

Web address: <http://health.utah.gov/medicaid>

## TABLE OF CONTENTS

06 - 90	National Provider Identifier	2
06 - 91	Revised CMS 1500 Claim Form	3
06 - 92	Physician Fee Schedule - Basic RVU Update	3
06 - 93	Medicare Crossover Through POS	3
06 - 94	Anesthesia Billing	4
06 - 95	Coding Changes	4
06 - 96	Criteria #42 - Varicose Vein Stripping	5
06 - 97	Newborn Genetic Screening	5
06 - 98	Prolotherapy	5
06 - 99	MRI and Multiple Sclerosis	5
06 - 100	MRI and Cardiac Imaging	6
06 - 101	Modifiers	6, 7
06 - 102	Corneal Transplants	7
06 - 103	Observation Codes	7
06 - 104	Medical Supplies	7, 8
06 - 105	Dental Updates	9
06 - 106	Transportation, Lodging and Meals While Obtaining Out-of-State Medical Services	9
06 - 107	Medicaid Managed Care Plans/ Non- Contracting Providers	10
06 - 108	Physician Billings For Office Admin Drugs	10
06 - 109	Change in Pharmacy Reimbursement	10
06 - 110	CHEC Requires Lead Screening	10
06 - 111	Targeted Case Management	11
06 - 112	<u>Home and Community-Based Waiver For Technology Dependent/ Medically Fragile Provider Manual Updated</u>	11
06 - 113	Heart Assist Devices	11

## BULLETINS BY TYPE OF SERVICE

All Providers	06-90, 107
Ambulatory Surgery Centers	06-91, 102
Anesthesiologists	06-91, 94, 95, 105
Certified Nurse Midwife	06-91, 97
CHEC Services	06-91, 110
Dental Providers	06-105
Home Health Agencies	06-112
Hospital	06-92, 94-96, 99-103, 109
Medical Supplier	06-91, 93, 104
Oral Surgeon	06-91, 105
Pharmacy	06-93, 104, 109
Physician Services	06-91-104, 108-110, 113
Radiologists	06-91, 95, 99, 100
Targeted Case Management	06-111
Transportation Providers	06-92, 107

World Wide Web: <http://health.utah.gov/medicaid>

### Medicaid Information

- Salt Lake City area, call 538-6155.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- From other states, call 1-801-538-6155.

### Requesting a Medicaid publication?

Send a Publication Request Form.

- by FAX: 1-801-536-0476
- by mail to: Division Of Health Care Financing  
Box 143106, Salt Lake City UT 84114-3106

---

---

“NPI: Get It. Share It. Use It.”

**06 - 90 National Provider Identifier**

On October 1, 2006, there will only be 235 days left before the NPI compliance date of May 23, 2007. It is important that you get your NPI now. To apply for a NPI online, visit the NPPES website; <https://nppes.cms.hhs.gov> , or download the paper application form at [www.cms.hhs.gov/nationalprovidentstand/](http://www.cms.hhs.gov/nationalprovidentstand/) and mail it to the address on the form; or authorize an employer or other trusted organization to obtain a NPI for you through bulk enumeration.

Statistics show that about 35 percent of eligible Utah providers have obtained a NPI. Out of that total, only about 11 percent of Medicaid enrolled providers have submitted a NPI to Provider Enrollment for cross walking to a current Medicaid provider number. Once you get your NPI and share it with your payers, Medicaid must integrate the NPI into our claims processing system and processes. Also, testing transactions using your NPI with your Medicaid provider number(s) may take some time and cannot even begin until after you obtain your NPI. If you delay applying for your NPI, you risk your ability to meet the NPI compliance date and deter us from completing the testing process in time for you to begin receiving payments under your NPI. If you have a NPI, please fax it to (801) 536-0471 or mail the information along with your Provider Name, Medicaid Provider Number, Provider Taxonomy Code, and 9-digit zip code to Medicaid Provider Enrollment, P O Box 143106, Salt Lake City, UT 84114-3106.

