

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 (801) 538-6155.

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- By FAX: (801) 536-0476
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## 11 - 01 Health Care Patient Identity Protection

Medical identity theft is increasing at an alarming rate. Medical identity theft occurs when a third party obtains health care services or generates fake invoices to receive insurance payment using an unsuspecting person's identity. In addition, some health insurance fraud involves the sharing of a valid medical identification card with someone other than the individuals covered by the health plan.

Utah has enacted guidelines beyond HIPAA and ARRA federal regulations with the intention of further protecting patient records. In its 2009 General Session, the Utah Legislature modified state law to read as follows:

### Utah Code Annotated Title 26, Chapter 21, Part 25 - Health Care Patient Identity Protection

(2)(a) In order to discourage identity theft and health insurance fraud, and to reduce the risk of medical errors caused by incorrect medical records, a medical facility or a health professional office shall request identification from an individual prior to providing in-patient or out-patient services to the individual.

(b) If the individual who will receive services from the medical facility or a health professional office lacks the legal capacity to consent to treatment, the medical facility or a health professional office shall request identification:

- (i) for the individual who lacks the legal capacity to consent to treatment; and
- (ii) from the individual who consents to treatment on behalf of the individual described in Subsection (2)(b)(i).

(3) A medical facility or a health professional office:

(a) that is subject to EMTALA:

- (i) may not refuse services to an individual on the basis that the individual did not provide identification when requested; and
- (ii) shall post notice in its emergency department that informs a patient of the patient's right to treatment for an emergency medical condition under EMTALA;

(b) may not be penalized for failing to ask for identification;

(c) is not subject to a private right of action for failing to ask for identification; and

(d) may document or confirm patient identity by:

- (i) photograph;
- (ii) fingerprinting;
- (iii) palm scan; or
- (iv) other reasonable means.

(4) The identification described in this section:

(a) is intended to be used for medical records purposes only; and

(b) shall be kept in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996.

The *Utah Medicaid Provider Manual Section I*, subsection 5-7, is modified to read:

### 5 - 7 Health Care Patient Identify Protection

A provider should ask patients for identification, such as picture identification, to assure the individual presenting the card is the same person on the Medicaid Identification Card. Medicaid is a benefit only to eligible persons. Possession of a Medicaid card does not ensure the person presenting the card is eligible for Medicaid.

(Utah Code Annotated, Title 26, Chapter 21, Part 25)

In addition, please note the following reminder provided at the beginning of subsection 5, "A Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient's eligibility EACH TIME and BEFORE services are rendered."

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**11 - 02 Utah Medicaid Newsletter**

Utah Medicaid providers are encouraged to join an e-mail list server to receive notices of program changes, announcements of MIBs, and other information. To subscribe to the Utah Medicaid Newsletter, send an e-mail to [medicaidops@utah.gov](mailto:medicaidops@utah.gov). You will receive confirmation of your subscription. You may unsubscribe at any time.

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**11 - 03 Discontinuation of Sending Certain Prior Authorization Letters by Mail**

Utah Medicaid currently sends providers notification of prior authorization decisions (both approvals and denials) via both facsimile and standard mail.

Beginning January 1, 2011, Utah Medicaid is discontinuing the practice of sending approval and denial notices to providers through standard mail. Providers will continue to receive these notifications via facsimile.

In addition, Utah Medicaid is discontinuing the practice of sending approval letters to Medicaid recipients through standard mail. Medicaid recipients will continue to receive denial notices through standard mail.

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**11 - 04 Criteria Menu on Medicaid Website**

Beginning January 1, 2011, the Utah Medicaid website will have a new feature that provides the Criteria for Medical and Surgical Procedures that are currently only available as an attachment to the Physician and Hospital provider manuals. Please see the Medicaid home page "Health Care Providers" section ([www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid)) and choose the option for "Criteria". There will be a drop-down menu that lists the current criteria for Individual Procedures and Imaging that are currently in the *Medical and Surgical Procedures List*, or have recently been removed from the manual and changed to unmodified InterQual criteria.

During the transition to using only InterQual SmartSheet formatting, the documents found in the drop-down menu will be a combination of InterQual Smartsheet formatting and the traditional formatting that Utah Medicaid has used in the past. Over the next year, Utah Medicaid anticipates all criteria, custom or unmodified InterQual, will be in the SmartSheet formatting and will be available in the new criteria drop-down menu.

Please remember that when Utah Medicaid changes criteria, an updated version of the criteria will be posted on the website, as well as in the provider manual; therefore, providers are encouraged to check the website and the Medicaid Information Bulletin regularly. Requests that are submitted with outdated criteria and/or outdated Prior Authorization Request Forms will not be considered complete, and will be returned to the provider without being processed.

Although the formatting of the InterQual SmartSheets will ultimately be more discernible and easily understood, there may be some initial confusion regarding how to interpret the rules and required documentation for each particular indication listed on the SmartSheets. For clarification on how to read and interpret the InterQual SmartSheets, please contact the Prior Authorization Unit by calling the Medicaid Information Line and following the prompts to Prior Authorization.

Please be aware, the SmartSheets are a guide to assist providers in understanding what critical documentation must be submitted with the prior authorization request form in order for the criteria to be met.

