

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 - 61 Statewide Provider Training

Utah Medicaid providers are invited to attend the 2007 Medicaid Statewide Provider Training Seminar. The seminar will include important information regarding the National Provider Identifier (NPI), reporting third party payments, and other billing issues. Please register your desired session(s) either by going to this web site <http://www.surveymonkey.com/s.asp?u=822183875300> or the Medicaid web site at <http://health.utah.gov/medicaid/>.

City	Date	Address	Time
Tooele	7/31	Tooele County Court House 47 So Main, Tooele	9:00 AM
Ogden	8/01	Ogden Regional Medical Center 5475 So 500 East Ogden	9:00 AM or 1:30 PM
Monticello	8/07	San Juan Hospital 364 West 100 North, Monticello	9:00 AM
Price	8/08	South Eastern Health Dept 28 South 100 East, Price	9:00 AM
Logan	8/14	Bear River Health Dept 655 East 1300 North, Logan	9:30 AM
FQHC	8/15	860 East 4500 South # 206 SLC/ Video Conference	1:00 PM
Salt Lake	8/21	State Library 250 North 1950 West, SLC	9:00 AM or 1:30 PM
Salt Lake	8/22	South County DWS 5735 South Redwood Rd, SLC	9:00 AM or 1:30 PM
Fillmore	8/28	Fillmore Hospital 674 South HWY 99, Fillmore	1:00 PM
Layton	8/29	Davis Hospital 1600 West Antelope Drive, Layton	9:00 AM
Provo	9/05	Utah Valley Hospital Women & Children Center, Provo	2:00 PM
Orem	9/06	Timpanogos Regional Hospital 750 West 800 North, Orem	9:00 AM
Richfield	9/11	Sevier County EMS Building 50 West 925 North, Richfield	1:30 PM
Cedar City	9/12	Iron County School District 2077 West Royal Hunter DR, Cedar City	9:00 AM
St George	9/13	Dept of Workforce Services 162 North 400 East, St George	10:00 AM or 2:00 PM
Roosevelt	9/18	Northeastern Medical Center 210 West 300 North, Roosevelt	1:00 PM
Vernal	9/19	Ashley Valley Medical Center 151 West 200 North, Vernal	9:30 AM

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07 - 62 Delay in Paper Claims Processing

Due to an interruption in service by our data entry contractor, you may experience a significant delay in your paper claims being processed. Medicaid is evaluating several solutions to address this problem.

The Division strongly encourages you to submit all claims electronically through UHIN. If you are not already enrolled with Utah Health Information Network (UHIN), visit their web site at <http://www.uhin.com/>. Click on "Getting started" for additional information or contact UHIN by phone (801) 466-7705. Information is available on Medicaid's web page at <http://health.utah.gov/hipaa/>.

Clearinghouses are an alternative for providers to send electronic transactions.

Please note the following when submitting claims requiring attachments:

- A. It is not necessary to submit paper claims for attachments including Coordination of Benefits (COB). When submitting COB information in an electronic format, be sure to include payer payment amount, patient liability and reason codes with amounts for contractual obligations; it is not necessary to submit an Explanation of Benefits (EOB).
- B. If your system does not have the capability to transmit COB, you may submit the claim electronically. When the Medicaid remittance is received, fax the remittance along with the other payer EOB. Please fax COB attachments to ~~801-536-0463~~. Staff will manually match the information and process the claim.
- C. Manual review attachments should be faxed to ~~801-536-0481~~. Staff will manually match the information and process the claim.

CORRECTION 6/14/07 Fax COB attachments to 801-536-0481 and manual review attachments to 801-536-0463.

Medicaid anticipates accepting electronic attachments by the end of 2007.

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07 - 63 Claim Reconciliation Tool

"UHINTracker" is a new tool available through UHIN. Tracker is an Internet-based tool and so does not require the provider to purchase and maintain any additional software or hardware (as long as the provider can access the Internet with a high-speed connection).

UHINTracker provides many benefits to the provider office such as removing the need to open mail and matching claims to remittances and payments. UHINTracker has the functionality to automatically reconcile the provider's billing and payment transactions. The tool utilizes HIPAA-required code sets that are designed to help providers comply with their obligations under HIPAA privacy and security standards. Providers can go to one place and use one process to obtain claim status and payment information from all UHIN participating payers.

To sign up for UHINTracker, or for more information, contact UHIN at (801) 466-7705.

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07 - 64 BES and DWS Consolidation

The Utah Legislature has approved the consolidation of eligibility workers from the Department of Health's Bureau of Eligibility Services (BES) with the Department of Workforce Services (DWS). The transfer of staff and budget will take place on July 1, 2007. The objective of this consolidation is to improve customer service and to achieve operational efficiencies.

For more information, visit the DWS web page <http://jobs.utah.gov/edo/dohdws/dwsdefault.asp>.

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07 - 65 Publication Request Form on Web

Providers can now access a publication request form from the Medicaid web site instead of waiting on hold for a customer service agent to assist over the telephone. The publication request form can be used to request remittance advices, warrant tracers, fee schedules, publications, forms, and provider manuals. Simply print the form, fill it out legibly, and fax or mail it to the Document Control Unit. Fax number is (801) 536-0476.