Medicaid wants all providers, with the exception of pharmacies, to begin using a NPI along with the Medicaid provider number on electronic claims beginning October 1, 2006. Beginning December 1, 2006, pharmacies may begin using either their NPI or Medicaid provider number on electronic claims submitted through Point of Sale. If pharmacies have a NPI, Medicaid requests that they provide us with the NPI before sending it on a claim the first time. If a pharmacy has the prescribing physicians NPI, they may begin sending it on their electronic claims in the Prescriber Identifier Field beginning December 1, 2006. All NPI values must be qualified as a NPI. Now is not the time to procrastinate. If you do not have a NPI, **get it**. If you have a NPI, **share it**. Medicaid will be ready for you to **use it** along with your Medicaid provider number on claims from October 1, 2006 to May 22, 2007. Remember, “Getting a NPI is free - not having one can be costly.”

Medicaid staff are currently working with the UHIN National Provider ID Subcommittee and NMEH NPI Sub-Workgroup to assist in the implementation of NPI.

Medicaid will keep you informed of our progress with implementing the NPI.

Visit the Medicaid Website at <http://www.health.utah.gov/medicaid> for additional NPI useful links and training resources.

□

---

---

**06 - 91 Revised CMS 1500 Health Insurance Claim Form**

Effective February 1, 2007, Medicaid will only accept the revised CMS 1500 (version 08/05). Providers may begin billing on the new claim form beginning October 1, 2006. During the transitional period between October 1, 2006 and January 31, 2007, multiple versions will continue to be accepted, however, if it is possible to begin using the new claim form on October 1, Medicaid would prefer that you do so.

The new CMS 1500 claim form will accommodate the reporting of the National Provider Identifier (NPI). Medicaid will use a dual strategy and capture your Medicaid provider number and your NPI to verify correct matching in a crosswalk to eliminate any payment issues. UHIN Standard #56 contains specific instructions regarding usage of the new claim form, including placement of the NPI and Medicaid ID. The standard is available at [www.uhin.com](http://www.uhin.com).

Third Party Liability (TPL) billing instructions have also changed due to the new form. Refer to the Utah Medicaid Provider Manual, General Attachments Section.

Providers should contact their vendors to prepare for the changes.

To view the claim form along with other documents, access through the National Uniform Claim Committee at [www.nucc.org](http://www.nucc.org)

Medicaid encourages electronic submission of claims. Providers interested in electronic billing should contact the Utah Health Information Network (UHIN) at (801) 466-7705 or online at <http://health.utah.gov/hipaa> and access Enrollment.

Remember to use the link to the Medicaid website as it provides you with important up to date information and important links. [Http://health.utah.gov/medicaid](http://health.utah.gov/medicaid)

□

---

---

**06 - 92 Physician Fee Schedule - Basic RVU Update**

Effective July 1, 2006, an update of the basic RVU was completed. Relative value units (or RVU's) represent the relative difference in providing services for physician codes. These values are from national physician practice surveys. The Division's source for the most recent update is [2006 The Essential RBRVS \(Ingenix\)](#).

The exercise for updating RVU's included calculating the total dollars paid out under the prior RVU's and then applying the new RVU's to the codes and adjusting the total dollars paid so that it matched the total dollars previously paid out. In essence, rebasing RVU's was budget-neutral to Utah Medicaid.

In addition to the rebasing, Utah Medicaid implemented a 2% (rounded) rate increase allowed by the 2006 Utah Legislature. The increase was added to the total dollars paid after the RVU rebasing. While total dollars projected to be paid went up, providers may discover higher payments for some procedure codes, while other codes are paid at a lower rate. These variations depend greatly on whether the new RVU was higher or lower than the previous RVU.