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## 11 - 05 Outpatient Hospital Reimbursement Methodology Update

Effective July 1, 2011, Utah Medicaid will be converting its outpatient reimbursement system to use the applicable Medicare reimbursement methodology. In the interim, Utah Medicaid will not be completing its state fiscal year 2011 planned conversion of outpatient hospital reimbursements to a fixed fee schedule payment system. (The fixed fee conversion was noted previously in the May 2010 Interim Medicaid Information Bulletin, article 10-56.) The July 1, 2010, fixed fee conversion already in place will continue until the new reimbursement system is implemented.

The Division is working very closely with the Utah Hospital Association, Utah hospitals, and other interested stakeholders during this conversion process. The methodology change is subject to approval of a State Plan Amendment by the Centers for Medicare and Medicaid Services (CMS).

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## 11 - 06 Physician Manual Updates

### Biophysical Fetal Profile Clarification

For reimbursement coverage, documentation of the components of biophysical fetal profile with scoring is required. The non-stress test and amniotic fluid index alone will not be accepted for payment of code 76818.

### Drug Screening Tests

CPT codes 80100 or 80101, used for drug screen testing, should be ordered to reflect only those drugs likely to be present based on the patient's medical history or current clinical presentation. Urine and serum tests which are for the same class are considered duplicative, and therefore, not covered. Medicaid considers drug screening for medico-legal purposes or employment purposes as not medically necessary. The medical necessity of completing additional tests beyond those of abuse must be well documented by the diagnoses submitted.

### Evaluation and Management

With the implementation of NCCI edits, payment issues are being identified which have not been identified in the past. Utah Medicaid providers should be aware that if they bill a hospital evaluation (admission or consultation) for a patient, then all subsequent evaluation and management services for that patient should be billed as an established patient.

For example, the provider bills code 99460 (Initial hospital newborn evaluation and management), and then two weeks later bills the code 99381 (Initial comprehensive preventive medicine visit). The code 99381 will be denied, because the patient is considered an established patient. The established patient code 99391 is the correct code to bill for payment.

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## 11 - 07 Procedures Removed from Manual Review

The following CPT codes have been removed from requiring manual review:

- 30460 Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate
- 33967 Insertion of intra-aortic balloon assist device, percutaneous
- 87800 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
- 93580 Percutaneous transcatheter closure of congenital interatrial communication (i.e. fontan fenestration, atrial septal defect) with implant
- 93650 Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement
- 93651 Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation
- 93652 Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia by ablation

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## 11 - 08 Criteria for Medical and Surgical Procedures Update

### Arthroscopy Criteria Update Effective November 16, 2010:

Arthroscopy, Diagnostic +/- Synovial Biopsy, Ankle  
 Arthroscopy, Diagnostic +/- Synovial Biopsy, Hip  
 Arthroscopy, Diagnostic +/- Synovial Biopsy, Shoulder  
 Arthroscopy, Diagnostic +/- Synovial Biopsy, Wrist  
 Arthroscopy, Surgical, Ankle  
 Arthroscopy, Surgical, Elbow  
 Arthroscopy, Surgical, Hip  
 Arthroscopy, Surgical, Shoulder  
 Arthroscopy, Surgical, Wrist  
 Arthroscopy, Temporomandibular Joint (TMJ)

### Criteria #2: Spine Criteria Update Effective November 16, 2010:

Fusion, Cervical Spine  
 Fusion, Lumbar Spine

### Criteria #22: Gastric Bypass Surgery for Obesity Effective January 1, 2011

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## 11 - 09 Medical and Surgical CPT Code List Updated

### Non-Covered

87797 Infectious agent detection, NOS, direct probe technique  
 96360 Intravenous infusion, hydration; initial 31 minutes to one hour

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## 11 - 10 Anesthesia Manual Update

The following section has been revised below:

### **Limitations:**

- B4.** Chronic pain management coverage and limitations for trigger point and epidural block injections are described in Section 2. Refer to the *Physician Provider Manual*.

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## 11 - 11 2011 Coding Updates

The ICD-9-CM diagnosis codes have been updated in the Inpatient and ER Diagnosis Lists for Medicaid and can be found at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid).

### **ICD-9-CM**

#### Covered Codes for ER Diagnosis:

488.01 Influenza due to identified avian influenza virus with pneumonia  
 488.11 Influenza due to identified novel H1N1 influenza virus with pneumonia  
 724.03 Spinal stenosis, lumbar region, with neurogenic claudication  
 780.33 Post traumatic seizures

- 780.66 Febrile nonhemolytic transfusion reaction
- 786.31 Acute idiopathic pulmonary hemorrhage in infants [AIPHI]
- 786.39 Other hemoptysis

Covered Codes for Inpatient Diagnosis:

- 488.01 Influenza due to identified avian influenza virus with pneumonia
- 488.11 Influenza due to identified novel H1N1 influenza virus with pneumonia
- 724.03 Spinal stenosis, lumbar region, with neurogenic claudication
- 786.31 Acute idiopathic pulmonary hemorrhage in infants [AIPHI]
- 786.39 Other hemoptysis

## January 2011 HCPCS – CPT Codes

Covered Codes:

- 11045 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each added 20 sq cm, or part thereof
- 11046 Debridement muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed) each added 20 sq cm, or part thereof
- 11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed) each added 20 sq cm, or part thereof
- 37220 Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- 37221 Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty with same vessel, when performed
- 37222 Revascularization, endovascular, open or percutaneous, iliac artery, each added ipsilateral iliac vessel; with transluminal angioplasty
- 37223 Revascularization, endovascular, open or percutaneous, iliac artery, each added ipsilateral iliac vessel; with transluminal stent (placement(s), includes angioplasty within same vessel, when performed
- 37224 Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty
- 37225 Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed
- 37226 Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- 37227 Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty with the same vessel, when performed
- 37228 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty
- 37229 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed
- 37230 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- 37231 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
- 37232 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each added vessel; with transluminal angioplasty
- 37233 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each added vessel; with atherectomy, includes angioplasty within the same vessel, when performed

- 37234 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each added vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- 37235 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each added vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
- 38900 Intraoperative identification (i.e. mapping) of sentinel lymphnode(s), includes injection of non-radioactive dye, with performed
- 43283 Laparoscopy, surgical, esophageal lengthening procedure (i.e. collis gastroplasty or wedge gastroplasty)
- 43338 Esophageal lengthening procedure (i.e. collis gastroplasty or wedge gastroplasty)
- 43753 Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (i.e. for gastrointestinal hemorrhage), including lavage if performed
- 43754 Gastric intubation and aspiration, diagnostic; single specimen (i.e. acid analysis)
- 43755 Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (i.e. histamine, insulin, pentagastrin, calcium, secretin), includes drug administration
- 43756 Duodenal intubation and aspiration, diagnostic; includes imaging guidance; single specimen (i.e. bile study for crystals or afferent loop culture)
- 43757 Duodenal intubation and aspiration, diagnostic; includes image guidance; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration
- 49327 Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (i.e. fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple
- 49412 Placement of interstitial device(s) for radiation therapy guidance (i.e. fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple
- 49418 Insertion of tunneled intraperitoneal catheter (i.e. dialysis, intraperitoneal chemotherapy instillation, management of ascites) complete procedure, including image guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous
- 57156 Insertion of vaginal radiation afterloading apparatus for clinical brachytherapy
- 61781 Stereotactic computer-assisted (navigational) procedure; cranial, intradural
- 61782 Stereotactic computer-assisted (navigational) procedure; cranial, extradural
- 61783 Stereotactic computer-assisted (navigational) procedure; spinal
- 64569 Revision or replacement of cranial nerve (i.e. vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
- 64570 Removal of cranial nerve (i.e. vagus nerve) neurostimulator electrode array and pulse generator
- 74176 Computed tomography, abdomen and pelvis; without contrast material
- 74177 Computed tomography, abdomen and pelvis; with contrast material
- 74178 Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast materia(s) and further sections in one or both body regions
- 76881 Ultrasound, extremity, nonvascular, real-time with image documentation, complete
- 76882 Ultrasound, extremity, nonvascular, real-time with image documentation, limited, anatomic specific
- 82930 Gastric acid analysis, includes Ph if performed each specimen
- 85598 Phospholipid neutralization; hexagonal phospholipid
- 88177 Cytopathology, evaluation of fine needle aspirate; immediately cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site
- 90460 Immunization administration through 18 years of age via any route of administration with counseling by physician or other qualified health care professional; first vaccine/toxoid component. Limited to the caravan service for administration of vaccines in the vaccines for children program.
- 90461 Immunization administration through 18 years of age via any route of administration with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component. Limited to the caravan

- service for administration of vaccines in the vaccines for children program.
- 90654 Influenza virus vaccine, split virus, preservative free, for intradermal use
- 90666 Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use
- 90667 Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use
- 90668 Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use
- 91013 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion during 2-dimensional data study (i.e. stimulant, acid or alkali perfusion)
- 92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
- 92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
- 92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
- 92227 Remote imaging for detection of retinal disease (i.e. retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
- 92228 Remote imaging for monitoring and management of active retinal disease (i.e. diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
- 93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed
- 93452 Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- 93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- 93454 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation
- 93455 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography
- 93456 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization
- 93457 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography and right catheterization
- 93458 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
- 93459 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) with bypass graft angiography
- 93460 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
- 93461 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) with bypass graft angiography
- 93462 Left heart catheterization by transseptal puncture through intact septum or by transapical puncture
- 93463 Pharmacologic agent administration (i.e. inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurement before, during, after and repeat pharmacologic agent administration, when performed

- 93464 Physiologic exercise study (i.e. bicycle or arm ergometry) including assessing hemodynamic measurements before and after
- 93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization
- 93564 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (i.e. aortocoronary saphenous vein, free radical artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (i.e. internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed
- 93565 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography
- 93566 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography
- 93567 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supraaortic aortography
- 93568 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography
- 96446 Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

Non-Covered Codes:

- 29914 Arthroscopy, hip, surgical; with femoroplasty (i.e. treatment of cam lesion)
- 29915 Arthroscopy, hip, surgical; with acetabuloplasty (i.e. treatment of pincer lesion)
- 29916 Arthroscopy, hip, surgical; with labral repair
- 31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (i.e. balloon dilation), transnasal or via canine fossa
- 31296 Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (i.e. balloon dilation)
- 31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (i.e. balloon dilation)
- 31634 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (i.e. fibrin glue), if performed
- 33620 Application of right and left pulmonary artery bands (i.e. hybrid approach stage 1)
- 33621 Transthoracic insertion of catheter for stent placement with catheter removal and closure (i.e. hybrid approach stage 1)
- 33622 Reconstruction of complex cardiac anomaly (i.e. single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (i.e. hybrid approach stage 2, Norwood bidirectional Glenn, pulmonary artery banding)
- 53860 Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence
- 64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
- 64611 Chemodenervation of parotid and submandibular salivary glands, bilateral
- 65778 Placement of amniotic membrane on the ocular surface for wound healing, self-retaining
- 65779 Placement of amniotic membrane on the ocular surface for wound healing, single layer, sutured
- 66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent
- 66175 Transluminal dilation of aqueous outflow canal; with retention of device or stent
- 80104 Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
- 83861 Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity
- 84112 Placenta alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative

- 86481 Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension
- 86902 Blood typing; antigen testing of donor blood using reagent serum, each antigen test
- 87501 Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype
- 87502 Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or subtypes, reverse transcription and amplified probe technique, first 2 types or sub-types
- 87503 Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or subtypes, multiple reverse transcription and amplified probe technique, each additional influenza virus type or sub-type beyond 2
- 87906 Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (i.e. integrase, fusion)
- 88120 Cytopathology, in situ hybridization (i.e. FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual
- 88121 Cytopathology, in situ hybridization (i.e. FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology
- 88363 Examination and selection of retrieved archival (i.e. previously diagnosed) tissue(s) for molecular analysis (i.e. Kras mutational analysis)
- 88749 Unlisted in vivo (i.e. transcutaneous) laboratory service
- 90664 Influenza virus vaccine, pandemic formulation, live, for intranasal use
- 90867 Therapeutic repetitive transcranial magnetic stimulation treatment; planning
- 90868 Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session
- 91117 Colon motility study, minimum 6 hours continuous recording (including provocation tests, (i.e. meal, intracolonic balloon distension), pharmacologic agents, if performed
- 95800 Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (i.e. by airflow or peripheral arterial tone), and sleep time
- 95801 Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (i.e. by airflow or peripheral arterial tone)
- 99224 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: problem focused interval history; problem focused examination; medical decision making that is straightforward or of low complexity
- 99225 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity
- 99226 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed; examination; medical decision making of high complexity

Codes Requiring Prior Authorization:

- 22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2  
Written PA .... ICD-9 CM: 81.00, 03.09, 80.51
- 22552 each additional interspace  
Written PA .... ICD-9 CM: 81.00, 03.09, 80.51
- 43327 Esophagogastric fundoplasty partial or complete; laparotomy  
Written PA .... ICD-9 CM: 44.66
- 43328 Esophagogastric fundoplasty partial or complete; thoracotomy  
Written PA.... ICD-9 CM: 44.66
- 43332 Repair, paraesophageal hiatal hernia (including fundoplication) via laparotomy, except neonatal; without implantation of mesh or other prosthesis

	Written PA....	ICD-9 CM:	53.72
43333	Repair, paraesophageal hiatal hernia (including fundoplication) via laparotomy, except neonatal; with implantation of mesh or other prosthesis		
	Written PA....	ICD-9 CM:	53.72
43334	Repair, paraesophageal hiatal hernia (including fundoplication) via thoracotomy, except neonatal; without implantation of mesh or other prosthesis		
	Written PA....	ICD-9 CM:	53.84
43335	Repair, paraesophageal hiatal hernia (including fundoplication) via thoracotomy, except neonatal; with implantation of mesh or other prosthesis		
	Written PA ....	ICD-9 CM:	53.84
43336	Repair paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis		
	Written PA ....	ICD-9 CM:	53.80
43337	Repair paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis incision, except neonatal; without implantation of mesh or other prosthesis		
	Written PA....	ICD-9 CM:	53.80
64568	Incision for implantation of cranial nerve (i.e. vagus nerve) neurostimulator electrode array and pulse generator		
	Written PA....	ICD-9 CM:	02.93, 86.96

Codes Not Covered for Assistant Surgeon:

11045	11046	11047	29914	29915	29916	31295	31296	31297	31634	33620	33621	33622
37220	37221	37222	37223	37224	37226	37227	37228	37229	37230	37231	37232	37233
37234	37235	37725	38900	43283	43338	43753	43754	43755	43756	43757	49327	49412
49418	53860	57156	61781	61782	61783	64566	64568	64569	64570	64611	65778	65779
66174	66175											

Post Operative Days - Zero days: (Codes in italics are file updates of existing codes)

20979	27095	31601	32604	36002	36680	36800	36810	38900	40806	43753	43754	43755
43756	43757	49418	54230	57156	66174							

Post Operative Days – 10 days:

10040	10060	10080	10120	10140	10160	11045	11200	12001	12002	12004	12011	12013
12020	12031	12032	12041	12051	15786	17000	17003	17004	17110	17111	17260	17261
17340	17360	20520	20665	20670	21076	21315	21355	21356	21920	22520	22521	22526
23700	24065	24200	24640	25065	26010	26011	27040	27086	27256	27257	27275	27323
27570	27605	27613	27860	28001	28002	28190	28630	28635	28636	28660	28665	28666
30000	30020	30110	30210	30300	30560	30999	31000	31002	31239	31290	31291	31292
31293	31294	31295	31296	31297	31634	33621	36470	36471	36570	36571	36576	36578
36581	36582	36583	36585	36589	36590	36823	36832	37220	37221	37222	37223	37224
37226	37227	37228	37229	37230	37231	37232	37233	37234	37235	37725	40800	40804

