

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 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 MHF
Box 143106, Salt Lake City UT 84114-3106

10 - 59 Statewide Provider Training

Utah Medicaid providers are invited to attend the 2010 Medicaid Statewide Provider Training Seminar. This year's session will include important information regarding hospital services (outpatient/inpatient), dental services, Medicare topics, 5010, ICD 10, client benefits, billing issues, PCN services, pharmacy services, vision services, and many other new items. Each session will run approximately 2 to 2.5 hours.

Providers are encouraged to submit suggestions for additional training. Submit your RSVP or suggestions for training topics to: medicaidops@utah.gov or telephone (801) 538-6485, 1-800-662-9651 "option 5", or (801) 538-6155 "option 5".

When leaving information, include your group, how many will be in attendance, contact name, and telephone number.

City	Date	Address	Time
Tooele	July 28	Tooele Health Dept 151 N. Main (Room 180) Tooele, Utah	9:00 AM
Ogden	July 29	Ogden Regional Medical 5475 S. 500 E. (Oak Room) Ogden, Utah	9:00 AM or 1:30 PM
Logan	Aug 3	Environmental Health Bldg 85 E. 1800 N. Logan, Utah	9:30 AM
American Fork	Aug 4	American Fork Hospital 170 N. 1100 E. Classroom 1 (West entrance) American Fork, Utah	9:00 AM
Montezuma Creek (Indian Health Providers Only)	Aug 10	Montezuma Creek East Highway 262 Montezuma Creek, Utah	10:00 AM
Monticello	Aug 11	San Juan Hospital 364 W. 100 N. Monticello, Utah	9:30 AM
Price	Aug 12	Southeastern Health Dept 28 S. 100 E. Price, Utah	9:00 AM
Salt Lake City	Aug 17	State Library 250 N. 1950 W. Salt Lake City, Utah	9:00 AM or 1:00 PM
Salt Lake City	Aug 18	South County DWS 5735 S. Redwood Road Salt Lake City, Utah	9:00 AM or 1:00 PM
Provo	Aug 24	Utah Valley Hospital 1134 N. 5 th West Clark Auditorium Provo, Utah	9:00 AM

Salt Lake - FQHC (FQHC Providers Only)	Aug 25	860 E. 4500 S. #206 SLC/Video Conference Salt Lake City, Utah	1:00 PM
Richfield	Sept 1	Sevier County EMS Building 50 W. 925 N. Richfield, Utah	1:00 PM
Fillmore	Sept 2	Fillmore Hospital 674 S. Hwy 99 Fillmore, Utah	9:30 AM
Nephi	Sept 2	Central Valley Medical Center 48 W. 1500 N. Nephi, Utah	1:30 PM
Heber	Sept 8	Heber Health Dept 55 S. 500 E. Conference Room B Heber, Utah	9:30 AM
Roosevelt	Sept 9	The Villa 200 N. 300 W. Roosevelt, Utah	9:30 AM
Panguitch	Sept 21	Garfield Memorial Hospital 200 N. 400 E. Conference Room, Admin Bldg Panguitch, Utah	1:00 PM
Cedar City	Sept 22	Iron Country School District 2077 W. Royal Hunte Drive Cedar City, Utah	9:00 AM
St. George	Sept 23	Dept of Workforce Services 162 N. 400 E. St. George, Utah	10:00 AM or 1:30 PM

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10 - 60 Federal Provider Audits

The Centers for Medicare & Medicaid Services (CMS) provider page (<http://www.cms.gov/PERM/>) was developed to help providers better understand the Payment Error Rate Measurement (PERM) process and what may be required during a PERM review. The provider FAQ contains answers to the questions that are most commonly asked by providers.

PERM providers should e-mail PERMProviders@cms.hhs.gov to inquire about upcoming PERM provider open forum calls in your state, education opportunities, or with any provider-specific questions. **The open forum call for Utah will be Wednesday, July 14, 2010.**

Also, as a provider, you may be part of a measurement or an audit separate from the PERM review. Additional information is available on the CMS website at <http://www.cms.gov/ProviderAudits>.

