

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

TABLE OF CONTENTS

07 - 01	National Provider Identifier	2
07 - 02	Utah's Premium Partnership "UPP"	3
07 - 03	UB-04 Replaces UB-92	3
07 - 04	25 Modifier Billing Requirements	3, 4
07 - 05	Request for Records	4
07 - 06	Long Term Care Managed Care Program	4
07 - 07	Interpretive Services	5
07 - 08	HCPCS 2007	5, 6, 7, 8
07 - 09	Hospital ER-Only Diagnoses	8, 9
07 - 10	Inpatient Hospital - DRG Update	9
07 - 11	Pregnancy Ultrasound Code Combination Issue	9
07 - 12	Laboratory Issue	9
07 - 13	Prior Authorization for Rehab Services	10
07 - 14	Medical-Surgical Criteria Updates	11, 12
07 - 15	Diabetes Education	12
07 - 16	Home Health	12
07 - 17	Medical Supplies - 2007 Codes	13
07 - 18	Denture Services	13
07 - 19	Audiology	14
07 - 20	Outpatient PT/OT/Speech Services	14
07 - 21	Mental Health, Substance Abuse, Homeless, Early Childhood Targeted Case Management Providers	14, 15
07 - 22	Physician Billing for Office Admin Drugs	15
07 - 23	Change in Pharmacy Reimbursement	16
07 - 24	Drug Criteria & Limits Section Updated	16
07 - 25	Pharmacy Coverage Highlights	16, 17

BULLETINS BY TYPE OF SERVICE

All Providers	07-01, 02, 05, 07
Anesthesiologists	07-08
Assistant Surgeons	07-08
Audiologists	07-19
Dental Providers	07-18
Home Health Agencies	07-16
Hospital	07-03, 08-10, 13, 14
Laboratory Services	07-12
Long Term Care, Managed Care	07-06
Medical Supplier	07-17
Pharmacy	07-17, 23-25
Physician Services	07-04, 08, 11, 12, 14, 15, 17, 22, 24, 25
PT/OT/Speech Services	07-20
Radiologists	07-08, 11
Targeted Case Management	07-21

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.”

07 - 01 National Provider Identifier

On January 1, 2007, there will only be 143 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/ 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 50 percent of eligible Utah providers have obtained a NPI. Out of that total, only about 25 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.

IMPORTANT DATES TO REMEMBER

October 1, 2006. Medicaid wants all providers, with the exception of pharmacies, to begin using a NPI along with the Medicaid provider number on electronic claims.

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. All NPI values must be qualified as a NPI.

December 1, 2006. If a pharmacy has the prescribing physician's NPI, they may begin sending it on their electronic claims in the Prescriber Identifier Field. 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**.

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.”

□

07 - 02 Utah's Premium Partnership for Health Insurance

It's time to get up! The Utah Department of Health announces its newest program called UPP (Utah's Premium Partnership for Health Insurance, pronounced "up"). Individuals and families may qualify based on family size, income, employment, and if they do not have health insurance.

If your clients qualify, UPP will reimburse them to help pay for their employer-sponsored health insurance premiums. Benefits include receiving up to \$150 per adult and up to \$100 per child in the family—every month! UPP makes health insurance premiums more affordable. It's time for your clients to get up!

For more information, visit www.health.utah.gov/upp or call 1-888-222-2542.

□

07 - 03 UB-04 Replaces UB-92

The UB-04 claim form has been approved and will replace the UB-92 for institutional claims. To view the new form along with other documents, access the National Uniform Billing Committee at <http://www.nubc.org/>.

Providers can begin submitting the UB-04 beginning March 1, 2007. Either the UB-04 form or the UB-92 form may be used between March 1, 2007, and May 22, 2007. Effective May 23, 2007, all institutional paper claims must be submitted on the UB-04 and any UB-92 submitted to Medicaid will be returned to the provider.

The National Provider Identifier (NPI) will be accommodated on the new claim form in Locator 56. The Medicaid provider number is accepted in Locator 57.

NOTE: Medicaid requires institutional claims to be billed electronically.
Medicaid claims are to be billed to electronic mail box HT000004-001
Medicare/Medicaid Crossover claims are to be billed to electronic mail box HT000004-005.

Please see Standard 57 on the UHIN website at http://standards.uhin.com/standards_index.htm .

The purpose of Standard #57, *UB-04 Form Locator Elements*, is to clearly describe the use of each form locator in the UB-04 (CMS-1450) claim billing form and its crosswalk to the HIPAA 837 004010X096A1 Institutional implementation guide. The purpose of standardizing the use of the UB-04 is to create a more uniform electronic claim environment. UHIN Standard #57, *UB-04 Form Locator Elements*, is compatible with all HIPAA requirements. It creates a uniform billing method for institutional claims.

□

07 - 04 ****Important**** 25 Modifier Billing Requirements

According to CPT guidelines, the 25 modifier is intended to indicate significant additional evaluation and management service beyond the evaluation and management service included in a procedure when the physician thinks significant separately identifiable evaluation and management service was done beyond the procedure billed. The physician is responsible for reviewing documentation to submit claims which warrant an E&M service in addition to the service provided in another procedure.

Medicaid has provided a period of time to evaluate the 25 modifier and has faced an overwhelming number of claims with incorrect coding. Additional information to educate providers was given through provider training in August and September and in the October MIB article (06-101). Claims are being submitted with the 25 modifier when the evaluation and management service was the only code submitted, submitted with a minor procedure such as drawing blood or giving a vaccine which does not include an E&M service, and submitted when the services are only those included in the procedure. The majority of claims would process through the system without the 25 modifier. The number of claims warranting payment for the 25 modifier have been for patients with multiple trauma or complicated medical conditions.

The submission of documentation with request for manual review with modifier 25 has overwhelmed the system. Effective February 1, 2007, Medicaid will have to return to the former policy of not recognizing modifier 25 and the system will pay according to the editing program and correct coding initiative edits.

