

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

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## 08 - 01 National Provider Identifier (NPI)

### *Important Message to All Providers (Except Pharmacies)*

Beginning January 1, 2008, Utah Medicaid providers, with the exception of pharmacy providers, will get warning message(s) relating to each NPI non-compliant claim for those providers receiving paper remittance statements. Look for warning codes: **109 NPI missing, 111 NPI invalid format, and 110 NPI not matched**. Double-check your claims if you are seeing these messages to make sure you are placing NPIs on your claims properly. These edits will not stop payments for now, if your legacy number is valid, but could cause claims to be rejected on March 1, 2008. Medicaid will continue to accept both the NPI and Medicaid provider number on claims on or after March 1, 2008, as long as the NPI is in the primary identification fields.

It has come to the attention of Utah Medicaid that some clearing houses are stripping the NPIs off claims prior to submitting them to Medicaid for claims processing. Clearinghouses may be adding the NPIs back to the Remittance Advice, so that providers are unaware that NPIs are being removed prior to being sent forward. If you are currently submitting your NPI and Medicaid provider number on claims and your claims are filed through a clearinghouse or software vendor, contact them to verify that the NPI is being submitted. Also, confirm that the NPI being submitted on the claim is the same NPI that you report to Utah Medicaid for the Medicaid number on the claim. Validation of this information is critical to avoid any potential reimbursement issues upon NPI implementation.

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 they are 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) began September 2007. More detailed information is available at [www.cms.hhs.gov/nationalprovidentstand/](http://www.cms.hhs.gov/nationalprovidentstand/).

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://health.utah.gov/medicaid> for additional NPI useful links and training resources.



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## 08 - 02 Medicaid Client Spend-down or Other Payments to Receive Medicaid; The Provider's Role

Medicaid enrollees who have income greater than the allowed limits may choose to spend down to the income limits. They do this by sending a payment to the Department of Workforce Services (DWS) office equal to the difference between their countable income and the income limit, or by incurring medical bills equal to that difference. In the past, some Medicaid providers have paid the spend down for certain enrollees.

Effective December 1, 2007, Medicaid can no longer accept payments of an enrollee's spend down when the source of the funds is from a Medicaid provider's own funds, or if a Medicaid provider has loaned the money to the enrollee. Federal laws do not let providers pay a client's spend down or loan money to a client for the spend down payment. This policy also includes payments of a premium under the Medicaid Work Incentive Program, payment of the asset copayment for the Prenatal Medicaid Program, and payment of the enrollment fee for the Primary Care Network (PCN).

Instead, enrollees must pay the spend down themselves. Another option is for a Medicaid provider to allow an enrollee to incur the medical expense. The enrollee can present the bills to the Medicaid agency to meet the spend down. The enrollee is responsible to pay medical bills directly to the provider when the bills are used to meet a spend down. The provider and the enrollee can work out a repayment plan together. This does not work for enrollees who are enrolled in a Medicaid managed care plan (including a mental health care plan); however, those enrollees can use old medical bills to meet a current month's spend down when the bills are from months they did not have Medicaid coverage and the enrollee still owes the bill.

The premium owed for the Medicaid Work Incentive, the asset co-payment for the Prenatal Program, and the fee owed for

the PCN program cannot be met with medical bills. However, a pregnant woman who must pay a spend down because she is over the income limit for the Prenatal Program can use incurred medical bills to meet the spend down.

The practice of a provider using a provider's own funds to pay an enrollee's spend down could place the provider in jeopardy of legal penalties such as fines or imprisonment. The Medicaid agency does not want to place any of its valued providers at risk of any legal actions.

Medicaid providers may continue to act as representative payee for Medicaid clients so long as they comply with 20 CFR section 404 subpart U. We are working with DWS to document that representative payees operate in accordance with those rules.

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### 08 - 03 Provider Agreement

Section I of the Medicaid Provider Manual, 6-1 Provider Agreement, has been revised. The first paragraph reads as follows:

A provider enrolls as a Medicaid Provider by completing the Medicaid Provider Application and signing the Provider Agreement. A provider must execute the Agreement before he/she is authorized to furnish Medicaid services. When the State accepts the provider's application and the agreement is signed, the State will notify the provider by approval letter with effective date of enrollment.

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### 08 - 04 Provider Manual - Section I

The General Information Section I, of the Utah Medicaid Provider Manual, has been updated. Please note the following revisions on pages 43, 47 and 53:

#### 9-7 Retroactive Authorization (page 43)

##### A. Retroactive Medicaid Eligibility

When a client becomes eligible for Medicaid after receiving services which would have required prior authorization, Medicaid may consider a prepayment review, rather than denying reimbursement solely because prior authorization was not obtained. The provider should explain this circumstance on the Request for Prior Authorization form, with documentation supporting the medical necessity for the service. Even under this condition, the submitted medical record documentation must comply with Medicaid coverage authorization requirements for coverage of the service retroactively. For example, a patient receiving a sterilization procedure should have medical record information submitted which includes a history of the problem, trial of conservative measures, required laboratory studies, including biopsy when appropriate, sterilization consent, and a confirmation note that they are mentally competent to sign for the procedure just as it is required when prior authorization is requested before the sterilization procedure.

