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Additional Medicaid Information

Salt Lake City Area: (801) 538-6155

Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, Nevada: 1-800-662-9651

Other States: (801) 538-6155

Request a Medicaid Publication

Send a Publication Request form:

By Fax: (801) 536-0476

By Mail: Division of Medicaid and Health Financing
PO Box 143106, Salt Lake City, UT 84114

Unless otherwise noted, all changes take effect on July 1, 2014

14-78 Utah Medicaid Provider Statistical and Reimbursement (PS&R) Report

Prior to State Fiscal Year 2014, the Utah State Plan Attachment 4.19-B, page 1, which is incorporated into Utah Administrative Rule R414-1-5 by reference stated, "In-state hospitals, beginning with the providers' fiscal year ending on or after January 1, 2012, shall complete the Title XIX sections of their Medicare Cost Report." The Medicaid-specific cost report information will be used to calculate a Medicaid CCR that will then be used in place of the Medicare CCR for outpatient hospital reimbursements as applicable.

Effective in State Fiscal Year 2014, the Utah State Plan Attachment 4.19B, page 1, was amended to remove the requirement for in-state hospitals to complete the Title XIX sections of the Medicare Cost Report. With this change, hospitals with fiscal reporting periods including June 30, 2013, are still required to complete this information; however, it would not be required for reporting periods beginning on or after July 1, 2013.

Upon request, Utah Medicaid will continue to provide a Provider Statistical and Reimbursement (PS&R) report for the fee-for-service claims data in order to accommodate Medicare Cost Report submissions as described above. The PS&R report provides summary statistical data including: total covered charges, units, and reimbursement (including supplemental payments) by fiscal period. This report provides data to aid in the provider cost reporting relative to Utah Medicaid reimbursement.

Please note that the data in this report only includes fee-for-service information. Any managed care plan claims data would need to be requested of the appropriate managed care organization.

To request a fee-for-service report, contact Andrew Ozmun at aozmun@utah.gov, or (801) 538-6733.

14-79 Physician and VFC Enhancement Payments Update

As last noted in the April 2014 MIB article 14-51, physicians could self-attest to program eligibility based on either board certification or 60% claim history (based on all paid Medicaid services, including managed care) within the approved code set for the Physician Enhancement program. Originally, it was determined that eligibility based on 60% code history would only be tested once (when the provider originally self-attests). Based on recent CMS guidance, it has been determined that eligibility based on 60% testing may be re-evaluated each calendar year if a physician attests/re-attests in calendar year 2014.

With this updated guidance, providers, who are not currently approved for these payments, may attest/re-attest based on the 60% criteria. Physicians, who attest/re-attest prior to June 30, 2014, and who meet or exceed the 60% threshold, as described above, will be eligible for payments for services back to the beginning of calendar year 2014. After June 30, 2014, a provider who attests and passes this 60% threshold will be retro-eligible for enhanced payments back to the beginning of the calendar year quarter in which they completed the self-attestation. For example, if a physician were to attest on July 15, 2014, and met the 60% threshold, the physician would only be eligible for enhanced payments for services rendered on or after July 1, 2014.

Unless otherwise noted, all changes take effect on July 1, 2014

14-80 Sessions Remaining for Statewide Provider Training

Utah Medicaid providers are invited to attend the 2014 Medicaid Statewide Provider Training Seminar. The remaining sessions will address common billing errors, tips on billing Utah Medicaid, prior authorizations, managed health care, and important changes regarding Medicaid. In addition, the Office of Inspector General will present information to help prevent and reduce fraud, waste, and abuse.

Each session will run approximately 2 to 2 ½ hours. All office staff are invited to attend. Please RSVP either by e-mail at providertrainingsupport@utah.gov, or by phone at 1-800-662-9651 or (801) 538-6485 or (801) 538-6155, and select option 8. Please include your name, name of your group, how many will be in attendance, which session you plan to attend, and a contact name and phone number.

We look forward to seeing you! The schedule is as follows:

Statewide Provider Training Schedule 2014

CITY	DATE	PLACE	TIME
Richfield	7/14/14	EMS Building 50 West View Drive Conference Room	1:00 p.m. - 3:00 p.m.
Fillmore	7/15/14	Fillmore Community Medical Center 674 South Highway 99 Classroom	10:00 a.m. - 12:00 p.m.
Roosevelt	7/16/14	Northeastern Counseling Center 285 West 800 South Conference Room	10:00 a.m. - 12:00 p.m.
Tooele	7/31/14	Tooele County Health Department 151 North Main Street Room #180	10:00 a.m. - 12:00 p.m.
Park City	8/5/14	Park City Medical Center 900 Round Valley Drive Private Dining Room (Café)	10:00 a.m. - 12:00 p.m.
American Fork	8/6/14	American Fork Hospital 170 North 1100 East Education Center Classroom	11:00 a.m. - 1:00 p.m.
Salt Lake City	8/12/14	State Library for the Blind & Disabled 250 North 1950 West Multi-Purpose Room	10:00 a.m. - 12:00 p.m.
Salt Lake City	8/12/14	State Library for the Blind & Disabled 250 North 1950 West Multi-Purpose Room	1:30 p.m. - 3:30 p.m.
Logan	8/18/14	Bear River Health Department Baylee Building 655 East 1300 North Rooms #153 & #154	9:30 a.m. - 11:30 a.m.

