

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

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### Medicaid Information

- Salt Lake City area, call 801-538-6155.
- 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

## 09 - 43 Statewide Provider Training

Utah Medicaid providers are invited to attend the 2009 Medicaid Statewide Provider Training Seminar. This year's session will include important information regarding hospital services (outpatient and inpatient), dental services, Medicare topics, client benefits, billing issues, PCN services, pharmacy services, vision services, and many other new items. The session will run approximately 2 to 2 ½ hours.

Providers are encouraged to submit any suggestions for additional training. Please submit your RSVP and training topic suggestions to:

E-Mail: [medicaidops@utah.gov](mailto:medicaidops@utah.gov) or

Telephone: 801-538-6485, or toll-free 1-800-662-9651 (option 5) or 801-538-6155 (option 5).

When leaving information, please state the name of your group, how many will be in attendance, what session you plan to attend, and a contact name and telephone number.

We look forward to seeing you.

### Seminar Schedule 2009

| City             | Date   | Address   | Time                  |
|------------------|--------|---|-----------------------|
| Tooele           | Aug 4  | Tooele Health Dept<br>151 N. Main<br>Tooele, Utah                             | 9:00 AM               |
| Ogden            | Aug 6  | Ogden Regional Medical<br>5475 S. 500 E.<br>Ogden, Utah (Cedar Room)          | 9:00 AM or<br>1:30 PM |
| Logan            | Aug 11 | Environment Health Bldg<br>85 E. 1800 N.<br>Logan, Utah                       | 9:30 AM               |
| Salt Lake - FQHC | Aug 13 | SLC / Video Conference<br>860 E. 4500 S. #206<br>Salt Lake City, Utah         | 1:00 PM               |
| Montezuma Creek  | Aug 18 | Montezuma Creek Health<br>Center<br>East Highway 262<br>Montezuma Creek, Utah | 1:00 PM               |
| Monticello       | Aug 19 | San Juan Hospital<br>364 W. 100 N.<br>Monticello, Utah                        | 9:00 AM               |
| Price            | Aug 20 | South Eastern Health Dept<br>28 S. 100 E.<br>Price, Utah                      | 9:00 AM               |
| Salt Lake        | Aug 25 | State Library<br>250 N. 1950 W.<br>Salt Lake City, Utah                       | 9:00 AM or<br>1:00 PM |
| Salt Lake        | Aug 26 | South County DWS<br>5735 S. Redwood Rd<br>Salt Lake City, Utah                | 9:00 AM or<br>1:00 PM |

|               |         |  |                        |
|---------------|---------|--|------------------------|
| Richfield     | Sept 9  | Sevier County EMS Bldg<br>50 W. 925 N.<br>Richfield, Utah                                      | 1:00 PM                |
| Fillmore      | Sept 10 | Fillmore Hospital<br>674 S. Highway 99<br>Fillmore, Utah                                       | 9:00 AM                |
| Nephi         | Sept 10 | Central Valley Med Center<br>48 W. 1500 N.<br>Nephi, Utah                                      | 1:30 PM                |
| American Fork | Sept 15 | American Fork Hospital<br>Classroom 1 (West entrance)<br>170 N. 1100 E.<br>American Fork, Utah | 9:00 AM                |
| Provo         | Sept 17 | Utah Valley Hospital<br>Women Center classroom #2<br>1034 N. 5 <sup>th</sup> W.<br>Provo, Utah | 1:00 PM                |
| Panguitch     | Sept 22 | Garfield Memorial Hospital<br>Conference room, Admin Bldg<br>200 N. 400 E.<br>Panguitch, Utah  | 1:00 PM                |
| Cedar City    | Sept 23 | Iron County School District<br>2077 W. Royal Hunte Dr.<br>Cedar City, Utah                     | 9:00 AM                |
| St. George    | Sept 24 | Dept of Workforce Services<br>162 N. 400 E.<br>St. George, Utah                                | 10:00 AM or<br>1:30 PM |
| Heber         | Sept 29 | Heber Health Dept<br>Room 100<br>55 S. 500 E.<br>Heber, Utah                                   | 9:30 AM                |
| Roosevelt     | Sept 30 | Northeastern Med Center<br>210 W. 300 N.<br>Roosevelt, Utah                                    | 9:30 AM                |

