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#### **Additional Medicaid Information**

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## 15-94 PRISM's Release 3: Timelines

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

We have received questions from providers regarding the validation process providers will need to step through after PRISM's Release 3 Go-Live in February 2016 and whether that process is related to the re-credentialing activity they are currently working on in the MMIS. An explanation of the differences is below with a timeline of activities.

**Re-credentialing** is the process providers must go through every 3-5 years to re-enroll as a Medicaid provider. The last batch of the current cycle of the re-credentialing letters was sent May 1, 2015. Providers who have not re-credentialled have until March 2016 to finish re-credentialing. The next cycle of re-credentialing will happen in PRISM with the first letters to be sent approximately November 2016.

**Validation** for PRISM's Release 3 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. Current Medicaid providers' enrollment record will be converted to the new system in order to ease the transition between the MMIS and PRISM, as well as eliminate the need for providers to re-enroll as a Medicaid provider. We will alert providers when this occurs; providers will have time to review the converted information, to validate that it is correct and make any needed modifications to the information in PRISM. Providers will receive a letter specifying the provider portal URL web address with instructions on how to log in to PRISM to validate and modify information. The window for validation in PRISM will be included in the letter, but it is anticipated to be February 1, 2016 – December 31, 2016. Online training will be available to assist with navigating the steps, along with contact information in case providers encounter problems during the process.

The timeline of re-credentialing and validation activities includes:

**May 1, 2015:** Last batch of current cycle re-credentialing letters mailed to providers

**Current day – March 2016:** Providers submitting documentation to re-credential with Medicaid

**February 1, 2016:** PRISM's Release 3 Go-Live

**March 2016:** Providers to finish re-credentialing in current cycle in PRISM

**February – December 2016:** Providers validate converted enrollment information in PRISM

**Approximately November 2016:** First batch of future re-credentialing letters to be mailed to providers

**Approximately March 2019:** Providers to finish re-credentialing in the future cycle in PRISM

Click on this link, <https://medicaid.utah.gov/Documents/pdfs/RevalidRecred.pdf>, to view the timeline of the re-credentialing and validation activities related to MMIS and PRISM.

The PRISM Team invites providers, and/or administrative staff working with providers who will access the system for provider enrollment, to test the system for Release 3. Testing will be conducted November 20, 2015 – January 7, 2016 and can be performed at the provider's office. We will be asking providers or administrative staff to do one or more of the following to test the system throughout part of one day:

- Validate converted provider enrollment data
- Make any needed modifications to enrollment data
- Enter new enrollment data into the system

Providers signed up so far to test PRISM's Release 3 include representation from Intermountain Healthcare, University Healthcare, Community Health Centers, Utah Cancer Specialists, pharmacies and home health/hospice agencies. We welcome participation from additional hospitals, clinics or other provider entities. If you and/or your administrative staff are interested in participating in system testing for Release 3 with the PRISM Project, please email [prism@utah.gov](mailto:prism@utah.gov) with your contact information. You can also email [prism@utah.gov](mailto:prism@utah.gov) with questions about PRISM.

In addition, provider training for all components of PRISM's Release 3 will be available through the Medicaid website in January and February 2016. Please bookmark the PRISM Training Home Page for providers, <https://medicaid.utah.gov/prism-provider-training>, for training specifics that will be added as the time nears.

We will continue to share updated information through future MIB articles, the Medicaid website, and information sent by email from Medicaid staff. Updated information can be found on the Medicaid website under the Administration & Publications tab by selecting "Medicaid Information System (PRISM)" or by clicking [here](#).

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## **15-95 Hyperbaric Oxygen Therapy Criteria Updates**

Effective July 1, 2015, the following indications have been added to the criteria for Hyperbaric Oxygen Therapy (HBOT):

- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management
- Osteoradionecrosis as an adjunct to conventional treatment
- Cyanide poisoning

The indications below remain active in the 2015 criteria, in addition to the new indications listed above:

- Acute carbon monoxide intoxication
- Decompression illness
- Acute arterial gas embolism
- Gas gangrene with documentation of gram stain consistent with a Clostridium species
- Acute traumatic peripheral ischemia in a salvageable area as an adjunct to standard care
- Crush injuries and suturing of severed limbs
- Progressive necrotizing infections
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts
- Mycoses (actinomycosis, mucormycosis, Conidiobolus cornato)
- Diabetic wounds of the lower extremities which have failed at least thirty consecutive days of standard wound care therapy and are classified as Wagner grade III or higher
- Osteoradionecrosis of the jaw only
- Soft tissue radionecrosis for hemorrhagic proctitis as an adjunct to conventional treatment

## 15-96 Inpatient Psychiatric Hospital Admissions

Effective July 1, 2015, pending the Centers for Medicare and Medicaid Services (CMS) approval of the submitted State Plan Amendment change, prior authorization (PA) is no longer required for inpatient psychiatric hospital admissions for fee-for-service Medicaid clients. Although the PA requirement has been removed from these services, the claims for inpatient psychiatric hospital admissions are still subject to post-payment review, as all inpatient hospital stays. As stated in the July 2015 version of the *Utah Medicaid Hospital Manual for Hospital Services*, "The Hospital Utilization Review Program is administered and operated in accordance with the provisions in Utah Code Title 63A, Utah Administrative Services, Chapter 13, Office of Inspector General of Medicaid Services."