Click on link to access the 2-page form: <http://www.health.utah.gov/medicaid/pdfs/RemitForm3-07.pdf>

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07 - 66 National Provider Identifier *IMPORTANT NOTICE*****

The Utah Medicaid Program will continue to pay claims submitted electronically with only the Medicaid Provider Identifier after May 23, 2007. Health care providers must get a NPI, register the NPI with Provider Enrollment, and begin to use the NPI on paper and electronic claim submissions. Refer to the Companion Guides on the Medicaid web site at <http://health.utah.gov/medicaid> for instructions on X12 transactions.

Utah Medicaid providers are responsible for determining if they are a covered health care provider and are required to obtain and use a NPI for billing all standard transactions, or if they are an atypical provider and will continue to use a 12-digit Medicaid provider contract number for billing. Atypical providers do not provide services that fit within the realm of "health care" as defined by 45 CFR 160.103; and therefore, are not eligible to obtain a NPI. NPI assignment does not mean that a provider is a covered health care provider and required to use a NPI for all standard transactions. Although all health care providers need a NPI, the Utah Medicaid Program does not expect the provider types listed below to submit claims with a NPI:

- Non-ambulance transportation providers
- Home and Community-Based Services or Waiver providers
- Case Management providers
- Managed Care Health Plans

Atypical providers may continue to use their 12-digit Medicaid provider contract number for electronic submissions (billing, electronic remittances, and eligibility requests) with one important change. A new Trading Partner Number (TPN) HT000004-801 becomes available effective May 21, 2007. Atypical providers are required to update their online EDI Enrollment forms and transmit to and receive from the new TPN mailbox after May 23, 2007.

Providers may verify that their NPI has been registered by contacting Provider Enrollment at (801) 538-6155 or toll free at 1-800-662-9651. For those providers who have not registered their NPI with Medicaid, please fax it to (801) 536-0471 or mail the information along with your provider name, Medicaid provider number, taxonomy code, and 9-digit zip code to Medicaid Provider Enrollment, PO Box 143106, SLC, UT 84114-3106. For those providers who have not applied for a NPI, this can be done online at <http://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.

Medicaid Provider Enrollment began pending all new provider applications without a NPI effective May 1, 2007. All new enrolling health care providers have 60 days to provide their NPI information. If the NPI information is not submitted within 60 days, the enrollment application will be denied.

Utah Medicaid currently accepts the CMS-1500 (8/05), 2006 ADA, and UB-04. The grace period for accepting all current versions of these forms will be ending effective July 1, 2007. Any claims not submitted on the updated forms will be returned to providers.

CMS has posted new FAQ's related to the previously posted NPI Compliance Contingency Guidance. To view these FAQ's, you should:

- Go to the CMS dedicated NPI web page at www.cms.hhs.gov/nationalprovidentstand/
- Scroll down to the section that says, "Related Links Inside CMS"
- Click on NPI Frequently Asked Questions
- To find the latest FAQ's, click on the arrows next to "Date Updated", look for the word "New" in red font beside the most recent FAQ's.

Medicaid staff are currently working with the UHIN National Provider ID Subcommittee to assist in the implementation of NPI. Medicaid will keep you informed of our NPI Contingency Plan.

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

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07 - 67 Out-of-State Transportation

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

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

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

If commercial transportation by ground or air carrier is used, it will be set up and paid directly by Medicaid. If transportation by personal vehicle is possible and used, the reimbursement is the state rate, or \$0.18 per mile. The reimbursement for bus, shuttle, or medically necessary taxi trips to and from the airport, the medical facility, and/or place of lodging are limited to \$30 per ride and a maximum cap of \$120 per out-of-state medical service visit or trip. Receipts must be submitted with the request for reimbursement.

Lodging and Meal Per Diem Associated with Out-of-State Transportation (Beyond 120 miles of the Utah border)

Overnight stays and meals associated with out-of-state travel may be allowed. A per diem for meals and overnight lodging may be authorized for the recipient, except for the days the recipient is receiving inpatient services. If the recipient is a child age 20 years and under, an additional per diem for meals and lodging may be authorized for a parent or care giver. If the recipient is an adult age 18 and older, an additional per diem for meals and lodging may be authorized for the attendant, but only for the days the attendant is giving care and attending to the recipient.

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

Limitations

1. Receipts must accompany requests for reimbursement for lodging and any ground transportation except personal vehicle mileage.
2. Requests for reimbursement for transportation services must be made within one year of the date of the service.
3. All out-of-state transportation, lodging, or meals must be prior authorized in order to be reimbursed.

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07 - 68 Nutrition and Supplemental Nutrition

Criteria has been established for nutrition and supplemental nutrition effective August 1, 2007.

Nutrition - General

All nutritional products must be prescribed by a physician, and except for medical foods for inborn errors of metabolism, must be prior authorized.

To be covered, the nutritional products must meet the definition of "medical food" (MF) as defined in the Orphan Drug Act Amendments of 1988 [21 USC 360ee (b)(3)] which states a medical food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Generally, to be considered a MF, a product must, at a minimum, meet the following criteria:

- The product is a food for oral or tube feeding,
- The product is labeled for the dietary management of a medical disorder, disease, or condition, and
- The product is labeled to be used under medical supervision, and is primarily obtained through hospitals, clinics, and other medical and long term care facilities.