Unless otherwise noted, all changes take effect on July 1, 2014

Brigham City	8/18/14	Brigham City Hospital 950 South Medical Drive Boardroom	2:00 p.m. - 4:00 p.m.
Ogden	8/19/14	Ogden Regional Medical Center 5475 South 500 East Oak & Cedar Room	10:00 a.m. - 12:00 p.m.
Ogden	8/19/14	Ogden Regional Medical Center 5475 South 500 East Oak & Cedar Room	1:30 p.m. - 3:30 p.m.

14-81 New Medicaid Member Card FAQs

Starting **July 2014**, Medicaid and Primary Care Network (PCN) members will receive a new wallet-sized plastic Medicaid card. The new card will replace the current color-coded, full sheet of paper that shows the member’s eligibility each month. Below are some frequently asked questions to help in the transition of using the new Medicaid member card.

What information is on the new card?

The new wallet-sized cards will not have eligibility information listed on them. Instead, they will have the member’s **name, Medicaid ID number, and date of birth**. The back of the card has helpful contact information and websites for both providers and members.

Who will receive a new card?

Each Medicaid member in a household will receive their own card. The new Medicaid member card will be used whenever the member is eligible for Medicaid. A new card will NOT be mailed each month. Replacement cards will be issued if a card is lost or damaged.

How do I know if my patients are eligible for Medicaid?

Before providing services to card holders, you will need to verify your patients’ Medicaid eligibility. There are two ways to help you do so:

- 1) The Eligibility Lookup Tool: <https://medicaid.utah.gov/eligibility>
- 2) AccessNow: 1-800-662-9651

What is the Eligibility Lookup Tool?

The Eligibility Lookup Tool is a website that allows a provider to electronically view a member’s Medicaid eligibility and plan enrollment information. The Lookup Tool will also tell you if the patient is restricted to a specific provider and if the patient is responsible for co-pays. In addition, the Eligibility Lookup Tool can be used to verify PCN and Children’s Health Insurance Program (CHIP) eligibility.

Unless otherwise noted, all changes take effect on July 1, 2014

What do I need to do to get access to the Eligibility Lookup Tool?

In order to be in compliance with HIPAA, we must assure that only those that have the right to this information have access. A provider will have to register with the State of Utah Master Directory (UMD). Upon selecting “Eligibility Lookup Tool” (<https://medicaid.utah.gov/eligibility>) you will be prompted to log into the UMD before accessing the tool.

If you have not previously created a UMD Utah-ID and password, you can create an account from the login screen. The system will walk you through the activation process after you have selected “Create Account” in the shaded box to the left. Each Eligibility Lookup Tool user (e.g. each staff member in a provider’s office) will need their own UMD Utah-ID. Additionally, you will need to disable your pop-up blocker to allow pop-ups on the Medicaid website in order to view the Eligibility Lookup Tool results.

Please refer to the Provider Eligibility Lookup Tool Quick Start Card for an example of the Provider Lookup Tool and a guide to use the tool. To locate the Provider Eligibility Lookup Tool Quick Start Card go to the Medicaid website (<https://medicaid.utah.gov/whats-new>) and select the [Eligibility Lookup Tool Quick Start Card for Providers](#) link.

What information will I need to verify my patient’s eligibility?

To verify your patient’s eligibility on the portal you will need the information off of the Medicaid card which includes **member’s name, Medicaid ID and date of birth**. A provider must also have a Provider ID (NPI or API) known to Medicaid.

Why does the new card say “Verify the Medicaid Member’s Identity with a Photo ID”?

To prevent someone else from fraudulently using a Medicaid card to get health care services, please verify your patient’s identity. It is up to each provider to decide how to verify identity; one example is a photo ID.

What information is produced by the Eligibility Lookup Tool?**Providers can view:**

- Member demographics
- Member eligibility (including the past 36 months)
- Eligibility for the next month (after benefit issuance which is 6 business days before the end of the month)
- Plan enrollment information
- Provider restrictions
- Patient co-pays
- TPL and other health insurance

How will my patients know their health/dental plans, co-payments or benefit information?