□

---

---

**06 - 93 Medicare Crossover Claims Through Point of Sale**

Beginning November 1, 2006, Utah Medicaid's Point of Sale System will be available for Medicare/Medicaid Part B Coordination of Benefits. Providers may follow either of two options for claims processing:

- (1) Bill Medicare and allow the claim to be forwarded as a crossover claim by your Medicare intermediary, or
- (2) Bill Medicaid direct in NCPDP format after Medicare has paid.

Both methods require the Medicare ICN number to be placed in the alternate ID number field (330CW) in the claim segment. The Medicare payment must be reflected in the COB segment with standard qualifiers (341HC) and other payer amount paid (431DV) fields.

As a reminder, Medicaid will process crossover claims for payment of co-insurance and deductible.

□

## 06 - 94 Anesthesia Billing

Anesthesia providers billing ASA procedure codes electronically are reminded to report anesthesia time in minutes. Please verify that the correct MJ qualifier is being output by your software program. UHIN Standard #1 requires that anesthesia time be reported in minutes instead of units.

Anesthesia providers billing ASA procedure codes on paper claim forms are reminded to report the anesthesia time in minutes. Enter the number of minutes in Box 24G of the CMS-1500 form by putting an MJ before the number for the minutes. Example: MJ120 in Box 24G.

If an ASA procedure is submitted without minutes or the correct MJ qualifier, Medicaid will pay one time unit per the Anesthesiology Manual, Section 2-1.

Postoperative pain management using code 01996 is an exception to the instructions listed above. Units will be attached to this code but no time payment is made. Submit claims with a UN qualifier indicating units, a single unit per date of service, and a "P" modifier. There will be no additional payment related to the physical status of the patient. The code describes a daily pain management service and code 01996 is reimbursed beginning the day following surgery. There is only one exception to this policy, refer to the Limitations Section 9 - B.3 in the Physician Manual.

Anesthesia providers billing for dental services should use code 41899 with the appropriate "P" (physical status) modifier and the actual anesthesia time in minutes. Prior Authorization is required under certain conditions. Refer to the Dental or Oral Surgeon Provider Manuals for criteria. Follow the instructions outlined above using the MJ qualifier.

Obstetrical anesthesia is an exception to Medicaid's policy concerning multiple procedures performed during a single anesthetic administration. Refer to Section 3 Anesthesiology; Chapter 4, Multiple Procedures in the Physician Manual. Providers billing for anesthesia related to delivery are reminded that for neuraxial analgesia/anesthesia for planned vaginal delivery which becomes a Cesarean delivery, the code 01967 should be used to begin the procedure. When C-Section is imminent, discontinue use of code 01967 and change to code 01968. Continue on with straight time as for general surgery, reporting minutes for each anesthesia code. Procedure codes 01968 and 01969 are add-on codes which must always be submitted with the primary code 01967. These codes will not be reimbursed when billed as the only procedure code.

□

## 06 - 95 Coding Changes

### Codes Covered

- 00840 Anesthesia for Intraperitoneal procedures (because this code covers anesthesia for numerous procedures, the requirement for PA has been removed)
- 38220 Bone marrow; aspiration only (removed from prior authorization)
- 38221 Bone marrow biopsy, needle or trocar (removed from prior authorization)
- 99234 Observation or inpatient hospital care
- 99235 Observation or inpatient hospital care
- 99236 Observation or inpatient hospital care
- S3620 Newborn screening test. (The code **S3620 submitted with the BL modifier** is to be used by certified nurse midwives or clinics to bill for the state laboratory newborn screening kit when the procedure is completed through them instead of the hospital. The state laboratory newborn screening kit code includes the initial lab tests and a followup test about two weeks from birth. The venipuncture code may be billed in addition to S3620-BL).

### Codes for Manual Review

Hydration therapy is not a covered service in Medicaid unless there is clinical documentation of dehydration by electrolyte panel. These codes will not be paid in addition to the J-code and evaluation and management service.