□

07 - 05 Request for Records - Reminder

The Medicaid agency may request records that support provider claims for payment under programs funded through the agency. Such requests must be in writing and identify the records to be reviewed. Responses to requests must be returned within 30 days of the date of the request. Responses must include the complete record of all services for which reimbursement is claimed and all supporting services. If there is no response within the 30-day period, the agency will close the record and will evaluate the payment based on the records available. See <http://www.rules.utah.gov/publicat/code/r414/r414-01.htm#T14>.

The Medicaid Program Integrity Unit would like to remind providers of the importance of returning requested records within the 30-day time frame allowed. Extensions cannot be granted. Medicaid Program Integrity will not accept records after the 30-day time period.

□

07 - 06 Long Term Care Managed Care Program is Undergoing Changes (FlexCare, WeberMACS, and Molina Independence Care Programs)

The Long Term Care Managed Care Program, also known as the FlexCare, WeberMACS, and Molina Independence Care Programs, is undergoing some important changes.

The Long Term Care Managed Care (LTC-MC) Program was originally started by Utah Medicaid in 1999 as a demonstration project. The purpose of the demonstration was to show that eligible Medicaid recipients could successfully be deinstitutionalized by providing an array of long term care services in home and community-based settings.

Utah received authorization to run the LTC-MC Program from our federal Medicaid partners, the Centers for Medicare and Medicaid Services (CMS). Originally, CMS granted Utah permission to run the program under combination 1915 (a) and (b) authority. CMS recently concluded that in order to operate the program on an ongoing basis, Utah needed to make some changes to the program's design. As such, Utah Medicaid has been working with CMS to develop a program CMS will authorize and support on an ongoing basis.

The new program that has been developed to replace the LTC-MC Program will be called **The New Choices Waiver**. This waiver is a 1915 (c) Home and Community-Based Waiver Program that provides services on a fee-for-service basis rather than under a managed care arrangement.

In addition to the New Choices Waiver, Utah currently runs five other 1915 (c) Home and Community-Based Waivers: Waiver for Individuals 65 or older (Aging Waiver), Waiver for Individuals with Acquired Brain Injuries (ABI Waiver), Waiver for Individuals with Mental Retardation and Related Conditions (MR/RC Waiver), Waiver for Individuals with Physical Disabilities (PD Waiver), and Waiver for Individuals who are Technology Dependant (Tech Dependent or Travis C. Waiver).

Early in 2007, the Medicaid agency will be working with participants currently on the LTC-MC Program to help them convert to the New Choices Waiver. After current participants have been admitted into the New Choices Waiver, new applicants will be admitted during the Spring of 2007.

The Medicaid agency is in the process of meeting with a variety of provider and consumer groups to explain the changes that lie ahead, the services included in the New Choices Waiver, and the need for new service providers for the Waiver.

Providers interested in becoming New Choices Waiver providers, or those with additional questions about the Waiver, may contact Kathleen Bowman, Medicaid Long Term Care Bureau, either by phone: (801)-538-6497 or by Email: newchoiceswaiver@utah.gov.

□

07 - 07 Interpretive Services

The Division of Health Care Financing has contracted with four companies to provide interpretive services to Medicaid, CHIP, and PCN clients who have Limited English Proficiency (LEP). These contracts make interpretive services available by phone 24 hours a day, 7 days a week, 365 days a year, without prior appointment. The telephone services cover approximately 180 spoken languages. Additionally, the number of interpreters who are available for scheduled, in-office interpretive services has increased. The contractors have demonstrated a high level of commitment to professional/ethical standards, to cultural sensitivity and to high standards for training and testing of medical terminology, which enables them to provide a superior level of service for clients.

The contracts cover interpretive services for Medicaid, CHIP, and PCN clients who are not enrolled in a Managed Care Plan (MCP), or for carve out services including pharmacy and chiropractic care. Interpreting for dental services has been modified to cover only those with Traditional Medicaid. All other Medicaid programs are not covered for dental interpreting services. Clients who are members of a MCP must use the interpretive services offered by the MCP, except for the carve out provision described above. Clients who are members of a Prepaid Mental Health Plan (PMHP) should continue to use the interpretive services provided by the plan. Interpreters will only be provided for services normally covered by the program for which the client is eligible, to include setting up appointments.

Details on how to access these services and the information that is needed for billing purposes can be found on the Medicaid website at <http://health.utah.gov/medicaid/pdfs/InterpretGuide10-06.pdf>. (Please note there is a phone number change for Linguistica International). You may also contact the Medicaid Information Line for instructions on obtaining these services. □

07 - 08 HCPCS 2007

Covered Codes

00625 Anesthesia for procedures on the thoracic spine and code...not utilizing one lung ventilation
 00626 Anesthesia for procedures on the thoracic spine and code...utilizing one lung ventilation
 15002 Surgical preparation...trunk, arms, legs; first 100 sq sm or 1%...infants or children
 15003 Surgical preparation...trunk, arms, legs; each additional 100 sq sm or 1% of body area...
 15004 Surgical preparation...mouth, neck, ears, orbits, genitalia...multiple digits; first 100 sq sm or 1%...
 15005 Surgical preparation...face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq sm or 1% of body area of infants or children...
 15731 Forehead flap with preservation of vascular pedicle (i.e. axial pattern flap...)
 17311 MOHS micrographic technique...head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5
 17312 MOHS micrographic technique...head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage
 17313 MOHS micrographic technique...trunk, arms, or legs; first stage, up to 5 tissue blocks
 17314 MOHS micrographic technique...trunk, arms, or legs; each additional stage...
 17315 MOHS micrographic technique...each additional block after first 5 tissue blocks, any stage...
 19301 Mastectomy, partial (i.e. lumpectomy, tylectomy, quadrantectomy, segmentectomy);
 19302 Mastectomy, partial...with axillary lymphadenectomy
 19303 Mastectomy, simple, complete
 19304 Mastectomy, subcutaneous
 19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes
 19306 Mastectomy, radical, including pectoral muscles...(urban type operation)
 19307 Mastectomy, modified radical, including...but excluding pectoralis major muscle
 25109 Excision of tendon, forearm, and/or wrist, flexor or extensor, each
 25606 Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation
 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
 25608 Open treatment of distal radial intra-articular fracture...with internal fixation of two fragments
 25609 Open treatment of distal radial intra-articular fracture...with internal fixation of three fragments
 27325 Neurectomy, hamstring muscle
 27326 Neurectomy, popliteal (gastrocnemius)
 28055 Neurectomy, intrinsic musculature of foot
 33202 Insertion of epicardial electrode(s); open incision (i.e. thoracotomy, median sternotomy . . .)
 33724 Repair of isolated partial anomalous pulmonary venous return (i.e. scimitar syndrome)
 33726 Repair of pulmonary venous stenosis
 35302 Thromboendartectomy, including patch graft, if performed; superficial femoral artery
 35303 Thromboendartectomy, including patch graft, if performed; popliteal artery