Medical foods are distinguished from the broader category of foods for special dietary use and from foods that make health claims by the requirement that medical foods be used under medical supervision. The term "medical foods" does not pertain to all foods fed to sick patients. Medical foods are foods that are specially formulated and processed (as opposed to a naturally occurring foodstuff used in its natural state) for the patient who is seriously ill or who requires the product as a major treatment modality.

Total Nutrition

1. Total parenteral (intravenous) nutrition. Parenteral products are identified by protein content. The physician's order must specify the kilo calories necessary per day. Parenteral infusions are identified and reimbursed per day by kilo calories requirements. Other additives are identified in Chapter 2-3, I.V. Therapy.
2. Total nutrition by enteral tube feedings. Covered for outpatient Medicaid clients and residents of long term care facilities. All total nutrition by enteral tube feedings require a physician's order or prescription for the specific nutritional product. To be approved, the enteral product must be given by gastrostomy, jejunostomy, nasogastric, nasoduodenal, or nasojejunal tube. Enteral products are prescribed by the physician with the specific product best suited to the patient's medical condition. Total nutrition by enteral tube feeding is covered when current disease or dysfunction, including dysphagia, of the digestive tract caused nutritional deficiency with insufficient nutrients to maintain body weight by impaired delivery of nutrients to the small bowel or due to impaired digestion and absorption by the small bowel, or both.
3. Total nutrition without enteral tube feeding. Total nutrition by oral intake is covered for children (0 through age 20) if all of the following are documented:
 - (A) Current disease or dysfunction of the digestive tract, including dysphagia, which causes nutritional deficiency with insufficient nutrients to maintain body weight by impaired delivery of nutrients to the small bowel or due to impaired digestion and absorption by the small bowel, or both.
 - (B) Current documentation that the client has been unable for the last three months to reach or maintain the 10th percentile for weight for age and sex by taking food orally.
 - (C) Review of the client's medical records must document the client's specific diagnosis(es) and current condition which requires medical food supplementation.
 - (D) The health care provider must document by peer review medical literature that the prescribed medical food will improve the clinical outcome(s), besides body weight, and limit disease progression for the client's specific diagnosis(es) and current condition when compared to non-medical food.

Supplemental Nutrition

1. Supplemental nutrition by feeding tube. Supplemental nutrition and appropriate supplies are covered for children (0 through age 20) with partially functioning gastrointestinal tracts. The supplemental nutrition must be administered through a tube, or it may be consumed part orally and part administered through a tube. If a tube is required, supplies and pumps may be authorized. The same criteria, (A)-(D), as #3 above, Total Nutrition without enteral tube feeding, must be met.
2. Oral Nutritional Supplements (without feeding tube).
 - (A) For children and adults, oral supplemental nutrition is covered to treat inborn errors of metabolism. In patients with inborn metabolic errors, the metabolic pathway is disrupted and excessive accumulation of an amino acid or other product may result. These medical food supplements are available through NDC codes in the Pharmacy Program without prior authorization, but is not available through HCPCs codes in the Medical Supplies Program. Upon request, a peer reviewed medical literature review and review of the client's medical records must document that total nutrition with the prescribed medical food will improve the clinical outcome(s), besides body weight, and limit disease progression for the client's specific diagnosis(es) and current condition when compared to non-medical food.
 - (B) Medicaid will approved nutritional supplements for covered infants and children ages 0 to 5 years, with or without feeding tubes, who live at home and are in the WIC program, for quantities which exceed the WIC program allowed amounts. If a tube is required, supplies and pumps may be authorized. Nutritional products must be a medical food and prescribed by the physician for the specific diagnosis(es) of the client's condition.
One of the following conditions must be documented:
 - (1) The target weight of a child cannot be attained with oral feedings
 - (2) The oral food intake is inadequate due to weakness, illness, or disease
 - (3) The child is concurrently using a ventilator or oxygen, or has a tracheostomy and is unable to reach or maintain age appropriate weight.
 - (C) Medicaid will approved nutritional supplements for covered clients ages 5 through 20 years. The same criteria, (A)-(D), as #3 above, Total Nutrition without enteral tube feeding, must be met.

Coverage Limitations for Nutritional Products

1. Only nutritional supplements as defined in the above section are covered. All other supplemental nutrition is not covered. Most enteral products are available from a local grocery store with a pharmacy by using food stamps. The client should request the in-house pharmacy to order the enteral products which can then be carried through the grocery line and paid for with food stamps.
2. Oral nutritional supplements for adults are not a Medicaid benefit except for clients with inborn errors of metabolism.
3. Oral nutritional supplements with breast milk, baby food, infant formula, and other non-medical foods are not a Medicaid benefit.
4. For re-authorizations for ongoing care:
 - (A) The need to document the recipient weight under the 10th percentile is waived.
 - (B) The need to resubmit documentation of peer review medical literature is waived, if it has been previously submitted unless the medical diagnosis has materially changed.

Nutritional Products and Residents of Long Term Care Facilities

Parenteral solutions and total enteral therapy administered through a tube is covered for patients residing in long term care facilities.