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**09 - 44 Utah Medicaid Identification Card**

The identification card for Utah Medicaid recipients has changed. The new ID cards are being issued for more recipients throughout the state. Providers can expect to encounter both versions of the Medicaid cards when seeing Utah Medicaid recipients. Either card is valid for the time period identified on the card.

The new Medicaid ID cards may have an impact on the way Utah Medicaid providers and their office personnel interpret the Medicaid card. In order to reintroduce the new card, there is an example included in this article.

Some characteristics of the card will not change. There are, however, many significant differences between the versions currently in use. The new design is intended to more closely conform to the size of medical cards already being used in the healthcare community. The Medicaid card will continue to be printed on 8.5 x 11 size paper and the background color for the body of the card remains the same; Traditional and Emergency Only - purple, Non Traditional - blue, Primary Care Network - yellow, and QMB Only - peach.

The recipient may choose to detach the body of the card from the top address area on the sheet of paper. The card may then be folded to make a smaller version of the Medicaid ID card.

Each quadrant of the card may contain information essential to the provider. The back of the card will be used for spend-down cases with incurred medical bills. It is recommended that you make a copy of the card for your records. The card may be unfolded for copying, and all relevant information will be on a single copy. Spend-down clients with incurred medical bills will have additional information for providers printed on the back of the card.

Below is an example of the new Medicaid ID card as it appears at the time it is mailed to the client. The card is still valid if the recipient chooses to detach the address section. Either Medicaid ID card type is valid for the time period identified on the card.

Demographic Organization/Unit  
751 QUALITY DR  
AMERICAN FORK, UT 84303-8306

Promote    Prevent    Protect

## Utah Department of Health

MOTHER TEST  
1111 S STATE ST  
SLC, UT 84111-4501

|   |  |
|---|--|
| <p><b>Special Instructions</b><br/>Name:</p> <p><b>Co-Pay Codes</b><br/><input type="checkbox"/> Co-pay required for non-emergency use of ER &amp; Pharmacy</p> | <p>2815 - UIC      <b>TRADITIONAL MEDICAID ID CARD</b><br/>The people listed on this card are eligible for medication/pharmacy services.</p> <p>Eligible From: March 01, 2009 - March 31, 2009<br/>Health Plan: Healthy U      Restrained: Yes      TPL: Yes</p> <p><b>PROVIDER and CLIENT:</b> The Medicaid Card should be presented before receiving services. Keep a copy of this card for your records. If there are any changes on insurance coverage, call the TPL Unit 538-4758 or 1-800-621-2237. If you have any questions about coverage or how to use this card, call Medicaid Information at 538-6122 or 1-800-943-6834.</p> <p>Attempt to modify this card in any way or allowing use by people not listed on this card is illegal.</p> |
|---|--|

| Name/ID                             | DOB/Age         | Co-Pay Provider  | Restrictions   | TPL/Medicaid Information  |
|-------------------------------------|-----------------|--|--|---|
| CHILD TEST<br>DR0200PH03 (F)<br>MOM | 05/11/2006<br>7 | <input type="checkbox"/> Healthy U 1-801-444-7222<br>Wendell Mental Health Center<br>1-801-464-3333<br>JOSEPH H KARLUND MD<br>BMTHS 1688 | Hospital: Lakeview Hospital<br>Prescriber: Henry B. Tall<br><br>Urgent Care: West Jordan Urgent Care | Bevel Health<br>159 S. Main Street, Salt Lake City,<br>UT 84102-0312<br>Policy Holder: DAN RYAN<br>ID#: 56222222 Group#: J0888888 |

