

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

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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

07 - 32 National Provider Identifier

Over 1.6 million National Provider Identifiers (NPIs) have been issued nationwide. Do you have yours?

If you are a healthcare provider who bills for clients eligible for Utah Medicaid Programs, you need a NPI, pursuant to federal regulation 45 CFR Part 162.

As of April 1, 2007, there will only be 53 days left before the NPI compliance date of May 23, 2007. The implementation of NPI is a complex process that will impact all business functions pertaining to your practice, office, or institution including: billing, reporting, and payment. This is why providers are urged to get, share, and use their NPI NOW to avoid a disruption in cash flow. The Centers for Medicare and Medicaid Services (CMS) continues to urge providers to include legacy identifiers on their NPI applications. This information is critical for health plans and healthcare clearinghouses in the development of crosswalks to aid in the transition to the NPI.

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business and with health plans that request it. In fact, as outlined in current regulation, all providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes – including designation of ordering or referring physician. Providers should also consider allowing health plans or institutions for whom they work, to share their numbers for them.

Effective May 1, 2007, Medicaid Provider Enrollment will start pending all new provider applications without NPI information. The new enrolling healthcare providers will have 60 days to provide their NPI information. If the NPI information is not submitted within 60 days, the enrollment application will be denied.

NPIs are FREE!

Healthcare providers should know that getting a NPI is free. Providers do not need to pay an outside source to obtain a NPI. All CMS education on the NPI is also free. CMS does not charge for education or materials. If you are still confused about what a NPI is and how to get it, share it, and use it, more information about the NPI can be found at the CMS NPI page www.cms.hhs.gov/nationalprovidentstand/ on the CMS website.

Getting your NPI

Providers can apply for a NPI online at <https://nppes.cms.hhs.gov>. If a provider does not know if they are required to have a NPI, or would like to request a paper application, call the NPI enumerator at 1-800-465-3203.

Sharing 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.

To find your nine-digit ZIP code, enter your address at this postal service web site:

<http://zip4.usps.com/zip4/welcome.jsp> and your last four digits will be displayed.

Medicaid will be contacting providers that we have determined are “atypical”, or non-medical providers, with information about an alternative billing process for submitting electronic claims with a Medicaid Provider Number.

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.

Remember, “Getting a NPI is free – not having one can be costly.”

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07 - 33 National Provider Identifier (NPI) Impact on Referrals

Effective May 23, 2007, you must use the referring physician's NPI as the I.D. number of the referring physician (Box 17a) on the CMS-1500 form or the corresponding field on the electronic 837. Any other numeric identifier will cause delay or denial of payment.

Medicaid clients enrolled in either the Restriction Program or the Case Management Program have a Primary Care Physician (PCP) listed on their Medicaid card. The PCP must give an appropriate referral before Medicaid will pay for services from any other provider. Only the PCP may give a referral. If the consulting physician finds it necessary to refer to another physician, the referral must be given by the PCP on the patient's Medicaid card.

Document all referrals. Referrals may be provided verbally or in writing. Both the referring physician and the servicing provider should document the referral in the client's records. Include the PCP's name, PCP's NPI number, the date(s) the referral is intended to cover, and the number of visits, if appropriate. Typically referrals are valid for 90 days from the date of issuance or are valid for a specified number of visits. Referrals can be extended for up to one (1) year but this must be specified at the time the referral is issued.

Care Coordination & Restriction Program Referrals

Information for Restriction PCP's: Clients who are enrolled in the Restriction Program MUST have a referral from their Primary Care Provider (PCP) to see a consulting physician. The only exception is in the case of an emergency. Medicaid recommends that you provide your NPI to the consulting physician when you refer your restricted clients for care. In addition, document in the client's records the consulting provider's name, date(s) referred for care and any clinical information pertinent to the referral.

Information for Consultants/Specialists: Effective May 23, 2007, the Restriction PCP's NPI must be used in the referring provider box 17a on the CMS-1500 or the corresponding field on the electronic 837 in order to be paid correctly when a restricted patient is referred to you for consult or care. Any other referring physician identifier will cause denial in payment of claims. Always ask the referring physician for his or her NPI when a restricted client is referred to your office. Document in the client's medical record the PCP's name, the PCP's NPI and the date(s) referred for care. A new referral will be needed when the date(s) expire. Both the referring physician and the servicing provider are responsible for documenting the referral.

