

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 - 85 Delay in Paper Claims Processing

Due to an interruption in service by our data entry contractor, there has been a significant delay in paper claims being processed. Medicaid has awarded the contract to a new vendor. We will keep you posted as to the progress. In the interim, we are working on other solutions to process the backlog of claims.

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/> .

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07 - 86 Electronic Billing Instructions

Below are instructions for submitting third party payments electronically. The Division strongly encourages you to submit all claims electronically through UHIN, including coordination of benefits information.

To electronically bill secondary claims to Utah Medicaid *** Do not fax paper claims ***				
Enter third party payment and the patient responsibility and then transmit to the appropriate Medicaid Trading Partner Number (TPN)				
If primary payer	When primary payer is	Transmit electronic claim to	Will deny	Additional action to take
pays	Medicare	HT000004-005		none
	Commercial	HT000004-001		none
pays zero	Medicare	HT000004-005		none
	Commercial	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to ORS (801) 536-8513
denies	Medicare	HT000004-001*	x	fax Medicaid Remittance w/ denial & EOBs to Medicaid (801) 536-0481
	Commercial	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to ORS (801) 536-8513
If your software will NOT allow "third party payment" or "patient responsibility", transmit your claims to the appropriate Medicaid TPN anyway and follow the instructions below. (Remember to ask your software vendor to update your software.)				
pays	Medicare	HT000004-005	x	fax Medicaid Remittance w/ denial & EOBs to Medicaid (801) 323-1584
	Commercial	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to Medicaid (801) 536-0481
pays zero	Medicare	HT000004-005	x	fax Medicaid Remittance w/ denial & EOBs to Medicaid (801) 323-1584
	Commercial	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to ORS (801) 536-8513
denies	Medicare	HT000004-001*	x	fax Medicaid Remittance w/ denial & EOBs to Medicaid (801) 536-0481
	Commercial	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to ORS (801) 536-8513
* Exception to the rule – usually Medicare primary goes to HT000004-005.				

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07 - 87 Correction to MIB Article 07 - 62

The fax numbers were published incorrectly in the July MIB, article 07-62. The correct fax numbers are bolded below.

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 **801-536-0481**. Staff will manually match the information and process the claim.
- C. Manual review attachments should be faxed to **801-536-0463**. Staff will manually match the information and process the claim.

Medicaid anticipates accepting electronic attachments by the end of 2007.

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07 - 88 Centers For Medicare & Medicaid Services Launches DOQ-IT University

The Centers for Medicare & Medicaid Services (CMS) announced the national launch of DOQ-IT (Doctor's Office Quality Information Technology) University, or DOQ-IT U, to support health information technology (HIT) in physicians' offices.

DOQ-IT U is an interactive, web-based tool designed to provide solo and small-to-medium sized physician practices with the education for successful HIT adoption, including lessons on culture change, vendor selection and operational redesign, along with clinical processes. The nationally available e-learning system is available at no charge.

DOQ-IT University is expected to provide assistance to physicians across the United States in the adoption and implementation of electronic health records and care management practices. DOQ-IT U will provide lessons in assessment, planning and implementation methodologies that will be disease and population specific, incorporating clinical decision support, and evidence-based medicine guidelines. This e-learning platform will be utilized to provide physicians with a self-paced curriculum and associated tools, based on adult learning principles, available at their convenience. Additional features, such as surveys, utilization tracking, and Continuing Medical Education/Continuing Education Unit (CME/CEU) offering/issuing capabilities will also be included in the near future.

The first learning sessions (modules), available now, focus on physician office workflow redesign, culture change, and communication necessary for successful Electronic Health Record (EHR) adoption, implementation of care management, and the incorporation of a strong patient self-management component to clinical care. Disease specific modules, starting with diabetes, will include a patient self-management component, which is critical to successfully managing patients with chronic disease.

DOQ-IT U is being developed and managed by the Quality Improvement Organization (QIO) program, under contract to CMS. A QIO is present in each U.S. state, territory, and the District of Columbia.

A technical advisory panel (TAP) composed of leading medical experts from the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), the American Board of Internal Medicine (ABIM), Healthcare Information and Management Systems Society (HIMSS), Private Payers, American Health Information Management Association (AHIMA), and Patient Self Management experts, has been convened and will provide content, consultation and evaluation of the care management/DOQ-IT U modules.

For more information, please see CMS' DOQ-IT U web site at: <http://elearning.qualitynet.org>.