41000	41005	41115	41250	41251	41252	41800	41805	41822	41826	41828	41830	42000
42300	42310	42320	42700	43273	44970	45915	46030	46050	46080	46220	46320	46500
46706	46900	46910	46916	46917	46922	46924	46937	46940	46942	47562	48400	48511
49021	49327	49412	51710	51715	53860	54050	54160	54200	55706	57061	57513	57520
57522	58120	58345	58350	58562	58611	58800	59151	59812	59820	59821	59870	60000
61781	61782	61783	62264	62280	62281	62282	62298	62361	62362	62365	64566	64569
64570	64611	65135	65270	65420	65778	65779	66020	66030	66175	66220	66500	66985
66999	67030	67299	67413	67515	67700	67710	67715	67840	67850	68135	68371	68440
68801	68810	68811	68815	68840	69020	69420	69421	69433				

Post Operative Days – 42 days:

11046	11047	22551	22552	29914	29915	29916	33620	33622	43280	43283	43327	43328
43332	43333	43334	43335	43336	43337	43338	46999	58262	64568	66983	66984	67399
67400	67405	67880	67901	67902	67903	67904	67906	67908	67909	67911	67914	67917
67950	67961	67999	68130	68330	68340	68399	68700	68899	69300	69399		

For all of the above lists, please see the attachments section of the *Physician and Anesthesiology Provider Manual* at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid).

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## 11 - 12 Psychiatric Inpatient Admission

Inpatient psychiatric admissions in areas outside of the contracted mental health program require prior authorization through Medicaid. The HCPCS code G0379, direct admission of patient for hospital observation (Psychiatric Inpatient), will be the code used by the nurse to link the hospital psychiatric inpatient acute admission to the prior authorization.

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**11 - 13 Attention: Mental Health Centers, Substance Abuse Agencies, and Psychologists**

Under Section 6507 of the Affordable Care Act, all states must incorporate and activate all edits contained in CMS' National Correct Coding Initiative (NCCI). This will be required for all Medicaid claims with dates of service on or after October 1, 2010, and for claims which are submitted on or after April 1, 2011.

Because the NCCI will affect the way fee-for-service claims are edited, all fee-for-service claims submitted on or after April 1, 2011, regardless of date of service, must include the servicing provider's National Provider Identifier (NPI) on the line level of the claim so that claims are not incorrectly denied. Only one servicing provider NPI is allowed per claim.

If psychologists are not in a group or agency, but are enrolled with Medicaid as an independent provider, the psychologist only needs to report the NPI on the claim level.

If providers need to obtain NPIs, visit: <http://nppes.cms.hhs.gov> or call 1-800-464-3203.

NCCI edits define when two procedure codes, when provided by the same servicing provider on the same day, may not be reported together, except when allowed by NCCI. Therefore, to ensure the NCCI editing is applied correctly, the servicing provider's NPI on the line level (in addition to the agency NPI on the claim level) is critical.

Please note: For many of the CPT code combinations, NCCI editing allows providers to use a modifier to indicate the two services provided on the same date by the same servicing provider were two separate and distinct procedures.

For information on the NCCI, providers may go to the CMS website at: <http://www.cms.gov/> and click on the 'Medicaid' tab. On the Medicaid page, click on 'NCCI and MUE Edits' and under 'Downloads', click on 'Medicaid NCCI Edits for Practitioner Services.' You will be required to respond to the Disclaimer page, then you may open the document that contains the CPT code combinations. CMS may replace this list quarterly; therefore, providers will be responsible to review the file quarterly.

On the Medicaid page, please also see the "Medicare Modifier 59 Article" that explains when the 59 modifier may be used on a claim to indicate that the services in the code combination were separate and distinct services. Next to each CPT code combination in the 'Medicaid NCCI Edits for Practitioner Services' list, it is specified whether a modifier may be used when the services are provided by the same servicing provider. When the same servicing provider has provided the two services, the modifier is allowed, and the claim contains the modifier, then both services may be reimbursed.

Over the next few months, Utah Medicaid Provider Enrollment staff will also begin working with providers to enroll the servicing providers and affiliate them with their agency. In general and currently, only the agency is the enrolled Medicaid provider.

If you have questions, contact Merrila Erickson at (801) 538-6501 or e-mail at [merickson@utah.gov](mailto:merickson@utah.gov).

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**11 - 14 Attention: Mental Health Centers**

The Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Mental Health Centers*, has been updated as follows:

- In Chapter 1-5, qualifications regarding who can prescribe rehabilitative services and who can render services have been corrected and clarified. See Chapter 1-5, A. 2. b. and c., and Chapter 1-5, B. 2. d. and e.
- In Chapter 1-5, A. 3. and B. 3., who may supervise individuals exempted from licensure has been clarified.
- Based on these changes, the 'Who' section of Chapters 2-2, 2-5, 2-6, 2-7 and 2-8 has also been revised.
- In Chapter 2-7, under the 'Record' section, #7, clarification has been provided regarding documentation requirements.
- In Chapter 2-10, under the 'Who' section, the providers who may perform this service have been clarified, and the provider list has been rearranged.

Providers may access the current and revised manual at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid). If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or e-mail at [merickson@utah.gov](mailto:merickson@utah.gov).