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10 - 61 Office of Internal Audit Services - Program Integrity Message

Request for Records

Letters requesting medical records for review by the Program Integrity staff are sent to the mailing address listed on the Medicaid provider file. If no mailing address is listed, the request will be sent to the service address. It is the responsibility of the provider to contact Medicaid Provider Enrollment with any changes or updates.

Letters requesting medical records for review by the Program Integrity staff may also be sent to the provider electronically utilizing a secure e-mail address. Electronic requests for records must be approved by the Office of Internal Audit Services.

Fax address changes to (801) 536-0471, or mail to: Medicaid Operations
Attn: Provider Enrollment
PO Box 143106
Salt Lake City, UT 84114

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10 - 62 Utah HIT Survey

Utah Medicaid is participating in the Medicaid Health Information Technology (HIT) Incentive Payment Program. This program is supported through the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), as part of the American Recovery and Reinvestment Act of 2009.

Federal requirements, for participation in this program, have urged Utah Medicaid to complete an "As-Is" assessment of all Medicaid-eligible providers and hospitals. A letter was sent to providers, May 19, 2010, requesting participation in an online survey. The survey is currently available and will need to be completed by July 20, 2010 (an extended deadline).

The survey is located at <http://www.surveymonkey.com/s/Utah-HIT-SURVEY>.

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10 - 63 Retroactive Authorization Policy

Please note the *General Information - Section I* and the *Physician Manual* will be updated July 1, 2010. The retroactive authorization section has been updated to clarify that for services in which multiple providers may be eligible for reimbursement, either the provider or the facility may submit the retroactive authorization request.

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10 - 64 Important Message for Pharmacy Claim Billing

Utah Medicaid will be changing the reject code, transaction response status, and additional message for duplicate and possible duplicate claims.

Beginning July 1, 2010, the NCPDP reject code '83 - Duplicate Paid/Captured Claim' will be returned on duplicate claims with a transaction response status of 'D'. The additional message field will contain 'Duplicate - Claim Not Paid'. Possible duplicate claims will return a claim status response of 'R' Reject, with an NCPDP reject code of '83 - Duplicate Paid/Captured Claim'. The additional message field will contain 'Possible Duplicate - Claim Not Paid'. Both claims will return the authorization number, pricing, and RX information of the paid claim.

A duplicate claim is defined as the same client, provider, drug code, date of service, and RX number. Utah Medicaid defines a possible duplicate claim as the same client, drug code and date of service.

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10 - 65 Pharmacy Coverage Highlights

Prior Authorization on Hold

The prior authorization announced for Sabril, in the April 2010 Medicaid Information Bulletin, will not be placed on prior until further notice.

Over the Counter (OTC) List Updates

Utah Medicaid has removed electrolyte solutions, such as Pedialyte and generic equivalents, from the covered OTC List. In cases of medical necessity, electrolytes for children may be requested on a case-by-case basis through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Zyrtec and Miralax have been added to the Medicaid OTC List.

Drugs on Prior Authorization, Effective July 1, 2010

Colcrlys:

Gout Criteria:

- Minimum age 18 years old.
- Documented failure on Allopurinol.
- Documented failure on or contraindication to corticosteroids and NSAIDs.
- Trail of non-branded colchicines.

Familial Mediterranean Fever Criteria:

- Minimum age 4 years old.
- Documented diagnosis of Familial Mediterranean Fever.

Uloric:

- Minimum age 18 years old.
- Documented failure, contraindication, or intolerance to Allopurinol.
- No concomitant use of Azathioprine, Mercaptopurine, or Theophylline.

Zovirax Ointment:

- One fill per lifetime will be granted upon request.
- Subsequent fills will be authorized with documented evidence of immunosuppression and mucocutaneous infection of herpes simplex.

DUR Board Actions Effective Immediately

The DUR Board has approved a quantity limit of five patches per month for the Synera patch. This will be enforced with computer edits.

The DUR Board has approved a maximum daily dose of 24mg on Suboxone, Subutex, and generics. The prior authorization on these drugs will remain in effect.