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07 - 89 HHS Launches New Web Site on HIPAA Privacy Compliance and Enforcement

To coincide with the fourth anniversary of the enforcement of the HIPAA Privacy Rule, the Department of Health and Human Services (HHS) announced the launch of an enhanced web site that will make it easier for consumers, health care providers and others to get information about how the Department enforces health information privacy rights and standards.

In launching the web site, Winston Wilkinson, the Director of the HHS Office for Civil Rights, noted: "HHS has obtained significant change in the privacy practices of covered entities through its enforcement program. Corrective actions obtained by HHS from these entities have resulted in change that is systemic and affects all the individuals they serve."

The Health Information Privacy web site provides comprehensive information about the Privacy Rule, which creates important federal rights and requirements to protect the privacy of personal health information. The enhanced web site, <http://www.hhs.gov/ocr/privacy/enforcement> provides information for consumers, health care providers, health plans and others in the health care industry about HHS's compliance and enforcement efforts.

The new information describes HHS activities in enforcing the Privacy Rule, the results of those enforcement activities, and statistics showing which types of complaints are received most frequently and the types of entities most often required to take corrective actions as a result of consumer complaints. The other information on the web site covers consumers' rights to access their health information and significantly control how their personal health information is used and disclosed, as well as guidance about how to submit complaints about possible violations of the law and extensive guidance for entities who must comply with the rule.

HHS issued the patient privacy protections pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The first and only comprehensive federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by HHS, these standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. The regulation covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions (e.g., enrollment, billing and eligibility verification) electronically. HHS has conducted extensive outreach and provided guidance and technical assistance to providers and businesses to help them to implement the new privacy protections. These materials are available at <http://www.hhs.gov/ocr/hipaa> .

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07 - 90 UHINTracker Update

The Utah Health Information Network (UHIN) has developed an innovative product that allows provider offices the ability to decrease office overhead and increase cash flow. For pennies a day, UHINTracker will allow a member provider to perform several valuable functions without buying new software or hardware.

UHINTracker providers can update the status of a claim electronically without wasting telephone time. UHINTracker will reconcile electronic payments that go to the provider's bank account, and will give claims aging reports and exception reports. Information can be sorted, filtered, printed, archived, and used with the provider's accounting/practice management system.

The implementation of UHINTracker will complement an office's current practice management system or billing software and allow even further control over the claims processing procedure. UHIN members will be able to eliminate much of the administrative cost and hassle associated with reconciling their patients' medical claims to payments received. This tool has the ability to improve overall cash flow for medical offices as well as save healthcare dollars overall.

UHINTracker not only provides four detailed reports that will provide offices with valuable information, but also allows staff the ability to complete Claim Status Requests electronically. The ability to perform Claim Status Requests and receive Claim Status Responses equates to minimizing, if not eliminating, frustrating phone calls and countless hours spent on hold researching claims. In addition, UHINTracker offers the convenience of printing single page Explanation of Benefits for Coordination of Benefits requirements.

Medicaid encourages its providers to participate in the usage of UHINTracker. For demonstrations and questions, contact Jason Pryor, UHIN, 801-466-7705, or Veronica Rynders, Zions Bank, 801-594-8041. (You may be able to have a 45-day free "test drive" with your own data.) Sign up forms and pricing can be found at www.UHIN.com under "Electronic Commerce Agreement - click here".

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07 - 91 PERM Reviews

The federal government has initiated a new payment error rate evaluation program called PERM. Under PERM, a sample of both paid and denied Medicaid claims will be selected for review by a federal contractor. The contractor will contact the provider who received payment for the claim, and request records. Those records will be audited to show that the service was medically necessary, and was paid in accordance with Medicaid policy.

You may be contacted over the next few months by a company named Livanta. This is the company that the federal government has contracted with to evaluate Medicaid payments. They will be asking for all documentation you may have regarding a given claim. Failure to respond timely to the request for records will result in a finding that the claim was paid incorrectly, and any funds paid by Medicaid will be recovered.

It is essential if you are contacted by Livanta, that you comply with the request for records. Under federal regulations, the federal government or its contractors may request copies of any documentation justifying payment under Medicaid. Failure to provide records is grounds for recovery, even if the service was later determined to be appropriate. Recovery based on not providing sufficient documentation is not eligible for appeal and funds paid will be recovered. If you have any questions regarding this information, please contact Steven Gatzemeier at 801-538-6584.