Case Management Referrals

When a Medicaid client has a Primary Care Provider (PCP), this provider must give an appropriate referral before Medicaid will pay for medical services received from any other provider. Only a Medicaid client's PCP can provide a referral to a specialist. If the specialist determines a need for the client to see a second consulting physician, the PCP must give another referral. The specialist may NOT provide the referral in place of the PCP. The PCP may make any referral in writing or verbally. Effective May 23, 2007, the PCP should provide the specialist with his or her NPI. The consulting physician should enter the PCP's NPI in box 17a on the CMS-1500 or the corresponding field on the electronic 837.

Both the PCP and the servicing provider are responsible for documenting that the PCP authorized the referral. When Medicaid conducts a post payment review, they will look for the following in the patient's records documenting the referral:

- Date the PCP contacted the consulting provider
- PCP's NPI
- PCP's name
- Any clinical information that is pertinent to the referral

Payment may be retracted if the referral information is not in the medical record.

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07 - 34 National Provider Identifier (NPI) for Access Now

Access Now, Medicaid's telephone client eligibility verification system, now accepts either the 10-digit National Provider Identifier (NPI) followed by the pound sign (#) OR the 12-digit Provider Contract Number followed by the pound sign (#) as authority to access the data. If your NPI is not yet registered with Utah Medicaid, Access Now will direct you to the Provider Enrollment Team to update your records.

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07 - 35 Limiting Number of Medicaid Recipients Served

Some Medicaid providers have questioned whether their becoming a Medicaid provider requires them to accept all Medicaid recipients as patients. The answer is a qualified no.

A provider may limit the number or percentage of Medicaid clients in his/her practice as long as those limitations are based on non-discriminatory factors. However, a provider may not refuse to accept a client if the reason for not serving the client is one of the prohibited factors identified in the Title VI of the Civil Rights Act. Those limitations are race, age, color, sex, creed, national origin or disability. Other federal laws prohibit discrimination based on specific factors. Federal law also prohibits a Medicaid provider from refusing to accept Medicaid due to the existence of other insurance.

However, a provider may elect to only accept a certain percentage of his/her practice under Medicaid, or may elect only to accept Medicaid patients seen in a specific venue (such as the emergency room). Other reasons for not accepting a Medicaid client that apply to the other clients in the practice such as broken appointments, not paying allowed co-payments, etc. would be acceptable. As long as those limitations are not based on one of the prohibited actions under the Civil Rights Act or related acts, no action will be taken against a provider for adhering to limitations on the number, percentage or setting in which Medicaid recipients will be accepted.

To be safe, a provider would be wise to set up established business guidelines that delineate the limitations on accepting Medicaid patients, and abide by those limitations. Exceptions that would allow for accepting Medicaid clients outside the established guidelines would be acceptable as long as those exceptions did not violate the prohibited actions identified above.

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07 - 36 Paper Claim Updates: CMS-1500 (08/05), UB-04, 2006 ADA

Medicaid encourages providers to bill electronically; however, we realize there are times when a provider must send a paper claim. Nationally, the paper claim forms have been updated in order to accommodate the National Provider Identifier (NPI) and other data elements. Medicaid can accept all new claim forms. The CMS-1500 (08/05) claim form must be utilized by April 1, 2007. The UB-04 and 2006 ADA forms must be utilized by May 23, 2007. Any claim submitted on an old claim form after the dates listed above will be returned to the provider.

With implementation of the new paper claim forms, there are data elements that are essential to the processing of the claim. These include:

1. National Provider Identifier (NPI) and Taxonomy – The NPI is mandated for usage by all providers effective May 23, 2007. Do not submit your NPI on the old claim forms. Submit your NPI in addition to your Medicaid Provider ID until May 23, 2007. Your taxonomy code should be submitted after May 23, 2007, in place of your Medicaid Provider ID. Some providers are “atypical” providers and are unable to obtain an NPI. Atypical providers should continue to use their Medicaid Provider ID after May 23, 2007. The NPI, Medicaid Provider ID and/or taxonomy should be submitted in the following boxes:

- a. CMS-1500 (08/05): Box 17a, 17b, 24J, 24J shaded, 33a, 33b
 - b. UB-04: Box 56, 57, 76, 77, 78, 79
 - c. 2006 ADA: Box 49, 54
2. Servicing Location – If you have only one NPI but previously used multiple Medicaid Provider IDs (payment contracts), it is necessary to submit the servicing location. This address must match the address associated to your payment contract, including the 9-digit zip code.
 - a. CMS-1500 (08/05): Box 32
 - b. UB-04: Box 1
 - c. 2006 ADA: Box 56
 3. National Drug Code (NDC) – The Deficit Reduction Act requires providers to submit the NDC associated to drugs administered in the physician’s office. These include HCPCS “J” codes in addition to some “A”, “Q”, and “K” codes. Currently Medicaid requires this on services billed on the CMS-1500.
 - a. NDC – Box 24D shaded
 - b. Drug Unit Price – Box 24K shaded
 - c. Basis of Measurement Qualifier and Units – Box 24G shaded
 4. Coordination of Benefits – Medicaid is the payer of last resort. Third Party Liability (TPL) information must be submitted on the claim when there has been another payer prior to Medicaid. Data elements must include the actual payment amount received from the payer, patient responsibility, and contractual amount including reason codes. For specific instructions see the General Attachment Section of the Provider Manual or go to <http://health.utah.gov/medicaid/> Coordination of Benefits Instructions.

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07 - 37 Notification of New Fax Numbers

In order to better facilitate the needs of our providers, Medicaid is adding additional fax numbers. Please send your documentation to one of the following numbers:

Manual Review: (801) 536-0463

Hospital: (801) 536-0974

Hospice: (801) 536-0493

Long Term Care: (801) 536-0474

Customer Service: (801) 536-0481 (all other correspondence other than manual review)

All other fax lines remain the same.

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07 - 38 Pharmacy Co-pay Increase for Non-Traditional Medicaid

Effective April 1, 2007, the pharmacy co-pay for Non-Traditional Medicaid will be \$3.00 per prescription. There will continue to be no monthly maximum co-pay.

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07 - 39 Medicaid On-Line Discontinues Claim Status Feature

The claim status feature of the Medicaid On-Line (MOL) system will be discontinued beginning May 15, 2007. Medicaid encourages providers to utilize the HIPAA compliant 276/277 claim status and response through Medicaid’s EDI partner, Utah Health Information Network (UHIN) . For Utah Medicaid’s specific instructions, the 276/277 companion guide is available at: http://health.utah.gov/hipaa/pdfs/comguides/276_277.pdf . For more information about UHIN go to: <http://www.uhin.com/>

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07 - 40 Physical Therapy and Occupational Therapy Updates

Occupational Therapy Criteria for Children

Occupational Therapy for children has been developed and is available in the current Occupational Therapy Medicaid Provider Manual available online at www.health.utah.gov/medicaid/.

Physical Therapy and Occupational Therapy

Beginning April 1, 2007, the annual limits for physical and occupational therapy have been raised from 10 to 20 visits without prior authorization. This means a patient can receive 20 PT and 20 OT visits without prior authorization per calendar year. The criteria remains the same as used in the past for these prior authorizations.

07 - 41 Medical Supplies

Opened codes requiring prior authorization

A6531 Gradient compression stocking, below knee, 30-40 mmhg, each
 A6534 Gradient compression stocking, thigh length, 30-40 mmhg, each
 S8422 Gradient pressure aid (sleeve), custom made, medium weight

Opened codes

L0120 Cervical, flexible, non-adj (foam collar)
 L8042 Orbital prosthesis, provided by non-physician
 E2366 Power wheelchair accessory; battery charger, single mode, each (replacement only, not to be billed to new wheelchair)

Revised criteria for CPAP machines

The apnea/hypoxia index (AHI) for ages 15 and older requires an AHI > 15, for children from age 9 through 14 requires an AHI > 6, for children through age 8 requires and AHI > 3.

07 - 42 Audiology

Opened codes - effective April 1, 2007

92552 Pure Tone audiometry (threshold) air only, not to be billed with any comprehensive examinations as it is part of that exam
 92553 Pure Tone audiometry (threshold) air and bone, not to be billed with any comprehensive examinations as it is part of that exam
 92567 Tympanometry (impedance testing)
 92568 Acoustic reflex testing

07 - 43 Dental

Opened code - effective February 1, 2007

D5660 Add clasp to existing partial denture. Use if a tooth having a clasp has been extracted and new clasp is needed.

07 - 44 Dental and Ambulatory Surgical Centers

As soon after April 1, 2007, as programming can be completed, the reimbursement to a free-standing ambulatory surgical center for dental cases treated in the surgical center will be set at \$975.00 per case using code 41899. In the past, code 41899 was paid to ambulatory surgical centers based on a percent of billed charges.