Members will receive a Benefit Letter in the mail that contains all their plan information. When there are changes, Medicaid will send a new Benefit Letter. In addition, members can call the Medicaid Member Services hotline at 1-844-238-3091 to check eligibility. In the near future, they will also have a web tool, similar to the Eligibility Lookup Tool, to check their eligibility online.

Will this card be used for hospital presumptive eligibility and Baby Your Baby programs?

Yes, the card will be used for presumptive eligibility programs, which includes Hospital Presumptive Eligibility and Baby Your Baby.

Unless otherwise noted, all changes take effect on July 1, 2014

Will clients receive a different medical card once their presumptive eligibility ends and they are approved for ongoing Medicaid?

No, they will not. They will continue to use the same card.

What will the new card look like?



For more information about the new Medicaid member card, please visit <https://medicaid.utah.gov/whats-new>.

14-82 Hospital Presumptive Eligibility and Baby Your Baby Eligibility Information

The following changes are effective July 1, 2014. Additional information was sent to Hospital Presumptive Eligibility (HPE) and Baby Your Baby (BYB) eligibility workers in June.

Changes that affect both the HPE and BYB programs:

- Upon approval, HPE and BYB workers will now give a “Presumptive Eligibility Receipt” to clients as proof that the HPE or BYB program has been approved.
- Veteran’s income is exempt from counting for presumptive eligibility, in addition to educational and child support income.

Additional changes that affect the HPE program only:

- Previously, a client could receive one period of HPE every six months. With the exception of the Pregnant Women HPE category, a client now can only receive one period of HPE per calendar year. A woman can still receive HPE once per pregnancy under the HPE Pregnant Women category.
- Clients also have the option to “opt out” of applying for ongoing medical assistance when applying for HPE.

Additional change that affects the BYB program only:

Unless otherwise noted, all changes take effect on July 1, 2014

- Medical coverage for the BYB program will end the last day of the month following the month the BYB coverage was approved, unless the recipient applies for ongoing medical assistance. If the recipient applies for ongoing medical assistance, BYB coverage will continue until the Department of Workforce Services (DWS) approves or denies the application. A BYB recipient will no longer need to call DWS to request an extension.
-

14-83 Medicaid Providers Enrolled with a Shared FEIN

In the process of reviewing Utah Medicaid's current provider information, it has been identified that some providers are enrolled with a Federal Employer Identification Number (FEIN) /Tax ID that is shared with other providers, and the FEIN does not belong to the individual provider. The FEIN may belong to a corporation, group, or facility.

If you are a provider enrolled with a shared FEIN, and not already enrolled as a group with Medicaid, please submit a group application packet, along with the required documents and a list of names and NPIs that are currently enrolled that you would like affiliated to your group. The deadline for submitting the required information is August 31, 2014.

It is mandatory to enroll as a group to continue sharing a FEIN, to ensure that you are enrolled correctly and that money is reported to the correct FEIN for IRS reporting. Please note that a delay in complying with this requirement may result in your claims not being processed.

The application packet can be found on the Medicaid website at <https://medicaid.utah.gov/become-medicaid-provider>. If you have further questions, please contact Provider Enrollment at (801) 538-6155, or 1-800-662-9651, option 3 then 4.

14-84 Diagnoses Lists Updated

Effective July 1, 2014, the following attachments will be updated in the *Utah Medicaid Hospital Services Provider Manual*:

- Authorized Emergency Inpatient Diagnoses List
- Authorized Emergency Diagnoses List

The lists are available on the Medicaid website at <https://medicaid.utah.gov>.

Unless otherwise noted, all changes take effect on July 1, 2014

14-85 Coding Updates

CPT Code Change

22558 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar. Prior authorization is required. See Utah Medicaid website Coverage and Reimbursement Lookup Tool at: <https://medicaid.utah.gov> -> Health Care Providers -> Coverage and Reimbursement Tools -> Coverage -> Coverage and Reimbursement Lookup Tools

Endoscopy

The following CPT codes have been ranked to correct a reference file discrepancy:

31545 31546 31636 31638 43194 43195 43196 43197 43198 43212 43213 43214 43229 43233 43253
43266 43270 43274 43275 43277 45341 45342 45391 45392 52343 52346 52353 52402

ICD-9-CM Procedure Diagnosis Codes

Sterilization and abortion procedures require prior authorization. Infertility treatments are non-covered services under Medicaid to any provider, including the hospital. The following procedure diagnosis codes have been corrected to be reimbursed only with a Medicaid Authorization/Consent Form, or are non-covered:

Sterilization: 65.63 66.4 66.97

Abortion: 69.01 69.52 69.59 74.3

Infertility/Reconstruction: 65.72 65.75 65.92 66.8 66.93 66.95 70.62 70.64

87.82 and 87.83 are limited to prior authorization for fallopian occlusive device evaluation.