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07 - 92 Utah Medical Benefits Web Site Available

The Division's new Utah Medical Benefits web site, www.health.utah.gov/umb provides easy access for Medicaid, CHIP, and PCN recipients as well as providers to information about Utah's medical assistance programs. Visitors to the site can receive benefit training, locate a Health Program Representative and learn about health plans. CHIP recipients can also make a health plan selection. Visitors can access links to many resources such as online medical assistance applications and can print and order forms or publications including the Medicaid, CHIP, and PCN Member Guides. The Frequently Asked Questions (FAQs) and answers page may provide information without the need for making a phone call.

If you have comments or recommendations regarding what information you would like to find available on the web site, click on the web site's Contact Us Link, or contact Amy Schouten, ASCHOUTEN@utah.gov, 801-538-6822.

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07 - 93 Prior Authorization Fax Numbers

To reach the Prior Authorization Unit, dial Customer Service at 801-538-6155 or toll free 1-800-662-9651, then press **Option 3, 3**, and then one of the following options:

Option 1	Dental, Audiology, Vision	Fax # 536-0958 or Fax # 536-0167
Option 2	Pharmacy, Psychiatric	Fax # 536-0477
Option 3	Medical Supplies, Special Beds	Fax # 536-0951
Option 4	Surgery, Sleep Studies, Diabetic Teaching	Fax # 536-0472 or Fax # 536-0956
Option 5	Emergency Only Wheelchairs	Fax # 323-1562 Fax # 536-0468
Option 6	Home Health, Hyperbaric, PDN	Fax # 536-0955
Option 7	MRI, P.T./ O.T., Speech, Rehab	Fax # 536-0160

The Prior Authorization Unit has updated its fax numbers for prior authorization requests. If you experience a problem with one of the fax numbers listed above, please use the general Utilization Management Unit Fax number 801-538-6382.

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07 - 94 National Provider Identifier

The NPI is here. The NPI is now. Are you using it?

The Utah Medicaid Program will continue to pay claims submitted electronically with only the Medicaid Provider Identifier until further notice. 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.

It is highly recommended that all providers begin to submit a few claims with only a NPI to ensure uninterrupted claims processing when the contingency plan ends. You may currently be billing with your NPI and Medicaid provider number and receiving payment because your Medicaid provider number is registered correctly. It is important to note that Utah Medicaid is not populating its cross walk with NPI's taken from claims submission.

Providers should 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 it is required to have a NPI, or would like to request a paper application, call the NPI enumerator at 1-800-465-3203.

Dissemination of Data from the National Plan and Provider Enumeration System (NPPES) is scheduled to begin September 4, 2007. More detailed information is available at www.cms.hhs.gov/nationalproviderstand/.

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 its NPI Contingency Plan.

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

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07 - 95 National Provider Identifier - Pharmacy Impact

Please note the following important billing information for pharmacies only.

Effective October 1, 2007, the Service Provider ID field of all pharmacy Point of Sale (POS) claims must contain the pharmacy's registered National Provider Identifier (NPI). Utah Medicaid will reject POS claims with adjudication dates on or after October 1, 2007, that contain any other number in this field. The Service Provider ID field must contain the pharmacy's NPI and the Qualifier must be 01 to indicate a NPI value.

Pharmacies may continue to use all valid Prescriber ID values, as well as the NPI if known, in the Prescriber ID field until further notice.

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07 - 96 Medicaid Preferred Drug List - Correction to MIB

The July MIB Article 07 - 73 needs correction and clarification. In the narrative about the PDL override provision, it says that the physicians may write "DAW-Medically necessary". That is incorrect. They MUST write "Dispense as written - Medically necessary". The law does not allow for abbreviations and Medicaid will not accept them.

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07 - 97 Tamper Resistant Prescription Pads

In May 2007, Congress revised a bill mandating that effective October 1, 2007, written prescriptions for drugs under the Medicaid program must be on tamper resistant prescription pads. Utah Medicaid has been awaiting direction from the Centers for Medicare and Medicaid Services (CMS) to understand exactly what will be required. That information has now been released.

Effective October 1, 2007, **all** new written Medicaid prescriptions (except for those of residents of nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), or other specified institutional and clinical settings) must be written on tamper resistant prescription pads. The following requirements are mandated for these types of prescriptions.