- 90760 IV infusion for hydration, initial, up to one hour
- 90761 Each additional hour of IV infusion for hydration, up to 8 hours

### Non-Covered

- 73725 MRA, lower extremity, with and without contrast
- 75552 Cardiac MRI for morphology without contrast
- 75553 Cardiac MRI for morphology with contrast
- 75554 Cardiac MRI for function, with or without morphology, complete study
- 75555 Cardiac MRI for function, with or without morphology, limited study

□

---

---

**06 - 96 Criteria #42 - Varicose Vein Stripping**

In the Criteria for Medical/Surgical Procedures, Criteria #42, page 48, a listing of specific covered codes has been deleted from the first paragraph, because the listed codes were not current. It will be replaced with the statement, "Refer to the CPT Medical/Surgical List for non-covered procedure codes." Also, on page 48, item 3 under 'Non-coverage' has been changed to read, "Laser ablation and radio frequency ablation of the saphenous vein are not covered as alternatives to vein ligation and stripping. Medicaid covers the least costly alternative method and these procedures are additive to traditional ligation and stripping procedures."

□

---

---

**06 - 97 Newborn Genetic Screening**

The code S3620 with BL modifier will be used by outpatient providers to indicate newborn genetic screening test (36) completed through the state laboratory. This code will be paid along with the code for phlebotomy, code 36415.

□

---

---

**06 - 98 Prolotherapy**

Prolotherapy is a procedure for strengthening lax ligaments by injecting proliferating agents or sclerosing solutions directly into torn or stretched ligaments, or into a joint or adjacent structure to create scar tissue. The injected material is usually dextrose, glycerine, phenol, and lidocaine (described as P2G), but zinc sulfate and psyllium seed oil have also been used. Often triamcinolone or another steroid is added to the injection. Currently, evidence-based, controlled trials are insufficient to determine whether prolotherapy exceeds the effects of a placebo. This procedure is non-covered in Medicaid because it is considered investigational, experimental, and unproven. Codes noted to be used for this procedure (i.e. 20550, 20600-20610) are subject to post payment review.

□

---

---

**06 - 99 MRI and Multiple Sclerosis**

MRI is the most sensitive imaging technique for detection of intra cranial lesions associated with multiple sclerosis. However, the extent of cranial MRI abnormalities does not correlate well with degree of clinical disability. It is known that MRI changes seen in MS are nonspecific. Review of the clinical research indicates that MRI may not be accurate for ruling in or out MS because the MRI imaging of the brain has high sensitivity, but low specificity. The information derived from MRI imaging must be considered in the context of the patients history and clinical evaluation; therefore, this disease remains predominately a clinical diagnosis. MRI imaging of the brain does not require prior authorization, but spinal MRI does require prior authorization.

Spinal MRI may be approved under the following conditions:

1. Patients with primary progressive MS and myelopathy when the imaging study may affect therapeutic treatment or impact patient outcome.
2. Reassessment of disease burden before starting or modifying therapy, (i.e. interferon, IV immunoglobulin, mitoxanotrone, steroid).
3. Unexpected worsening of condition with neurological deficit.
4. Clinical evidence or suspicion of a secondary treatable condition.

Serial MRI imaging to follow disease course is non-covered because it offers little benefit in clinical practice.

□

---

---

## 06 - 100 MRI and Cardiac Imaging

Echocardiography and 64-MDCT imaging are the most specific and sensitive diagnostic tests available for cardiac diagnostic imaging. Duplex scan and 64-MDCT is becoming the standard for lower extremity vascular imaging. Based on the fact that the standard for diagnostic imaging has changed, the following codes will be closed for all clients in Medicaid including children.

73725 MR Angiography, lower extremity, with or without contrast materials  
 75552 Cardiac MRI for morphology without contrast  
 75553 Cardiac MRI for morphology with contrast  
 75554 Cardiac MRI for function, with or without morphology, complete study  
 75555 Cardiac MRI for function, with or without morphology, limited study

□

## 06 - 101 Modifiers

### Modifier 25

It is the responsibility of the provider to review the documentation for significant separately identifiable service and submission of the E&M code at the appropriate level for the service provided.