Anesthesiologists billing using code 41899 should continue to bill using the appropriate “P” modifier (Physical Status) and the actual anesthesia time in minutes.

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 and “M” before the number of minutes. If the patient is age 5 years or older, these services require prior authorization which is obtained by the treating dentist.

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07 - 45 Inpatient Hospital

Additional statement to the January 2007 MIB, article 07-10, information addressing detoxification: Medical necessity for detoxification is based on an average length of stay of three days for withdrawal. The average length of stay is a national standard maintained in the Diagnosis Related Grouper and published each October in Federal Register.

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07 - 46 Update to Inpatient Diagnosis Table

The Utah Medicaid Table of Authorized Emergency Inpatient Diagnosis has been updated for April 1, 2007. Inpatient Hospital services do not require a co-insurance payment with one of the following diagnoses:

- 038.0 - 038.9 Septicemia
- 066.41 West Nile fever with encephalitis
- 324 - 326 Intracranial and intraspinal abscess
- 446 - 446.19 Acute bronchitis and bronchiolitis
- 518.7 Transfusion related acute lung injury
- 518.81 **Acute** respiratory failure
- 640 - **640.9** Hemorrhage in early pregnancy
- 770.87 Respiratory arrest of newborn
- 779.85 Cardiac arrest of newborn
- 780.31 Febrile convulsions
- 780.32 Complex febrile convulsions
- 785.52 Septic shock
- 925 - **925.2** Crushing injury of face, scalp and neck

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07 - 47 Coding Issues

Covered codes

- 58558 Hysteroscopy, surgical with sampling (i.e. endometrial biopsy, polypectomy); with or without D&C
Removed from requirement for prior authorization
- 83880 Natriuretic peptide

Code 61795

Computer assisted stereotactic volumetric procedure, code 61795, is not covered for endoscopic nasal and sinus surgery. The code 61795 will post a mutually exclusive edit and deny with codes related to nasal and sinus surgery.

Pregnancy ultrasound and fetal non-stress test

The code 59025 (fetal non-stress test) and 76815 (limited) combination is paying more than the code 76818 (complete biophysical with fetal non-stress test). The payment for 76815 has been evaluated and an adjustment was made to bring the payment in line with other codes. Consult the fee schedule for pricing.

Botulinum Toxin Type A

Item #5 under the Injectables - Criteria and Instruction - Botulinum Toxin A, of the Physician Manual, now includes the following:

5. . . . Hyperhidrosis (excessive sweating) and gastroparesis.

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07 - 48 Physician Consultation

Consultation services are considered physician services and reimbursed only to the physician. Under incident to service in Utah Medicaid, the nurse practitioner may complete the history and examination to assist the physician in working the patient up for a consultation. However, it is the expectation that the physician will complete a hands-on examination. The physician consultant must clearly document in the medical record that he or she completed the primary components of the examination related to the reason for the consultation request which impact determinations of the differential diagnoses, summarize conclusions, and formulate the treatment plan. The physician and the nurse practitioner must personally document in the medical record his/her portion of the consultation. An initialed checklist and statement that the physician agrees with the nurse practitioner's evaluation and management plans **will not be sufficient** as documentation for a consultation service.

Utah Medicaid does not reimburse Physician Assistants (PA) for consultation services.

For reimbursement of consultation service the medical record must include:

- 1) documentation of the written or verbal request for the consultation from an appropriate source and the need for the consultation;
- 2) the consultant's opinion and documentation supporting a given E&M level per the 1997 documentation guidelines; and
- 3) the written report to the requesting physician. This written report is a separate document and cannot replace documentation in the medical record.

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07 - 49 Use of Checklists and Templates

CORRECT USE OF THE CHECKLIST IN EVALUATION AND MANAGEMENT DOCUMENTATION as outlined in Medicare Part B, June 2006, has been adapted for review of office visits.