1. This only applies to written prescriptions. Prescriptions that are electronic in nature (those that are faxed, taken over the phone, or transmitted through other electronic means) are not covered under this law.
2. This only applies to new prescriptions filled on or after October 1, 2007. It does not apply to refills of prescriptions initially filled prior to October 1, 2007, until law requires a new prescription.
3. You must still comply with all federal and state laws regarding the types of documentation that must be maintained and how prescriptions are filled.

If a pharmacy fills a prescription that does not comply with the requirements above, funds paid by Medicaid will be recovered. Prescribers will have to ensure that their pads that are used to write Medicaid prescriptions meet the following requirements in order to be considered "tamper resistant". If not, the patient will likely be sent back to get another prescription written on a complying pad.

Effective **October 1, 2007**, the prescription pad must contain **at least one** of the following three characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Effective **October 1, 2008**, to be considered tamper resistant, a prescription pad **must contain all three** of the above characteristics.

If you do not know how to find a vendor for tamper resistant prescription pads, you may call 1-877-750-4047 ext. 0 and ask for Utah's tamper resistant pad information. Your Purdue representative can also provide you with free tamper resistant pads.

Successful implementation of the above requirements will require support of both prescribers and pharmacies. We recognize that the time frame is difficult to meet, but the requirement is a federal law, and we do not have the authority to change it. Please contact the Medicaid Pharmacy Team at 801-538-6293 or 801-538-6495 if you have questions.

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07 - 98 Pharmacy Coverage Highlights

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

Vivitrol

1. Billable by J-Code, along with the appropriate NDC (National Drug Code), when administered by a physician in a mental health or substance abuse treatment clinic.
2. Diagnosis of alcohol abuse.
3. Negative urine screen for opioids or passed naloxone challenge.
4. Description of the psychosocial support to be received by the patient, as indicated by chart notes or a brief letter of medical necessity.
5. Negative screen for liver problems.

Soliris

- The DUR Board will review individual requests for this drug.

The prior authorization requirements become effective October 1, 2007, for the Traditional Medicaid, Non-Traditional Medicaid, and Primary Care Network programs.

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07 - 99 **Injectable Covered for Substance Abuse Treatment Providers**

Substance abuse treatment providers using the injectable drug, Naltrexone (Vivitrol), may bill Medicaid for this drug using the procedure code J2315 (depot form, 1 mg) along with the appropriate NDC (National Drug Code) on the claim. Medicaid will reimburse substance abuse agencies for this drug only when administered to Medicaid clients with alcohol abuse or alcohol dependence diagnoses.

Prior authorization is required. See article 07-98 above for requirements. To obtain prior authorization, please fax the request to 801-536-0477.

If you have questions about what information must be included on the prior authorization request, contact the Bureau of Coverage and Reimbursement Policy at 801-538-6155, option 3, 3, 2, or visit www.health.utah.gov/medicaid/pharmacy.

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07 - 100 **Mental Health, DHS Contracted Mental Health, and Substance Abuse Manuals Updated**

The Utah Medicaid Provider Manual for Mental Health Centers will be updated October 1, 2007. Changes include clarifying limitations for providing tele-health services and the mode of delivery. See Chapters 2-2, 2-5, and 2-9. In addition, some non-substantive changes to correct wording have been made.

The Utah Medicaid Provider Manual for DHS Contracted Mental Health Providers will be updated October 1, 2007. Non-substantive changes have been made to correct wording.

The Utah Medicaid Provider Manual for Substance Abuse Treatment Providers will be updated October 1, 2007. Non-substantive changes to correct wording have been made also.

The manuals can be accessed on the Internet at <http://www.health.utah.gov/medicaid/tree/index.html>.

If you do not have Internet access or have questions, please contact Merrila Erickson, 801-538-6501, merickson@utah.gov

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07 - 101 **Dental Code Covered**

Effective October 1, 2007, dental code D7910, suture of recent small wounds up to 5 cm, is opened for general dentists.

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07 - 102 **Medical Supplies**

Criteria for Cranial Remodeling Orthosis

Code S1040, Cranial remodeling orthosis, rigid, with or without soft interface, includes fitting and adjustments, will require criteria effective October 1, 2007.

Criteria : Post surgery for craniosynostosis or positional plagiocephaly: (All of the following must be met)

- a. Torticollis identified and treated.
- b. Repositioning attempted 2-3 mos or until 6 mos of age.
- c. Differences in diagonal cranium measurements greater than 1 cm.
- d. Younger than 12 mos of age.