The following are inappropriate coding uses of modifier 25 and will be denied:

- Submitting the E&M code with the modifier 25 when the evaluation and management service is the sole service provided.
- Adding modifier 25 to the E&M service when the only additional procedures provided are laboratory (80000 range), radiology (70000 range), and/or vaccination administration (90471, 90472) codes. Each of these procedures will automatically pay the E&M with the procedure without modifier 25. Examples of other procedure codes which will pay in addition to the E&M service when modifier 25 is not used include:
 

93000	92567	94060	94010	95004	95860
95904	95903	95934	92557	92567	94640
- Placing the modifier 25 on the claim when the E&M service describes only the primary procedural service without any significant separately identifiable evaluation and management service.
- Placing the modifier 25 on procedure codes.
- Placing the modifier 25 on a second E&M service on the same date. Medicaid will not pay two E&M services. The provider is instructed to bill the E&M code which most closely describes the total service provided.

### Modifier 59

The modifier 59 is being placed on codes when it is not necessary and results in delayed processing of claims. For example, if the CT or MRI procedures are in different sites, do not put a modifier 59 on one of the codes. Some examples of the code combinations where this is occurring include 74160 and 72193; 74150 and 72192; 76942 and 76770; 72131 and 76375; 44780, 47600, and 35840; 29826 and 29823; 29891 and 20680; 37201 and 36216; 27814, 11010, and 29515; 95861, 95900, and 95904.

### Other modifier billing issues

- Medicaid will pay either the administration fee with the J-Code (NDC) or pay the E&M code. Medicaid will never pay the administration fee and the office code with the J-Code. By adding the 25 modifier on the E&M code and the 59 modifier on the administration fee, the claim becomes suspended. By not adding the modifiers, the E&M code will pay with the J-Code (NDC). The administration codes involved in this issue include 90772, 90760/90761, 90765/90766. The chemotherapy code 96413 is usually paid over the E&M service with other administration fee codes.
- Placing the 57 modifier on the claim will only suspend the claim in the system. Medicaid does not pay.
- Submitting the modifier 25 on the E&M code with a 59 modifier on the code 51701, 69210, 17250, or 94760 creates problems, because these codes are always incidental to the E&M procedure. By excluding the modifier 25, the E&M code will pay and post an incidental edit with the procedure codes.
- The consultation codes (99241-99245, 99251-99255) are paid when consultation is the only service provided. There is an exception for some procedures such as cardiac and respirator procedures which are necessary for the specialist to complete the consultation. These procedures will pay with the consultation code without the modifier 25 on the E&M code. Examples of procedures paid with the consultation code include:
 

93550	93018	93016	93320	93325	94060
94010	95004	95860	95904	95900	95903
93934					

5. Circumcision (54450) is not a covered procedure, exceptions must have prior authorization. By leaving the modifier 25 off of the E&M service, it will automatically pay.

□

---

---

## 06 - 102 Corneal Transplants

Medicaid does not cover corneal transplant tissue or other organ procurement separately from the DRG. The payment for organ preparation is included with the DRG payment to the hospitals. Therefore, the procurement of corneal tissue for corneal transplant (code 65710) is not covered in an ambulatory surgical center.

□

---

---

## 06 - 103 Observation Codes

Observation codes 99218-99236 are covered by Medicaid. Although Medicare allows 48 hours of observation service, Medicaid policy remains firm that observation is only covered when the service provided is less than 24 hours to determine if hospital admission is warranted. See *Physician Manual, Section 2, Chapter 2, item 16*.