35304 Thromboendartectomy, including patch graft, if performed; tibioperoneal trunk artery
 35305 Thromboendartectomy, including patch graft, if performed, tibial or peroneal artery, initial vessel.
 35306 Thromboendartectomy, including patch graft, if performed; each additional tibial or peroneal artery . . .
 35537 Bypass graft, with vein; aortoiliac
 35538 Bypass graft, with vein; aortobi-iliac
 35539 Bypass graft, with vein; aortofemoral
 35540 Bypass graft, with vein; aortobifemoral
 35637 Bypass graft, with other than vein; aortoiliac
 35638 Bypass graft, with other than vein; aortobi-iliac
 35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous . . .
 35884 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous . . .
 44157 Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy . . .
 44158 Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir . . .
 47719 Anastomosis, choledochal cyst, without excision
 48105 Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis
 49325 Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with . . .
 49326 Laparoscopy, surgical; with omentopexy (omental tackin procedure) . . .
 49402 Removal of peritoneal foreign body from peritoneal cavity
 49435 Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit . . .
 54865 Exploration of epididymis, with or without biopsy
 55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application . . .
 55876 Placement of interstitial device(s) for radiation therapy guidance (i.e. fiducial markers, dosimeter), . . .
 56442 Hymenotomy, simple incision
 57558 Dilation and curettage of cervical stump
 58957 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy . . .
 58958 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy . . .
 64910 Nerve repair; with synthetic conduit or vein allograft (i.e. nerve tube), each nerve
 64911 Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve
 67346 Biopsy of extraocular muscle
 76776 Ultrasound, transplanted kidney, real time and duplex doppler with image documentation
 76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal . . .
 76814 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal . . .
 76998 Ultrasonic guidance, intraoperative
 77001 Fluoroscopic guidance for central venous access device placement, replacement (catheter only . . .
 77002 Fluoroscopic guidance for needle placement (i.e. biopsy, aspiration, injection, localization device)
 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic . . .
 77012 Computed tomography guidance for needle placement (i.e. biopsy, aspiration, injection, localization . . .
 77031 Stereotactic localization guidance for breast biopsy or needle placement (i.e. for wire localization or . . .
 77032 Mammographic guidance for needle placement, breast (i.e. for wire localization or for injection), each . . .
 77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with . . .
 77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with . . .
 77053 Mammary ductogram or galactogram single duct, radiological supervision and interpretation
 77054 Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation
 77055 Mammography; unilateral
 77056 Mammography; bilateral
 77057 Screening Mammography; bilateral (2-view film study of each breast)
 77071 Manual application of stress performed by physician for joint radiography, including contralateral joint . . .
 77072 Bone age studies
 77073 Bone length studies (orthorentgenogram, scanogram)
 77074 Radiologic examination, osseous survey; limited (i.e. for metastases)
 77075 Radiologic examination, osseous survey; complete (axial and appendicular skeleton)
 77076 Radiologic examination, osseous survey; infant
 77077 Joint survey, single view, 2 or more joints (specify)
 77078 Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (i.e. hips, . . .
 77079 Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton . . .
 77080 Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (i.e. hips . . .
 77081 Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular . . .
 77083 Radiographic absorptiometry (i.e. photodensitometry, radiogrammetry) 1 or more sites
 82107 Alpha-fetoprotein (AFP); AFP-L3 fraction isoform and total AFP (including ratio)
 83698 Lipoprotein-associated phospholipase A2, (LP-PLA2)
 86788 Antibody; west nile virus, IgM
 86789 Antibody; west nile virus
 87498 Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique
 87641 Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant . . .
 94002 Ventilation assist and management, initiation of pressure or volume preset ventilators for . . .
 94003 Ventilation assist and management, initiation of pressure or volume preset ventilators for . . .
 94610 Intrapulmonary surfactant administration by a physician through endotracheal tube
 94644 Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour
 94645 Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional . . .

Codes Requiring Prior Authorization

- 37210 Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids . . .
PRIOR APPROVAL: Written ICD-9 218.0-218.9 Refer to Criteria #12
- 58541 Laparoscopy, surgical, supracervical hysterectomy; for uterus 250 g or less
PRIOR APPROVAL: Telephone ICD-9: 68.31, 68.39 Refer to Criteria #14²
- 58542 Laparoscopy, surgical, supracervical hysterectomy; for uterus 250 g or less with removal of tube(s) . . .
PRIOR APPROVAL: Telephone ICD-9: 68.31, 68.39, 65.63. Refer to Criteria #14²
- 58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
PRIOR APPROVAL: Telephone ICD-9: 68.31 68.39 Refer to Criteria #14²
- 58544 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal . . .
PRIOR APPROVAL: Telephone ICD-9: 68.31 68.39, 65.63 Refer to Criteria #14²
- 58548 Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and . . .
PRIOR APPROVAL: Telephone ICD-9: 68.61, 40.50 Refer to Criteria #14²

The cardiac MRI codes (75552-75555) were going to be closed beginning October 1, 2006, but a decision was made after the MIB was published that the codes would be covered with prior authorization when supportive documentation is submitted to indicate why the cardiac MRI is required in addition to the other tests completed on the patient. The information submitted will be physician reviewed. This prior authorization policy will be required regardless of patient age. See protocol in 40B Imaging section of the Medical and Surgical Criteria.