Opened Codes for Pull-ons (will reimburse the same rate as corresponding diaper/brief codes)

- T4525 Adult-sized disp incont, underwear, pull on, sm, each (not for adult incontinence without a related disability)
 T4526 Adult-sized disp incont, underwear, pull on, med, each (not for adult incontinence without a related disability)
 T4527 Adult-sized disp incont, underwear, pull on, lg, each (not for adult incontinence without a related disability)

T4528 Adult-sized disp incont, underwear, pull on, xlg, each (not for adult incontinence without a related disability)

T4531 Ped-sized disp incont product, pull on, sm/med, each (not for incontinence without a related disability)

T4532 Ped-sized disp incont product, underwear/pull on, lg, each (not for incontinence without a related disability)

Discontinued Codes

B4184 Parenteral nutrition solution, lipids, 10% with administration set, (500 ML = 1 unit)

B4186 Parenteral nutrition solution, lipids, 20% with administration set, (500 ML = 1 unit)

Both codes are replaced by:

B4185 Parenteral nutrition solution, per 10 grams lipids, (500 ML = 1 unit)

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07 - 103 Covered Code

The following CPT code is retroactively covered January 1, 2007.

77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection (epidural, transforaminal, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint) including neurolytic agent destruction.

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07 - 104 ER Only Diagnosis Codes

The following diagnosis codes are covered October 1, 2007, for ER patients.

040.41 Infant botulism

040.42 Wound botulism

058.21 Human herpes virus 6 encephalitis

058.29 Other human herpes virus encephalitis

415.12 Septic pulmonary embolism

423.3 Cardiac tamponade

449 Septic arterial embolism

733.45 Aseptic necrosis of jaw bone

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07 - 105 Asthma Update

The Utah Department of Health Asthma Program is offering training opportunities to physician practices and clinics to implement components of the Chronic Care Model into their practice. The Chronic Care Model is an organizing framework for improving chronic illness care and a tool for improving care at both the individual and population level. For more information, visit <http://www.improvingchroniccare.org/change/index/html>.

The Asthma Program will provide a half-day workshop on the Chronic Care Model and the National Asthma Guidelines. The program was developed to assist the practice to develop a work plan and provide support for the team in completing the work plan. The benefits of participating in the asthma quality improvement training include:

- improve continuity of care,
- improve patient compliance with management plans,
- improve patient satisfaction with service, and
- adapt interventions of other chronic conditions in your practice.

To find out more, contact the Utah Department of Health Asthma Program at 801-538-9272 or e-mail rjorgens@utah.gov

The Asthma Provider Manual was developed by Utah providers, based on the National Asthma Education and Prevention Program's (NAEPP) Guidelines, to address diagnosis and medication issues in the management of asthma. The manual includes four sections: Pediatric, Adult, Medications and Resources. You may request all four sections or just those that apply to your practice. (Available online: PDF and PDA versions) (Available by mail: print and CD-ROM versions).

All copies are free of charge. For more information, call 801-538-9272 or visit www.health.utah.gov/asthma.



07 - 106 Chronic Pain Management Coverage

Physician services for pain management are restricted to any willing physicians who are **approved** based on the criteria outlined in the Utah Medicaid Physicians Provider Manual Section II: Criteria for Surgical Procedures, Criteria #45: Chronic Pain Management and Attached Consult Request Form as follows:

1. Medicaid will reimburse for a comprehensive pain consultation only through an **approved**, willing provider who can provide a multi-disciplinary approach to pain that includes evaluations by a board-certified pain specialist, a physical therapist, and a mental health professional. Medicaid will program the approved providers in the reference file system. Approved providers must be identified in the MMIS system to be reimbursed.
2. The comprehensive pain evaluation requires prior approval. Evaluation and treatment is limited to the development of a comprehensive treatment plan. Utah Medicaid will cover the pain specialist physician visits under a global fee payment. The global fee allows for one physician visit for assessment and one additional physician visit for treatment plan coordination with the Medicaid client. If additional visits are needed to complete the comprehensive treatment plan they are covered under the global fee and cannot be billed separately. Also, one psychologist/psychiatrist visit, and one physical therapy evaluation are included in the prior approval.
3. The treatment plan is provided to the primary care provider (PCP), the designated Care Coordinator and the designated Prepaid Mental Health Plan liaison.
4. Additional visits or services other than the comprehensive evaluation and treatment plan formulation must follow existing coverage requirements and be coordinated with the primary care physician (PCP) and may require separate prior approval.