#### 10-4 Documentation and Signature Requirements (page 47)

Note: Since July 1, 1998, audits have been completed using the 1997 Evaluation and Management guideline developed by the Centers for Medicaid and Medicare Service (CMS). Effective January 1, 2008, the Department will include the 1995 Evaluation and Management guideline as an alternative in an audit. The provider must stipulate at the time of an audit whether they are submitting evaluation and management services under the 1995 or the 1997 Evaluation and Management CMS guideline. Auditing will proceed under the one guideline named by the provider.

The physician's manual is updated to reflect the change in policy in the use of the CMS 1995 Evaluation and Management Guideline, described in the General Information, Section I.

#### 11-13 Requesting Review of Claim That Exceeds Billing Deadline (page 53)

When Payment Can Be Made on "Late" Claims

2. [When a] Medicaid client received retroactive eligibility.  
[When] you have Medicaid eligibility verification to show that a client received retroactive eligibility, and the TCN on the denied claim is within the billing deadline based on the date eligibility was determined for the client. Procedures requiring prior authorization must meet coverage requirements to receive payment.

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## 08 - 05 Tamper Resistant Prescription Pads Update

In May 2007, Congress passed a bill that required that effective October 1, 2007, written prescriptions for drugs under the Medicaid program must be on tamper-resistant prescription pads. The effective date of this bill has now been changed to April 1, 2008.

Effective April 1, 2008, all new written Medicaid prescriptions (except those for 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:

1. Applies only to written prescriptions. Prescriptions that are electronic (those that are faxed, taken over the phone, or transmitted through other electronic means) are not covered under this law.
2. Applies only to new prescriptions filled on or after April 1, 2008. Does not apply to refills of prescriptions initially filled prior to April 1, 2008, until law requires a new prescription.
3. Compliance with all federal and state laws regarding the types of documentation and how prescriptions are filled must be maintained.

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 pads 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 compliant prescription form.

Effective April 1, 2008, the prescription form 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 or 1-877-290-4262 and ask for Utah's tamper-resistant pad information.

Successful implementation of the above requirements will require support of both prescribers and pharmacies. 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 any questions.

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## 08 - 06 Pharmacy Point of Sale System, Hours Available and Reject Code Messages

The following is a reminder of the hours during which the Point of Sale system is available for claims processing and also information about NCPDP reject (error code) messages. This article was originally published in the April 1997 MIB. It has been modified slightly from its original content.

### Hours Available

The Medicaid Point of Sale system is available **Monday through Saturday from 6 a.m. to midnight. On Sunday, Point of Sale is available from noon to midnight.**

During these hours, from time to time, a pharmacist may experience a problem getting an electronic claim through to the State of Utah. Instead of receiving an authorization number or transaction control number (TCN), the screen shows "system unavailable" or "host processing failure" or something similar. This means Medicaid did not receive the claim. The pharmacist may choose to report the problem and initiate action.

If the pharmacist chooses to make a phone call, the call must be directed to the specific "switch" company that the pharmacy or pharmacy corporate office has contracted with to carry the Medicaid claim to the State computer center. Such companies serve as private traffic control centers for routing pharmacy claims from their various sources to many payer destinations. There are two "switches" serving as intermediaries between Utah Medicaid pharmacists and the Utah

Medicaid computer center –WEBMD (formerly Envoy), and RelayHealth (formerly NDC).

For certain types of problems, WEBMD shows a screen message that contains the letters “EV” followed by a number. This indicates the switch is having difficulties. RelayHealth does not identify itself directly this way. WEBMD can be reached at its Help Desk, 1-800-333-6869. RelayHealth can be reached at 1-800-388-2316. If the switch company cannot fix the problem, they will contact the phone company or the State and initiate action.

If you have questions that have not been resolved, contact Medicaid Information at (801) 538-6155 or 1-800-662-9651.