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**09 - 45 Coding Updates**

Prior Authorization

The following codes will require prior authorization in order to control cosmetic procedures:

- 19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction
- 54162 Lysis or excision of penile post-circumcision adhesions

The following codes will require written prior authorization:

- 54150 Circumcision, using clamp or other device with regional dorsal penile or ring block > 28 days old.  
 Prior: Written . . . . . ICD9-CM: 64.0 . . . . .criteria 9B
- 54161 Circumcision, surgical excision, older than 28 days of age.  
 Prior: Written . . . . . ICD9-CM: 64.0 . . . . .criteria 9B

90 Post-Op Days

- 43770 (Gastric banding code which CMS and other insurance groups have set at 90 days)
- 50590 (The code in the file is for the hospital S0400 global service - replaced with physician code 50590)

Nursing Code Update

Administration code 90772 was deleted in January 2009 and replaced with code 96372 with the same descriptor. The Nurse Practitioner Manual and the Certified Nurse Midwife Manual have been updated to reflect this change.

Covered Codes

- 44206 Colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)
- 44207 Colectomy, partial, with anastomosis with coloproctostomy (low pelvic anastomosis)
- 44208 Colectomy, partial, with anastomosis with coloproctostomy (low pelvic anastomosis) with colostomy
- 44211 Colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy when performed
- 44212 Colectomy, total, abdominal, with proctectomy, with ileostomy

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**09 - 46 Modifier 22 in Obstetrical Services**

Beginning July 1, 2009, all obstetrical and delivery procedure codes submitted with modifier 22 will require submission of documentation (e.g., Operative report) for review prior to payment. Clarification as to what services are considered part of the procedure and which services may be considered for enhanced payment with the modifier 22, is provided through the American College of Obstetricians and Gynecologists (ACOG). The following is a summary of the information.

The 22 modifier is appropriately applied to the obstetrical global delivery code when there are multiple gestations or complications during the delivery which place the mother or fetus at risk of adverse outcome. When applying the 22 modifier, it is important to document the additional or unusual services provided. It is not adequate to simply list a diagnosis.

According to ACOG, the following are examples of services which are included in the global delivery package which should not be reported separately:

- First and second degree lacerations
- Induction of labor (indicated induction)
- Rupture of membranes (premature, spontaneous, or part of induction AROM)
- Admission to the hospital for delivery
- Labor management
- Fetal monitoring

- Postpartum orders
- Ferning test
- Elevated maternal temperature
- Laceration, not repaired
- Post-term pregnancy
- Shoulder dystocia or “difficult delivery” without any documentation
- IV oxytocin
- Cytotec (Misoprostol)

According to ACOG, the following are examples of occurrences which should be reported with a 22 modifier and the appropriate supportive documentation:

- Third and fourth degree lacerations
- Shoulder dystocia
- Maneuvers used in difficult delivery
- Lacerations (with documentation of repair and time spent)

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## 09 - 47 Observation Services

The Hospital Provider Manual contains the following information on policy for observation services:

### Limitations (page 19)

Use of observation status to submit ancillary charges associated with outpatient surgery, other . . . Observation services must not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure.

### Exception

There are circumstances in which a patient is admitted to inpatient service with the intent of remaining more than 24 hours and . . . (i.e. cardiac arrhythmia, asthma, congestive heart failure).