- (A) Covered supplies include:
 - (1) Parenteral solutions.
 - (2) A monthly parenteral nutrition administration kit which includes all catheters, pump filters, tubing, connectors, and syringes relating to the parenteral infusions.
 - (3) Enteral solution for total enteral therapy given by tube and includes all supplies and pumps.
- (B) Long term care facilities and home health agencies must have personnel trained to place and care for TPN and EN naso-gastric gastrostomy or jejunostomy tubes.

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07 - 69 Medical Supplies

Effective July 1, 2007, the following changes will be implemented:

Intermittent Urinary Catheters

The criteria for urinary catheters has been revised to allow up to 120 catheters per month for code A4352, and A4353 if sterile technique is required. For those requiring sterile technique the criteria is amended to add, "Consideration of other medical conditions will be evaluated on an individual basis for medical necessity."

CPAP Filters for Patient-Owned Devices

A7038, Filter, disposable, used with positive airway pressure device, patient-owned, is limited to one filter every 90 days.

A7039, Filter, nondisposable, used with positive airway pressure device, patient-owned, is limited to one filter every five years.

Exception for Lease/Rental Modifier LL

Codes with the LL modifier are capped at 12 months and become a purchase except for Oximeter, E0445LL; CPAP, E0601LL; BPAP, E0470LL; and the associated Humidifier, E0562LL devices are capped, but these caps are not considered a purchase and the equipment remains the property of the supplier. The supplier may bill using the additional modifier "MS" for maintenance and service of these devices every six months following the rental cap. Prior authorization is required.

Opened Codes

A4612, Battery, heavy duty, replacement for patient-owned ventilator

A4616, Battery, heavy duty, replacement for patient-owned ventilator

E0482, Cough assist device, as purchase only

A4338, Indwelling catheter; foley type, two-way latex with coating, each (2 per month)

E0194, Air fluidized bed. The modifier has changed from a capped rental, "LL", to a monthly rental, "RR".

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07 - 70 Intensity Modulated Radiation Therapy (IMRT)

Criterion #44 of the *Criteria for Medical and Surgical Procedures* will be deleted from the manual, effective July 1, 2007. This procedure continues to be a non-covered service. Requests for coverage must be requested through the Utilization Review Committee.

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07 - 71 Medicaid Transformation Grant

In February, 2007, Utah Medicaid was awarded a grant from the Centers for Medicare and Medicaid Services (CMS) under the Medicaid Transformation Grants, Appropriation No. 7570516. The Transformation Grant for Utah Medicaid involves developing a Utah Pharmacotherapy Risk Management System with an Electronic Surveillance Tool (Utah ePRM). This grant brings together staff from the Utah Division of Health Care Financing, the Utah College of Pharmacy, the School of Medicine, the Department of Pediatrics, the Office of Health Care Statistics, and the Salt Lake VA Medical Center to modernize Utah Medicaid's health delivery system.

The targeted interventions planned for this grant include:

- Prescriber notification of potential therapy problems by letters, and in some severe situations, by telephone.
- Identification of prescriber outliers and use of face to face academic detailing.
- Detection of client fraud and abuse and expanded use of the restriction Lock-In program.
- Patient reviews for those clients at high risk.
- Medication Therapy Management Services (MTMS) by certified pharmacists.

Appropriate therapy and safety outcomes will be the overall focus of this program including under-use of needed medication. The six areas of focus will include a) diabetic therapy, b) hypertension therapy, c) asthma therapy, d) antipsychotic therapy, e) pain management, and f) anticoagulation therapy.



07 - 72 Pharmacy Coverage Highlights

New prior authorizations have been put into place for the following drugs:

Avastin®

- Minimum age - 18 years old
- Documentation of diagnosis of metastatic carcinoma of colon or rectum OR non-squamous, non-small cell lung cancer OR macular degeneration
- Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity

Invega™

- Minimum age - 18 years old
- Diagnosis of schizophrenia
- No prior therapeutic failure on risperidone
- Not approved for use prior to trial of risperidone
- Patient fails to take multiple daily doses of anti-psychotics and cannot tolerate a single daily dose of risperidone
- Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity

Vectibix™

- Minimum age - 18 years old
- Diagnosis of metastatic colorectal cancer
- Disease progression on or following fluoropyrimidine-, oxplatin-, and irinotecan-containing chemotherapy regimens
- Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity

Ziana™

- Age requirement - 12-19 years old
- Patient must try and fail on a combination of both generic tretinoin gel and clindamycin gel
- Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity

The following Prior Authorization criteria have been updated. Changes in the criteria are italicized:

Byetta®

- Minimum age requirement - 17 years old
- The patient cannot be using insulin. Byetta cannot be a replacement for insulin
- Byetta will only be approved as an adjunct therapy in the treatment of Type II Diabetes
- Patient must be taking metformin, a sulfonourea (identify by name) or both **OR** a TZD (*glitazone*) *alone or in combination with metformin*
- The patient cannot be in end-stage renal disease or on dialysis
- The patient may not have a diagnosis of gastroparesis
- Provide information showing a lack of glycemic control
- Initial authorization is for 1 year - renewal requires documentation that the patient is stable on Byetta and not on insulin