### Point of Sale Reject Code Messages

The Medicaid Point of Sale system uses National Council for Prescription Drug Programs (NCPDP) reject codes to reply to requests for payment from pharmacy providers. You should receive a complete NCPDP message from Medicaid Point of Sale. If you receive incomplete messages, for example, only the number 64, please call your software vendor and ask for a system upgrade. With the upgrade, you will be able to view the NCPDP messages in their correct form. If you receive the message that the client is not eligible, that message is correct at that moment. If clients state they are eligible, ask them to provide a current Medicaid card. □

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## 08 - 07 Preferred Drug List Update

During the 2007 legislative session, the Utah State Legislature passed Senate Bill 42 allowing Medicaid to adopt a preferred drug list (PDL). Medicaid began phasing in a preferred drug list on October 1, 2007. In order to implement the preferred drug list, Medicaid has taken the following steps:

- The first official P&T Committee meeting was held on August 7, 2007. These meetings are open to the public and generally are held at 7:00 AM on the third Friday in the Cannon Health Building at 288 N. 1460 W. in Salt Lake City.
- Persons who wish to address the P&T Committee may contact Duane Parke at (801) 538-6841 at least 7 calendar days prior to the meeting. Comments from visitors, while welcome, may be limited due to time constraints.
- The P&T Committee consists of an academic pharmacist, a hospital pharmacist, a chain store pharmacist, an independent pharmacist, a governmental pharmacist, a pediatrician, family practice physician, psychiatrist, and an internist.
- The Drug Information Service at the University of Utah summarizes and updates clinical efficacy and safety information from the Oregon Evidence-Based Practice Center or the Drug Information Service. These materials will be posted in advance on the Pharmacy Services Website <http://health.utah.gov/medicaid/pharmacy>.
- The P&T Committee will advise Medicaid in choosing preferred agent(s) for each selected class of drugs based on clinical efficacy and safety.
- Division staff then examine confidential cost information and make a recommendation on which drugs in a class should be preferred.
- Prescribers may document medical necessity in a patient’s chart and hand write “Medically Necessary - Dispense As Written” on prescriptions for non-preferred drugs. Please note: the override does not affect mandatory generic dispensing laws. If a generic version of a drug is available, the brand name will continue to require prior authorization.

The Medicaid Preferred Drug List continues to expand on a monthly basis. Currently, Prilosec OTC and Prevacid are preferred proton pump inhibitors. Vytorin, Lipitor, and Crestor are preferred high potency statins.

Avandia, Avandaryl, Avandamet, Actos, Actoplus Met, and Duetact are preferred TZD oral hypoglycemics and TZD oral hypoglycemic combinations. Older oral hypoglycemics access has not changed.

Roche Diagnostics and LifeScan brand diabetic meters, strips, and lancets are preferred diabetic supply brands. Glucose test meters are still not reimbursed by Medicaid. Lancet devices are limited to one per six months. Becton Dickenson will be the preferred insulin syringe.

All preferred drugs and diabetic supplies are NDC specific. Please refer to the Medicaid Pharmacy Website for a list of these NDC’s. □

## 08 - 08 Pharmacy Update on Dual-Eligible Clients

The WellPoint Point-of-Sale Facilitated Enrollment (POS FE) process was designed to make sure that clients with both Medicare and Medicaid (“dual eligibles”) who are not yet enrolled in a Part D prescription drug plan are still able to get services immediately at the pharmacy when the pharmacist sees legitimate evidence of the client having Medicare and Medicaid. This process helps eliminate any possible “coverage gap” as the prescription drug coverage of dual eligible clients is transferred from Medicaid to the Medicare program.

When the Part D program began in 2006, Wellpoint’s primary goal was to make sure that dual eligible clients could get their prescriptions filled in situations where no plan enrollment could be determined. This approach resulted in some claims being paid incorrectly and subsequently being reversed to pharmacies. Medicare and WellPoint/UniCare, through their contracted PBM, have taken steps to minimize reversals to pharmacies and make the POS FE process a more user-friendly and reliable process.

Going forward, instead of reversing claims for clients who could not be confirmed to be eligible for Medicaid, WellPoint/UniCare will send a notice to these people, requesting that they either provide proof of Medicaid or that they reimburse WellPoint/UniCare for the cost of the claim(s). Pharmacies are asked to continue to use this system to facilitate timely and appropriate care for Medicaid’s dual eligible clients.

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## 08 - 09 Pharmacy Prior Authorizations

The following new prior authorizations will be effective on January 1, 2008:

Tykerb:

- Minimum age: 18 years old.
- Diagnosis of advanced or metastatic breast cancer whose tumor overexpress HER2.
- Prior therapy including an anthracycline, a taxane, and trastuzumab.
- To be given in combination of capecitabine.
- Prior authorization is given for 1 year.
- Reauthorization: Updated letter of medical necessity.

Xibrom:

- Prior trial of any indicated medication.
- Approved for one bottle for a 2 week period following procedure or surgery.

Xolegel:

- Minimum age 12 years old.
- Documented trial/failure of generic formulation of ketoconazole within the last 12 months.
- Prior authorization is given for 6 months.
- Reauthorization: Telephone call from physician’s office or pharmacy.

The following prior authorizations are changed, effective immediately:

-Relenza PA minimum age is changed to age 7. Treatment must be started within 72 hours of diagnosis.