14-86 Nurse Practitioner Services

Effective April 1, 2014, the following codes were opened to nurse practitioners (provider types 37 and 47):

J0561 Injection, penicillin G benzathine, 100,000 units

11750 Excision nail and matrix, part/complete, permanent removal

11765 Wedge excision of skin of nail fold

Unless otherwise noted, all changes take effect on July 1, 2014

14-87 Laboratory Coding Update

CPT codes 88346 and 88347 (immunofluorescent study, each antibody, direct method/indirect method, respectively) are now on manual review if more than one unit is reported. Reporting of multiple units requires documentation of multiple specimens.

This change is based on the 2014 NCCI Policy Manual, which includes the following instructions:

“If a single antibody staining procedure for one or more antibodies is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one service may be reported for each separate specimen.”

14-88 Coding Change for Qualitative Urine Drug Screening by High Complexity Method

Utah Medicaid has opened code G0431 for qualitative urine drug screening by high complexity method (e.g. immunoassay, enzyme assay). The corresponding CPT code 80101 has been closed. Code G0431 reimburses a set amount per patient encounter, regardless of the number of drugs analyzed, that roughly corresponds to payment of five units of 80101.

Providers should transition from use of 80101 to use of G0431 beginning July 1, 2014. Note: CPT code 80104 should continue to be used for qualitative urine drug screening by multiplexed screening kits.

14-89 Physician Services – Ultrasound in Pregnancy

The following changes have been made in the Physician Services Provider Manual:

H. Ultrasound in Pregnancy

- One routine office ultrasound for all pregnant women at about 18 weeks of gestation. When the member experiences complications at less than 14 weeks gestation, one ultrasound is allowed in addition to the one at 18-20 weeks. The screening ultrasound should be submitted with the addition of the diagnosis code V22.0, V22.1, or V23.3.
- Indications for ultrasound in the first trimester include ectopic pregnancy, spontaneous abortion (threatened, incomplete, missed), molar pregnancy, first trimester bleeding, and intrauterine device.
- Members with an incompetent cervix must be referred to a perinatal center for a transvaginal ultrasound. Abdominal ultrasounds cannot diagnose an incompetent cervix and are non-covered.

14-90 Physician Manual Update – Diabetes Self-Management Training

The Utah Department of Health will no longer provide diabetic self-management training services. The diabetic self-management training services acceptable to Medicaid are:

- Nationally recognized American Diabetes Association (ADA) certified diabetes educators [refer to www.diabetes.org]
 - American Association of Diabetes Educators (AADE) [refer to www.diabeteseducator.org]
-

14-91 Hospital Services Manual Changes

Clarification has been made to the “3-day payment window” and readmissions within 30 days policy. The changes are underlined below.

Regarding “3-day payment window”

Services performed for a Medicaid client by the admitting hospital or by an entity wholly owned or wholly operated by the hospital, on either the date of an inpatient admission or during the three calendar days immediately preceding admission, are considered inpatient services. This three-day payment window applies to diagnostic and non-diagnostic services that are clinically related to the reason for the inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

Regarding readmissions within 30 days

Readmissions within 30 days – Refer to Utah Administrative Rule R414-1-12 and readmission review information outlined in the Superior Systems Waiver.

14-92 Hospital Services Manual Change – Reference to Cognitive Services Limitations

A reference to the cognitive services limitations, as found in the Physician Services Manual, was added to the Hospital Services Manual. The following is a reiteration of the limitation:

Cognitive services by a provider are limited to one service per client per day. These services are defined in the CPT Manual as office visits, hospital visits except for those following a package surgical procedure, therapy visits, and other types of nonsurgical services. When a second office visit for the same problem or a hospital admission

Unless otherwise noted, all changes take effect on July 1, 2014

occurs on the same date as another service, the physician must combine the services as one service and select a procedure code that indicates the overall care given.

14-93 Federally Qualified Health Centers and Rural Health Clinics

Effective July 1, 2014, all FQHCs and RHCs must bill specific procedure codes, in addition to code T1015. Claims billed with only code T1015 will be denied and will have to be resubmitted with the proper supporting codes.

14-94 Outpatient MRI Studies Policy Clarification

Effective July 1, 2014, failure to obtain a prior authorization (PA), when indicated, for outpatient MRI studies completed in independent radiology centers or hospitals, may result in denial of reimbursement for the technical and/or professional components.

Indications for PA for MRI studies may be found on the Utah Medicaid website at: <https://medicaid.utah.gov>. Choose "health care providers" on the top drop down menu → "prior authorization" → "criteria" → "Medical Criteria" → select the appropriate MRI study from the "Criteria for Imaging" drop-down menu.