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**11 - 15 Attention: Mental Health Centers - Providers of Targeted Case Management for the Chronically Mentally Ill**

The Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Targeted Case Management for the Chronically Mentally Ill*, has been updated as follows:

- In Chapter 1-4, the list of qualified providers has been revised to clarify qualifications regarding who can render services and supervision requirements.

Providers may access the current and revised manual at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid). If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or e-mail at [merickson@utah.gov](mailto:merickson@utah.gov).

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**11 - 16 Attention: Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse Providers**

The Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse*, has been updated as follows:

- In Chapter 1-5, qualifications regarding who can prescribe rehabilitative services and who can render services have been corrected and clarified. See Chapter 1-5, A. 2. b. and c., and Chapter 1-5, B. 2. f. and g.
- In Chapter 1-5, A. 3. and B. 3., who may supervise individuals exempted from licensure has been clarified.
- Based on these changes, the 'Who' section of Chapters 2-2, 2-5, 2-6, 2-7 and 2-8 has also been revised.
- In Chapter 2-7, under the 'Record' section, #7, clarification has been provided regarding documentation requirements.
- In Chapter 2-10, under the 'Who' section, the providers who may perform this service have been clarified, and the provider list has been rearranged.
- In Chapter 4-5, the list of qualified providers has been revised to correlate with the way providers are listed in Chapter 1-5.

Providers may access the current and revised manual at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid). If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or e-mail at [merickson@utah.gov](mailto:merickson@utah.gov).

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**11 - 17 Attention: 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 Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Rehabilitative Mental Health Services for Children Under Authority of the Division of Child and Family Services or Division of Juvenile Justice Services*, has been updated as follows:

- In Chapter 1-4, qualifications regarding who can prescribe rehabilitative services and who can render services have been corrected and clarified. See Chapter 1-5, A. 2. b. and c., and Chapter 1-5, B. 2. f. and g.
- In Chapter 1-4, A. 3. and B. 3., who may supervise individuals exempted from licensure has been clarified.
- Based on these changes, the 'Who' section of Chapters 2-2, 2-5, 2-6, 2-7 and 2-8 has also been revised.
- In Chapter 2-7, under the 'Record' section, #7, clarification has been provided regarding documentation requirements.
- In Chapter 2-9, under the 'Who' section, the providers who may perform this service have been clarified, and the provider list has been rearranged.

Providers may access the current and revised manual at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid). If you do not have Internet access, or have questions, contact Merrila Erickson at (801) 538-6501 or e-mail at [merickson@utah.gov](mailto:merickson@utah.gov).

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## 11 - 18 Licensed Home Health Services

Under the **State Plan Benefit**, provider type 54 is authorized to bill the following HCPCS codes:

- T1001 Nursing assessment/evaluation
- T1019 Personal care services
- T1021 Home health aide or certified nurse assistant, per visit

Under the **Home and Community-Based Waiver Services Programs**, provider type 54 is authorized to bill the following HCPCS codes\*:

- H0034 Medication training and support, per 15 minutes
- H0038 Self-help/peer services, per 15 minutes
- H2010 Comprehensive medication services, per 15 minutes
- S5115 Home care training, non-family; per 15 minutes
- S5120 Chore services; per 15 minutes
- S5125 Attendant care services; per 15 minutes
- S5126 Attendant care services; per diem
- S5130 Homemaker service, NOS; per 15 minutes (AW hour)
- S5135 Companion care, adult; per 15 minutes
- S5150 Unskilled respite care, not hospice; per 15 minutes (AW hour)
- S5151 Unskilled respite care, not hospice; per diem
- S5185 Medication reminder service; per month
- T1005 Respite care services, up to 15 minutes (hour)
- T1019 Personal care services; per 15 minutes, outpatient, (hour)
- T1021 Home health aide or certified nurse assistant, per visit
- T2017 Habilitation, residential, waiver; per hour

\* Providers are only authorized to bill for Home and Community-Based Waiver Services that are listed on the recipient's approved care plan.

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## 11 - 19 Home Health Manual Updated

The *Home Health Manual* will be updated to follow Utah Medicaid's current practice in regards to prior authorization. The sections will show written (W) request, except for the initial request which will show written or telephone prior authorization.

### Code T1003

Criteria Section: Prefill oral meds. Added see limitations "s"

Deleted simple dressings statement

**Code G0154**

Criteria Section: Prefill oral meds. Added see limitations "s"

Deleted simple dressings statement

Descriptor Section; Dressing changes: Added the word "complex" to wound care may be ordered BID. To the criteria section with this descriptor, added see limitations "P" to the current section.

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**11 - 20 Pharmacy Coverage Highlights**

The following drugs will require prior authorization effective January 1, 2011, under the following criteria:

**Forteo**

- Available for the following diagnoses at high risk for bone fracture:
  - Postmenopausal women diagnosed with osteoporosis.
  - Women and men diagnosed with osteoporosis likely caused by systemic glucocorticoid therapy.
  - Men diagnosed with osteoporosis (primary or hypogonadal).
- Quantity limit of one injector every 28 days.
- Prior authorization period is for 24 months with no renewal option.