-Tamiflu PA minimum age is changed to age 1 for both treatment and prophylaxis. Treatment must be started within 72 hours of diagnosis.

-Synagis: Utah Medicaid has traditionally begun the Synagis season with Primary Children Medical Center’s announced onset of the RSV season. Medicaid will now automatically begin the Synagis season on November 1, if the RSV season has not yet started. Patients will still be approved for a total of 5 injections for 6 months.

Note: The Injectable Medications List, an attachment of the Physician Manual, has been corrected to follow the pharmacy information provided in the Pharmacy Manual related to Synagis.

-Botox: Utah Medicaid does not cover Botox for cosmetic or off-label uses. This includes migraine, sialorrhea, and gastroparesis.

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## 08 - 10 Nursing Home - Family Liability

Effective January 1, 2008, Utah Medicaid will automatically apply family liability totals to nursing home and hospice claims. It will no longer be necessary for providers to report family liability totals on the claim after this date. The family liability will need to be reported on claims with a date of service prior to January 1, 2008. The family liability will be applied to the first claim(s) to enter our system (nursing home or hospice) until the liability is met.

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## 08 - 11 Home Health Updates

The Home Health Agency provider manual has been updated January 1, 2008.

The following information has been revised:

### 1-4 Definitions

The information in subsection G, related to the requirement for a surety bond, has been removed. Discussions with the regional CMS office in Denver indicate that the surety bond for a home health agency is no longer a requirement with CMS.

The following information has been added:

### 4-8 Private Duty Nursing

Private duty nursing is an optional program which is covered within the Home Health Program. Private duty nursing service may be indicated to prevent prolonged institutionalization in children under 21 who are medically needy and categorically eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Child Health Evaluation and Care (CHEC) program.

Eligibility and Access requirements:

1. The patient must meet EPSDT eligibility requirements for being under age 21, categorically needy and medically needy.
2. The patient must require more than four continuous skilled nursing hours of care per day.
3. The patient must have a written physician order establishing the need for private duty nursing service.
4. Providers shall submit an initial prior authorization request with medical documentation which demonstrates the need for the service. The private duty nursing provider must develop a plan of care consistent with the patient diagnosis, severity of illness, and intensity of service.
5. Medicaid may cover private duty nursing service if the quality and cost effectiveness justify it over other alternatives of care.
6. Private duty nursing is only available if a parent, guardian, or primary care giver is committed to and capable of performing the medical skills necessary to ensure quality of care and a safe environment for the periods of time when private duty nursing service is not provided. The home health agency must verify that the care giver receives the specialized training necessary to provide hands-on care in the home.

Coverage and Limitations:

1. Medicaid covers private duty nursing for a period of time for patients in transition from the hospital to allow sufficient training of the care giver.
  - a) Private duty nursing service needs are expected to decrease over time. The number of private duty nursing hours approved after initial approval will be based on the level of nursing skill required to care for the patient which is determined by the Skilled Nursing Needs Form. The PDN grid may be used only when the provider does not think the care needs are accurately reflected in the Skilled Nursing Needs Form. These tools are included in the attachments section of this manual.
  - b) An active weaning process is to be followed after the patient is initially discharged from the hospital. As care needs decrease, the number of nursing hours approved will be decreased. The goal is to have the patient to 8 hours a day within a four month period. Once the care givers have been given sufficient training to meet the patient's needs, private duty nursing service ends.
  - c) Maximum or an increased number of hours are to be used only when acute exacerbations of the illness occur

which require a short term, temporary increase in skilled needs. The patient may receive up to 20-24 hours of private duty nursing care only under the following circumstances:

1. After initial hospital discharge, for up to 2-3 days to enable the care giver(s) to become trained in the home on procedures.
  2. After a subsequent hospitalization, for up to 2-3 days to allow care giver(s) training in any new procedures or changes in care.
  3. If the primary care giver is unable to provide home care due to care giver illness or temporary incapacity, up to 2-3 days of private duty nursing service may be authorized.
- d) 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.
  - e) Private duty nursing is for the medically necessary skilled nursing needs of the patient. No services will be authorized if the care is a duplication of care reimbursed under another benefit or funding source.
  - f) Private duty nursing is not covered for custodial or sitter care to ensure compliance with treatment, respite care to allow the care giver to go to work or sleep, behavioral or eating disorders, or observation or monitoring for medical conditions not requiring skilled nursing.
2. Skilled nursing services may be considered for coverage during the transition period from the hospital while training is required, in ventilator dependent patients, and in patients with a tracheotomy who are not able to handle secretions.
    - a) Private duty nursing service may be allowed for up to four months for a patient with a new tracheotomy with an additional two months with documentation of continuing acute problems. When the condition of the child has stabilized and acute care is no longer required, the care givers must be trained and prepared to provide skilled services such as periodic suctioning.
    - b) When a patient is decannulated, the weaning process will allow up to 4 hours of nursing visits for the first 24-72 hours.
    - c) Total parental nutrition coverage for up to two months for acute phase with additional authorization based on the need for continued therapy.
    - d) Intravenous therapy coverage up to two months for a single episode. The number of hours required for a single infusion must be at least four continuous hours and require monitoring and treatment by a skilled nurse. An additional period of authorization may be approved based on medical necessity for continuing therapy.
    - e) Decubitus care for stage three or four ulcers, colostomy or ileostomy care for new or problematic cases, suprapubic care for new or problematic cases, continuous nasogastric or gastrostomy tube feedings for new or problematic cases are covered until the patient is stable and/or the care giver(s) are trained to assume care.
    - f) Mechanical ventilator support is required for at least eight hours per day and weaning steps are in process in conjunction with the physician, but the patient requires monitoring until medically stable.
      - 1) Ventilator setting changes are required at night.
      - 2) Oxygen supplementation for the ventilator dependent patient is at or below a fraction of 40 percent (FiO<sub>2</sub>).
      - 3) Nursing support is needed during the hours spent on BiPap or CPAP until the patient is medically stable.
    - g) The patient on oxygen will be considered for private duty nursing when the patient has desaturation when on room air for 15-20 minutes as indicated by a pulse oximetry reading below 85% accompanied by increases in respiratory rate and/or heart rate.
  3. Long term private duty nursing for the ventilator dependent, stable patient is limited to eight hours per day.
  4. When the private duty nurse cares for two patients in the home, the claim of each patient should be submitted with the UN modifier.

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## 08 - 12 Physician Manual Updated

The Physician Manual has been updated January 1, 2008. In Section 2, Covered Services, Consultation Service, items 6a and 6b were updated to add the physician assistant as a provider who may complete portions of patient work up. The physician must document the services they perform while completing the primary components of the consultation service for reimbursement.

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## 08 - 13 New Fax Number for Sterilization Consent Forms

In order to better facilitate the needs of our providers, Medicaid is adding fax number (801) 237-0745 for the submission of sterilization consent forms. All other fax lines will remain the same. Please be sure all required fields on the form are filled out and signed before faxing. All incomplete forms will be returned.

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## 08 - 14 Emergency Diagnoses Codes

The list of emergency covered diagnoses codes was recently reviewed and found to contain many codes which have not been updated in the file to meet current ICD-9 coding guidelines. Some unspecified codes were removed from the file because a specific, acute diagnosis is required to support ER service.

The updated January 2008 version of the Authorized Diagnoses for Emergency Department Reimbursement can be found at <http://www.health.utah.gov/medicaid/tree/index.html> as an attachment to the Hospital Manual. If you do not have Internet access, contact Medicaid Operations for a mailed or faxed copy of the list, (801) 538-6155 or 1-800-662-9651.

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## 08 - 15 Medical Supplies

### Opened codes

K0019 Arm pad, each  
 K0038 Leg strap  
 K0005 Ultra light weight wheelchair (rental only)  
 K0052 Swing away, detachable foot rest, each  
 E2386 Power wheelchair accessory, foam filled drive tire, any size, each  
 E2387 Power wheelchair accessory, foam filled castor tire, any size, each  
 E2601 General use wheelchair cushion, width < 22 inches

### Opened code with criteria

E0482 Cough stimulating device  
 Criteria - All of the following:  
 1. Care managed by a pulmonologist/specialist.  
 2. Inability to spontaneously cough.  
 3. Limited thoracic cage expansion, or on a ventilator.

### Codes with prior authorization added

K0065 Spoke protectors  
 E1235 Wheelchair, pediatric size, rigid, adjustable, w/o seating system  
 E1237 Wheelchair, pediatric size, folding, adjustable, w/o seating system  
 E2208 Wheelchair accessory, cylinder tank carrier, each

### Enteral and Supplemental Nutrition for WIC age children

Medicaid covers nutritional supplements for Medicaid enrolled infants and children ages 0-5 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. Medicaid will pay for all covered nutrition and require no WIC program participation, if the condition of the child requires "total nutrition through a tube." 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. Breast milk substitutes, such as Similac and Enfamil, are not covered whether taken by mouth or by tube.

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## 08 - 16 Emergency Only Program

The Emergency Only Program has created an email address for receiving electronic transfer of documents. The email address is [EOD@utah.gov](mailto:EOD@utah.gov). Please note that no correspondence or inquiries on claims will be responded to through this secure email address.

As the provider, you can now submit your documentation in several ways: email, fax, or mail. The email address is a new addition and will support PDF files containing confidential information. When you submit your documentation, you will receive an auto-generated response to notify you that the documentation you sent was received.