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10 - 66 Estimated Acquisition Cost (EAC)

Due to budget shortfalls, there has been a required reduction in the Medicaid pharmacy drug Estimated Acquisition Cost (EAC) basis of reimbursement. Effective July 1, 2010, the EAC will be reduced to Average Wholesale Price (AWP) minus 17.4%.

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10 - 67 Preferred Drug List Update

The Medicaid Preferred Drug List (PDL) continues to expand on a monthly basis. The Medicaid P&T Committee has recently considered low molecular weight heparin derivatives, newer anti-emetics, anti-cholinergic inhalers, and DPP-4 Inhibitors for diabetes. Final decisions for these drug classes will be posted on the Medicaid Pharmacy Program Website.

For more information, or to download a list of current NDC's on the Medicaid PDL, visit the Medicaid Pharmacy Website at <http://health.utah.gov/medicaid/pharmacy>.

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10 - 68 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 2010 - Prostaglandin Eye Drops and Alpha Adrenergic Eye Drops
August 2010 - Nasal Antihistamines and Ocular Antihistamines
September 2010 - Statins

Drug class reviews are now being handled by the Pharmacotherapy Outcomes Research Center at the University of Utah College of Pharmacy. Manufacturers who wish to submit materials for a drug class review should send to:

Gary M. Oderda, Pharm.D., M.P.H.
Professor and Director
Pharmacotherapy Outcomes Research Center
University of Utah College of Pharmacy
421 Wakara Way, Suite 208
Salt Lake City, UT 84108

Materials will need to be received 60 days prior to the P&T Committee meeting date.

Persons who wish to address the P&T Committee may contact Jennifer Zeleny at (801) 538-6339 at least seven days before the P&T Committee meeting to request time on the agenda. Comments from visitors, while welcome, may be limited due to time constraints.

For more information and important updates regarding the P&T Committee schedule, visit the Medicaid Pharmacy Services Website at <http://health.utah.gov/medicaid/pharmacy> or e-mail Jennifer Zeleny at jzeleny@utah.gov.

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10 - 69 Pharmacy Services Through IHS and Tribal 638 Programs

Pharmacy services provided at an Indian Health Service (IHS) facility or a Tribal 638 Program may be reimbursed by Utah Medicaid. The IHS or Tribe must follow the Medicaid requirements as set forth in the *Utah Medicaid Pharmacy Provider Manual*.

The *Pharmacy Provider Manual* has been updated to include a description of the IHS/Tribal 638 Program and the Utah Medicaid billing requirements. Chapter 7 has been added to the manual.

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10 - 70 Medical Supplies Policy - Wheelchairs

Utah Medicaid will send a letter to the medical supplier and the client for each authorized power wheelchair and customized wheelchair. The letter will inform the medical supplier and the client that a bill cannot be submitted until the subsequent evaluation is completed by the physical therapist or occupational therapist.

This follow-up evaluation is to train the client on how to use the power or customized wheelchair and to assure the client is receiving the properly authorized equipment. Providers are required to maintain appropriate documentation of services rendered and training provided.

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10 - 71 CPAP and Bi-PAP Policy Update

Effective July 1, 2010, criteria for CPAP (code E0601LL) and Bi-PAP (codes E0470LL and E0471RR) will follow InterQual criteria as found in Appendix 1 and Appendix 2 at the end of the *Medical Supplies Manual*.

Humidifiers (code E0562LL) will only be reimbursed in conjunction with Bi-PAP codes.

InterQual has compliance criteria that must be followed. Initial application prior authorizations will be given for four months. Ongoing prior authorization requests, for an additional eight months, will require submission of documentation showing the patient is meeting compliance criteria and showing symptom improvement.

Maintenance service will be prior authorized every six months upon receipt of documentation showing compliance. Adherence is met if the patient has used the device for at least four hours per night on 70 percent of the nights during the previous service period.

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10 - 72 Sleep Study Coverage

Effective July 1, 2010, Utah Medicaid will cover polysomnography (CPT codes 95810 and 95811) without prior authorization, with a limit of one of each procedure per client per 12 month period. When apnea is identified during a hospitalization, every attempt should be made to perform polysomnography prior to patient discharge from the hospital. When medically appropriate, polysomnography with CPAP trial (95811) must be performed initially if the anticipated treatment includes use of CPAP/Bi-PAP.