□

---

---

## 06 - 104 Medical Supplies

### Supplies for CPAP after the Capped Rental Period

Rentals for CPAP and BPAP machines (without backup feature) include the masks, tubing, and supplies to operate the systems. These are capped after 12 months but remain the property of the supplier. All maintenance and service remains the responsibility of the supplier and the "MS" modifier may be billed for the "maintenance and service" every six months. However, after the 12-month cap or if the device is patient owned, the masks, tubing, and filters may be billed separately using the proper coding in accordance with the limitations listed in the Medicaid Medical Supplier Manual. Prior authorization is required.

### Prior Authorization Removed

Prior Authorization requirements have been removed from codes **L7520**, Repair of prosthetic device, labor component, and **L4205**, Repair of orthotic device, labor component.

### Intermittent Urinary Catheters

The unit limit for A4351, Intermittent urinary catheter; straight tip, with or without coating has been raised to 100 per month. Quantities above 100 will require prior authorization. This code has been reduced in reimbursement to reflect 85% of the Medicare allowable fee. Codes A4352 and A4353 remain at 10 units per month unless sterile technique is required and more than 10 units may be authorized under the following criteria.

#### Criteria for Intermittent Urinary Catheterization:

Intermittent urinary catheterization is covered when medically necessary and the recipient or care giver can perform the procedure. When clean, non-sterile catheterization technique is used, Medicaid will provide 10 intermittent catheters per month unless there is documentation of the medical necessity for sterile technique.

When sterile catheterization is necessary, up to 100 catheters per month may be approved by prior authorization. It is expected that most sterile catheterizations will be temporary measures for short periods of time. The recipient using sterile technique must meet one of the following criteria:

1. The recipient is immunosuppressed, for example (not all-inclusive):
  - on a regimen of immunosuppressive drugs post-transplant,
  - on cancer chemotherapy,
  - has AIDS, or
  - has a drug-induced state such as chronic oral corticosteroid use.

2. The recipient has radiologically documented vesico-urethral reflux while on a program of intermittent catheterization.
3. The recipient is a spinal cord injured female with neurogenic bladder who is pregnant (for duration of pregnancy only).
4. The recipient has had distinct, recurrent urinary tract infections, while on a program of clean, non-sterile intermittent catheterization, twice within the 12-months prior to the request for sterile intermittent catheterization.

Use of Coude (curved) tip catheters in females is rarely medically necessary. A Coude tip catheter is considered medically necessary for either male or female recipients only when a straight tip cannot be used.

### Major Changes in Power Wheelchair Coding

Effective October 1, 2006, Medicaid is implementing the following new HCPCs coding for power wheel chairs:

- K0815, POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0816, POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0822, POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0823, POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0824, POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0825, POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0826, POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0827, POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0828, POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0829, POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0835, POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0841, POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0843, POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0890, POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
- K0891, POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
- K0898, POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED

**ALL LISTED WHEELCHAIR CODES REQUIRE PRIOR AUTHORIZATION**

□

---

---

## 06 - 105 Dental Updates

### Dental Services Correction

Due to the last minute changes in the adult dental program, the July 2006 dental article terminating the adult dental benefits for Traditional Medicaid recipients was in error. The following is the corrected article:

Beginning July 1, 2006, adults with **Traditional Medicaid** will continue unchanged to receive dental benefits.

Beginning July 1, 2006, **Non-Traditional Medicaid** dental coverage will be terminated, including coverage for emergency dental services.

PCN coverage for adult dental benefits will continue unchanged.

Ambulatory Surgical Center services for dental cases will continue to be covered under the existing criteria, but the dental services are not covered.

### Combined Orthodontic/Surgical Treatment Cases

Medicaid requires that a licensed orthodontic specialist and a licensed maxillofacial oral specialist be used to treat combined orthodontic/surgical cases. Reimbursement will not be made to general dentists who perform the orthodontic or surgical treatment for combined orthodontic/surgical cases.