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## 08 - 17 Mental Health Centers, Substance Abuse Treatment and DHS Contracted Mental Health Providers

Changes have been made to the Utah Medicaid Provider Manual for Mental Health Centers. Chapter 1-11, Collateral Services, has been revised to clarify billing or reporting these services and documentation requirements. In Chapter 2-7, wording has been revised to clarify the definition of family psychotherapy.

Changes have been made to the Utah Medicaid Provider Manual for Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse. Chapter 1-10, Collateral Services, has been revised to clarify billing or reporting these services and documentation requirements. In Chapter 2-7, wording has been revised to clarify the definitions of family psychotherapy.

Changes have been made to the Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors. Chapter 1-11, Collateral Services, has been revised to clarify billing or reporting these services and documentation requirements. In Chapter 2-4, wording has been revised to clarify the definitions of family psychotherapy.

In all three manuals, references to the names of services in effect prior to October 1, 2003, were left in the manuals to help transition to the new service names implemented to comply with the Health Insurance Portability and Accountability Act (HIPAA). These former service names have now been deleted.

The manuals are available on the internet at <http://www.health.utah.gov/medicaid/tree/index.html>.

In the updated manuals, pages which state, "Page Updated January 2008" in the upper right corner have been revised. A vertical line in the margin is next to the text that has been changed.

If you do not have Internet access or have questions, contact Merrila Erickson at (801) 538-6501 or [merrickson@utah.gov](mailto:merrickson@utah.gov)

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## 08 - 18 Prolonged Services

Prolonged service codes 99358-99359 have been brought forward for clarification. These prolonged service codes are for services before and after direct face-to-face patient contact. In Medicaid, we will consider payment for these codes when the service is related to coordination of care or patient care discussions with parents or family members. These services are not covered for team conferences or review of medical records. Therefore, these codes will appear in the January 2008 list of non-covered codes. Prolonged service codes 99354-99357 remain open to indicate service for covered prolonged services.

Note: Documentation of the total E&M service time must be in the record along with the time spent specifically for coordination of care and counseling patient and/or family.

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## 08 - 19 Ultrasound in Pregnancy

Pregnancy ultrasounds will be medically reviewed when the number exceeds ten per twelve month period. Criteria #39, in the Criteria for Medical and Surgical Procedures, has been modified January 1, 2008.

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## 08 - 20 2008 HCPCS

The Surgical Procedures list in the Hospital Manual and the CPT List of Medical and Surgical Procedures in the Physician Manual have been updated to reflect current ICD-9 and CPT code changes effective January 1, 2008.

### Covered Codes Effective January 1, 2008

01935 Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic  
 01936 Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic  
 20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radio . . .  
 24357 Tenotomy, elbow, lateral or medial (i.e. epicondylitis, tennis elbow, golfer's elbow) percutaneous . . .  
 24358 Tenotomy, elbow, lateral or medial (i.e. epicondylitis, tennis elbow, golfer's elbow) debridement, soft . . .  
 24359 Tenotomy, elbow, lateral or medial (i.e. epicondylitis, tennis elbow, golfer's elbow) debridement, soft . . .  
 27267 Closed treatment of femoral fracture, proximal end, head; without manipulation  
 27268 Closed treatment of femoral fracture, proximal end, head; with manipulation  
 27269 Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed  
 27726 Repair of fibula nonunion and/or malunion with internal fixation  
 27767 Closed treatment of posterior malleolus fracture; without manipulation  
 27768 Closed treatment of posterior malleolus fracture; with manipulation  
 27769 Open treatment of posterior malleolus fracture, includes internal fixation, when performed  
 32421 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent  
 32422 Thoracentesis with insertion of tube, includes water seal (i.e. for pneumothorax), when performed . . .  
 32550 Insertion of indwelling tunneled pleural catheter with cuff  
 32551 Tube thoracostomy, includes water seal (i.e. for abscess, hemothorax, empyema), when performed . . .  
 32560 Chemical pleurodesis (i.e. for recurrent or persistent pneumothorax)  
 33257 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac . . . limited . . .  
 33258 Operative tissue ablation and reconstruction of atria, performed at the time of . . . extensive. . . without . . .  
 33259 Operative tissue ablation and reconstruction of atria, performed at the time of . . . extensive. . . with . . .  
 35523 Bypass graft, with view; brachial-ulnar or -radial  
 36593 Dec clotting by thrombolytic agent of implanted vascular access device or catheter  
 41019 Placement of needles, catheters, or other device(s) into the head and/or neck region . . .  
 49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, . . . 5 cm diameter or less.  
 49204 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, . . . 5.1-10.0 cm diameter  
 49205 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, . . . > 10.0 cm diameter  
 49440 Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast . . .  
 49441 Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including . . .  
 49442 Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including . . .  
 49446 Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic . . .  
 49450 Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic . . .  
 49451 Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report  
 49452 Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including . . .  
 49460 Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, . . .  
 49465 Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, . . .  
 50385 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral . . .  
 50386 Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without . . .  
 51100 Aspiration of bladder; by needle  
 51101 Aspiration of bladder; by trocar or intracatheter