Retroactive authorization requests for fee-for-service Medicaid clients, for dates of service prior to July 1, 2015, should continue to be submitted to the PA staff, using a current PA Request Form that is found on the Utah Medicaid website under Health Care Providers > Prior Authorization > General PA Forms.

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## 15-97 Dental Manual Clarification

Third molar extractions may be a covered service when at least one of the third molars has documented pathology that requires extraction. Removal of the remaining third molars during the same procedure is allowed per provider discretion.

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## 15-98 Emergency Services Program for Non-Citizens

The *Utah Medicaid Provider Manuals for Hospital Services, Physician Services, and Section I: General Information*, have been revised to clarify the Emergency Services Program for Non-Citizens information.

In the revised Physician and Hospital Manuals, the explanation of criteria for the Emergency Services Program for Non-Citizens was simplified; the procedure codes were removed, and providers are referred to Section I: General Information. Section I: General Information contains an updated definition of Emergency Services Program for Non-Citizens, clarification of the billing process, and other information.

Refer to the manuals for change details at <https://medicaid.utah.gov>, and the Coverage and Reimbursement Code Lookup Tool for CPT code information at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

## 15-99 Provider Preventable Conditions Diagnoses List

Medicaid will utilize the MS-DRG Grouper to identify provider preventable conditions (PPC). The Utah Medicaid Provider Preventable Conditions Diagnoses List will be archived. For further information, providers are referred to the Medicare list of PPC diagnoses and the Utah Medicaid Hospital Services Manual.

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## 15-100 Chiropractic Manual Updates

The Chiropractic Provider Manual has been updated to reflect the following changes:

Effective October 1, 2015, Utah Medicaid will no longer utilize the Chiropractic Health Plan (CHP) to issue chiropractic prior authorizations. Providers must re-enroll with Utah Medicaid to be reimbursed for claims for services performed on or after October 1, 2015. Claims for services performed on September 30, 2015, or prior will continue to be reimbursed to CHP.

In addition, beginning on October 1, 2015, use code 98940 (Chiropractic manipulative treatment (CMT); spinal) for all chiropractic services. The office visit codes 99202 and 99212 will no longer be available to bill chiropractic consultations.

Chiropractic visits will be limited to twelve per year per recipient. Additional visits will require a prior authorization through Utah Medicaid. Chiropractic services are only available for pregnant women and EPSDT-eligible children ages six years and above.

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## 15-101 Member Enrollment in ACO Plans

Enrollment in an Accountable Care Organization (ACO) is now required in thirteen counties. The Division requires all Medicaid members living in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties to enroll in an ACO physical health plan (PHP). A member must select an ACO plan (Healthy U, Molina, Health Choice Utah, or SelectHealth Community Care) at the time he or she is determined eligible. Not all ACOs are available in each county.

The *Utah Medicaid Section I: General Information Provider Manual*, Chapter 4-1, has been updated for October 1, 2015. The manual is available at <https://medicaid.utah.gov>.

## **15-102      Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual Updates**

The *Utah Medicaid Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual* has been updated for October 1, 2015. Updates include the following:

- Chapter 2-11 and Chapter 3-3, under “Record”, in subsection A., clarification has been made regarding programs that follow these documentation requirements.
- Chapter 4, Procedure Codes and Modifiers, a correction has been made to procedure code H2017 to reflect policy in Chapter 2-11.

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

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## **15-103      Primary Care Network (PCN) Provider Manual Updated**

The *Utah Medicaid Primary Care Network Provider Manual* and its attachments have been updated for October 1, 2015. To view the manual, go to <https://medicaid.utah.gov>.

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## **15-104      Implementation of Fingerprint-Based Criminal Background Checks**

Effective January 1, 2016, Provider Enrollment will be implementing a new provider enrollment screening process for providers identified 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.*

Unless otherwise noted, all changes take effect on October 1, 2015

*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.”*

Prior to implementation, new policies for provider enrollment and screening will be communicated to providers in subsequent Medicaid Bulletins.