Emend®

- Used in combination with corticosteroid and 5HT3 agents to prevent acute and delayed nausea and vomiting associated with initial and repeat doses of highly emetogenic cancer chemotherapy including high-dose Cisplatin
- *Patients receiving the following chemotherapy regimens that are classified by the National Comprehensive Cancer Network (NCCN) as high emetic risk may receive Emend as a first-line treatment:*
 - ▶ *Cisplatin > or = 50mg/m²*
 - ▶ *Cyclophosphamide > 1,500mg/m²*
 - ▶ *Dacarbazine*
 - ▶ *Mechlorethamine*
 - ▶ *Procarbazine (oral)*
 - ▶ *Streptozocin*
 - ▶ *Altretamine*
 - ▶ *Carbustine > 250mg/m²*
 - ▶ *AC combination defined as either doxorubicin or epirubicin with cyclophosphamide*

- Patients on *other chemotherapy regimens* must have failed on a trial of Zofran, Kytril, Anzemet, Aloxi, or other 5HT3 agent
- Initial authorization is for 6 months, 3 doses per chemotherapy session
- Re-authorization requires a telephone request from the physician's office

Entries for Zelnorm and Stadol Nasal Spray have been removed from the *Drug Criteria and Limits* manual attachment. These drugs are no longer manufactured.

Please note - Pharmacy Prior Authorizations has a new fax number. PA requests should now be faxed to (801) 536-0477.

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07 - 73 Medicaid Preferred Drug List

During the 2007 legislative session, the Utah State Legislature passed Senate Bill 42 allowing Medicaid to adopt a preferred drug list (PDL). Medicaid's goal is to begin to phase in a preferred drug list beginning fall 2007. Medicaid initially plans to implement a PDL for proton pump inhibitors and statins. In order to meet this goal, Medicaid is taking the following steps:

- A Pharmacy and Therapeutics (P&T) Committee will be empaneled and begin meeting at the end of June 2007.
- The P&T Committee will consist of an academic pharmacist, hospital pharmacist, chain store pharmacist, independent pharmacist, pediatrician, family practice physician, psychiatrist, and an internist.
- The P&T Committee may invite two specialists to each meeting to advise on the drug class under consideration.
- The P&T Committee will advise the DUR Board and Medicaid in choosing preferred agent(s) for each selected class of drugs based on clinical efficacy and cost.
- Letters will be mailed to notify clients and providers of the changes in the Medicaid benefits.
- Continual public updates about the PDL implementation process will be provided through the Amber Sheet, MIB, and Pharmacy Services web site at <http://health.utah.gov/medicaid/pharmacy> .

Once the PDL becomes effective:

If a prescriber wishes to prescribe a non-preferred drug, he or she will need to write the words "*DAW - Medically Necessary*" on the prescription and document the reason in the patient's medical record in order for Medicaid to cover the drug.

Pharmacies that receive prescriptions for non-preferred agents with the words "*DAW - Medically Necessary*" written on the prescription will need to put a DAW code of "1" and a submission clarification code of "7" on the claim in order for it to be covered.

Additional details will be provided as the actual implementation date approaches.

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07 - 74 Physician Billing for Office Administered Drugs

The Deficit Reduction Act requires providers to submit the NDC associated with 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 claim form.

- A. NDC - Box 24D, shaded area
- B. Drug Unit Price - Box 24F, shaded area
- C. Basis of Measurement Qualifier and Units - Box 24G, shaded area. Use the following qualifiers:
 - ME - for milligrams
 - ML - for milliliters
 - GR - for grams
 - UN - for units

Outpatient hospital departments that are billing individually for drugs must also provide the NDC when billing Medicaid on the UB-04 claim form.

When billing a procedure that requires a NDC code (done under contract with a payer), enter the NDC on the line immediately below the REV Code and Procedure Code (Form locator 43), the Units preceded by a qualifier (Form locator 46), and the Unit Price (Form locator 47).

When billing the CMS-1500 or the UB-04 electronically, the information needs to be reported in the following X12 fields (contact your software vendor for specific information):

2410 LIN03= NDC number preceded with N4 (LIN02=N4).

2410 CTP05-1= Units qualifier (GR, ML, ME, UN)

2410 CTP04= Number of units (place the number of units immediately after the units qualifier)

2410 CTP03= Cost or Unit Price

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07 - 75 Calculations for the DRG

In the past, Medicaid has calculated the DRG from the first five diagnoses listed on the claim. The calculation will now include all listed diagnoses. In accordance with Uniform Hospital Discharge Data Set (UHDDS), all diagnoses affecting the current hospital stay must be reported. Diagnoses reported in addition to the principle diagnosis are those diagnoses designated and defined as conditions that coexist at the time of admission (comorbidities) or develop after the admission (complications) and affect the treatment received during the admission and/or affect the length of stay.

Appropriate additional diagnoses will affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, and increased nursing care and/or monitoring. All diagnoses and procedures must be supported by physician documentation in the body of the health record. Diagnoses that have no bearing in the current hospital admission should not be reported.

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07 - 76 Anesthesia Coverage

Anesthesia code 00851 cannot be paid unless the surgeon has obtained prior authorization for the tubal ligation, because the code specifically states tubal ligation/transection. A prior bulletin indicated that anesthesia procedures could be paid without prior authorization for sterilization. A legal opinion indicates anesthesia may be considered for payment related to code 00840, but not 00851.