14-95 Physical Therapy and Occupational Therapy Evaluation and Re-evaluation Codes

The following codes are opened to allow for billing of physical therapy and occupation therapy evaluation and re-evaluation:

- 97002 Occupational therapy evaluation
- 97003 Physical therapy re-evaluation
- 97004 Occupational therapy re-evaluation

Unless otherwise noted, all changes take effect on July 1, 2014

14-96 Physical Therapy and Occupational Therapy Modifier Use Change

Utah Medicaid is updating its claims adjudication system. As a result, prior authorization requests and claims for physical therapy and occupational therapy services will require the addition of an identifying modifier (GP or GO) to T1015, the code utilized for these services.

Physical Therapy: GP with T1015
Occupational Therapy: GO with T1015

Prior Authorization

Effective July 1, 2014, prior authorization (PA) requests without the appropriate modifier will be returned to the provider for the addition of the modifier. This modifier facilitates the PA process and allows the PA staff to determine what type of therapy is requested.

Claims

Medicaid recommends beginning immediately to add the GP modifier when submitting claims for physical therapy services, even though it is optional. Providers must continue adding the GO modifier when submitting claims for occupational therapy services.

14-97 Medical Supplies Codes Opened

The following HCPCS codes are opened:

A4432 Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each. Effective April 9, 2014.
E1228 Special back height for wheelchair. Prior authorization is required. Effective March 27, 2014.

14-98 Orthotic and Prosthetic Codes

Utah Medicaid has reviewed the orthotic and prosthetic HCPCS code groups. The majority of these codes have now been opened to provider types 62 and 91. These codes were previously limited to outpatient hospitals. Please use the Coverage and Reimbursement Lookup Tool to verify allowed provider type(s), and other criteria or limitations that are applicable to the codes.

Unless otherwise noted, all changes take effect on July 1, 2014

14-99 Dental Services – Partial Dentures

Effective July 1, 2014, partial dentures will be limited to EPSDT eligible members, ages 6-20 years of age. Current criteria still apply.

D5211 Maxillary partial denture, resin base

D5212 Mandibular partial denture, resin base

D5213 Maxillary partial denture, cast metal framework with resin denture bases

D5214 Mandibular partial denture, case metal framework with resin denture bases

14-100 Dental Manual Update

The *Utah Medicaid Provider Manual for Dental Services* has been updated as follows:

4B-16 ORTHODONTIA

Note: Orthodontic treatment is limited to one per lifetime. Medicaid does not cover re-banding or multistage orthodontic treatment.

14-101 Dental Claim Forms

Utah Medicaid currently uses the American Dental Association (ADA) 2006/J400 Dental Claim Paper Form for billing. In 2012, the ADA released the new American Dental Association® Dental Claim Form (J430). The ADA Dental Claim Form has been revised to incorporate a significant change in the HIPAA standard, which now enables a dentist to include a diagnosis code (ICD-9-CM) when needed on a claim.

Effective immediately, providers may begin submitting the 2012 Dental Claim Form (J430) to Utah Medicaid. Utah Medicaid will accept both the 2012 Dental Claim Form (J430) and the 2006 Dental Claim Form until further notice.

Unless otherwise noted, all changes take effect on July 1, 2014

14-102 Home Health Agencies Manual Clarification – Long-Term IV Use

The following information was added to the *Utah Medicaid Home Health Agencies Provider Manual* to clarify when a long-term IV line is not required:

When a client is to receive a medication, such as an antibiotic for a 7 to 10 day period, it is expected that some type of long-term IV administration line will be placed. Pregnant women and other individuals, if medically indicated, who have well-documented risk of infection, are excluded from this requirement, and may have a visit every 3 days for peripheral line maintenance.

14-103 Home Health Agencies Manual – Private Duty Nursing – Policy Clarification

The language concerning private duty nursing (PDN) services in the *Utah Medicaid Home Health Agencies Provider Manual* has been clarified. Clarification includes:

1. Expanded descriptions of covered populations.
2. Simplified description of requested documentation.
3. More explicit guidelines for adjustment of PDN services during either active weaning or increases in services.
4. Clarified billing processes when multiple members receive services in the same home.

In response to inquiries regarding the validity of the Utah Medicaid PDN Acuity Grid, which is used to determine medical necessity and quantify the number of PDN hours authorized, Medicaid assures providers and members that the grid was independently validated and shown to accurately capture care needs and acuity and to have acceptable inter-rater reliability.

For more information, refer to the *Utah Medicaid Home Health Agencies Provider Manual* at <https://medicaid.utah.gov>. Select: Health Care Providers → “Administrative Information” → “Manuals” → “Utah Provider Medicaid Manual” → “Medicaid Provider Manuals” → “Home Health Agencies” → “HomeHealth” → “Private Duty Nursing (PDN)”.

14-104 Pharmacy Program Policy Updates

Pharmacy Copay Override

IMPORTANT: In order to prevent Utah Medicaid members from being charged in excess of \$15 in pharmacy copays each month, we ask pharmacy providers to utilize the copay override.