**Xolair**

- Minimum age requirement: 12 years old.
- The patient must have tried all other therapies for a time period generously adequate (at least 4 months) to establish indisputable failure of each.
- The request must include the following information:
  - Documentation of all failed therapies tried, and reason for requesting Xolair.
  - Include the desired starting dose of Xolair in the request.
  - Include the patient's baseline IgE value and weight in the written request.
- The patient must have regular appointments to receive the medication in the prescriber's office.
- The patient must remain in the office for a minimum of 90 minutes to allow for observation and treatment of anaphylaxis, if necessary.
- If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase.
- Initial authorization is for 6 months; renewal is given by telephone request from the prescriber's office.

**Additional DUR Board Activity:**

Cambria payment will be limited to nine packets per month.

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## 11 - 21 Reorganization of the Pharmacy Prior Authorization Manual and Injectable Medications List

The *Drug Criteria and Limits* attachment to the *Pharmacy Manual* will no longer contain the prior authorization criteria for physician-administered drugs that are billed as a medical benefit. These criteria will now be available in the *Injectable Medications List* attachment to the *Physician and Anesthesiology Manual*.

Additionally, some of the criteria have been re-alphabetized by drug name instead of disease state in the *Drug Criteria and Limits* attachment. This did not change the prior authorization criteria, but should make the manual more user-friendly.

The following drug limits, or prior authorization criteria, were clarified or amended:

- Mutual exclusivity of long-acting narcotics was restated for clarity.
- Butalbital containing products were removed from the manual, as these products were removed from coverage in the July 2009 MIB.
- 5HT3 Anti-Emetics were removed from clinical PA and placed on the Preferred Drug List (PDL).
- Botulinum Toxin criteria were changed to reflect all available Botulinum Toxins, and the new FDA-approved indications.
- Low Molecular Weight Heparin derivatives were changed to reflect clinical PA criteria for Non-Traditional Medicaid clients. Traditional Medicaid clients will be subject to PDL requirements.
- PPI criteria were amended to reflect the PDL policy.
- Provigil and Nuvigil criteria were clarified to reflect that these two agents are mutually exclusive.

The following criteria from the *Injectable Medications List* attachment were removed:

- Rotashield - This medication is currently available through Vaccines For Children (VFC), and is no longer managed or paid by Medicaid.
- Botulinum Toxins - These medications do not require prior authorization when billed by a HCPCS code as a physician-administered drug. However, Medicaid will monitor utilization of these drugs and reconsider placing a prior authorization requirement if inappropriate utilization becomes an issue.

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## 11 - 22 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 newer antihistamines, fluoroquinolones, and antiplatelet agents. For more information, or to download a list of current NDC's on the Medicaid PDL, visit the Utah Medicaid Pharmacy Services website at <http://health.utah.gov/medicaid/pharmacy>.

All contracts with manufacturers are based on a calendar year. Where possible, contracts are rolled over beginning January 1 of each year. However, the manufacturer bids vary from year to year. Changes for some existing PDL drug classes may appear in early January. Be sure to check the Utah Medicaid Pharmacy Services website to stay on top of these changes at <http://health.utah.gov/medicaid/pharmacy>.

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## 11 - 23 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 current schedule of upcoming drug classes for review are as follows:

January 2011 - Hormonal contraceptives and topical immunomodulators

February 2011 - Topical estrogens

March 2011 - Estrogen hormonal replacement

For more information and important updates regarding the P&T Committee schedule, visit the Utah Medicaid Pharmacy Services website at <http://health.utah.gov/medicaid/pharmacy>, or e-mail Lisa Hulbert at [lhulbert@utah.gov](mailto:lhulbert@utah.gov).

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## 11 - 24 Laboratory Manual Update

### Drug Screening Tests

CPT codes 80100 or 80101, used for drug testing, require submission of the laboratory results of all drug classes tested. Urine and serum tests which are for the same class are considered duplicative, and therefore, not reimbursed. The medical necessity of completing additional tests beyond those of abuse must be well documented by the diagnoses submitted.

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## 11 - 25 Professional Providers of Radiology and Laboratory Services

With the implementation of the National Correct Coding Initiative (NCCI), claims that have resulted in payment in the past will now require greater attention to appropriate modifiers and the billing of multiple procedures on individual lines.

**Modifier 26 - Professional Component:** When a physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure code.

**Modifier 76 - Repeat Procedure or Service by Same Physician:** It may be necessary to indicate that a procedure was repeated subsequent to the original procedure. This circumstance may be reported by adding modifier 76 to the repeated procedure. The medical necessity of repeat procedures must be documented and may be reported by adding modifier 76 to the repeated procedure. The following examples support medical necessity:

Example 1: X-ray may be completed prior to treatment of a fracture or dislocation and another may be required after reduction of the fracture to confirm correct alignment.

Example 2: A second non-stress test or ultrasound reading and interpretation for a twin.

**Modifier 77 - Repeat Procedure by Another Physician:** The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure.

- Repeat procedures must be identified with modifiers 76 or 77 as appropriate to indicate that the procedure was done a second time at a different episode on the same day. The procedure must meet the requirements for medical necessity. (For example: A chest film is repeated, because the patient condition has changed or is required to evaluate the placement of a line, endotracheal tube, or g-tube in a neonate.)

- Modifiers 76 or 77 should not be used to report multiple interpretations by the same or different physicians or other health care professionals for the same EKG or x-ray procedure for quality control purposes. However, when the second interpretation of the same procedure shows a different finding that alters/contributes to the diagnosis and treatment of the patient, use of modifier 76 or 77 is appropriate.