- 75552 Cardiac MRI for morphology without contrast
PRIOR APPROVAL: Written ICD-9 746.9 Refer to Criteria #40B²
- 75553 Cardiac MRI for morphology with contrast
PRIOR APPROVAL: Written ICD-9 746.9 Refer to Criteria #40B²
- 75554 Cardiac MRI for function, with or without morphology, complete study
PRIOR APPROVAL: Written ICD-9 746.9 Refer to Criteria #40B²
- 75555 Cardiac MRI for function, with or without morphology, limited study
PRIOR APPROVAL: Written ICD-9 746.9 Refer to Criteria #40B²
- 77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
PRIOR APPROVAL: Written ICD-9 173.5-175.0, 198.81 Refer to Criteria #40B²
- 77059 Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
PRIOR APPROVAL: Written ICD-9 173.5-175.0, 198.81 Refer to Criteria #40B²

Codes Requiring Manual Review

- 19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma
PRIOR APPROVAL: Not Required Attach documentation to claim

Non-Covered Codes

- 15830 Excision, excessive skin...abdomen, infraumbilical panniculectomy
- 15847 Excision, excessive skin...abdomen, (i.e. abdominoplasty) includes...
- 19300 Mastectomy for gynecomastia
- 22526 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral...guidance; single level
- 22527 Percutaneous intradiscal electrothermal annuloplasty...one or more additional levels
- 22857 Total disc arthroplasty (artificial disc) anterior approach...single interspace
- 22862 Revision...total disc arthroplasty (artificial disc)...single interspace
- 22865 Removal of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace
- 32998 Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including . . .
- 33203 Insertion of epicardial electrode(s); endoscopic approach (i.e. thoracoscopy, pericardioscopy)
- 33254 Operative tissue ablation and reconstruction of atria, limited (i.e. modified maze procedure)
- 33255 Operative tissue ablation and reconstruction of atria, extensive (i.e. maze procedure); without . . .
- 33256 Operative tissue ablation and reconstruction of atria, extensive (i.e. maze procedure); with . . .
- 33265 Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (i.e. modified maze . . .
- 33266 Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (i.e. maze . . .
- 33675 Closure of multiple ventricular septal defects;
- 33676 Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection . . .
- 33677 Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without . . .
- 43647 Laparoscopic, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
- 43648 Laparoscopic, surgical; revision or removal of gastric neurostimulator electrodes, antrum
- 43881 Implantation or replacement of gastric neurostimulator electrodes, antrum , open
- 43882 Revision or removal of gastric neurostimulator electrodes, antrum, open**
- 48548 Pancreaticojejunostomy, side-to-side anastomosis (puestow-type operation)
- 49324 Laparoscopy, surgical; with insertion of intraperitoneal cannula or catheter, permanent
- 49436 Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter
- 57296 Revision (including removal) of prosthetic vaginal graft; open abdominal approach
- 70554 Magnetic resonance imaging, brain functional MRI; including test selection and administration of . . .

- 70555 Magnetic resonance imaging, brain functional MRI; requiring physician or psychologist administration . . .
- 72291 Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation . . .
- 72292 Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation . . .
- 77011 Computed tomography guidance for stereotactic localization
- 77013 Computerized tomography guidance for, and monitoring of, parenchymal tissue ablation
- 77014 Computed tomography guidance for placement of radiation therapy fields
- 77021 Magnetic resonance guidance for needle placement (i.e. biopsy, needle aspiration, injection, . . .
- 77022 Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation
- 77082 Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture . . .
- 77084 Magnet resonance (i.e. proton) imaging, bone marrow blood supply
- 77371 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment . . .
- 77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment . . .
- 77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including . . .
- 77435 Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more . . .
- 83913 Molecular diagnostics; RNA stabilization
- 87305 Infectious agent antigen detection by enzyme immunoassay technique, qualitative . . .
- 87640 Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified . . .
- 87653 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified . . .
- 87808 Infectious agent antigen detection by immunoassay with direct optical observation; trichomonas . . .
- 91111 Gastrointestinal tract imaging, intraluminal (i.e. capsule endoscopy), esophagus with physician . . .
- 92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report
- 92640 Diagnostic analysis with programming of auditory brainstem implant, per hour
- 94004 Ventilation assist and management, initiation of pressure or volume preset ventilators for . . .
- 94005 Home ventilator management care plan oversight of a patient (patient not present) in home . . .
- 94774 Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate . . .
- 94775 Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate . . .
- 94776 Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate . . .
- 94777 Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate . . .
- 95012 Nitric oxide expired gas determination
- 96020 Neurofunctional testing selection and administration during invasive imaging functional brain mapping . . .
- 96040 Medical genetics and genetic counseling services each 30 minutes face to face with patient/family
- 96904 Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus . . .
- 99363 Anticoagulant management for an outpatient taking warfarin, physician review and interpretations . . .
- 99364 Anticoagulant management for an outpatient taking warfarin, physician review and interpretations . . .

Post Operative Days

Zero Post-Operative Days

49435 55876

10 Post-Operative Days

33202 49325 49436 55875 57558 37210 49326 54865 56442 67346

42 Post-Operative Days

15002	15003	15004	15005	15731	15830	15847	17311	17312	17313	17314	17315	19105
19300	19301	22526	22527	22865	25109	25606	25607	25608	25609	27325	27326	28055
35302	35303	35304	35305	35306	35537	35538	35883	35884	44157	44158	47719	48105
49324	49402	58541	58542	58543	58544	58548	58957	58958	64910	64911		

Not Covered for Assistant Surgeon

15002	15003	15004	15005	15731	15830	15847	17311	17312	17313	17314	17315	19105
19300	19301	22526	22527	22865	25109	25606	25607	25608	25609	27325	27326	28055
37210	49324	49325	49326	49402	49435	49436	54865	55875	55876	56442	57296	57558
64910	64911	67346										