Keep the following important documentation guidelines in mind when using a template and/or checklist:

- Examination templates and checklists are acceptable documentation provided the provider has clearly indicated what was examined and the findings to support the level of service billed.
- A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings.
- Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) must be described.
- The provider must document and describe any specific and pertinent abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of "abnormal" without elaboration is insufficient documentation. A key explaining checklist symbols must be available, if requested.
- Signature requirements remain the same in the use of checklists. Per NCP PHYS-001, "an indication of a signature in some form needs to be present." Documentation must support legible identification of the billing provider, per the 1997 Evaluation and Management Documentation guidelines.
- The Review of Systems (ROS) and Past Family Social History (PFSH) may be recorded by ancillary staff or completed by the patient on a form or checklist. The checklist must have a place for the physician to document that he/she reviewed the information and make a notation supplementing or confirming the information recorded

by others. If the ROS and/or PFSH are unchanged from an earlier encounter, it does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may be documented by noting the date and location of the earlier ROS and/or PFSH with a description of any new findings and/or a statement that all other elements are unchanged.

- When referring to an earlier encounter to document the ROS and/or PFSH, all elements documented and performed in the earlier visit must be reviewed in the current visit. Any variation or elements not reviewed must be documented in the current note.
- Only the provider can perform the History of Present Illness (HPI). The provider is ultimately responsible for submitting appropriate documentation. Each item on a checklist requires an active response for each exam component performed or question asked. It is not appropriate to use a common template which states that all components listed were performed unless otherwise noted by the physician.
- In addition, there must be a written summary of the assessment, and a treatment plan. The primary components of the E&M service as outlined in the 1997 E&M guidelines must be clearly documented. For example, a template used for education is not a covered service.

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07 - 50 Polysomnography - Sleep Studies

The Physician Manual, Covered Services Section 2, has been updated with additional item 37:

Polysomnography or sleep studies are covered when the center has a medical director board certified in sleep medicine and at least one registered polysomnography technician. If the medical director is not board certified in sleep medicine, the center must indicate the name of the board certified sleep medicine physician or board certified sleep medicine diplomate (Ph.D) who will complete the reading of the study.

A correction to the Physician Manual has been made to Specific Non-Covered Services, Section P:

Certain services are excluded from coverage because medical necessity, appropriate utilization, and cost effectiveness of the service cannot be assured. A variety of lifestyle factors contribute to the "syndromes" associated with some of these services, and there is no specific therapy or treatment identified except for those that border on behavior modification, experimental or unproven practices. Services include:

- 1) *Sleep clinics removed. Coverage will be described in the coverage section*
- 2) Pain clinics
- 3) Eating disorders clinics
- 4) Wound clinics

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07 - 51 Medical-Surgical Criteria Update

Criteria #21: Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy (HBO) is a medical treatment used to help resolve certain medical problems. In certain circumstances, it represents the primary treatment modality while in others it is an adjunct to surgical and pharmacologic interventions. HBO therapy places the patient in an enclosed pressure chamber breathing 100% oxygen at greater than one atmospheric pressure.

- Prior authorization is required on CPT code 99183 and ICD.9.CM code 939.5
- Therapy may be provided as an inpatient or outpatient service, but only in a hospital where immediate ER and ICU care is available. Hospital-based means that there is 24/7 medical staff coverage and accreditation or pending accreditation through the Undersea & Hyperbaric Medical Society as a level one facility. Therapy must be administered only in an enclosed full body pressure chamber.