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## **15-105 Code Updates**

### **Covered Code with Prior Authorization Removed**

50370 Removal of transplanted renal allograft. Effective July 1, 2015.

### **Covered Codes with Provider Types Updated**

For details refer to the Coverage and Reimbursement Code Lookup tool at:

<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>

#### **Effective January 1, 2015**

G0434 Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter

H2019 Therapeutic behavioral services, per 15 minutes

76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete

76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited

#### **Effective July 1, 2015**

H0038 Self-help / peer services, per 15 minutes

21554 Excision, tumor, soft tissue neck or anterior thorax, subfascial, 5 cm or greater

21557 Radical resection of tumor, soft tissue of neck or anterior thorax; less than 5 cm

#### **Effective August 1, 2015**

77427 Radiation treatment management, 5 treatments

Unless otherwise noted, all changes take effect on October 1, 2015

**Effective October 1, 2015**

98940 Chiropractic manipulative treatment-spinal, 1-2

99212 Office/outpatient visit established

99202 Office/outpatient visit new

**Covered Opened Codes**

33800 Endovasc rep of desc thorac aorta, inc subclavian

33881 Endovasc rep of desc thorac aorta, w/o subclavian

33883 Insert endovasc prosth, thoracic aorta

33884 Endovasc prosth, thoracic aorta, add on

33886 Endovasc prosthesis delayed after prosthesis delayed after endovasc repair

33889 Artery transposition/endovasc thoracic aorta, by NC

33891 Car-Car bypass grft/endovasc thoracic aorta, by NCK

**Surgical Diagnosis Codes Opened - Effective July 1, 2015**

37.68 Insert percutaneous heart assist device

44.95 Lap gastric restrictive procedure

44.98 Lap adjustment gastric band device

84.64 Insert part disc prosthesis lumbosacral

88.96 Intraoperative MRI, other

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**15-106 Medical Supply Code Updates**

Please see the following coverage changes for the below medical supply codes:

A4353 Intermittent urinary cath, with insertion supplies. Effective July 1, 2015, the monthly quantity limit is raised to 180.

E0190 Positioning cushion/pillow/wedge, and shape or size. Effective October 1, 2015, will require manual pricing.



Unless otherwise noted, all changes take effect on October 1, 2015

E0639 Patient lift, moveable room to room, includes all components/accessories. Effective August 1, 2015, will require manual pricing.

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## **15-107 ICD-10 Updates**

### **ICD-9-CM Conversion to ICD-10-CM**

The following documents have been updated to reflect the conversion from the 9th Edition of the International Classification of Diseases, Clinical Modification (ICD-9-CM) to the 10th Edition of the International Classification of Diseases, Clinical Modification (ICD-10-CM):

#### **Diagnosis Lists – Archived October 1, 2015**

- Utah Medicaid Table of Authorized Emergency Diagnoses
- Utah Medicaid Table of Authorized Emergency Inpatient Diagnoses
- Primary Care Network (PCN) Authorized Diagnoses for Emergency Department Reimbursement

The information in the diagnosis lists will be replaced with a diagnosis download tool available at:  
<http://health.utah.gov/medicaid/stplan/lookup/FeeScheduleDownload.php>

#### **Provider Manuals and Attachments – Updated October 1, 2015**

- Long Term Care
- Long Term Care Attachment LTC-E-10A
- Section I: General Information
- Physician
- Nurse Practitioner
- Chiropractic (diagnosis codes were removed from the manual)
- Hospital
- PCN CPT List
- Pharmacy
- Drug Criteria and Limits
- Utah Medicaid ICD-10 Reference for Fee-for-Service Pharmacy Claims
  - This is a new attachment consolidating and updating the six attachments containing ICD-9-CM diagnosis codes: Pharmacy Antipsychotics Adult, Pharmacy Antipsychotics Ages 6-10, Pharmacy Antipsychotics Ages 7-19, PCN ICD-9 Adult, PCN ICD-9 Ages 6 or Less, PCN ICD-9 Ages 7-10 or Less. These attachments will be archived.

**ICD-10 and Impact on Outpatient Fee-for-Service Pharmacy Claims Processing**

Effective October 1, 2015, Utah Medicaid is required to transition from using ICD-9 diagnosis codes to the new ICD-10 diagnosis codes. As a result, outpatient pharmacy claims that require a diagnosis code for adjudication must be submitted with a valid and appropriate ICD-10 diagnosis code for dates of service on and after October 1, 2015. Pharmacy providers are encouraged to work with prescribers prior to October to obtain a new ICD-10 diagnosis code.

Examples of medications that will require a new ICD-10 diagnosis code include: stimulants, antipsychotics, tobacco cessation medications, and cancer pain regimens.