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## 11 - 26 Outpatient Providers of Radiology and Laboratory Services

With the implementation of the National Correct Coding Initiative (NCCI), it is important that claims submitted with the 59 modifier can be supported by the following documentation:

- A procedure or service that was distinct or independent from other services performed on the same day.
- Procedures/services that are not normally reported together.
- Mutually exclusive or “separate procedures” as appropriate under the circumstances.

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## 11 - 27 Audiology Provider Update

New Audiology HCPCS code Non-Covered:

L8693 Auditory Osseointegrated device abutment, any length, replacement only

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## 11 - 28 Dental Provider Updates

Minor modifications have been made to the *Utah Medicaid Dental Services Provider Manual*. No changes have been made to the status of codes or criteria unless noted below.

Section 1-14, Orthodontia: Manual changed to correct status of pregnant women receiving this service. Policy now reads as follows:

Medicaid provides orthodontia services for children 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.

Medicaid provides orthodontia services for pregnant women who have a handicapping malocclusion as a result of a recent accident or disease, of such severity that they are unable to masticate, digest, or benefit from their diet.

The following new Dental HCPCS codes are Non-Covered:

D1352  
D3354  
D5992  
D5993  
D6254  
D6795  
D7251  
D7295

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**11 - 29 Dental Benefit**

Policy allows only two prophylaxis treatments (code D1110 or D1120) per eligible Medicaid recipient, per calendar year.

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**11 - 30 Medical Transportation Clarification**

The *Utah Medicaid Medical Transportation Manual* has been updated to clarify taxi services. Clients are required to use the Medicaid contractor for non-emergency transportation as outlined in the 1914 (b) Waiver. The current contract holder is PickMeUp Services. PickMeUp Services can be contacted at 1-888-822-1048.

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**11 - 31 Medical Supplies New HCPCS Codes**Non-covered Codes

A4566  
A9273  
E0446  
E1831  
L3674  
L4631  
L5961

Covered Codes

A7020  
E2622  
E2623  
E2624  
E2625

Discontinued Codes

K0734  
K0735  
K0736  
K0737  
L3670  
L3675

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## 11 - 32 Medical Supplies Manual Updates

Clarification language for Section 2-7, Oxygen and Related Respiratory Equipment.

Clarification language for Section 6, Retroactive Authorization for Medical Supplies.

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## 11 - 33 Medical Supplies List Updates

Various modifications have been made to the *Medical Supplies List* attachment to correct minor errors. Please review the current attachment to the *Medicaid Supplies Manual* on the Medicaid website to assure the information you are using is current and accurate. The attachment can be found at: [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid).

Unless otherwise indicated, changes are effective January 1, 2011.

**Wheelchairs:** Codes which previously listed an age limit have had that restriction removed. Requests for a wheelchair base and accessories should be requested based on the size of the individual client and appropriateness based on the medical needs.

**Diapers:** Codes which previously listed an age limit have had that restriction removed. Requests for diapers should be based on the size of the individual client. Other criteria and limits remain the same.

**Code A4565:** Sling; will allow one per month.

**Code A4310:** Correction to code description.

**Codes A4351, A4352, A4353:** Changes made to units allowed.

**Codes E0791, E0781:** Change to criteria and instruction.

**Code E1399:** DME providers have been substituting code E1399 for codes E0637 (combination sit to stand system, any size, with set lift feature, with or without wheels) and E0638 (standing frame system, any size, with or without wheels). Effective January 1, 2011, code E1399 will no longer be accepted for any type of stander.

In addition, two stander codes will be added; **E0641** (standing frame system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels) and **E0642** (standing frame system, mobile (dynamic stander), any size including pediatric). These codes will require prior authorization and will be limited to EPSDT-eligible children only. Providers submitting requests for these items will have to provide documentation to support the medical necessity guidelines for Medicaid, or the request will be denied.

**Code E0562:** Heated humidifier will be allowed as a separate code with C-PAP devices. The code will continue to be a capped rental.

**Code A7030:** Full face mask used with positive airway pressure device will allow two per year.

**Codes A7039, E0445, E0470, E0562, E0691:** Change in limits.

**Codes E2601, E2602, E2603, E2604, E2605, E2606, E2607, E2608, E2611, E2612, E2613, E2614, E2615, E2616, E2619, E2620, E2621, E2622, E2623, E2624, E2625** are all codes for wheelchair cushions and wheelchair backs. Criteria for these items will now follow InterQual requirements. The criteria will be accessible on the Medicaid website. Select the *Medical Supplies Manual*, then "Attachments", and then the appropriate appendix from the list.

**Code K0005:** Prior authorization will be required when this chair is being purchased.

**Codes E1399, K0739, K0740, L4205, L4210:** Change in comments/limits.

**Code S1040:** Cranial remodeling orthosis, rigid with or without soft interface criteria will be InterQual. The criteria will be accessible on the Medicaid website. Select the *Medical Supplies Manual*, then "Attachments", and then the appropriate appendix from the list.

**Prosthetic Codes:** The following prosthetic codes have had modifications made to criteria. Comments and/or limits can be found in the provider manual:

L5000 L5666 L5668 L5673 L5679 L5681 L5683 L5685 L6660 L6675 L7500 L7510 L7520 L8400  
L8410 L8420 L8430 L8435 L8440 L8460 L8470 L8480 L8485

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