The following are required to provide pain management services:

1. Evaluation and treatments involve an interdisciplinary model that focuses on the comprehensive management of the physical, psychological, social and spiritual needs of patients.
2. Physicians must be board-certified by the American Board of Anesthesiology (ABA) and/or American Academy of Pain Medicine.
3. Evaluations and development of the behavioral health component of the comprehensive treatment plan by a clinical psychologist/psychiatrist is covered with prior approval into the pain management consultation as a medical benefit and are not part of the PMHP contract.
4. The PCP agrees to continue the primary care management of the patient, including prescribing pain medication, referrals to appropriate therapies and services and coordination of the comprehensive treatment plan as outlined by the pain specialist management.
5. Medicaid recipients approved for a comprehensive pain evaluation will be automatically enrolled in the Care Coordination and Restriction Program.

To bill for services covered under the Chronic Pain Management Program, refer to the following guidelines. Approved providers must be identified in the Medicaid claims system to receive the listed payment(s).

Claims must be submitted using the individual provider's NPI (National Provider Identifier). Group providers or clinics are not authorized to be reimbursed at the rates posted below.

Procedure Code - Fee-For-Service	Service	Provider Type	Payment
99245	Psychiatric Eval	Psychiatrist	\$480.00
S5190	Psychiatric Eval	Psychologist	\$480.00
99245	Pain Specialist Eval	Physician	\$400.00
97001	Physical Therapy Eval	Physical Therapist	\$38.00

1. Billing for the Psychiatric Evaluation and the Pain Specialist Evaluation: The pain specialist must bill procedure code 99245 to be paid a global fee that covers all visits necessary to develop a comprehensive treatment plan. The initial psychiatric evaluation and management service should be billed under code 99245 if performed by a psychiatrist and code S5190 if performed by a psychologist.
2. Approved Physical Therapy providers must bill code 97001 for the PT evaluation. Traditional Medicaid patients have a limit of 20 visits without authorization using code T1015. Non-Traditional Medicaid patients have a limit of 10 visits. The evaluation visit will not apply to the visit limits. Any visits over the benefit will require prior authorization.
3. Procedure code 96116 (neurobehavioral status exam) cannot be billed separately as it is part of the psychiatric evaluation.
4. Nurse practitioners will not be paid for the comprehensive evaluation, but may provide regular benefit services.

The Chronic Pain Referral Form is accessible at:

<http://health.utah.gov/medicaid/pdfs/Physician/Physicnattach/ChronicPainForm1-1-06.pdf>

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07 - 107 Private Duty Nursing Acuity Grid Scoring 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 home health agency may contact Coverage & Reimbursement Policy Prior Authorization Unit (1-800-662-9651 or 801-538-6155, option 3, 3, 6) to determine if the client meets the criteria for skilled nursing.

The number of hours of private duty nursing a client may receive may be determined by the score on the Private Duty Nursing Acuity Grid. Family/guardian/care givers are required to provide some of the nursing care. Twenty 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 home health agency is not covered.

The scoring is applied as follows:

- | | |
|----------------------------|--|
| 15 to 35 points | The client may receive up to 8 hours per day of shift care. |
| 35 to 40 points | The client may receive up to 10 hours per day of shift care. |
| 40 to 50 points | The client may receive up to 12 hours per day of shift care. |
| 51 points and above | The client may receive up to 14 hours per day of shift care. |

The client may receive 20 to 24 hours of shift care only in the following circumstances:

- Up to 30 days after initial hospital discharge, as medically necessary, to enable family/care giver(s) to become trained in home care and procedures;
- Up to 14 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 14 days per episode, if primary family/care giver is unable to provide home care due to care giver illness or temporary incapacity.

The following is the Private Duty Nursing Acuity Grid provided for Home Health Agencies. Scoring features have been added October 1, 2007.