All prior authorization requests that exceed the allowable amount listed above will be subject to review by prior authorization staff using the UDOH Custom Criteria for polysomnography (*Criteria for Medical and Surgical Procedures*) and will require mandatory secondary review by the appropriate Utilization Review committee before prior authorization approval will be given.

In all cases, it is the responsibility of the provider to determine whether prior authorization has been approved before proceeding with the polysomnography.

Facility payment for the technical portion of the polysomnography is limited to a Utah Medicaid approved center having, at a minimum, oversight by a diplomat of the American Board of Sleep Medicine and a registered polysomnography technician.

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10 - 73 NPWT Criteria

Criteria for Negative Pressure Wound Therapy (NPWT) will be updated to remove the requirement that the wound vac has to be placed at the time of surgery or debridement and may be placed within 72 hours of surgery and debridement.

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10 - 74 Abortion, Hysterectomy, and Sterilization Forms

All Sterilization Consent Forms, Hysterectomy Acknowledgment Forms, and Abortion Acknowledgment and Certification Forms that are signed on or after August 1, 2010, must be submitted on the new, updated forms that are available on the Utah Medicaid Website at <http://health.utah.gov/medicaid/provhtml/forms.htm>.

1. **Sterilization Consent Form** - This form is required for all tubal ligations, vasectomies, and hysteroscopic tubal occlusion device procedures.

The Sterilization Consent Form is not required for procedures such as salpingo-oophorectomy and orchiectomy when performed for medical purposes.

2. **Hysterectomy Acknowledgment Form** - This form is required for all hysterectomies.
3. **Abortion Acknowledgment and Certification Form** - This form is required for all induced abortions.

Requests signed after August 1, 2010, will not be accepted on the previous forms. Only the new, updated forms will be accepted.

In all cases, it is the responsibility of the provider to determine whether a procedure requires prior authorization.

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10 - 75 Institutional Inpatient Crossover Claims

Inpatient crossover claims are occasionally affected by prior payments made on an outpatient claim submitted to Medicare for a Part B-only client. The following are instructions regarding how to bill claims to receive proper reimbursement:

- Provider must bill the outpatient services to Medicare first.
- If provider accepts assignments, the claim should crossover from Medicare to Medicaid Crossovers. If the claim does not crossover from Medicare, the provider can bill the outpatient charges through the crossover system to receive crossover reimbursement.
- Bill the inpatient claim to Medicaid or the appropriate Medicaid health plan listing all charges (including the outpatient charges already billed).

Report the third party payment information as listed below:

Rural Hospitals - Inpatient services to be paid fee-for-service by Medicaid:

- Take the inpatient total claim charge and subtract the outpatient total claim charge; enter this amount in the patient responsibility.
- Enter the actual money received on the outpatient claim from Medicare and Crossovers in the Third Party Payment (TPL) field.
- Take the inpatient total claim charge, subtract the amount in patient responsibility, subtract the amount in TPL, and report the balance as a contractual write-off.

Urban Hospitals - Inpatient services to be paid by Medicaid on a DRG include payment for the outpatient charges already paid by Medicare and Crossovers. Use the following billing process:

- Go to the Medicaid online DRG calculator at: <http://health.utah.gov/medicaid/stplan/inpatient.htm> and calculate the DRG reimbursement for the claim.
- Take the DRG reimbursement amount and subtract the total outpatient charges previously paid by Medicare and Crossovers. Enter this amount as patient responsibility.
- Enter the actual money received on the outpatient claim from Medicare and Crossovers in the Third Party Payment (TPL) field.
- Enter either a positive or negative contractual adjustment to make the claim balance for an electronic submission.