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07 - 77 Corrections to MIB and Manual

Article 07-51, of the April 2007 MIB, requires correction to the Hyperbaric Oxygen Therapy, Criteria #21, prior authorization requirement item 3. The *Criteria for Medical and Surgical Procedures*, an attachment to the Hospital Manual and Physician Manual, page 13, is correct for April 2007. See below paragraph with the addition of the word "current."

- 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 **current** 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.

The *Criteria for Medical and Surgical Procedures*, Chronic Pain Management, Criteria #45, has a typographical error on page 52. The code 96116 is listed as the procedure code for neuropsychological testing. This is incorrect. The correct code should be **96118**.

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07 - 78 Modifiers

Effective April 1, 2007, modifier 25 was discontinued for manual review. Effective July 1, 2007, modifiers 24 and 59 will be discontinued from manual review for Medicaid payment. The claims will process according to Medicaid edits and current coding algorithm.

If a denial is received for modifier 59 from the editing program, providers may then submit appropriate medical records to document a distinct, separate procedural service. Only modifier 59 will be considered for review after the fact. There has been a large number of claims using modifier 24, 25, and 59 inappropriately. Denied claims and unpaid modifiers will continue to have rights to request a hearing. Modifier 57 will continue to not be accepted by Medicaid for payment.

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07 - 79 Coronary Drug Eluting Stents

Effective July 1, 2007, drug eluting stents will no longer be a benefit. Payment of angioplasty and stents are covered only when performed for the following diagnostic codes:

- 410.9 Acute myocardial infarction
- 411.1 Acute coronary syndrome

On September 14, 2006, the FDA issued an initial statement related to concerns about adverse events related to coronary drug eluting stents (DES). The DES are associated with a small increase in stent thrombosis compared to bare metal stents after one year post stent implantation. According to the FDA, larger and longer pre-market clinical trials for post-implantation studies need to be completed to include patient compliance with antiplatelet therapy.

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07 - 80 Cytogenetics and Molecular Diagnostics

Effective July 1, 2007, Cytogenetic studies 88230 through 88299 are not covered services.

Molecular diagnostic tests in the code range 83890 to 83914 will be reviewed for medical necessity when greater than two units are billed.

Some test are necessary for infectious disease testing, while others are used to determine the hereditary potential of a disease or syndrome. Medicaid must look at the efficacy and medical reasonableness of the test completed for reimbursement. Medicaid does not cover genetic testing for screening or when the genetic testing will not affect medical treatment.

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07 - 81 Transplantation Services

The transplant service rule has been updated. The update may be found online at <http://www.rules.utah.gov/publicat/code/r414/r414-10a.htm>.

Note the following changes in the revised rule.

- Although the provider must comply with the updated rule, prior authorization is not required for cornea, kidney, heart, and liver transplantation.
- Except for cornea and bone marrow transplant, the transplant center must be Medicare certified for the specific type of transplantation performed.
- Two random drug screens are now included in the evaluation for prior authorization of transplants.
- It is no longer required that the psycho-social evaluation be done by a certified or board eligible psychiatrist.

The following has been updated July 1, 2007, in the *Criteria for Medical and Surgical Procedures*, **Criteria #25 Bone Marrow Transplant**

- A. Bone marrow transplantation services may be provided for a Medicaid eligible client of any age who meets the criteria.
- B. The client for bone marrow transplantation must meet requirements of either section 1 or 2 below:
 1. Allogenic and syngeneic bone marrow transplantations will be approved for payment only when the client has an HLA-matched donor. The donor must be compatible for all or a five-out-of-six match of World Health Organization recognized HLA-A, -B, and -DR antigens as determined by appropriate serologic typing methodology.
 - a. The Department authorizes payment for a search of related family members, unrelated persons or both to find a suitable donor.
 - b. The transplant center staff must complete and submit to the Department for evaluation, a current medical literature review, documenting a probability of successful clinical outcome by having a greater than or equal to 75 percent one-year survival rate, or by having a greater than or equal to 55 percent three-year survival rate for patients receiving bone marrow transplantation for the specific diagnosis, condition, age of the client and type of transplant. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.
 2. Autologous bone marrow transplantations performed in conjunction with total body radiation or high dose chemotherapy, or both, may be covered if a current published medical literature review documents a maximum probability of successful clinical outcome by having a greater than or equal to 75 percent one-year survival rate, or by having a greater than or equal to 55 percent three-year survival rate for patients receiving bone marrow transplantation for the specific diagnosis, condition, age of the client and type of transplant. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.
 3. Clients for autologous bone marrow transplantations must have adequate marrow function and no evidence of marrow involvement by the primary malignancy at the time the marrow is harvested.
- C. The client for bone marrow transplantation must meet all of the following requirements:
 1. Medical assessment that the client is a reasonable risk for surgery with a likelihood of tolerance for immunosuppressive therapy;
 2. Medical assessment by the client's referring physician that the client has sufficient mental, emotional, and social stability and support to ensure that he/she and his/her parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program.
 3. Psycho-social assessment that the client has sufficient mental, emotional, and social stability and support to ensure that he/she and his/her parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program which is required.
 4. The client must have a strong motivation to undergo the procedure as documented by the medical and psycho-social assessment.
 5. If the client has a history of substance abuse, the client must successfully complete a substance abuse rehabilitation program or must have documented abstinence for a period of at least six