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## 09 - 48 Circumcision Policy

Effective July 1, 2009, circumcision policy has been added to the Criteria for Medical and Surgical Procedures attachment to the provider manual. Criteria #9B - Circumcision (for ages beyond 4 weeks) will read as follows:

### Documentation

1. Conservative treatment has been tried for at least six weeks in the last 6 months.
  - a) Instruction in penile care.
    - 1) Cleansing with aqueous cream rather than irritant soap.
    - 2) Parents taught gentle foreskin retraction and young boys taught dilation and stretching.
  - b) Use of topical steroidal and low potency steroidal medications to treat acute or recurrent foreskin inflammation.
    - 1) Hyaluronidase
    - 2) Topical bethamethasone cream
  - c) Treatment with topical antibiotics as necessary.
  - d) After one UTI, conservative treatment measures must be instituted.
    - 1) Dysfunctional elimination syndromes such as delayed voiding and constipation should be addressed in counseling session.
    - 2) Children should be encouraged to drink adequate fluid and cranberry juice should be mentioned for its benefit to maintain urine acidity.
    - 3) Children should have ready access to clean toilets and be instructed in proper hygiene.

2. Specifics of the inflammation or infection must be documented in the records submitted.
  - a) Number of instances
  - b) Frequency or spacing between cases

#### Indications

1. Balanitis Xerotica Obliterans: Repeated infection causes hardening of the foreskin, the inability to retract the foreskin and meatal stenosis. This condition is true phimosis when conservative treatment has not proven successful. This is defined as pathological phimosis and remains the one absolute indication for circumcision. True phimosis is distinguished by a whitish ring of hardened sclerotic skin at the tip of the prepuce. Studies report that this condition affects some 0.6% of boys.
2. Phimosis (Note: Tight foreskin is not phimosis). The epithelial lining of the prepuce and the glans is contiguous, such that preputial adhesions represent a normal feature of foreskin development. Loosening of foreskin occurs with maturity secondary to hormonal influence and intermittent erection. Physiological phimosis resolves spontaneously with maturity, leaving a 1% incidence at puberty. Paraphimosis is a condition which occurs when tight foreskin is forcibly prematurely retracted and becomes trapped behind the head of the penis. When an effort to retract foreskin is unsuccessful, an emergent dorsal slit is done. (Circumcision may be considered electively at a later date).
  - a) Phimosis is not an emergency and should be treated with conservative measures unless there are one of the following conditions.
    - 1) Obstruction of the urinary stream
    - 2) Hematuria/UTI
    - 3) Prepubertal pain
  - b) Multiple episodes of infection (>3) over more than 6 weeks when conservative measures have been tried (One).
    - 1) Balantitis
    - 2) Posthitis
    - 3) Penile cellulitis
3. Chronic Balanoposthitis (Note: Balanoposthitis is defined as inflammation of the foreskin and the glans penis). (One).
  - a) Children over age 5 with true phimosis or physiologic phimosis are surgical candidates if there is recurrent balanoposthitis or chronic balanoposthitis. (All). (Note: More genital dermatoses are diagnosed in uncircumcised males, *Mallon*.)
    - 1) If inflammation treated for six weeks of conservative therapy including careful hygiene and topical mild steroids has not resolved, then referral to an urologist is indicated. (Note: The antibiotic treatments for UTI are not effective in treating bacterial colonization of foreskin).
    - 2) Contact irritant dermatitis from irritating products or excessive cleansing has been ruled out.
    - 3) Infectious causes such as group A-beta hemolytic strep have been ruled out. (Note: Sexually active, abused or both males should undergo evaluation for sexually transmitted disease).
  - b) Children under age 5 without a medical indication should be treated with conservative measures.
    - 1) Topical antibiotic
    - 2) Penile hygiene
4. Recurrent atypical UTIs within the last year and no urinary tract abnormality by imaging.
  - a) UTI is defined by:
    - 1) Temperature > 38 °
    - 2) Signs and symptoms (one or more)
      - i) Infant, younger than 3 months
        1. Vomiting
        2. Lethargy
        3. Irritability
        4. Poor feeding
        5. Failure to thrive
      - ii) Child, over three months (one or more)
        1. Abdominal pain
        2. Loin tenderness
        3. Changes in continence
        4. Dysfunctional voiding