(Continued on next page)

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

Recipient _____

MID# _____

<u>ASSESSMENT NEEDS</u>	<u>POINTS</u>	<u>SCORE</u>
(choose one)		
Minimal ongoing assessments (less often than Q 6 hrs; at least daily) <input type="checkbox"/>	2.00	
Moderate ongoing assessments (hands-on Q 4-6 hrs) <input type="checkbox"/>	3.00	
(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) <input type="checkbox"/>	1.00	
VS/GLU/NEURO/Resp (Assess Q 4 hr or more often) <input type="checkbox"/>	2.00	
VS/GLU/NEURO/Resp (Assess Q 2 hr or more often) <input type="checkbox"/>	3.00	
TOTAL		
<u>MEDICATION/IV DELIVERY NEEDS</u>		
(choose one if applicable - does not include nebulizer meds)		
Oral or G Tube, NG, NJ: _____		
Medication delivery 1 to 3 doses per day <input type="checkbox"/>	1.00	
Medication delivery 4 to 6 doses per day <input type="checkbox"/>	2.00	
Medication delivery 7 doses per day or more <input type="checkbox"/>	4.00	
(choose one)		
No IV access <input type="checkbox"/>	0.00	
Peripheral IV access <input type="checkbox"/>	1.00	
Central Line of port, PICC Line, Hickman <input type="checkbox"/>	2.50	
(choose one)		
No IV medication delivery <input type="checkbox"/>	0.00	
Transfusion or IV Tx less than daily but at least weekly <input type="checkbox"/>	2.50	
V Tx less often than Q 4 hrs (does not include hep flush) <input type="checkbox"/>	4.50	
V Tx Q 4 or more often <input type="checkbox"/>	6.00	
(choose any that apply)		
Reg blood draws/IV Peripheral Site (# _____) <input type="checkbox"/>	4.5*	
Reg blood draws/IV Central Line (# _____) <input type="checkbox"/>	6.0*	
TPN <input type="checkbox"/>	6.00	
TOTAL		

<u>FEEDING NEEDS</u>	<u>POINTS</u>	<u>SCORE</u>
(choose any that apply)		
Routine oral feeding <input type="checkbox"/>	0.00	
Difficult, prolonged oral feeding <input type="checkbox"/>	2.00	
Occasional reflux and/or aspiration precautions <input type="checkbox"/>	0.50	
G-Tube, J-Tube, or Mic-key button <input type="checkbox"/>	0.50	
(choose one)		
No tube feeding <input type="checkbox"/>	0.00	
Tube feeding (routine bolus or continuous) <input type="checkbox"/>	2.00	
Tube feeding (combination bolus and continuous) <input type="checkbox"/>	2.50	
Complicated tube feeding, residual checks, aspiration precautions, (slow feed or other problems) <input type="checkbox"/>	3.00	
	TOTAL	

<u>RESPIRATORY NEEDS</u>	<u>POINTS</u>	<u>SCORE</u>
(choose one)		
No trach, patent airway <input type="checkbox"/>	0.00	
No trach, unstable airway (desats common, airway clearance issues) <input type="checkbox"/>	1.00	
Trach (routine care) <input type="checkbox"/>	1.00	
Trach (special care - wounds, breakdown, frequent pull-out, replacement) <input type="checkbox"/>	2.50	
(choose one)		
No suctioning <input type="checkbox"/>	0.00	
Infrequent suctioning (less than Q 8 but at least daily) <input type="checkbox"/>	0.50	
Suctioning Q 3 to Q 8 hrs (# _____) <input type="checkbox"/>	1.50	
Suctioning Q 2 hrs or more frequently (# _____) <input type="checkbox"/>	2.50	
(choose one)		
Oxygen - daily use <input type="checkbox"/>	1.00	
Oxygen PRN based on pulse oximetry, oxygen needed at least weekly <input type="checkbox"/>	0.50	
Humidification (direct) <input type="checkbox"/>	0.50	
(choose one)		
No ventilator <input type="checkbox"/>	0.00	
Ventilator; rehab transition/active weaning <input type="checkbox"/>	9.00	
Ventilator; weaning achieved <input type="checkbox"/>	6.00	
Ventilator; non-invasively at night <input type="checkbox"/>	8.00	
Ventilator; less than 12 hrs per day <input type="checkbox"/>	10.00	
Ventilator; ≥ 12 hrs per day but not continuous <input type="checkbox"/>	12.00	
Ventilator; no respiratory effort or 24 hr/day in assist mode <input type="checkbox"/>	14.00	
(choose one)		
No BiPAP or CPAP <input type="checkbox"/>	0.00	
BiPAP or CPAP up to 8 hrs per day <input type="checkbox"/>	4.00	
BiPAP or CPAP greater than 8 hrs per day <input type="checkbox"/>	6.00	
BiPAP ST (with rate) used to ventilate at night <input type="checkbox"/>	7.00	
BiPAP ST (with rate) with trach <input type="checkbox"/>	8.00	