□

07 - 09 Hospital ER-Only Diagnoses

Hospital ER-Only Diagnoses list additions/changes effective October 1, 2006

- 320-322 Bacterial Meningitis
- 323 Encephalitis, Myelitis, and Encephalomyelitis
- 324-326 Intracranial and intraspinal abscess
- 338.11 Acute pain due to trauma
- 341.2-341.21 Acute transverse myelitis
- 518.7 Transfusion related acute lung injury
- 518.81 Acute respiratory failure

519.11	Acute bronchospasm
608.2-608.24	Torsion of testis
649.3-649.34	Coagulation defects
770.87	Respiratory arrest of newborn
770.88	Hypoxemia of newborn
779.85	Cardiac arrest of newborn
780.31	Febrile convulsions
780.32	Complex febrile convulsions
958.91-958.99	Traumatic Compartment Syndrome
995.0	Other anaphylactic shock
995.1	Angioneurotic edema
995.21	Arthus phenomenon
995.23	Unspecified adverse effect of insulin
995.27	Other drug allergy
995.29	Unspecified adverse effect of other drug, medicinal, and biological substance properly administered
995.4	Shock due to anesthesia
995.50-995.59	Child maltreatment syndrome
995.61-995.69	Anaphylactic shock due to adverse food reaction
995.81-995.83	Other specified adverse effects, adult maltreatment
995.91-995.94	Systemic inflammatory response syndrome

□

07 - 10 Inpatient Hospital - DRG Update

Change is made to update DRG information. The DRG 433-437 are no longer valid for drug and alcohol detoxification. The DRG 523 is the correct code for this purpose. Drug and alcohol rehabilitation is not a covered service under this code.

□

07 - 11 Pregnancy Ultrasound Code Combination Issue

Code 59025 is included within code 76815 when the fetal biophysical profile consists of an AFI, *CPT Assist November 2004*. Code 76818 includes 59025 according to *The CPT Insider View 2001*. For reporting multiple gestation fetal biophysical profiles, code 76818 or 76819 should be reported for assessment of the first fetus, additional fetuses should be reported with either 76818 or 76819.

Code 76815 with 59025 provides more RVU's than those included in 76818; however, 76815 and 59025 will be paid when review supports medical necessity.

NOTE: Claims with pregnancy ultrasounds may be physician reviewed for medical necessity when the ultrasound frequency surpasses the number of pregnancy ultrasounds (i.e. greater than seven in nine months) described in the pregnancy ultrasound criteria #39.

□

07 - 12 Laboratory Issue

Please note that the following code is limited to one payment per service. This edit follows the American Society of Microbiology guidelines.

87621 Infectious agent detection by nucleic acid; papilloma virus, human, amplified probe technique

□

07 - 13 Prior Authorization for Rehabilitation Services

The following prior authorization requirements have been updated in the Hospital Manual; Rehabilitation Services, page 3, for January 1, 2007.

- B. Outpatient rehabilitation is limited to individual clients who qualify for the service. Prior authorization may be given based on established criteria. Outpatient therapy (OT, PT, Speech) is an optional service with a limited number of visits. Inpatient rehabilitation therapy service is intended to provide the therapy necessary to allow the patient to function without excessive outpatient followup therapy; and therefore, the maximum therapy service the patient can have under the DRG should be provided. Failure to provide this needed therapy during the patient's inpatient stay may affect the patient because adequate outpatient therapy visits may not be available.
- C. For approval, rehabilitation services must meet the following criteria:
1. The patient is medically/surgically stable and requires 24-hour nursing care or supervision by a registered nurse with specialized training in rehabilitation.
 2. The patient requires close medical supervision by a physician with specialized training in rehabilitation.
 3. This is the patient's first admission, or the patient has developed a new problem which now meets medical necessity for rehabilitation admission.
 4. The patient has a reasonable expectation of improvement in his/her activities of daily living which are appropriate for his/her chronological age and development that will be of significant functional improvement when measured against his/her documented condition at the time of the initial evaluation.
 5. For review of prior authorization, a worksheet with the following medical record documentation must be submitted:
 - a. The physiatrist or physical medicine history, physical and discharge summary, and nursing assessment.
 - b. The hospital discharge plan with rehabilitation, short and long term goals, and number of hours of therapy estimated for any given discipline.
 - c. The patient's physical, cognitive, and sensory capacity allows active participation in an intense rehabilitation program (5 ½ days/week) which includes a minimum of three hours of physical therapy and at least one other discipline (i.e. OT, Speech, etc.) which will restore function rather than maintain existing function at the time of admission.
 1. Submit the functional independent measurement (FIM) score for OT and PT pre-injury and post injury.
 2. Submit the FIM score for Speech therapy, if available.
- D. The physician or his/her designee must initiate the request for the prior authorization no later than the 5th working day after admission to the Rehabilitation Unit. The request must be sent in by FAX with all the pertinent information outlined in item C. If a request is submitted without all the required documentation, the request will start from the date of receipt rather than the date of admission.
- E. At receipt of the FAX...
- F. 1) the service(s) and reason(s) the authorization was not granted, 2) the regulations or rules which apply

QUICK Reference for Rehabilitation Services under criteria

Required written documentation on the faxed worksheet must include:

- physiatry history and physical, inpatient discharge summary
- nursing assessment
- hospital discharge plan with rehabilitation, short and long term goals which include the expected number of hours of therapy estimated for any given discipline.
- a statement that the patient's physical, cognitive, and sensory capacity allows active participation in an intense rehabilitation program (5 ½ days/week) which includes a minimum of 3 hours of physical therapy and occupational therapy or speech therapy in addition to the other therapeutic disciplines which will restore function rather than maintain existing function at the time of admission.
- a copy of the functional independent measurement (FIM) score for OT and PT pre-injury and rehabilitation admission status with discharge goal(s).
- a copy of the score for Speech therapy with audiology score, if available.

DRG 800

Disease Specific Criteria, patient has paralysis of two limbs or half of the body related to trauma or disease of the spinal cord.

