amounts are as follows:

- $8 for each non-emergency use of the emergency department
- $75 for each inpatient hospital stay (episode of care)
- $4 for each outpatient services visit (physician visit, podiatry visit, physical therapy, etc.)
- $4 for each outpatient hospital service visit (maximum of one per person, per hospital, per date of service)
- $4 for each prescription
- $1 for each chiropractic visit (maximum of one per date of service)
- $3 for each pair of eyeglasses

17-58 Hospital Services Provider Manual Updated

The Hospital Services Manual is updated. Providers may access the manual at: Hospital Services Manual.

Providers are encouraged to become familiar with the manual noting:

- Section 1. General Policy is updated removing the language, *'extending up to six weeks post-surgery'*
- Global surgical procedure is now defined as:
  - Global Surgical Procedure
    - Bundling of preoperative office visits and preparation, the operation, local infiltration, topical or regional anesthesia when used, and the normal, uncomplicated follow-up care.

- **Section 3.2. is revised:**
  Reconstructive or restorative services are only covered when medically necessary and performed on abnormal structures of the body to improve or restore bodily function or to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention. They are generally performed to improve function or treat a medical condition.

  Cosmetic procedures performed solely for the purpose of improving appearance are not covered services, including non-medically necessary procedures that are performed in the same episode as a covered procedure when there was more than one purpose for the cosmetic procedure.

  Reconstructive Breast Procedures Related to Cancer
  Coverage includes reconstruction of the breast on which the procedure was performed, reconstruction of the breast on which the procedure was not performed to produce a symmetrical appearance, and prostheses. Reconstructive surgeries require prior authorization and are limited to initial occurrences including multi-step procedures to achieve the final result. Repeat procedures may only be approved based on medical necessity.

Medical necessity as defined in R414-1-2 (18), shall be established through evidence based criteria.

- The following policy on medical supplies has been clarified: Medical supplies, appliances, and equipment required for the care and treatment of a client during an inpatient stay are covered Medicaid services under the DRG.

17-59 Anesthesiology Services Provider Manual Updated

The Anesthesiology Services Manual is updated. Providers may access the manual at: Anesthesiology Services Manual.

Providers are encouraged to become familiar with the manual noting:

- The definition of chronic pain *'as pain lasting longer than six months'* has been removed from the Anesthesiology Manual.

17-60 Women's Services Provider Manual Updated

Information in the Women's Services Provider Manual is updated and may now be found in the Physician Services Manual. The Women's Services Manual will be archived effective July 1, 2017.

Specific coverage on CPT or HCPCS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

17-61 Laboratory Services Manual Updated

The Laboratory Services Manual is updated and may now be found in the Physician Services Manual. The Laboratory Services Manual will be archived effective July 1, 2017.

Specific coverage on CPT or HCPCS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

The following attachments to the Laboratory Services Manual were archived, CLIA and Nucleic Acid Probes Guidelines. Information may be located in the Physician Services Manual and Tests Granted Waived Status Under CLIA effective July 1, 2017.

17-62 Ambulatory Surgical Centers (ASC) Provider Type 55

The reference file is updated to include additional service coverage in an ASC effective July 1, 2017. To verify coverage of a specific procedure in an ASC, refer to the Coverage and Reimbursement Code Lookup.

17-63 Home Health Services and Medical Supplies and Durable Medical Equipment (DME) Manuals Revised

The Home Health Services and Medical Supplies and DME manuals have undergone revisions to include the requirement for face-to-face encounters beginning on July 1, 2017. Qualified Medicaid providers ordering home health services or DME must meet the face-to-face encounter requirements for all Medicaid members in accordance with 42 CFR Part 440.70 and Utah Administrative Code R414-1-30. DME that requires face-to-face shall be the same as DME items required by Medicare.

17-64 Medical Transportation Manual Updated

The Medical Transportation manual is updated. Providers are encouraged to become familiar with the manual. Providers may access the manual at: Medical Transportation.

17-65 Rural Health Clinics and Federally Qualified Health Centers Services Manual Updated

The Rural Health Clinics and Federally Qualified Health Centers Services manual is updated. Providers are encouraged to become familiar with the manual. Providers may access the manual at: Rural Health Clinics and Federally Qualified Health Centers Services.