Unless otherwise noted, all changes take effect on July 1, 2014

For Traditional Medicaid and Non-Traditional Medicaid members, enrolled with an Accountable Care Organization (ACO), there can be instances where the member could be charged in excess of the \$15 maximum monthly copay amount. This may happen when members fill both carved-in and carved-out medications on the same date (carved-out medications are not covered by a managed care plan and include hemophilia treatment drugs, immunosuppressants, specific addiction therapy drugs, and psychotherapeutic drugs).

Fee-for-service (FFS) Medicaid has implemented a copay override that pharmacies may use only when they have billed multiple claims and received a member's copay amount in excess of \$15 across all Medicaid pharmacy claims filled on that date. The override will only work for claims billed to FFS Medicaid. This is why it is always important to bill ACO pharmacy claims first, and then FFS pharmacy claims.

To override the member's copay amount, the pharmacy must submit at the point-of-sale:

- Prior Authorization Type Code (NCPDP field 461-EU) with a value of 4
- Prior Authorization Number (NCPDP field 462-EV) with a value of 111

As a reminder, a provider may not refuse service to a Medicaid member based on the member's inability to pay their copayment. See 42 CFR 447.53(e).

340B Point-of-Sale Billing

Utah Medicaid participates in the 340B Drug Pricing Program product claims adjudication, billing, and rebate program. The 340B program has strict federal requirements. Information is limited to those aspects of the 340B program that pertain to Medicaid point-of-sale fee-for-service. In general, those aspects are:

1. Health Resources and Services Administration (HRSA), and CMS requirements
2. Claims billing
3. Claims adjudication

For information regarding the Accountable Care Organizations, please refer to the Medicaid managed care program.

A 340B covered entity is a facility eligible to purchase drugs through the 340B program. HRSA, a sister agency to CMS, oversees the 340B program. Covered entities receive deep drug discounts on drugs paid for by Medicaid. The responsibility for 340B program compliance, prevention of double discounts and diversion, rests entirely upon the covered entities. Medicaid's role is provider billing policy and education, claims processing policy, and rebate billing.

A covered entity that wishes to utilize contract pharmacy services to dispense section 340B outpatient drugs must have a written contract in place between itself and a specified pharmacy. Basic compliance issues for 340B contract pharmacies include:

1. Ensure against illegal diversion and duplicate discounts.
2. Maintain readily auditable records.

Unless otherwise noted, all changes take effect on July 1, 2014

3. Meet all other 340B Drug Pricing Program and Office of Pharmacy Affairs (OPA) requirements.
4. A signed certification submitted to the OPA, establishing that an agreement with contract pharmacies has fully addressed a plan to meet its ongoing responsibilities.

For Utah Medicaid to reimburse for a 340B drug prescription, the following are required of the covered entity:

1. Register pharmacy NPI with HRSA and notify Utah Medicaid of participation.
2. Execute all 340B contracts and agreements, and submit to OPA for confirmation.
3. Inform wholesalers and manufacturers of enrollment and intent to participate.
4. Recertify eligibility yearly.
5. Submit all Medicaid pharmacy claims for that NPI identifier with an NCPDP submission clarification code value of "20".
6. 340B Drug Pricing Program covered entities must ensure program integrity and maintain accurate records documenting compliance with all 340B program requirements.

When 340B claims are processed, the Medicaid system will validate the covered entity NPI to ensure it is eligible. Periodically, Utah Medicaid will validate this information against the OPA 340B list of eligible providers. 340B claims submitted from non-340B registered pharmacies will be denied. Conversely, non-340B indicated Medicaid claims submitted from a 340B NPI on the Medicaid list will also be denied.

Covered entities are subject to audit by the manufacturer, the federal government, as well as other oversight agencies/groups. Failure to comply may make the 340B covered entity liable to manufacturers for refunds of discounts or cause the covered entity to be removed from the 340B program. For further information, please see the HRSA website at: <http://www.hrsa.gov/opa/index.html>.

340B Improper Billing

Pharmacy providers billing with an improper identification code, or claims found to be out of compliance with federal and state requirements for 340B claims, must reverse and rebill the claims according to procedures similarly outlined in the Utah Provider Manual Section I, Chapter 11-1 (Rebilling Denied Claims) and Chapter 11-14 (Claim Corrections Through Re-submission).

These procedures must follow the accepted NCPDP standard for the reversal and rebilling of pharmacy claims in the pharmacy point-of-sale system.

Unless otherwise noted, all changes take effect on July 1, 2014

14-105 Providers of Rehabilitative Mental Health and Substance Use Disorder Services (Prepaid Mental Health Plans, Mental Health and Substance Use Disorder Treatment Providers and Department of Human Services (DHS) Providers)

Effective July 1, 2014, the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been reformatted and includes updated content.