5. Complaints of dysuria or frequency
- 3) Dipstick urine (one)
  - i) Leukocyte esterase and nitrate are positive, send urine culture and start antibiotic treatment.
  - ii) Leukocyte esterase is negative and nitrate is positive, send urine culture, start antibiotic but subsequent management depends on urine culture. (Note: Leukocyte esterase is positive and nitrate is negative, send urine for culture and microscopy. Do not start antibiotic unless clinical evidence of UTI. This may indicate infection outside of urinary tract. Both leukocyte esterase and nitrate are negative not a UTI search for another cause.)
- 4) Atypical UTI consists of organism other than prevalent enteric organisms such as Escherichia coli or enterococcus where there is quantification to 100,000 organisms.
- b) Imaging:
  - 1) Renal ultrasound to rule out structural abnormalities should be completed under any of the following conditions: (One)
    - i) In children over 6 months of age when the cause of the UTI is atypical (culture indicates the organism is not Escherichia coli bacteria) an ultrasound should be completed during the acute UTI infection. (Note: Atypical UTI may also include failure to respond to antibiotics within 48 hours, raised creatinine, or septicemia).
    - ii) For infants younger than 6 months with first-time UTI that responds to treatment, ultrasound should be carried out within 6 weeks of the UTI to rule out structural anomalies.
    - iii) Documented risk factors for underlying UTI pathology. (Check all that apply)
      - 1) Poor urine flow
      - 2) Antenatally diagnosed renal abnormality
      - 3) Family history of vesicoureteric reflux (VUR)
      - 4) Dysfunctional voiding
      - 5) Enlarged bladder
      - 6) Abdominal mass
      - 7) Evidence of spinal lesion
      - 8) Poor growth
      - 9) High blood pressure
  - 2) Additional renal imaging should be considered:
    - i) Micturating cystourethrogram (MCUG)
      - 1) Dilation found on ultrasound
      - 2) Poor urine flow on ultrasound
      - 3) Family history of VUR
    - ii) Dimercaptosuccinic acid (DMSA) renal scintigraphy scan should be considered 4-6 months following an acute infection like pyelonephritis to detect renal parenchymal damage in children. A CT scan is the appropriate imaging study for evaluation parenchymal damage in adults. (Note: There are not good studies at this time to demonstrate the optimum timing for DSMA renal scintigraphy scan to detect long term parenchymal damage.)
- C) Recurrent UTI (Note: Patients with high grade VUR, infants with congenital spinal abnormalities, and children with recurrent urinary tract infections may benefit from circumcision. However, studies have found no benefit from circumcision when it is performed at the same time as corrective surgery for VUR. The recommendation for circumcision must be made by the urologist under these circumstances.)
  - 1) Recurrent UTI is defined by: (One)
    - i) Two or more episodes of UTI with acute pyelonephritis/upper urinary tract infection.
    - ii) One episode of UTI with pyelonephritis/upper urinary tract infection plus one or more episodes of UTI with cystitis/lower urinary tract infection.
    - iii) Three or more episodes of UTI with cystitis/lower urinary tract infection.

#### Limitations

1. Requests for cosmetic surgery or surgery for social/cultural reasons are not covered. There must be documentation of medical necessity for approval of the procedure.
2. Contraindications to circumcision:
  - a) Prematurity

- b) Bleeding disorders
- c) Concealed or buried penis (under fat pad)
- d) Bilateral large hydroceles
- e) Penile abnormalities: hypospadias, epispadias, micropenis, ambiguous genitalia, megalourethra, webbed penis because the foreskin may be required later in reconstructive surgery.

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## 09 - 49 Nursing Home Personal Needs and Trust Accounts

The Office of Recovery Services (ORS) has determined that nursing home personal needs accounts and/or nursing home client trust accounts maintained for the benefit of Medicaid recipients are properly classified as part of a recipient's estate. Upon the recipient's death, the funds remaining in such accounts should be transmitted to ORS for the purpose of Medicaid reimbursement.