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10 - 76 Home Health Manual Updates

Home Health Aide Service

The *Home Health Manual* has been updated to permit Skilled Home Health Aide/Supportive Maintenance Home Health Aide (code T1021) to have an extended prior authorization period of 180 days. The 60-day prior authorization period will continue to be required for the initial authorization. The extended prior authorization period will be considered for reauthorization requests in which Medicaid has determined that the patient has a chronic condition and associated functional loss that are expected to last for at least one year.

It is important to note that although Medicaid prior authorization for T1021 may be granted for a 180-day period, per federal regulations, physician's orders and a written plan of care must be reviewed by the agency every 60 days. Agencies will be responsible for maintaining a record of the required 60-day reviews within the patient's home health record and shall be subject to post-payment review by Medicaid.

Outpatient Physical Therapy

Physical therapy prior authorization, item M, will now read:

A prior authorization is required for the physical therapy assessment (code S9131) which is used to determine whether a prior authorization will be given for home physical therapy, or if the patient should be able to receive the physical therapy assessment in the outpatient setting.

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10 - 77 Mental Health Centers

The *Utah Medicaid Provider Manual for Mental Health Centers* will be updated for July 1, 2010. The manual will contain many substantive changes and clarifications, including:

- In Chapter 2, some service definitions and provider qualifications have been clarified. In addition, some service limitations have been added or clarified;
- Documentation requirements for the psychotherapy services, pharmacologic management, and psychosocial rehabilitative services have been revised;
- In a new Section 1-12, information on billing or reporting multiple same-service contacts in a day has been added; and
- In Chapter 2, further elaboration regarding rounding rules for converting the time spent in a service to the number of billing units has been provided.

Due to numerous substantive changes through the manual, providers should review the updated manual in its entirety. The manual is available online at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

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10 - 78 Substance Abuse Treatment Services and Targeted Case Management Services for Individuals with Substance Abuse Disorders

The *Utah Medicaid Provider Manual for Substance Abuse Treatment Services* will be updated for July 1, 2010. The manual will contain many substantive changes and clarifications, including:

- In Chapter 2, some service definitions and provider qualifications have been clarified. In addition, some service limitations have been added or clarified;
- Documentation requirements for the psychotherapy services, pharmacologic management, and psychosocial rehabilitative services have been revised;
- In a new Section 1-11, information on billing or reporting multiple same-service contacts in a day has been added; and
- In Chapter 2, further elaboration regarding rounding rules for converting the time spent in a service to the number of billing units has been provided.

The *Utah Medicaid Provider Manual for Targeted Case Management for Substance Abuse* will be updated for July 1, 2010. The manual will contain many substantive changes and clarifications, including:

- In a new Section 4-6, an elaboration of client rights is provided;
- In Section 5-2, non-covered activities are clarified;
- In Section 5-3, limitations on reimbursable services are revised and updated;
- Also in Section 5-3, there are revisions to clarify team case management and when activities are covered as part of a substance abuse treatment service; and
- In Chapter 6, documentation requirements have been updated and information on rounding rules for converting the time spent in a day to the number of billing units is provided.

Due to numerous substantive changes through the manual, providers should review the updated manual in its entirety. The manual is available online at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

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10 - 79 Mental Health Centers - Providers of Targeted Case Management for the Chronically Mentally III

The *Utah Medicaid Provider Manual for Targeted Case Management for the Chronically Mentally III* will be updated for July 1, 2010. The manual will contain many substantive changes and clarifications, including:

- In Section 1-5, provider re-certification requirements are clarified;
- In Section 1-6, an elaboration of client rights is provided;
- In Section 2-3, non-covered activities are clarified;
- In Section 2-4, limitations on reimbursable services are revised and updated;
- Also in Section 2-4, there are revisions to clarify team case management and when activities are integral to the mental health service delivery; and
- In Chapter 3, documentation requirements have been updated and information on rounding rules for converting the time spent in a day to the number of billing or reporting units is provided.