□

07 - 14 Medical-Surgical Criteria Updates

Criteria #21 - Hyperbaric Treatment

Therapy may be provided as an outpatient service, but only in a hospital-based facility with accreditation through the Undersea & Hyperbaric Medical Society. For Medicaid coverage, the following definition and limitation section is added for clarification. The policy was renumbered.

“Hospital-based” means that the hyperbaric unit meets the guidelines for level-one care, as outlined by the Hyperbaric Undersea and Medical Society, which means the facility is located within the hospital or immediately adjacent to the hospital and there is immediate 24/7 medical staff coverage.

Limitations:

1. Hyperbaric oxygen therapy for deep wound (reaching tendon and bone) treatment is covered only when more than 30 days of standard wound treatment indicates wound healing has not occurred.
2. Hyperbaric oxygen therapy is not covered to simply speed up wound healing when granulation tissue is present.
3. HBOT is *not* considered medically necessary for superficial lesions. Medicaid does not cover wound clinics.

Criteria #40B - MRI Spine

Coverage

- A. For the patient with low back pain syndrome where there is no known cancer or septic disorder and there are no symptoms suggesting nerve, nerve root, spinal cord dysfunction, or myofascial pain. MRI may be medically reviewed for coverage when written documentation indicates the patient has not responded to at least a three-month trial of conservative treatment (i.e. pain medication, NSAIDs, and other alleviating procedures), including physical therapy instruction. A written summary of the physical therapist’s evaluation should include an attempt at physical therapy (i.e. 6 visits over 3 months). The physician may provide the physical therapy instruction (i.e. McKenzie exercises), but there must be an outline in the medical record documentation of the initial evaluation, exercise review with the patient, patient monitoring, and the physician’s instructions for home therapy by the osteopathic approach.
- B. An appropriate diagnosis must be submitted with the claim and the medical record must indicate the clinical signs and symptoms that support the medical necessity and reasonableness of ordering the MRI test. The patient’s record must show clinical evidence of myelopathy and/or radiculopathy, if the MRI is performed for evaluation of degenerative disc disease or herniated nucleus pulposus.
- C. Documentation of the standard medical imaging procedures completed should be submitted with the request for prior authorization. An MRI is reasonable when:
 - 1) standard medical imaging methods are inconclusive or the MRI may affect the treatment plan.
 - 2) when neurological deficit limits the feasibility of PT, the evaluation states why the patient cannot complete physical therapy.
 - 3) in an acute injury with neurological deficit, the physician’s documentation of complete neurological examination must support neurological deficit.
 - 4) in chronic back pain when there is an acute exacerbation of signs and symptoms of neurological deficit and the MRI will alter the treatment.
- D. The information derived from MRI imaging for Multiple Sclerosis must be considered in the context of the patient’s history and clinical evaluation; therefore, this disease remains predominately a clinical diagnosis. Serial MRI imaging to follow disease course is non-covered because it offers little benefit in clinical practice. MRI imaging of the brain does not require prior authorization, but spinal MRI does require prior authorization and 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, mitoxantrone, steroid).
 - 3) Unexpected worsening of condition with neurological deficit.
 - 4) Clinical evidence or suspicion of a secondary treatable condition.

Indications

- A. Degenerative or demyelinating diseases of the spinal cord
- B. Vertebral inflammatory lesions (i.e. epidural abscess, osteomyelitis)
- C. Congenital malformations
- D. Intramedullary lesions such as syringomyelia
- E. Neoplasms of spine and spinal cord
- F. Spinal trauma
- G. Spinal stenosis
- H. Myelopathy

Criteria #40B - Cardiac MRI

The 64-slice MDCT provides data similar to cardiac angiography and is becoming a replacement for angiography in many centers. Some studies indicate the multi-slice CT surpasses the cardiac MRI in accuracy, reliability, and quality. For consideration of a cardiac MRI, other cardiac imaging studies (i.e. angiography, TTE, and TEE) must have been completed in the last two months.

Coverage

For coverage consideration, the following information must be submitted for UR committee review:

1. An assessment of cardiac arrhythmia is provided.
2. Describe whether the cardiac issue(s) under consideration are anatomical and/or functional.
3. Provide reports of the completed cardiac evaluation tests.
4. Describe whether the patient has an allergy to dye or renal insufficiency which prevents the use of contrast (MDCT, MRA).

Limitations

1. The cardiac MRI does not duplicate other completed cardiac evaluation tests or there is a medically necessary reason MRI is required in addition to the cardiac evaluation tests completed.
2. The patient has been screened for MRI contraindications such as pacemaker, implanted defibrillator, Swan-Gantz catheter, recent coronary stenting (<6 weeks) and other conventional contraindications.

Criteria #40C - PET/CT Imaging

The gold standard of care of initial diagnostic work up for a tumor or cancer is the CT scan. The PET/CT scan is an invasive diagnostic test which combines the two studies with a lower level of radiation for the CT portion of the study. The PET/CT fusion procedure is currently under study by the National Oncological PET Registry (NOPR) under the request of Centers for Medicare and Medicaid Services (CMS). PET/CT fusion will only be considered for initial cancer evaluation by the Medicaid Utilization Review Committee after a 64-slice CT scan and before other procedures have been completed. A prior authorization may be obtained through the UR Committee on a case-by-case basis when documentation supporting medical necessity is submitted.

Coverage

- A. PET/CT is covered for **initial cancer staging** only when additional information is required prior to a procedure to determine the optimal anatomical location to perform an invasive diagnostic procedure or determine the feasibility of surgery for patients with an initial diagnosis of non small cell lung cancer, lymphoma, melanoma, colorectal cancer, esophageal cancer, or head/neck cancer.