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## 09 - 50 Mental Disease Services

### Services for individuals under age 21 in an Institution for Mental Disease (IMD) - Reimbursement Clarification

The term "institution for mental diseases" is defined in subsection 1905 (i) of the Social Security Act to mean "a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care and related services."

Inpatient psychiatric hospital services for individuals under age 21 include **only** inpatient services which are provided in an institution which is a psychiatric hospital.

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## 09 - 51 Home Health Manual Updates

Private Duty Nursing (PDN) and Skilled Nursing Checklist forms clarification:

- The service and the forms (PDN/Skilled Nursing Checklist) may be completed by the RN or LPN. Both tools will be corrected to reflect RN and LPN use.
- The PDN Grid is to be completed by the nurse for the period of time the nurse provided direct patient care to the client.

Prior authorization:

- When the skilled nurse provider finds the care needs of the patient are diminishing, the nurse should discuss decreased needs with the parent/caregiver. Documentation of the diminished skilled nursing need trend should be submitted to the prior authorization nurse 15 days prior to the recertification deadline so that notification of a potential decrease in service may be submitted to the parent/caregiver.

Home Health Service:

- Initial nursing assessment must be submitted within 48 hours of the service (changed from 24 hours).

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## 09 - 52 Laboratory Manual Updates

The code for heel stick was not updated when the code was changed to code 35416. This will be corrected in the Laboratory Manual. For clarification, several issues which have been in the Physician Manual will also be placed in the Laboratory Manuals including:

When the Affirm Test for DNA probes, codes 87660, 87510, or 87480 are billed, only one of the three codes will be paid to the physician. The system will post a mutually exclusive edit when more than one of these codes are billed.

Unspecified laboratory codes will no longer be accepted when there is a specific test available. The specific test must be ordered for reimbursement. Examples of this policy include:

- The code 87797 - Infectious agent not otherwise specified; direct probe technique, will no longer be accepted when the test completed is *Trichomonas vaginalis*, direct probe, code 87660.
- The code 87800 - Infectious agent detection; direct probe technique, will no longer be accepted when the test in *Chlamydia trachomatis*, direct probe, code 87490.

Medicaid follows the recommendations of the editing program which includes payment recommendations from the American Society of Microbiology, (i.e. code 87621 allowed once).

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## 09 - 53 Drug Delivery Implantation

Effective July 1, 2009, CPT code 11981, drug delivery implant, is open with manual review. The Evaluation and Management (E&M) code may be considered for payment, when it is the initial implantation of a covered drug and there is documentation supporting significant additional time spent in counseling (e.g., contraception). The E&M service for code 11982 and code 11983 is considered incidental to the procedure.

### Covered

11982 Removal, non-biodegradable drug delivery implant

### Manual Review

11983 Removal and reinsertion, non-biodegradable drug delivery implant  
 Prior Approval: Not required  
 Criteria: Attach documentation to claim

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## 09 - 54 Chronic Pain Consultation Modifications

The following are modifications to the Utah Medicaid Chronic Pain Consultation guidelines to help clients and providers better access chronic pain consultations:

1. The age restriction has been lifted in order to include children.
2. There is no prior authorization requirement. (Fax referrals directly to one of the approved Utah Medicaid pain providers listed below.)
3. The requirement that all recipients who are provided a pain consultation are automatically enrolled in the Restriction Program has been removed.
4. Group providers may bill under the group provider number (National Provider Identification) for services provided by an approved group member.
5. For dates of services on or after August 1, 2004, the following codes and modifiers must be used in order to receive reimbursement. These modifiers identify the service as a Chronic Pain Consultation in the MMIS system.

|          |  |
|----------|--|
| HE 99245 | Psychiatric Eval Psychiatrist            |
| HE S5190 | Psychiatric Eval Psychologist            |
| HH 99245 | Pain Specialist Eval Physician           |
| HH 97001 | Physical Therapy Eval Physical Therapist |