Due to numerous substantive changes through the manual, providers should review the updated manual in its entirety. The manual is available online at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

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10 - 80 Psychology Services

The *Utah Medicaid Provider Manual for Targeted Case Management for Psychology Services* will be updated for July 1, 2010. The manual will contain many substantive changes and clarifications, including:

- In Section 1-1, General Policy, clarification of coverage of pain management evaluations has been added;
- In Section 1-2, Service Coverage and Limitations, clarification of individuals eligible for services under this program has been revised;
- In Section 1-5, Definitions, additional terms have been defined; and
- In Chapter 2, there have been changes in the service documentation requirements and additional information has been provided on the rounding rules for converting the time spent to the number of billing units.

Due to numerous substantive changes through the manual, providers should review the updated manual in its entirety. The manual is available online at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

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10 - 81 Department of Human Services (DHS) Mental Health Providers Serving Children in State Custody (Foster Care) and Subsidized Adoptive Children Exempted from the Prepaid Mental Health Plan for Outpatient Mental Health Care

The current *Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors* will be revised and reissued under a new name, effective July 1, 2010. The revised manual will be entitled, *Rehabilitative Mental Health Services for Children Under Authority of the Division of Child and Family Services or Division of Juvenile Justice Services*. The revised manual will contain many substantive changes and clarifications, including:

- In Chapter 2, some service definitions and provider qualifications have been clarified. In addition, some service limitations have been added or clarified;
- Documentation requirements for the psychotherapy services, pharmacologic management, and psychosocial rehabilitative services have been revised;
- In a new Section 1-12, information on billing multiple same-service contacts in a day has been added, and further elaboration regarding rounding rules for converting the time spent in a service to the number of billing units has been provided;
- The Sections 2-8, 2-9, and 2-10 in the current provider manual that describes mental health treatment provided in residential setting will be removed from the revised manual; and
- Effective July 1, 2010, bundled rates may no longer be billed. Providers must bill only the specific treatment services provided in accordance with Chapter 2.

Due to numerous substantive changes through the manual, providers must review the revised manual in its entirety to ensure accurate billing of services. The manual is available online at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

In addition, effective July 1, 2010, there will be two major changes affecting providers:

1. Enrollment as a Medicaid Provider

All providers who delivered services to children under authority of the Division of Child and Family Services or Division of Juvenile Justice Services prior to July 1, 2010, must re-enroll with Medicaid's Provider Enrollment, effective July 1, 2010. This is necessary as providers must bill Medicaid directly for services provided on or after this date.

Medicaid provider application forms and instructions are available on the Medicaid website at www.health.utah.gov/medicaid under 'Health Care Providers'.

To enroll as a Medicaid provider, providers must have a National Provider Identifier (NPI). There are two ways to apply for a NPI. To enroll online, visit <http://nppes.cms.hhs.gov> or to request a paper application, call 1-800-465-3203.

Medicaid and DHS have provided trainings to inform providers about enrolling with Medicaid. In these trainings, providers were instructed on how to enroll with Medicaid. There are special procedures that must be followed if providers need to be affiliated with a group (e.g., providers working for a group home or part of a counseling group, etc.). The group, and each provider affiliated with the group who is working under his or her license or certificate, must complete the Medicaid application/forms and submit all forms to Medicaid together.

Because it is critical that these group practices are enrolled with Medicaid correctly, please contact Merrila Erickson at (801) 538-6501 if you have any questions on completing or submitting the Medicaid provider application/forms.

Providers must submit completed Medicaid provider application forms directly to Merrila Erickson. Providers may mail or fax forms as follows:

Mail: Bureau of Managed Health Care
Attn: M. Erickson
PO Box 143108
Salt Lake City, UT 84114-3108

Fax: (801) 538-6099
Attn: M. Erickson

2. Changes in How Services are Billed to Medicaid

Effective July 1, 2010, all providers must bill Medicaid directly for all services provided to children in state custody (foster care) and children with adoption subsidy who are exempted from the Prepaid Mental Health Plan for outpatient mental health services.

If you do not have Internet access, or have questions on any of the information contained in this article, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

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10 - 82 Psychotherapy Codes

Attention: Physicians, Osteopaths, and Group Practices

Procedure codes 90847, 90849, and 90853 are currently reimbursed on a per encounter basis. Effective July 1, 2010, these codes will be reimbursed on a per-15 minute unit. Please adjust your claims submission appropriately.

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