- Prior authorization allows up to 20 hyperbaric oxygen treatments. Request for an additional 20 HBO treatments requires weekly wound measurement for a client with a wound and A1C hemoglobin level for clients with diabetes. Medical literature does not document cost benefit for HBO beyond 40 treatments. Therefore, HBO treatment beyond 40 sessions is not a Medicaid benefit.
- A. Only approved by Medicaid for the following conditions with the following requirements:
1. Acute carbon monoxide intoxication
 2. Decompression illness
 3. Acute arterial gas embolism
 4. Gas gangrene with documentation of a gram stain consistent with a Clostridium species.
 5. Acute traumatic peripheral ischemia in a salvageable area as an adjunct to standard care. Document transcutaneous oxygen tension of tissue adjacent to the treatment area of less than 40mmHg which increases to 150mmHg or higher during inhalation of pure oxygen.
 6. Crush injuries and suturing of severed limbs. Document transcutaneous oxygen tension of tissue adjacent to the treatment area of less than 40mmHg which increases to 150mmHg or higher during inhalation of pure oxygen.
 7. Progressive necrotizing infections.
 8. Acute peripheral arterial insufficiency. Document transcutaneous oxygen tension of tissue adjacent to the treatment area of less than 40mmHg which increases to 150mmHg or higher during inhalation of pure oxygen.
 9. Preparation and preservation of compromised skin grafts. Most surgeons use drug treatment, but all other ancillary conservative wound management methods for preserving tissue postoperatively should be applied.
 10. There is inconsistent evidence in the literature for coverage of osteoradionecrosis. Based on current medical literature, hyperbaric treatment will be covered for osteoradionecrosis of the jaw only.
 11. Cyanide poisoning
 12. Mycoses (actinomycosis, mucormycosis, Conidiobolus cornato), only as an adjunct to conventional therapy when the disease process is refractory to antibiotic and multiple surgical treatment.
 13. Diabetic wounds of the lower extremities which have failed at least 30-consecutive days of standard wound care therapy and are classified as Wagner grade III or higher. Submitted documentation must include.
 - a. Documentation of debridement of devitalized tissue, maintenance of clean moist bed of granulation tissue with appropriate moist dressings, and necessary treatment to resolve infection. Documentation that osteomyelitis is not present.
 - b. Transcutaneous oxygen tension of tissue adjacent to the ulcer of less than 40mmHg which increases to 150mmHg or higher during inhalation of pure oxygen.
 - c. Submit the record of at least weekly wound measurements taken during the standard wound care. In normal healing, a wound reduction of 10-15% per week is expected. HBO will be considered only when documentation supports healing at this level is not met with standard wound management.
 - d. Documentation of glucose control with hemoglobin glycosylated (A1C) ≤ 7 .
 14. Soft tissue radionecrosis is covered only for hemorrhagic proctitis as an adjunct to conventional treatment. There is inconsistent evidence for use of HBO as an adjunct to conventional treatment for soft tissue radionecrosis of affected neurological or other tissues damaged by radiation.
- B. Physician Supervision Requirement: The physician must be in constant attendance during the entire treatment. This is a professional activity that cannot be delegated because it requires independent medical judgement by the physician. Constant monitoring and immediate availability of the physician is essential in all settings for all procedures.

Limitations

- A. HBO therapy must be used in addition to standard wound care. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated by weekly wound measurements.
- B. HBO therapy is not covered simply to speed up wound healing when granulation tissue is present.
- C. HBO therapy is not considered medically necessary for superficial lesions. Medicaid does not cover wound clinics.
- D. Evidence does not support coverage of osteomyelitis. Some studies indicate 90% of "refractory" osteomyelitis confirmed by x-ray and bone culture sites heal on the appropriate antibiotic alone.

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07 - 52 Attention Hospitals: Prepaid Mental Health Plan Updated Contact List for Authorization of Hospital Post-Stabilization Services for Psychiatric Care

The Federal Medicaid Managed Care Final Rule dictates when managed care plans must reimburse hospitals for post-stabilization services and when the hospital is financially responsible. (Refer to Article 03-105 of the October 2003 MIB for clarification.) <http://www.health.utah.gov/medicaid/provhtml/bulletins.html>

Under the Utah Medicaid Prepaid Mental Health Plan (PMHP), Medicaid contracts with nine mental health centers to provide all outpatient and inpatient mental health care. These centers are Bear River Mental Health, Central Utah Counseling Center, Davis Behavioral Health, Four Corners Community Behavioral Health, Northeastern Counseling Center, Southwest Behavioral Health Center, Valley Mental Health, Wasatch Mental Health, and Weber Human Services.

You must contact the PMHP listed on the enrollee's Medicaid card to obtain authorization for inpatient hospital psychiatric care. The phone numbers to request prior authorization are found in the General Attachments of the Medicaid Provider Manual and on the website below under *Managed Care Plan List (MCP's and PMHP's)*. <http://www.health.utah.gov/medicaid/provhtml/attachments.html>

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07 - 53 Psychological Testing: Code Changes

Attention: Health Plans, Mental Health Centers, Substance Abuse Treatment Providers, DHS Contracted Mental Health Providers and Psychologists:

CORRECTION

The April 2006 MIB, article number 06-46, Psychological Testing, stated, "The Procedure code 96118, Neuropsychological Testing Battery, is replaced by 96119."

It should have stated, "The Procedure code 96117, Neuropsychological Testing Battery, is replaced by 96118."

Contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov if you have any questions.

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07 - 54 Timely Filing Deadline

Medicaid is experiencing a large volume of providers who are sending in requests for review of claims past the one year filing deadline. According to the Code of Federal Regulations 42 (CFR), Section 447.45(d) (1), providers are required to submit a claim within one year of the date(s) of service to Medicaid to be considered for payment. It is your responsibility to get client coverage information when services are provided. Exceptions to the one year filing deadline can be found in the Medicaid manual, Section 1, 11-13.