Also, refer to the following chapters:

- Chapter 2-1, General Limitations, #3, and Chapter 2-4, Psychological Testing, have updated content regarding neurobehavioral status exam, procedure code 96116, and neuropsychological testing, procedure code 96118.

Payment for neurobehavioral status exams, procedure code 96116, is limited to three hours (three units), unless additional time is approved based on manual review. For both services, clarification is made that the service limit is per year.

Claims for both procedures require manual review.

If more than three hours (three units) for procedure code 96116 or eight hours (eight units) for procedure code 96118 are billed, providers must submit documentation for manual review. Documentation consists of medical records that give evidence of and support the billing as correct and valid. A Medicaid reviewer will assess the documentation to determine if additional payment will be made. If supporting documentation is not submitted, no additional payment will be made.

To submit documentation, either attach it to the claim or submit via FAX to the Bureau of Medicaid Operations at (801) 538-0463. If submitting documentation via FAX, include a coversheet that specifies whether it is for neurobehavioral status exam manual review or neuropsychological testing manual review.

- Chapter 2-1, General Limitations, #2, clarification is made regarding service substitution policy for Medicaid recipients with Non-Traditional Medicaid.
- Chapter 2-5, Psychotherapy, and Chapter 2-8, Pharmacologic Management Services (Evaluation and Management (E/M) Services), content regarding prolonged services has been updated and prolonged services codes 99356 and 99357 have been added.

The revised manual is available at <https://medicaid.utah.gov>.

Unless otherwise noted, all changes take effect on July 1, 2014

14-106 Physicians, Psychologists, Mental Health and Substance Use Disorder Treatment Providers/Prepaid Mental Health Plans, and Department of Human Services (DHS) Mental Health Providers

Effective July 1, 2014, the *Utah Medicaid Provider Manual for Psychology Services* has been reformatted and includes updated content.

Also, refer to Chapter 1-2, C., Service Coverage and Reimbursement Limitations, and Chapter 2-2, Psychological Testing, for updated content regarding neurobehavioral status exam, procedure code 96116, and neuropsychological testing, procedure code 96118.

Payment for neurobehavioral status exams, procedure code 96116, is limited to three hours (three units), unless additional time is approved based on manual review. For both services, clarification is made that the service limit is per year.

Claims for both procedures require manual review.

If more than three hours (three units) for procedure code 96116 or eight hours (eight units) for procedure code 96118 are billed, providers must submit documentation for manual review. Documentation consists of medical records that give evidence of and support the billing as correct and valid. A Medicaid reviewer will assess the documentation to determine if additional payment will be made. If supporting documentation is not submitted, no additional payment will be made.

To submit the documentation, either attach it to the claim or submit via FAX to the Bureau of Medicaid Operations at (801) 538-0463. If submitting the documentation via FAX, include a coversheet that specifies whether it is for neurobehavioral status exam manual review or neuropsychological testing manual review.

The revised manual is available at <https://medicaid.utah.gov>.

14-107 Prepaid Mental Health Plans, Mental Health and Substance Use Disorder Treatment Providers

Effective July 1, 2014, the *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness* has been reformatted and includes updated content.

The revised manual is available at <https://medicaid.utah.gov>.

Unless otherwise noted, all changes take effect on July 1, 2014

14-108 Updates to General Information – Section I

Effective July 1, 2014, the *Utah Medicaid Provider Manual, General Information – Section I*, includes the following revisions:

- Chapter 2-1, Medicaid Services, the definition of Child Health Evaluation and Care (CHEC) Services in #5 is clarified and the reference to psychology services in #9 is updated.
- Chapter 9-4, Prior Authorization Procedures, updates are made regarding programs that may require prior authorization.

The revised manual is available at <https://medicaid.utah.gov>.

14-109 Utah Medicaid Provider Manuals Revised

The following Utah Medicaid provider manuals have been revised and reformatted. To review the complete manuals, refer to the Utah Medicaid website at: <https://medicaid.utah.gov>. Previous versions will be archived.

- **Utah Medicaid Provider Manual for Chiropractic Medicine**
- **Utah Medicaid Provider Manual for Physical Therapy and Occupational Therapy Services**
Significant changes include: clarification of what a treatment session may include, documentation of the treatment session, re-evaluation, and documentation of a re-evaluation.

Manuals with New Titles

- **Utah Medicaid Provider Manual for Women’s Services**
Combines the following manuals: Services for Pregnant Women, Certified Nurse-Midwife Services, and Hospital Services - Birthing Center.
 - **Utah Medicaid Provider Manual for Speech-Language Pathology and Audiology Services**
Combines the following manuals: Speech-Language Services and Audiology Services.
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14-110 Clarification of January 2014 MIB Article 14-22

Please note the following clarification of January 2014 MIB article 14-22 regarding bilateral cochlear implants:

Coverage for bilateral placement of cochlear implants for CHEC (EPSDT) recipients was expanded beginning January 1, 2014, if the service is determined to be medically necessary. Cochlear implants are an optional service.