51102 Aspiration of bladder; with insertion of suprapubic catheter  
 55920 Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for . . .  
 57285 Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach  
 57423 Paravaginal defect repair (including repair of cystocele, if performed); laparoscopic approach  
 60300 Aspiration and/or injection, thyroid cyst  
 67041 Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane . . .  
 67042 Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina . . .  
 67043 Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane . . .  
 67113 Repair of complex retinal detachment (i.e. proliferative vitreoretinopathy, stage c-1 or greater, . . .  
 67229 Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant . . .  
 80047 Basic metabolic panel (calcium, ionized)  
 82610 Cystatin C  
 83393 Calprotectin, fecal  
 84704 Gonadotropin, chorionic (HCG); free beta chain  
 86356 Mononuclear cell antigen, quantitative (i.e. flow cytometry), not otherwise specified, each antigen  
 87500 Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance . . .  
 90736 Zoster (shingles) vaccine, live, for subcutaneous injection  
 90769 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, . . .  
 90770 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour . . .  
 90771 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up . . .  
 90776 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional . . .  
 99477 Initial hospital care, per day, for the evaluation and management of the neonate,  $\leq 28$  days of age . . .  
*PRIOR APPROVAL: Not Required. . . . CRITERIA: Approved for neonatologists, pediatricians, and rural family practitioners only.  
 Note: One initial hospital care per day code will be paid on the day. Therefore, when another provider bills the code 99295 or 99447, the remittance advice will post the message "mutually exclusive." Providers spending intensive care hours at the bedside in stabilizing the patient for transport to another facility should use the intensive care codes 99291-99292.*

#### **Non-Covered Codes Effective January 1, 2008**

20985 Computer-assisted surgical navigational procedure for musculoskeletal procedures; . . .  
 20986 Computer-assisted surgical navigational procedure for musculoskeletal procedures; . . .  
 20987 Computer-assisted surgical navigational procedure for musculoskeletal procedures; . . .  
 21073 Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service . . .  
 27416 Osteochondral autograft(s), knee, open (i.e. mosaicplasty) (includes harvesting of autograph(s))  
 28446 Open osteochondral autograft, talus (includes obtaining graft(s))  
 29907 Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis  
 33864 Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction . . .  
 34806 Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular . . .  
 36591 Collection of blood specimen from a completely implantable venous access device  
 36592 Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified.  
 50593 Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy . . .  
 52649 Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, . . .  
 68816 Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation  
 75558 Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow . . .  
 75559 Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress . . .  
 75560 Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow . . .  
 75562 Cardiac magnetic resonance imaging for morphology and function without contrast material(s),  
 75563 Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed . . .  
 75564 Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed . . .  
 87809 Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus  
 88381 Microdissection (i.e. sample preparation of microscopically identified target); manual  
 89322 Semen analysis; volume, count, motility, and differential using strict morphological criteria (i.e. kruger)  
 89331 Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, . . .  
 90284 Immune globulin (SCIG), Human, for use in subcutaneous infusions, 100 mg, each  
 90661 Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for . . .  
 90662 Influenza virus vaccine, split virus vaccine, preservative free, enhanced immunogenicity via increased . . .  
 90663 Influenza virus vaccine, pandemic formulation  
 93982 Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac . . .  
 95980 Electronic analysis of implanted neurostimulator pulse generator system . . . gastric neurostimulator . . .

- 95981 Electronic analysis of implanted neurostimulator pulse generator system . . .gastric neurostimulator . . .
- 95982 Electronic analysis of implanted neurostimulator pulse generator system . . . gastric neurostimulator . . .
- 96125 Standardized cognitive performance testing (i.e. Ross information processing assessment) per hour . . .
- 98966 Telephone assessment and management service provided by a qualified nonphysician . . . 5-10 minutes . .
- 98967 Telephone assessment and management service provided by a qualified nonphysician . . . 11-22 minutes
- 98968 Telephone assessment and management service provided by a qualified nonphysician . . . 21-30 minutes
- 98969 On-line assessment and management service provided by a qualified nonphysician health . . .
- 99174 Ocular photo screening with interpretation and report, bilateral
- 99358 Prolonged evaluation and management service before or after direct (face-to face) patient care. . .first hour;
- 99359 . . . each additional 30 minutes
- 99366 Medical team conference with interdisciplinary team . . . ≥ 30 minutes . . . non physician . . .
- 99367 Medical team conference with interdisciplinary team . . . ≥ 30 minutes . . . physician . . .
- 99368 Medical team conference with interdisciplinary team . . . ≥ 30 minutes . . . non physician . . .
- 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
- 99408 Alcohol and/or substance . . . abuse structured screening (i.e. AUDIT , DAST) 15 to 30 minutes.
- 99409 Alcohol and/or substance (other than tobacco) abuse structured screening (i.e. AUDIT , DAST), > 30 minutes.
- 99441 Telephone evaluation and management service . . . physician to an established patient . . . 5-10 minutes
- 99442 Telephone evaluation and management service . . . physician to an established patient . . .11-20 minutes
- 99443 Telephone evaluation and management service . . .physician to an established patient . . . 21-30 minutes
- 99444 Online evaluation and management service provided by a physician to an established patient . . .
- 99605 Medical therapy management service(s) provided by a pharmacist . . . initial 15 minute, new patient
- 99606 Medical therapy management service(s) provided by a pharmacist . . . initial 15 minute, established patient
- 99607 Medical therapy management service(s) provided by a pharmacist . . . each additional 15 minutes