For more information on ICD-10, please visit the Centers for Medicare and Medicaid Services website at: <http://www.cms.gov/Medicare/Coding/icd10/>

**Paper Claim Forms and ICD-10 Implementation**

October 1, 2015, is the official implementation date of ICD-10. In order to meet the mandate, Utah Medicaid will be changing the way it accepts and processes paper claims.

Beginning October 1, 2015, Utah Medicaid will require providers billing with paper claims to use the most current paper claims forms for date-of-service on or after October 1, 2015. The following are the most current forms by claim type:

- Dental claims: ADA 2012 Claim Form
- Professional claims: HCFA 1500 02-12 Claim Form
- Institutional claims: UB04 Claim Form

The old paper claim forms (Dental (ADA 2006) and HCFA (CMS-1500 08/05)) will not be accepted for date-of-service on or after October 1, 2015. In addition, paper claims with a date of service on or after October 1, 2015, must use ICD-10 diagnosis codes only. Otherwise, the paper claims will be returned to the provider.

**Electronic Data Interchange (EDI) Transactions and ICD-10**

Utah Medicaid providers should be aware of HIPAA ASC X12N standards and the use of ICD-10. Please refer to the V5010 ASC X12N Implementation Guides for information on ICD-10-specific requirements. EDI transactions that do not meet the requirements will receive a 999 rejection message code.

Secondly, files submitted that contain carriage returns or line feeds are causing discrepancies in the system. To ensure processing of EDI transactions without disruption, send files in 5010 X12 string format.

For questions regarding EDI transactions, contact the EDI Department at (801) 538-6155, or toll-free 1-800-662-9651, menu option 3, and then option 5.

Unless otherwise noted, all changes take effect on October 1, 2015

### **ICD-10 Implementation and Customer Support**

On October 1, 2015, Utah Medicaid will go live with the implementation of ICD-10 (International Classification of Diseases, 10<sup>th</sup> Edition). All claims submitted to Utah Medicaid with dates of service on or after October 1, 2015 must use ICD-10 coding, otherwise the claim will be rejected. Any claims with ICD-10 coding for dates of service prior to October 1, 2015 will also be rejected.

For all questions related to ICD-10, including claims submission and payment questions, please contact Medicaid Customer Service at (801) 538-6155 or toll-free 1-800-662-9651. Before calling Customer Service, please carefully review your 999 and 835 as these responses contain valuable information that will assist in determining why a claim was rejected or denied. If you receive a 999 rejecting the claim from UHIN, please contact the UHIN Help Desk at 1-877-693-3071.

For additional information and resources regarding ICD-10, please refer to the CMS ICD-10 website at the following address: <http://www.cms.gov/Medicare/Coding/ICD10/>

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### **15-108 Coverage Changes for Physician Administered Drugs**

Effective October 1, 2015, Utah Medicaid will implement programming to compare the Healthcare Common Procedure Coding System (HCPCS) code for physician administered drugs to the submitted National Drug Code (NDC). The program will compare the submitted information to a crosswalk of physician administered drugs and NDCs. If the submitted combination is unmatched, the claim will deny. Additionally, the NDCs must be eligible for the federal Medicaid drug rebate and active to be considered for reimbursement. This applies to claims administered in physician offices or in outpatient settings.

Please review the crosswalk and the associated effective dates online at <https://medicaid.utah.gov/pharmacy/resource-library>. The crosswalk identifies valid HCPCS to NDC matches which would qualify for payment on or after October 1, 2015. Providers and interested parties who wish to submit requests for consideration of additional HCPCS to NDC matches, or to make changes to existing matches, may do so via the Physician Administered Drug List Review Request Form, available online at <https://medicaid.utah.gov/pharmacy/prior-authorization>. Requests to consider prospective coverage of additional drugs, or to make changes to existing drugs, will be addressed in the order received. Understanding changes may be made to the crosswalk, interested persons should check frequently for updates to the list.

The Physician Administered Drug List is comprised of FDA approved drugs that are to be administered in physicians' offices or outpatient facilities by doctors or eligible staff. The drugs must be reasonable, necessary, and indicated for the diagnoses, or effective treatments of specific illnesses or injuries based on accepted standards of medical practice. All other program plan coverage and limitations will still apply. For specific program and plan coverage information, please refer to the Utah Medicaid Fee Schedule Download Tool at: <http://health.utah.gov/medicaid/stplan/lookup/FeeScheduleDownload.php>

Unless otherwise noted, all changes take effect on October 1, 2015

## **15-109 Interpretive Services Guide Updated**

The *Utah Medicaid General Attachment – Interpretive Services Guide* has been updated September 1, 2015. The attachment lists current Medical Interpretive Service State Cooperative Contractors and outlines steps on how to obtain medical interpretive services paid by Medicaid for a qualified Medicaid member.

The updated attachment is available at <https://medicaid.utah.gov>.