### General Anesthesia for Dental Cases by CRNA or Anesthesiologists

Anesthesia providers, CRNA or anesthesiologists, billing for dental services should use code 41899 with the appropriate "P" modifier (Physical Status) and the actual anesthesia time in minutes. Prior Authorization is required under certain conditions. Refer to the Dental or Oral Surgeon Provider Manuals for criteria. For electronic submissions, report anesthesia minutes using the MJ qualifier. For paper claims, report anesthesia minutes in Box 24G of the CMS-1500 form by putting an "MJ" before the number of minutes.

□

---

---

## 06 - 106 Transportation, Lodging and Meals While Obtaining Out-of-State Medicaid Services

### Transportation for Out-of-State Services (beyond 120 miles of the Utah border)

Transportation for out-of-state (beyond 120 miles of the Utah border) medical services is covered if the services are unavailable or cannot be performed in Utah. The transportation is limited to coverage for Medicaid services performed by Medicaid providers and must be prior authorized. The transportation will be the most cost-effective, but appropriate for the recipient's medical condition(s). If the transportation is within 120 miles of the border, it is excluded from this policy, but covered by the transportation contractor for in-state transportation.

Transportation covers the recipient and a parent or care giver, if the recipient is a child under the age of 20 years. Transportation may include an attendant for adults age 21 and older, if the recipient's medical condition requires attendant services while out of state.

### Lodging and Meal Per Diem Associated with Out-of-State Transportation

Overnight stays and meals associated with out-of-state travel (beyond 120 miles of the Utah border) may be allowed and requires prior authorization. A per diem for meals and overnight lodging may be preauthorized for the recipient, except for the days the recipient is receiving inpatient services. If the recipient is a child, age 20 years and under, an additional per diem for meals and lodging may be authorized for a parent or care giver. If the recipient is age 18 and older, an additional per diem for meals and lodging may be authorized for a non-parent attendant, if medically necessary, but only for the days the attendant is giving care and attending to the recipient.

The per diem for lodging and meals will be up to \$25 for lodging and up to \$25 for meals for a maximum total of \$50 per day per covered individual. To receive the out-of-state per diem, the department will require verification of housing and the dates of the days spent out of state for medical services and receipts for services are required. Nights staying with family or friends and associated meals are not eligible for the per diem. Reimbursement for lodging and meals is not available for the parent or care giver during the time the recipient is an inpatient in a medical facility.

□

---

---

**06 - 107 Medicaid Managed Care Plans/ Non-Contracting Providers**Limitations on Reimbursement to Non-Contracting Providers of Emergency Services

On February 8, 2006, President Bush signed into law the Deficit Reduction Act (DRA) of 2005. Section 6085 of the DRA created a new section 1932(b)(2)(D) of the Social Security Act. This legislation establishes a limit (as stated in the following paragraph) on the amount that emergency service providers, who do not have a Medicaid managed care contract, can be paid by Medicaid managed care plans.

A Medicaid provider who does not have a contract with a Medicaid managed care plan, and who furnishes emergency care to a beneficiary enrolled with that managed care plan, must accept as payment in full no more than the amount Medicaid fee-for-service would have paid.

This legislation is consistent with current Utah Medicaid practice.

The Medicaid managed care plans currently affected by this legislation include Healthy U, HOME Program, Molina, and the nine Prepaid Mental Health Plans (Bear River Mental Health, Central Utah Counseling Center, Davis Behavioral Health, Four Corners Community Behavioral Health, Northeastern Counseling Center, Southwest Center, Valley Mental Health, Wasatch Mental Health, and Weber Human Services).

□

---

---

**06 - 108 Physician Billings For Office Administered Drugs**

Beginning October 1, 2006, billings for drugs administered in the physicians office will need to include the NDC from the vial or container from which the drug is obtained, as well as the quantity of units administered. Beginning January 1, 2007, claims that do not include this information along with the HCPCS J-Code will be denied for payment. Modifications to the claim form are in place to accept this data.