17-66 Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual Updated

The *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* is updated.

In Chapter 1-3, Medicaid Behavioral Health Service Delivery System, in the Additional Options section, the definition of an Indian health care provider is clarified.

In Chapter 1-3, Medicaid Behavioral Health Service Delivery System, in the section, Evaluations Not Covered by the Prepaid Mental Health Plan, #2 is updated to refer providers to the Utah Administrative Rule, R414-10, Physician Services, for information on evaluations for individuals with conditions requiring chronic pain management services and evaluations prior to certain surgical procedures.

In Chapter 1-4, Scope of Services, and Chapter 1-10, Billings, information on providing services by telemedicine is updated. Providers must include the GT (Telehealth Services) modifier on the claim to indicate that the service was provided by telemedicine.

In Chapter 2-1, General Limitations, #2., clarification is provided on service substitution for individuals with Non-Traditional Medicaid. An inpatient day may be substituted for an outpatient day or an outpatient day may be substituted for an inpatient day.

In Chapter 2-1, General Limitations, #3., Service Coverage and Reimbursement Limitations, is updated.

Effective July 1, 2017, for fee-for-service claims submitted to Medicaid, the limit on neuropsychological testing, CPT code 96118, is changed from eight hours (eight units) per 12-month period to ten hours (ten units) per 12-month period. Neurobehavioral status exams, CPT code 96116, continue to be limited to three hours (three units) per 12-month period.

The manual review requirement is also removed. If additional units of service are needed, providers must obtain prior authorization. For information on obtaining prior authorization, providers may refer to Chapter 10, Prior Authorization, of the *Utah Medicaid Section I: General Information Provider Manual*. Providers may also refer to the Coverage and Reimbursement Lookup Tool for information on prior authorization for these procedure codes.

In Chapter 2-4, Psychological Testing, the Limits section is also updated accordingly.

Prepaid Mental Health Plans only: In Chapter 3-4, the definition of supportive living has been revised for clarity.

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

17-67 Non-Traditional Medicaid Income Eligibility Increase - Impact to PCN Members

Effective July 1, 2017, parents with monthly income up to 55 percent of the federal poverty level may be eligible for Medicaid. As a result, some Primary Care Network (PCN) members may now be eligible for Medicaid. If you have a patient who was eligible for PCN prior to July 1, 2017, they may now be eligible for a more comprehensive healthcare benefit which includes inpatient and outpatient hospital services, specialty care and behavioral health services. Former PCN members will no longer have access to routine dental care. Please check your patient's eligibility using the Eligibility Lookup Tool at: https://medicaid.utah.gov/eligibility.

17-68 Code Updates

Open

20553 Injection(s); single or multiple trigger point(s), 3 or more muscles
96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
99151 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Prior Authorization Removed

22585 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
43820 Gastrojejunostomy; without vagotomy
43825 Gastrojejunostomy; with vagotomy, any type
63275 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic
63277 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
63278 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral

63280 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63281 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic
63282 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar
63283 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacral
63285 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63286 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic
63287 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar
63290 Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level
99341 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99342 Home visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99343 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99344 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99345 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.
99347 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.

99348 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

99349 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

99350 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Manual Review Removed

64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

64634 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)

76818 Fetal biophysical profile; with non-stress testing

76819 Fetal biophysical profile; without non-stress testing

96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

96118 Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

Codes Open to Provider Type 45 – Group Practice

96150 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
96151 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
96152 Health and behavior intervention, each 15 minutes, face-to-face; individual
96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)

Codes Open to Provider Type 52 – Federally Qualified Health Clinic and 57 – Rural Health Clinic

96151 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)

Code Open to Provider Type 95 – Oral Surgeon

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Quantity Limit Update

96118 Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report, *10 units per rolling 12-month period*
99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes, *4 units per rolling 12-month period*
99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes, *3 units per rolling 12-month period*
E0445 Oximeter device for measuring blood oxygen levels noninvasively, *rental 1 unit per 30-day period*

Closed

S9453 Smoking cessation classes, non-physician provider, per session
A4550 Surgical trays
99070 Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)