(choose one)

No Nebulizer treatments <input type="checkbox"/>	0.00
Nebulizer treatments less than daily but at least QW: # _____ <input type="checkbox"/>	1.00
Nebulizer treatment Q 4 or less frequently: # _____ <input type="checkbox"/>	1.50
Nebulizer treatment Q 3 hrs: # _____ <input type="checkbox"/>	2.00
Nebulizer treatment Q 2 hrs or more frequently: # _____ <input type="checkbox"/>	3.0*

(choose one)

No Chest PT, ABI vest <input type="checkbox"/>	0.00
Chest PT, ABI vest or Cough Assist/less than daily, at least QW: # _____ <input type="checkbox"/>	0.50
Chest PT, ABI vest or Cough Assist/Q 4 or less frequently: # _____ <input type="checkbox"/>	1.50
Chest PT, ABI vest or Cough Assist/Q 3 hrs: # _____ <input type="checkbox"/>	2.00
Chest PT, ABI vest or Cough Assist/Q 2 hrs or more: # _____ <input type="checkbox"/>	3.0*

TOTAL**ELIMINATION NEEDS****POINTS SCORE****(choose those that best describe)**

Uncontrolled incontinence < 3 yrs of age <input type="checkbox"/>	0.00
Continence of bowel and bladder <input type="checkbox"/>	0.00
Uncontrolled incontinence, either bowel or bladder, \geq 3 yrs of age <input type="checkbox"/>	1.00
Uncontrolled incontinence, both bowel and bladder, \geq 3 yrs of age <input type="checkbox"/>	2.00
Intermittent straight catheter <input type="checkbox"/>	3.50
Uncontrolled incontinence (frequent linen change), \geq 3 yrs of age <input type="checkbox"/>	6.00
Ostomy care - at least daily <input type="checkbox"/>	3.00

TOTAL**SEIZURES****POINTS SCORE****(choose one)**

No seizure activity <input type="checkbox"/>	0.00
Mild seizures - at least daily, no intervention <input type="checkbox"/>	0.00
Mod seizures (req min intervention - at least daily) <input type="checkbox"/>	2.00
Mod seizures (req min intervention - 2 to 4 times per day) <input type="checkbox"/>	4.00
Mod seizures (req min intervention - \geq 5 times per day) <input type="checkbox"/>	4.50
Severe seizures (req IM/IV/Rectal med administration - at least daily) <input type="checkbox"/>	5.00
Severe seizures (req IM/IV/Rectal med administration - 2 to 4 times per day) <input type="checkbox"/>	5.50
Severe seizures (req IM/IV/Rectal med administration - \geq 5 times per day) <input type="checkbox"/>	6.00

TOTAL**THERAPIES/ORTHOTICS/CASTING****POINTS SCORE****(choose any that apply)**

Fractured or casted limb <input type="checkbox"/>	2.00
Splinting schedule (off/on at least BID) <input type="checkbox"/>	2.00
Basic ROM (at least Q shift) <input type="checkbox"/>	2.00
Body cast <input type="checkbox"/>	2.00

TOTAL**WOUND CARE****POINTS SCORE**

Wound Vac <input type="checkbox"/>	2.00
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(choose one)		
Stage 1-2, wound care at least daily, dressing change other than trach, PEG, or IV site <input type="checkbox"/>	2.00	
Stage 3-4, multiple wound sites <input type="checkbox"/>	3.00	
	TOTAL	

<u>PERSONAL CARE</u>	<u>POINTS</u>	<u>SCORE</u>
(choose if applicable)		
Requires personal care/hygiene (≥ 4 yrs of age) <input type="checkbox"/>	2.00	
	TOTAL	

<u>BEHAVIOR THAT INTERFERES WITH CARE</u>	<u>POINTS</u>	<u>SCORE</u>
No <input type="checkbox"/>	0.00	
Yes <input type="checkbox"/>	1.00	
	TOTAL	

<u>OTHER ISSUES</u>	<u>POINTS</u>	<u>SCORE</u>
Requires isolation <input type="checkbox"/>	3.00	
	TOTAL	

* Additional points may be provided based on documentation. NOTE: A maximum of ten points will be considered for blood draws.

TOTAL FOR ALL CATEGORIES ON NURSING ACUITY GRID:	_____	_____
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- * give points for each treatment
- ** give points for each blood draw up to a max of 10 pts

Care Manager completing: _____ Date: _____