Limitations

- A. In a patient with melanoma, a PET/CT scan is covered to evaluate recurrence of melanoma prior to surgery and to assess extranodal spread of malignant melanoma at initial staging.
- B. In a patient with lymphoma, the PET/CT is covered prior to surgery or when documentation supports medical necessity because a change in radiation treatment is anticipated.
- C. PET/CT scan is not covered for the evaluation of CNS disease such as dementia, cerebrovascular disease, metabolic or nutritional disorders, infections, pulmonary disease, or for neoplasms of the liver, musculoskeletal system, ovary, pancreas, thyroid, or parathyroid.
- D. PET/CT scan is not covered for screening in the absence of specific signs and symptoms of disease or as a work-up of patients with multiple sites of disease.

□

07 - 15 Diabetes Education

Individual or group diabetes education is paid under code S9455. This service requires prior authorization.

□

07 - 16 Home Health

Based on the high volume of home health and private duty nursing cases, requests can no longer be made by telephone. All requests must be faxed in to the utilization review nurse. The fax number is (801) 536-0955.

□

07 - 17 Medical Supplies - 2007 Codes**Covered Codes**

K0730RR Controlled dose inhalation drug delivery system, open as a monthly rental only.

Codes Requiring Prior Authorization

K0734 Skin protection wheelchair seat cushion, width less than 22 inches, any depth
 K0735 Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
 K0736 Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
 K0737 Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
 A8000 Helmet, protective, soft, prefabricated includes all components and accessories
 A8001 Helmet, protective, hard, prefabricated includes all components and accessories
 A8002 Helmet, protective, soft, custom fabricated includes all components and accessories
 A8003 Helmet, protective, hard, custom fabricated includes all components and accessories

Discontinued Codes - Effective January 1, 2007

K0093 Rear wheel zero pressure tire tube (insert)
 K0097 Wheel zero pressure tire tube
 E0977 Wedge cushion, wheelchair
 E0180 Pressure pad, alternating with pump
 E0701 Helmet with face guard and soft interface material, prefabricated
 L0100 Cranial orthosis (helmet), with or without soft interface, molded to patient

Wheelchairs

Medicaid covers wheelchairs for use in the home or residence. Options and accessories specific for use outside of the home are not covered. Power assist options on manual wheelchairs are not covered by Medicaid as they are not medically necessary for use in the home.

Criteria for CPAP machines for children age 20 and younger

- a. An AHI>15 for adults is documented during a minimum of 2 hrs of diagnostic polysomnography.
- b. There are AHI>5 and < to 14 events per hour with documented hypertension, ischemic heart disease.
- c. And AHI>3 is documented for children during a minimum of 2 hrs of diagnostic polysomnography.

Humidifiers

Heated humidifiers are included as part of the global fee for ventilators using codes E0450, E0461, E0463, and E0464. Humidifiers are included as part of the global fees for all oxygen concentrator systems.

Limit change for Intermittent Urinary Catheter Code A4351

Code A4351, Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each, has had the unit limit per month changed from 10 per month to 100 per month.

□

07 - 18 Denture Services

Denture codes D5110 and D5120 include routine post-delivery care and necessary adjustments for six months. Hard relines will be reimbursed six months after the initial placement.

Immediate denture codes D5130 and D5140 include routine post-delivery care and adjustments and soft liners for six months. Hard relines will be reimbursed six months after the initial placement.

□

07 - 19 Audiology

Beginning January 1, 2007, code V5275, ear impression, each, is being discontinued for use by Medicaid and will be replaced by V5264, ear mold/insert. Code V5264 is to be used for billing for ear molds/inserts after the initial 12 months following the provision for new hearing aids. The reimbursement for hearing aids includes the impression and mold as part of the global fee. Code V5264, or ear mold/insert, will globally include the costs for impressions, lab fees, and shipping and handling. Medicaid will reimburse \$38.00 for this code.

□

07 - 20 Outpatient PT/OT/Speech Services

Outpatient speech therapy, physical therapy, and occupational therapy delivered by outpatient hospital services should be billed using the HCPCS codes that are open and listed in the specific Medicaid Provider Manuals. **Revenue codes for these out patient services should not be used for billing these out patient services.**

□

07 - 21 Mental Health Centers, Substance Abuse Providers, Providers of Targeted Case Management for the Homeless, and Early Childhood (Ages 0-4) Targeted Case Management Providers:

Mental Health Centers - Targeted Case Management for the Chronically Mentally III

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, clarifies that foster care-related activities are not eligible for reimbursement and states that Medicaid reimbursement is available only if there are no other third parties liable for the service, including reimbursement under a medical, social, educational, or other program.

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 the Chronically Mentally III, have been updated to incorporate the DRA's language on covered case management activities and to include the limitations on foster care-related activities and Medicaid reimbursement.

Also, technical changes have been made in Chapter 1-3, Target Group, Section B, and to Chapter 2-4, Limitations on Reimbursable Services. In Chapter 4, Service Payment, Section C has been deleted and moved to Chapter 2-4.

The Utah Medicaid Provider Manual for Targeted Case Management for the Chronically Mentally III is on the Internet. Follow this link to the manual:
<http://www.health.utah.gov/medicaid/tree/index.html>

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

Substance Abuse Providers - Targeted Case Management for Individuals with Substance Abuse Disorders

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, clarifies that foster care-related activities are not eligible for reimbursement and states that Medicaid reimbursement is available only if there are no other third parties liable for the service, including reimbursement under a medical, social, educational, or other program.

To be consistent with the DRA, Chapter 5-1, Covered Services/Activities, and Chapter 5-2, Non-Covered Services/Activities, of the Utah Medicaid Provider Manual for Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse, have been updated to incorporate the DRA's language on covered case management activities and to include the limitations on foster care-related activities and Medicaid reimbursement.

Also, technical changes have been made in Chapter 4-4, Target Group, Section B, and to Chapter 5-3, Limitations on Reimbursable Services. In Chapter 7, Service Payment, Section C has been deleted and moved to Chapter 5-3.

The Utah Medicaid Provider Manual for Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse is on the Internet. Follow this link to the manual:

<http://www.health.utah.gov/medicaid/tree/index.html>

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

Targeted Case Management for the Homeless

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, clarifies that foster care-related activities are not eligible for reimbursement and states that Medicaid reimbursement is available only if there are no other third parties liable for the service, including reimbursement under a medical, social, educational, or other program.