**Prior Authorization Required January 1, 2008**

- 22206 Osteotomy of spine, posterior or posterolateral approach, three columns one vertebral segment (i.e. pedicle/vertebral body subtraction); thoracic  
PRIOR APPROVAL: Written ICD-9: 77.39 . . . . . Refer to Criteria #2<sup>2</sup>
- 22207 Osteotomy of spine, posterior or posterolateral approach, three columns one vertebral segment (i.e. pedicle/vertebral body subtraction); lumbar  
PRIOR APPROVAL: Written ICD-9: 77.39 . . . . . Refer to Criteria #2<sup>2</sup>
- 22208 Osteotomy of spine, posterior or posterolateral approach, three columns one vertebral segment (i.e. pedicle/vertebral body subtraction); each additional vertebral segment (list separately in addition to code for primary procedure)  
PRIOR APPROVAL: Written ICD-9: 77.39 . . . . . Refer to Criteria #2<sup>2</sup>
- 29828 Arthroscopy, shoulder, surgical; biceps tenodesis  
PRIOR APPROVAL: Telephone ICD-9: 80.21 . . . . . Refer to Criteria #4<sup>2</sup>
- 29904 Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body  
PRIOR APPROVAL: Telephone ICD-9: 80.27 . . . . . Refer to Criteria #4<sup>2</sup>
- 29905 Arthroscopy, subtalar joint, surgical; with synovectomy  
PRIOR APPROVAL: Telephone ICD-9: 80.27 . . . . . Refer to Criteria #4<sup>2</sup>
- 29906 Arthroscopy, subtalar joint, surgical; with debridement  
PRIOR APPROVAL: Telephone ICD-9: 80.27 . . . . . Refer to Criteria #4<sup>2</sup>
- 58570 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;  
PRIOR APPROVAL: Written ICD-9: 68.41 . . . . . Refer to Criteria #14 and Interqual
- 58571 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).  
PRIOR APPROVAL: Written ICD-9: 68.41,65.63 . . . . . Refer to Criteria #14 and Interqual
- 58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;  
PRIOR APPROVAL: Written ICD-9: 68.41 . . . . . Refer to Criteria #14 and Interqual
- 58573 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)  
PRIOR APPROVAL: Written ICD-9: 68.41,65.63 . . . . . Refer to Criteria #14 and Interqual
- 75557 Cardiac magnetic resonance imaging for morphology and function without contrast material;  
PRIOR APPROVAL: Written ICD-9: 46.9 Covered through age 20. . . . . Refer to Criteria #40B
- 75561 Cardiac magnetic resonance imaging for morphology and function . . . further sequences;  
PRIOR APPROVAL: Written ICD-9: 46.9 Covered through age 20. . . . . Refer to Criteria #40B

**Manual Review Required January 1, 2008**

86486 Skin test; unlisted antigen, each

Note: Coverage considered only for testing for exposure to a specific infectious organism. It is not covered as a replacement for tests commonly done for allergies through patch testing or intracutaneous testing.

**Assistant Surgeon Not Covered**

24357	24358	24359	27267	27268	27767	27768	29828	29904	29905	29906	32421	32422
32550	32551	32560	36593	41019	49440	49441	49442	49446	49450	49451	49452	49460
49465	50385	50386	51100	51101	51102	59920	60300	67229				

**Post Op Days 0**

20555	32421	32422	32550	32551	32560	36593	41019	49450	49451	49452	49465	51100
51101	51102	55920										

**Post Op Days 10**

24357	27267	27268	27767	27768	49440	49441	49442	49446	49460	50385	50386	60300
67041	67042	67043	67113	67229								

**Post Op Days 42**

22206	22207	22208	24358	24359	27269	27726	27769	29828	29904	29906	33257	33258
33259	35523	49203	49204	49205	57285	57423	58570	58571	58572	58573		

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