6. A multi-disciplinary consultation that includes a psychiatric evaluation and medical evaluation is still required. Physical therapy evaluations are optional and may be included as indicated by the pain specialist.
7. The Utah Medicaid Chronic Pain Referral Form is still required. The form may be downloaded from <http://www.health.utah.gov/medicaid/pdfs/Forms/ChronicPainForm.pdf> . The Chronic Pain Referral Form must be completed by the referring provider and faxed directly from the referring provider to the pain specialist.
8. There must be a primary care provider (PCP) involved and the PCP is to be the exclusive prescriber.
9. Willing Medicaid providers who are a board-certified pain specialist, physical therapist, or psychiatrist/psychologist and want to provide Chronic Pain Consultation(s), may call 801-538-6149 to be directed to the appropriate source for information on how to become an approved provider.
10. The current approved Utah Medicaid pain providers are:

Health Clinics of Utah  
 Attn: Joe Mason/Dr. R. Finnegan  
 3195 S. Main Street  
 Suite 200  
 Salt Lake City, UT 84115  
 Phone: 801-468-0354  
 Fax: 801-468-0353

Summit Pain Management  
 Attn: Dr. B. Urie/Dr. S. Lorden  
 5250 S. 320 W.  
 Suite 305  
 Murray, UT 84107  
 Phone: 801-262-7246  
 Fax: 801-262-3696  
 Toll Free: 1-866-366-7906

Interwest Pain Center  
 Dr. Vikas Garg  
 2380 N. 400 E.  
 Suite A  
 North Logan, UT 84341  
 Phone: 435-713-9681  
 Fax: 435-753-1201

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### 09 - 55 Providers of Targeted Case Management for the Homeless

The Utah Medicaid Provider Manual for Targeted Case Management for the Homeless has been revised to correct the limit on targeted case management services when a client is an inpatient. See Chapter 2-1, D.

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

In the updated manuals, pages which state, "Page Updated July 2009" 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 [merickson@utah.gov](mailto:merickson@utah.gov) .

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### 09 - 56 Estimated Acquisition Cost (EAC)

Due to budget shortfalls, there has been a required reduction in the Medicaid pharmacy drug EAC basis of reimbursement. Effective March 1, 2009, the EAC was reduced to Average Wholesale Price (AWP) minus 17%. This change in EAC will be restored to AWP minus 15% beginning July 1, 2009, for fiscal year 2010.

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### 09 - 57 Preferred Drug List Update

The 2009 State Legislature authorized Utah Medicaid to require a prior authorization for non-preferred drugs for clients on Traditional Medicaid, Non-Traditional Medicaid, and Primary Care Network. The PA requirement was effective May 18, 2009.

Authorization for non-preferred drugs (NPA) will be granted to clients who meet one of the following criteria:

- Trial and failure of at least one preferred agent in the class. Medicaid will require the name of the preferred product(s) tried, length of therapy and reason for discontinuation.
- Evidence of a potential drug interaction between current medication and the preferred product(s).
- Evidence of a condition or contraindication that prevents the use of the preferred product(s).
- Objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange.

The Medicaid Preferred Drug List continues to expand on a monthly basis. Medicaid is currently renegotiating PDL contracts for the 2009 calendar year, and negotiating new drug classes, including insulins, multiple sclerosis agents, urinary antispasmodics, fibric acid derivatives, niacin/statin combinations, skeletal muscle relaxants, alzheimer's cholinomimetics, migraine medications, nasal corticosteroids, osteoporosis agents, and antiparkinson agents. Please visit the Medicaid Pharmacy website at <http://health.utah.gov/medicaid/pharmacy> for up-to-date information and to download a list of current, contracted NDC's.