- months before the transplantation service. The Department reviews a request for transplantation services.
6. A current medical literature review completed by the transplant center staff and submitted to the Department for staff review and evaluation, documenting that the underlying original bone marrow disease will not recur and limit survival to less than 75% one-year survival rate, or less than 55% three-year survival rate. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.
- D. Any single contraindication listed below shall preclude approval for Medicaid payment for bone marrow transplantation:
1. Active infection.
 2. Acute severe hemodynamic compromise at the time of transplantation if accompanied by significant compromise of one or more vital end-organs.
 3. Active substance abuse.
 4. Presence of systemic dysfunction or malignant disease which could limit successful clinical outcome or interfere with compliance with a disciplined medical regimen or rehabilitation after transplantation.
 5. Neuropsychiatric disorder which could lead to non-compliance or inhibit rehabilitation of the patient.
 6. Pulmonary diseases:
 - a. Cystic fibrosis;
 - b. Obstructive pulmonary disease (FEV1 < 50% of predictable);
 - c. Restrictive pulmonary disease (FVC < 50% of predictable);
 - d. Unresolved pulmonary roentgenographic abnormalities of unclear etiology;
 - e. Recent or unresolved pulmonary infarction.
 7. Cancer, unless treated and eradicated for two or more years or unless a current medical literature review, completed by the transplant center staff and submitted to the Department for staff review and evaluation, documents a greater than or equal to 75% one-year survival rate, or a greater than or equal to 55% three-year survival rate, or by meeting the one-year and three-year survival rates after transplantation for the age group, specific cancer, diagnosis(es), condition, and type of transplantation proposed for the client. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.
 8. Cardiovascular diseases:
 - a. Intractable cardiac arrhythmias;
 - b. Symptomatic or occlusive peripheral vascular or cerebrovascular disease;
 - c. Severe generalized arteriosclerosis.
 9. Evidence of other major organ system disease or anomaly which could decrease the probability of successful clinical outcome or decrease the potential for rehabilitation.
 10. Behavior pattern documented in the client's medical or psycho-social assessment which could interfere with a disciplined medical regimen. An indication of non-compliance by the client is documented by any one of the following:
 - a. Non-compliance with medications or therapy;
 - b. Failure to keep scheduled appointments;
 - c. Leaving the hospital against medical advice;
 - d. Active substance abuse.
- E. Prior to the approval of transplantation, the transplantation team must document a plan of care agreed to by the parent(s) or guardian(s) of a client who is under 18 years of age to assure compliance to medication and follow-up care, if an indication of non-compliance documented by any of the behaviors listed in section D. 10., a through d is demonstrated by the parent(s) or guardian(s) of the client.
- F. The client for donor lymphocyte infusion must produce documentation by current medical literature review and the client's referring physician that the donor lymphocyte infusion is a medically necessary service as defined in Rule 414-1-2(18)(a) and (b).

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07 - 82 Private Duty Nursing Guidelines

Medically appropriate skilled nursing shift care, for clients up to 21 years old, may be covered where it has been determined that skilled management by a licensed nurse is required.

A client may be referred to the Utilization Review Department to determine if they meet the criteria for skilled nursing. The request for services should be initially submitted through the Medicaid Prior Authorization Unit.

The number of hours of private duty nursing a client may receive is determined by the score on the Private Duty Nursing Acuity Grid. This grid will be used when the Skilled Needs Form and other documentation submitted does not substantiate the need for services. Family/guardian/care givers are required to provide some of the nursing care. 20 to 24 hour care is only covered in certain circumstances described below. The banking, saving or accumulation of unused prior authorized hours to be used later for the convenience of the family or the nursing agency is not covered.

An active weaning process is to be followed after the client is initially discharged from the hospital. The goal is to have the client to 8 hours a day within a four-month period. The weaning process may begin with 20-24 hours for two to three days and then will progress until the client receives no more than 8 hours per day.

The scoring is applied as follows: (using the Private Duty Nursing Acuity Grid)

- 15-35 points The client may receive up to 8 hours of shift care
- 35-40 points The client may receive up to 10 hours of shift care
- 40-50 points The client may receive up to 12 hours of shift care
- 51 point and over The client may receive up to 14 hours of shift care

Maximum or increased number of hours are to be used only when acute exacerbations of the illnesses occur and require a short term, temporary increase in skilled needs. The client may receive up to 20-24 hours of shift care only in the following circumstances:

- Up to 2-3 days after initial hospital discharge, as medically necessary, to enable family/care giver(s) to become trained in the home and procedures;
- Up to 2-3 days after subsequent hospitalization, as medically necessary, to enable family/care giver(s) to become trained in any changes in home care and procedures;
- Up to 2-3 days per episode, if primary family/care giver is unable to provide home care due to care giver illness or temporary incapacity.

Note: Once 8 hours is reached, increased hours of service will be based on the above criteria.

When a client is decannulated, the weaning process from private duty nursing to the home health program will allow nursing visits (up to 4 hours per day) for the first 24-72 hours.