□

---

---

**06 - 109 Change in Pharmacy Reimbursement**

Beginning January 1, 2007, the new Federal Upper Limits guidelines will include all drugs for which an "A" rated version is available. The new price indicator will not be AWP, but will be AMP plus dispensing fee. States may calculate the FUL at any level below the maximum of 250% of the AMP.

The new reimbursement will be based on AMP. These reimbursements will be published in the January 2007 Medicaid Information Bulletin.

(Effective for Traditional Medicaid, Non-Traditional Medicaid, and Primary Care Network)

□

---

---

**06 - 110 CHEC Services Require Lead Screening**

Providers are reminded that the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend a lead risk assessment and blood lead level test for all Medicaid eligible children between the ages of 6 and 72 months. The *Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services* requires children receive a verbal risk assessment for lead toxicity at each well-child exam during these ages. In addition, a blood lead level test is required for children at 12 and 24 months, regardless of the determination of risk, based on the verbal risk assessment. A child must receive a blood lead level test immediately, whether classified high or low risk, if they have not received the required 12 or 24 month test.

More information on lead toxicity screening can be found in Section 2 - 5 (5) of the CHEC Manual. Section 2, CHEC Services, is on the Internet at [www.health.state.ut.us/medicaid/section2list.pdf](http://www.health.state.ut.us/medicaid/section2list.pdf).

If you do not have internet access, contact Medicaid Information for a copy of the revised CHEC manual, or use the Publication Request Form. For additional information or questions, call the Medicaid Information Hotline at 1-800-662-9651 or 1-(801)-538-6155.

□

---



---

## 06 - 111 Targeted Case Management

### Attention: Providers of Early Childhood Targeted Case Management Services

The Deficit Reduction Act (DRA) of 2005, Section 6052, Reforms of Case Management and Targeted Case Management, delineates case management activities eligible for Medicaid reimbursement and clarifies that foster care-related activities are not eligible for reimbursement.

To be consistent with the DRA, Chapter 2-2, Covered Services/Activities, and Chapter 2-3, Non-Covered Services/Activities, of the Utah Medicaid Provider Manual for Targeted Case Management for Early Childhood Development for Medicaid Eligible Children have been updated to incorporate the DRA's language on covered case management activities and to include the limitation on foster care-related activities.

Also, in Chapter 1-3, the Targeted Case Management program previously referred to as "Early Childhood Development" is changed to "Medicaid Newborns (0-4)" and the program formerly referred to as "Developmentally Disabled/Mentally Retarded (HCBS waiver)" is changed to "Individuals with Intellectual Disabilities (HCBS waiver)."

□

---



---

## 06 - 112 Home and Community-Based Waiver For Technology Dependent/ Medically Fragile Provider Manual Updated

Section 2 of the Home and Community-Based Waiver for Technology Dependent / Medically Fragile Provider Manual has been replaced in its entirety. The new Section 2 is available on the Medicaid website. A hard copy can also be obtained by calling Medicaid Information or by submitting a Publication Request Form.

If you have any questions, please contact Jeff Dean at (801) 538-6638 or [jeffdean@utah.gov](mailto:jeffdean@utah.gov).

□

---



---

## 06 - 113 Heart Assist Devices

The transplant program is an optional program with Medicaid. Effective October 1, 2006, the following codes are non-covered.

33960 Prolonged extracorporeal circulation for cardiopulmonary insufficiency, initial 24 hours  
 33961 . . . each additional 24 hours  
 33975 Insertion of ventricular assist device; extracorporeal, single ventricle  
 33976 . . . extracorporeal, biventricular  
 33977 Removal of ventricular assist device; extracorporeal, single ventricle  
 33978 . . . extracorporeal, biventricular  
 33979 Insertion of ventricular assist device, implantable, intracorporeal, single ventricle  
 33980 Removal of ventricular assist device, implantable, intracorporeal, single ventricle

□