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## 09 - 58 P&T Committee Schedule

The P&T Committee meets on the third Thursday of the month in the Cannon Health Building at 7:00 A.M. The schedule of upcoming drug classes for review is as follows:

July 2009 - Hepatitis C Agents

August 2009 - Cephalosporins, third generation

September 2009 - Targeted Immunomodulators

October 2009 - Antihistamines, second generation

Important updates regarding the P&T Committee schedule are available on the Medicaid Pharmacy website at <http://health.utah.gov/medicaid/pharmacy>, or email Duane Parke at [dparke@utah.gov](mailto:dparke@utah.gov) for further information.

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## 09 - 59 Pharmacy Coverage Highlights

The following prior authorization requirements will go into effect:

- Requests for barbiturate-containing compounds for headache treatment will be reviewed for use on an individual basis beginning July 1, 2009.
- Chantix will require a prior authorization beginning July 15, 2009. Chantix will be available to clients age 18 and older for smoking cessation for a total of 24 weeks per calendar year.

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## 09 - 60 Medical Supplies List

### HCPCS Codes Opened

A4413 Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each  
 A4425 Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each  
 T4543 Disposable incontinence product, brief/diaper, bariatric, each

As part of an ongoing process to assure the provider manual accurately reflects open codes and to improve the logic of how they are listed, numerous codes have been added, removed, or moved to another location in the manual. If staff use a printed version, it is strongly recommended that the updated pages be replaced.

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## 09 - 61 Oral Maxillofacial Surgeon Services

CPT codes are expanded to allow provider type 95, oral surgeons, to submit claims for emergency department services. The codes impacted are 99281, 99282, 99283, 99284, and 99285.

Effective July 1, 2009, dental services are eliminated for all non-pregnant adults on Traditional Medicaid. Physician services, medical, and surgical services if performed by an oral surgeon will continue to be covered for all recipient age groups. See provider manual for appropriate CPT codes.

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**09 - 62 Dental Services**

Effective July 1, 2009, dental services are eliminated for all non-pregnant adults on Traditional Medicaid.

The Orthodontia section of the Dental Manual (1-14) has been corrected to read as follows:

Medicaid provides orthodontia services for Medicaid eligible children and pregnant women who have a handicapping malocclusion due to birth defects, accidents, or abnormal growth patterns of such severity that it renders them unable to masticate, digest, or benefit from their diet.

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**09 - 63 Home Health Services Expanded**

Effective July 1, 2009, physical therapy will be available through home health for non-pregnant adults with appropriate prior authorization.

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**09 - 64 Physical Therapy (Independent)**

Effective July 1, 2009, physical therapy will be reinstated as a benefit for non-pregnant adults. Annually, the first twenty visits, which include the evaluation, do not require prior authorization. All additional visits require prior authorization. Please refer to the Physical Therapy (Independent) Provider Manual for additional limitations and non-covered services.

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**09 - 65 Occupational Therapy (Independent)**

Effective July 1, 2009, occupational therapy will be reinstated as a benefit for non-pregnant adults. Annually, the first twenty visits, which include the evaluation, do not require prior authorization. All additional visits require prior authorization. Please refer to the Occupational Therapy (Independent) Provider Manual for additional limitations and non-covered services.

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**09 - 66 P.T. and O.T. in Rehabilitation Centers**

Effective July 1, 2009, physical therapy and occupational therapy in rehabilitation centers will be reinstated as a benefit for non-pregnant adults. Annually, the first twenty visits, which include the evaluation, do not require prior authorization. All additional visits require prior authorization. Please refer to the P.T. and O.T. in Rehabilitation Centers Provider Manual for additional limitations and non-covered services.

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**09 - 67 Non-Traditional Medicaid Clients to Receive P.T. and O.T. Services**

Effective July 1, 2009, physical therapy and occupational therapy benefits in the Non-Traditional Medicaid program will be restored to levels available before November 1, 2008, which include:

- Treatment and services provided by a licensed physical therapist or occupational therapist.
- No prior authorization requirement.
- A maximum of 10 visits per calendar year for any combination of physical therapy and occupational therapy visits.

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