To be consistent with the DRA, Chapter 2-1, Covered Services/Activities, and Chapter 2-2, Non-Covered Services/Activities, of the Utah Medicaid Provider Manual for Targeted Case Management for the Homeless, have been updated to incorporate the DRA's language on covered case management activities and to include the limitations on foster care-related activities and Medicaid reimbursement.

Also, technical changes have been made in Chapter 1-3, Target Group, Section D, and to Chapter 2-3, Limitations on Reimbursable Services. In Chapter 4, Service Payment, Section C has been deleted and moved to Chapter 2-3.

The Utah Medicaid Provider Manual for Targeted Case Management for the Homeless is on the Internet. Follow this link to the manual:

<http://www.health.utah.gov/medicaid/tree/index.html>

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

Early Childhood (0-4) Targeted Case Management Providers

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, clarifies that foster care-related activities are not eligible for reimbursement and states that Medicaid reimbursement is available only if there are no other third parties liable for the service, including reimbursement under a medical, social, educational, or other program.

To be consistent with the DRA, Chapter 2 in the targeted case management provider manual has been updated to incorporate the DRA's language on covered case management activities and to include the limitations on foster care-related activities and Medicaid reimbursement.

Technical changes also have been made to Chapter 1-3, Target Group, Section B, and to Chapter 2-3, Limitations on Reimbursable Services. In Chapter 4, Service Payment, Section E has been deleted and moved to Chapter 2-3. In Chapter 5-2, Description of Procedure Codes, the procedure codes have been updated.

Internet Access

Providers may access the targeted case management provider manual on the Internet. Follow this link to the Medicaid provider manuals:

<http://www.health.utah.gov/medicaid/tree/index.html>

Providers may contact Russ Labrum at 538-6206 or via e-mail at russlabrum@utah.gov with any questions.

□

07 - 22 Physician Billing for Office Administered Drugs

Medicaid now requires billings for drugs administered in the physician's office to include the NDC from the vial or container from which the drugs are obtained, as well as the quantity of units administered. Beginning January 1, 2007, claims that do not include this information along with the HCPCS Code (codes beginning with "J" and some codes beginning with A, Q, K, or S that are associated with drugs) will be denied for payment. Modifications to the claim form are in place to accept this data. Note: vaccine billing is not affected by this policy.

□

07 - 23 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. Medicaid will begin implementing the reimbursement based on AMP (Average Manufacturer Price) plus the dispensing fee, when approved by CMS.

More information will be published in the Amber Sheet newsletter as it becomes available.

□

07 - 24 Drug Criteria and Limits Section Updated

Effective January 1, 2007, Medicaid will publish a revised version of the attachment, Drug Criteria and Limits, in the Provider Manuals. The prior authorization criteria that is already in place will not change; however, the appearance should make the information much easier to access.

□

07 - 25 Pharmacy Coverage Highlights

1. Medicaid will restrict the coverage of Fentora using the criteria that is in place for Actiq. Fentora and Actiq will both count towards the same cumulative limit of 120 units of oral Fentanyl per month, and will continue to be available for cancer patients only.
2. Medicaid policy limits coverage of Insulin pens to patients who are legally blind.
3. Ventavis will continue to require a prior authorization. It will not be a covered benefit for patients diagnosed with chronic obstructive pulmonary disease, severe asthma, or acute pulmonary infection. The Prodose AAD system for the inhaled delivery of Ventavis is available through the medical supplies program using code K0730 on a monthly rental.
4. Inhalers are limited per Medicaid client per month to reflect maximum allowed dosages recommended by the manufacturer. See table on page 17.

Inhaler Class	Generic Name	Brand Name	Product Size	Doses per Inhaler	Maximum No. In 30 Days
Nasal Anti-inflammatory inhalers	beclomethasone	Beconase AQ	25	200	2
	fluticasone	Flonase	16	120	1
	triamcinolone	Nasacort HFA	9.3	100	6
	triamcinolone	Nasacort AQ	16.5	120	2
	flunisolide	Nasarel	25	200	3
	mometasone	Nasonex	17	120	1
	budesonide	Rhinocort AQUA	8.4	120	2
Beta 2 agonists and Sympathomimetic Inhalers	Albuterol	generic	17 gm	200	4
		Proventil	17 gm	200	4
		Proventil HFA	6.7 gm	200	4
		Ventolin	6.8 gm	80	4
			17 gm	200	4
		Ventolin HFA	18gm	200	4
	Formoterol	Foradil		12	1
				60	2
	Metaproterenol	Alupent	14 gm	200	2
	Pirbuterol	Maxair	25.6 gm	300	3
	Pirbuterol	Maxair Autohaler	14 gm	400	1
	Salmeterol	Serevent	6.5 gm	60	1
			13 gm	120	1
Serevent Diskus			60	1	
Anti-cholinergic Inhalers	Ipratropium	Atrovent HFA	14 gm	200	2
	Ipratropium / Albuterol	Combivent	14.7 gm	200	2
	Tiotropium	Spiriva	30 cap.	30	1
Anti-inflammatory Inhalers	Beclomethasone	Qvar 40mg	7.3 gm	100	2
		Qvar 80mg	7.3gm	100	2
	Budesonide	Pulmicort Turbuhaler		200	2
	Flunisolide	AeroBid, AeroBid-M	7 gm	100	2
	Fluticasone MDI	Flovent	13 gm	120	1
				120	1
				120	2
	Fluticasone DPI	Flovent Rotadisk 50 mcg, 100 mcg, and 250 mcg		60	1
				60	1
				60	4
	Triamcinolone MDI	Azmacort	20 gm	240	2
Fluticasone / Salmeterol DPI	Advair diskus 100/50		60	1	
		Advair diskus 250/50	60	1	
		Advair diskus 500/50	60	1	
Mast cell stabilizer Inhalers	Cromolyn MDI	Intal	8.1 gm	112	3
			14.2 gm	200	2
	Nedocromil MDI	Tilade	16.2 gm	112	3

□