Unless otherwise noted, all changes take effect on July 1, 2014

14-111 Medical Supplies and Durable Medical Equipment (DME)

Claims programming was changed so items with a quantity limit can be automatically processed against the allowed limits programmed. All codes requiring a right or left side modifier will be denied if the modifier is not used. Refer to the Medicaid website Coverage and Reimbursement Lookup Tool at <https://medicaid.utah.gov> to determine the quantity limits.

Quantity limits for items that could have a bilateral application, will indicate the quantity allowed for one side. When ordering a medical supply or a DME item that could be used bilaterally, the request and claim must state if the item is for bilateral use or single side use and for which side (right or left). The applicable modifier(s) must be on the claim.

Examples:

Bilateral Use

Code L8420: Prosthetic sock, multiple ply, below knee, each. Medicaid allows up to 24 per year without a prior authorization. The provider orders 12 for bilateral use. The reimbursement request is submitted on one claim using two lines with the applicable modifier:

	Unit(s)	Code	Modifier 1	Modifier 2
Correct	6	L8420	RT	
Correct	6	L8420	LT	
Incorrect	12	L8420	RT	LT

Unilateral Use

Code L8420: Prosthetic sock, multiple ply, below knee, each. Medicaid allows up to 24 per year without a prior authorization. The provider orders 12 to use on the left side. The reimbursement request is submitted on one claim using one line with the applicable modifier:

	Unit(s)	Code	Modifier 1	Modifier 2
Correct	12	L8420	LT	
Incorrect	12	L8420		

Unless otherwise noted, all changes take effect on July 1, 2014

14-112 Provider Preventable Conditions (PPC) Policy Clarification

The following is intended to clarify the provider preventable conditions (PPCs) policy. The manual now emphasized that in the event of an outlier PPC claim, the provider will receive Remittance Advice (RA) confirming the occurrence of the outlier PPC and requesting submission of medical records. In addition, at the time of RA notification, a confirmatory letter may be generated, reiterating the occurrence of a PPC outlier and the need to submit documentation.

Requested records are expected to be submitted within 30 days of RA notification. If the medical records are submitted within the 30-day period, the claim will be reviewed and, if appropriate, processed and paid. If medical records are not submitted within the 30-day period, the claim will be denied for failure to submit the requested documentation in a timely fashion.

In addition, effective July 1, 2014, providers will need to submit an “Outlier PPC Medical Record Documentation Submission Form” along with the requested documentation. The purpose of the form is to facilitate timely review and adjudication of claims.

The form is available on the Utah Medicaid website at: <https://medicaid.utah.gov>, Administrative Information, Forms.

See example of the form:

Unless otherwise noted, all changes take effect on July 1, 2014

Outlier PPC Medical Record Documentation Submission Form

This form serves to facilitate timely claim review and adjudication and should be completed for all outlier PPC claims.

Recipient Name: _____ Recipient ID Number: _____

Dates of Service: _____ Date of PPC Occurrence: _____

PPC Diagnosis:

Precise definitions and codes for hospital-acquired conditions that qualify as PPCs are available on the Utah Medicaid website (<https://medicaid.utah.gov/>). Click on the "Health Care Provider" tab in the top menu bar and select: "Administrative Information" → "Manuals" → "Utah Medicaid Provider Manual" → "Medicaid Provider Manuals" → "Hospitals" → "Attachments" → "PPC-DiagnosisList[M-YY]".

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer, Stages III & IV
- Falls and Trauma
- Catheter-Associated Urinary Tract Infection
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control
- Surgical Site Infection, Mediastinitis, after Coronary Artery Bypass Graft
- Surgical Site Infection after Certain Orthopedic Procedure
- Surgical Site Infection after Bariatric Surgery
- Surgical Site Infection after Cardiac Implantable Electron Device
- Iatrogenic Pneumothorax with Venous Catheterization
- Deep Vein Thrombosis and Pulmonary Embolism after Certain Orthopedic Procedures

PPC-Associated Treatments and Procedures (please include dates):

In addition to the above information, submit the following documentation:

- Complete medical records from the associated hospital stay
- An itemized bill
- Notation of any charges claimed as "non-covered" due to being related to PPC occurrence or treatment

This form and all requested documentation should be submitted simultaneously via fax: (801) 536-0974.

If document files are large, a CD/DVD that contains this form and all requested documentation may be submitted via mailing address: Bureau of Medicaid Operations, ATTN: PPC, PO Box 143106, Salt Lake City, UT 84114-3106.