If you receive a denial for timely filing issue, do not submit another claim with the proof of timely filing documentation attached. Claims are keyed as a new claim and processed, and are not reviewed manually by Medicaid staff.

Proof of timely filing are business records prepared at the time the claim was first submitted within a year of the date of service. Copies of the original claim form will not be considered as sufficient documentation.

If you have proof you have filed within one year and your claim has denied, determine your actions by the message contained on your remittance advice. Providers with claims denied for procedure codes, modifiers, or other problems are encouraged to submit a void or replacement claim instead of billing another claim. If the void or replacement option is not used, your claim may deny for timely filing issues.

For claim status, we encourage you to submit a 276/277 Claim Status Request and Response transaction to determine if Medicaid has received the claim. Do not resubmit the claim until you have verified Medicaid has no record of the claim. When resubmitting the claim, do not attach proof of timely filing documentation. For questions of how to submit the 276/277 transaction, contact Medicaid at (800) 662-9651 or (801) 538-6155, option 3, then option 5.

If a client does not tell you they have Medicaid at the time of service and later tells you they had coverage, you have the choice of having the client remain a private pay client or submitting the claim to Medicaid. If the one year time period has lapsed and you choose to write off the claim and need to have a remittance advice, you can submit a claim for a denial. Clients cannot be billed for claims billed to Medicaid, regardless of payment status.

Fax timely filing documentation with the Transaction Control Number (TCN) or a copy of the remittance advice to Timely Filing at 1-801-536-0164.

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07 - 55 Pharmacy: Medicaid Coverage Updates

Cymbalta - The maximum daily dosage of Cymbalta is 60 mg. Monthly quantity limits for all strengths of Cymbalta will be set accordingly.

Lamisil - Lamisil now requires a prior authorization. The prescriber will be required to submit documentation of a diagnosis of onychomycosis in order to receive prior authorization. Coverage will be limited to 16 weeks per calendar year.

Nexavar - Nexavar now requires prior authorization. The prescriber will be required to submit documentation of patient's age and diagnosis.

Sutent - Sutent now requires prior authorization. The prescriber will be required to submit documentation of patient's age, diagnosis, and history of previous treatments.

Cyanocobalamin - Cyanocobalamin is not a covered benefit for any diagnosis, including pernicious anemia.

The Medicaid Supplies Manual will reflect the following updates:

Gradient compression stockings TL, 18-30 mmHg, are covered using code A6533.

Gradient compression stockings TL, 30-40 mmHg, are covered using code A6534.

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07 - 56 HCBS Provider Manual Updated

The Provider Manual for the Home and Community Based Services Waiver for Individuals 65 or Older has been updated and is available online for viewing and printing at <http://health.utah.gov/medicaid/stplan/bltc/AG/AG.htm>

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07 - 57 Covered Injectable Drugs

The following HCPCS J-Codes are opened effective January 1, 2007. These codes also require a National Drug Code (NDC) when billed.

Covered

J0129 Injection, Abatacept, 10 mg
J0364 Injection, Apomorphine Hydrochloride, 1 mg
J0594 Injection, Busulfan, 1 mg
J0894 Injection, Decitabine, 1 mg
J1324 Injection, Enfuvirtide, 1 mg
J2248 Injection, Micafungin Sodium, 1 mg
J9261 Injection, Nelarabine, 50 mg

Covered with Prior Authorization

J1458 Injection, Galsulfase, 1 mg
J1740 Injection, Ibandronate Sodium, 1 mg
J2170 Injection, Mecasermin, 1 mg
J2315 Injection, Naltrexone, depot form, 1 mg
J3243 Injection, Tigecycline, 1 mg
J3473 Injection, Hyaluronidase, recombinant, 1 USP unit
J7311 Fluocinolone Acetonide, intravitreal implant

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07 - 58 Transplantation Services Rule Modification

The following change in prior authorization requirement will be effective April 1, 2007, for the following transplantation services. The transplantation services rule (R41410A-6) will now state:

(1) Prior authorization is required for all transplantation services except for the following transplants:

- (a) cornea
- (b) kidney, heart and liver transplantation performed in a Utah transplant center which has been Medicare-approved for the last five or more years.

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