The following is the Private Duty Nursing Acuity Grid provided for Home Health Agencies.

(Continued on next page)

PRIVATE DUTY NURSING ACUITY GRID
(To be completed by the person completing the patient care)

Recipient _____

MID# _____

ASSESSMENT NEEDS

(choose one)

Minimal ongoing assessments (less often than Q 6 hrs; at least daily)

Moderate ongoing assessments (hands-on Q 4-6 hrs)

(choose one if at least 2 of the 4 assessments are ordered and documented)

VS/GLU/NEURO/Resp (Assess less often than Q 4, at least daily)

VS/GLU/NEURO/Resp (Assess Q 4 hr or more often)

VS/GLU/NEURO/Resp (Assess Q 2 hr or more often)

MEDICATION/IV DELIVERY NEEDS

(choose one if applicable - does not include nebulizer meds)

Oral or G Tube, NG, NJ: _____

Medication delivery 1 to 3 doses per day

Medication delivery 4 to 6 doses per day

Medication delivery 7 doses per day or more

(choose one)

No IV access

Peripheral IV access

Central Line of port, PICC Line, Hickman

(choose one)

No IV medication delivery

Transfusion or IV Tx less than daily but at least weekly

V Tx less often than Q 4 hrs (does not include hep flush)

V Tx Q 4 or more often

(choose any that apply)

Reg blood draws/IV Peripheral Site (# _____)

Reg blood draws/IV Central Line (# _____)

TPN

FEEDING NEEDS**(choose any that apply)**

- Routine oral feeding
- Difficult, prolonged oral feeding
- Occasional reflux and/or aspiration precautions
- G-Tube, J-Tube, or Mic-key button

(choose one)

- No tube feeding
- Tube feeding (routine bolus or continuous)
- Tube feeding (combination bolus and continuous)
- Complicated tube feeding, residual checks, aspiration precautions (slow feed or other problems)

RESPIRATORY NEEDS**(choose one)**

- No trach, patent airway
- No trach, unstable airway (desats common, airway clearance issues)
- Trach (routine care)
- Trach (special care - wounds, breakdown, frequent pull-out, replacement)

(choose one)

- No suctioning
- Infrequent suctioning (less than Q 8 but at least daily)
- Suctioning Q 3 to Q 8 hrs (# _____)
- Suctioning Q 2 hrs or more frequently (# _____)

(choose one)

- Oxygen - daily use
- Oxygen PRN based on pulse oximetry, oxygen needed at least weekly
- Humidification (direct)

(choose one)

- No ventilator
- Ventilator; rehab transition/active weaning
- Ventilator; weaning achieved
- Ventilator; non-invasively at night
- Ventilator; less than 12 hrs per day
- Ventilator; \geq 12 hrs per day but not continuous
- Ventilator; no respiratory effort or 24 hr/day in assist mode

(choose one)

- No BiPAP or CPAP
- BiPAP or CPAP up to 8 hrs per day
- BiPAP or CPAP greater than 8 hrs per day
- BiPAP ST (with rate) used to ventilate at night
- BiPAP ST (with rate) with trach

(choose one)No Nebulizer treatments Nebulizer treatments less than daily but at least QW: # _____ Nebulizer treatment Q 4 or less frequently: # _____ Nebulizer treatment Q 3 hrs: # _____ Nebulizer treatment Q 2 hrs or more frequently: # _____ **(choose one)**No Chest PT, ABI vest Chest PT, ABI vest or Cough Assist/less than daily, at least QW: # _____ Chest PT, ABI vest or Cough Assist/Q 4 or less frequently: # _____ Chest PT, ABI vest or Cough Assist/Q 3 hrs: # _____ Chest PT, ABI vest or Cough Assist/Q 2 hrs or more: # _____ **ELIMINATION NEEDS****(choose those that best describe)**Uncontrolled incontinence < 3 yrs of age Continence of bowel and bladder Uncontrolled incontinence, either bowel or bladder, \geq 3 yrs of age Uncontrolled incontinence, both bowel and bladder, \geq 3 yrs of age Intermittent straight catheter Uncontrolled incontinence (frequent linen change), \geq 3 yrs of age Ostomy care - at least daily **SEIZURES****(choose one)**No seizure activity Mild seizures - at least daily, no intervention Mod seizures (req min intervention - at least daily) Mod seizures (req min intervention - 2 to 4 times per day) Mod seizures (req min intervention - \geq 5 times per day) Severe seizures (req IM/IV/Rectal med administration - at least daily) Severe seizures (req IM/IV/Rectal med administration - 2 to 4 times per day) Severe seizures (req IM/IV/Rectal med administration - \geq 5 times per day) **THERAPIES/ORTHOTICS/CASTING****(choose any that apply)**Fractured or casted limb Splinting schedule (off/on at least BID) Basic ROM (at least Q shift) Body cast **WOUND CARE****Wound Vac** **(choose one)**Stage 1-2, wound care at least daily, dressing change other than trach, PEG, or IV site Stage 3-4, multiple wound sites

PERSONAL CARE

(choose if applicable)

Requires personal care/hygiene (\geq 4 yrs of age)

BEHAVIOR THAT INTERFERES WITH CARE

No

Yes

OTHER ISSUES

Requires isolation

NOTES: