

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

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### Medicaid Information

- S Salt Lake City area, call (801) 538-6155.
- S In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- S From other states, call (801) 538-6155.

### Requesting a Medicaid publication?

Send a Publication Request Form:

- By FAX: (801) 536-0476
- By mail to: Division of MHF  
Box 143106, Salt Lake City UT 84114-3106

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## 11 - 83 Medicaid Medical Director Message

Dear Fellow Clinicians,

On behalf of the many dedicated employees in Utah's Medicaid Program, I wish to express my personal appreciation for the efforts and hours you dedicate to your patients, who are covered by Medicaid. Together we are serving our fellow citizens of Utah with particular health care needs during difficult times.

Medicaid can only realize success with your partnership in caring for Utah's most vulnerable populations. You make the tough decisions, stay up late, strive to do your best, and demonstrate the compassion inherent in our shared profession of the healing arts. For this, I thank you.

If I can be of any assistance to you in any way, please feel free to contact me.

Joseph Cramer, MD FAAP  
Medicaid Medical Director  
[JGCRAMER@utah.gov](mailto:JGCRAMER@utah.gov)  
(801) 538-6316

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## 11 - 84 HIPAA Version 5010 Implementation

Beginning October 2011, Utah Medicaid will accept and create the X12 5010 standards for HIPAA electronic health care transactions in batch mode. This includes claims, eligibility inquiries, claim status, and other administrative transactions.

Electronic Data Interchange (EDI) responses will match to the transaction standard format that is submitted, except for the 835 (Claim Payment/Advice or Remittance Advice). Prior to the implementation date of January 1, 2012, Medicaid's system will generate X12 4010 835s unless a provider updates their EDI enrollment at <https://mmcs.health.utah.gov/hcferoll2/index.jsp>, and changes the 835 format preference to X12 5010 standard format.

### **Testing**

Utah Health Information Network (UHIN) is offering acceptance testing to its members. Medicaid strongly encourages providers to work with UHIN for initial testing. Contact UHIN at (877) 693-3071 to coordinate 5010 acceptance testing before you commence testing with Medicaid.

Medicaid will do provider testing with a select group of providers. However, the majority of providers will test in production after UHIN acceptance testing. Providers should transmit 5010 files to the production mailboxes: HT000004-001 for fee-for-service and HT000004-005 for crossover claims. The Medicaid EDI team can be contacted at (801) 538-6155 or toll-free 1-800-662-9651, options 3 and 5, regarding any testing issues. Once providers feel their testing is successful, the X12 4010 standard format can be discontinued (this may occur prior to January 1, 2012).

Testing for real-time transactions (270/271, 276/277 & 278, 999) is scheduled for the first quarter of 2012. We will invite providers and billers who have completed UHIN's acceptance testing to participate with Medicaid testing.

### **Remittance Advice Updates (835)**

Medicaid's recoupment of overpayments will be changing. Currently, claims are held against a credit balance until the claims submitted cover the balance owed. Beginning January 1, 2012, Medicaid will utilize the PLB segment of the 835 to report balance forward and current balance owed. Claims payment information will be released against the forward balance in the 835. Negative amounts in this segment are payments, and positive amounts are take backs.

Gross adjustments or provider-level adjustments/payments are currently reported in the PLB segment. Medicaid will utilize more of the PLB qualifiers to better define the type of lump sum adjustment/payment being made. Please ensure that your reports generated from the 835 show the PLB adjustments and reasons.

The allowed amount segment was removed from the 835. Medicaid will continue to report patient responsibility and third party liability (TPL) at the claim level.

With the implementation of the 5010 version of the 835, Medicaid will return the service provider NPI in addition to the billing provider NPI of the group practice.

### **Medicaid Online (BlueZone)**

With the implementation of real-time transactions in early 2012, Medicaid Online (HLRP access through BlueZone) will be eliminated. Providers using Medicaid Online need to check with their system programmers to assure they are able to utilize the 270/271 (eligibility) and 276/277 (claim status) transactions.

### **Notifications**

To receive Medicaid notices of program changes, announcements of MIBs, 5010 status updates and other information, sign up for the Utah Medicaid Newsletter email list serve at [medicaidops@utah.gov](mailto:medicaidops@utah.gov). You may also sign up to receive the UHIN Alerts Newsletter at <http://www.uhin.org/pages/membership/newsletter-alerts.php> for notification and payer's availability.

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## **11 - 85 EHR Incentive Program**

On April 4, 2011, the Utah Department of Health, Division of Medicaid and Health Financing, received a conditional approval from CMS regarding the State Medicaid Health Information Technology Plan (SMHP). This allows Utah to make Electronic Health Record (EHR) incentive payments to eligible Medicaid providers and hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Results of a recent 2010 Utah Medicaid HIT Survey indicate that 44.2% of respondents plan to apply for EHR provider incentives.

Preliminary registration at the CMS level is required and now open. Resources to assist you in eligibility determination and registration are available on the Medicare and Medicaid EHR Incentive Programs website at: <http://www.cms.gov/ehrincentiveprograms/>.

Information is available regarding the Utah Medicaid EHR Incentive Program at: <http://www.health.utah.gov/medicaid/provhtml/HIT.htm>. Utah registration will open October 3, 2011, with access to step-by-step instructions.

For questions or concerns, please call the HIT/EHR Hotline at (801) 538-6929, or send an email to: [EHRIncentive@utah.gov](mailto:EHRIncentive@utah.gov).

This is an invitation to get started!

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## 11 - 86 Medicaid Overpayments

Overpayments can be identified by either the provider or Utah Medicaid.

### Provider Identified

There are multiple ways to return an overpayment:

1. REPLACEMENT CLAIM
  - a. Requires TCN of the claim to be replaced (see instructions in July 2006 MIB, article 06-68).
  - b. The Medicaid system will void all charges on the original claim and process the replacement claim as a new original.
  - c. The recoupment of the overpayment will occur on the remittance statement out of future payments.
2. CUSTOMER SERVICE REPROCESS
  - a. Call customer service to reprocess the claim. The representative will void the original and submit a corrected claim through the system.
  - b. The recoupment of the overpayment will occur on the remittance statement out of future payments.
3. CHECK
  - a. Calculate correct overpayment. Providers frequently return the inappropriate amount of an overpayment, because they do not fully understand Medicaid's adjudication process.
    - i. Provider may be responsible for payment of an additional amount after Medicaid processing, or refund due to incorrect check refund amount. Payments or additional take-backs will appear in the remittance statement and may affect payments on other accounts.
    - ii. Calculation of overpayment due to Third Party Liability (TPL) payment. The following calculation is used to determine Medicaid's correct payment when TPL is involved:  
 Medicaid's allowed minus payment amount received from prior payer = Medicaid's new allowed.  
 Lesser of Medicaid's new allowed vs. other payer patient responsibility = Medicaid payment.  
 TPL is considered at the claim level for Medicaid claims and at the line level for crossover claims.
    - iii. Send a check made out to "Utah Medicaid" for the overpayment with adequate documentation to:  
 Medicaid Operations Overpayment  
 PO Box 143106  
 Salt Lake City, UT 84114-3106
    - iv. Adequate documentation includes:
      - (1) Payment grouped by provider name, provider NPI, or provider ID as submitted on the original claim
      - (2) Client name and client ID
      - (3) Transaction Control Number of claim (TCN or ICN)
      - (4) Date of service
      - (5) Original submitted charge
      - (6) Amount of the overpayment (grouped by NPI billed on the original claim)
      - (7) Detailed reason for the overpayment:
        - (a) Incorrect billing - provide the line number, correct units, procedure code, charges, etc.
        - (b) TPL - provide copy of the EOB from other payer(s).
        - (c) Credit balance letter or balance forward listed on remittance statement - balance due may be impacted weekly by adjudication cycle.
        - (d) Detailed other reason. Do not list "overpayment" only.
    - v. Do not send a replacement claim or have a customer service representative reprocess the claim as this will result in a duplicate recoupment of the funds.
    - vi. For checks being returned due to a credit balance letter or remittance statement balance forward, please mark "credit balance" on the envelope.

### Medicaid Identified

Depending on which Medicaid agency identifies the overpayment, recoupment may occur through the following methods:

1. Claims reprocessing and recoupment from future payments through remittance statement.
2. Overpayment recoupment letter.

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**11 - 87 CPT Code List Updated****Covered**

58350 Chromotubation of oviduct, including materials, opened to Non-Traditional Medicaid clients.

72148, 72149, 72158, 73218, 73219, 73223, 73718, 73719, 73720, 73722, 73723 are covered for EPSDT clients without prior authorization (PA). PA is required for anyone over age 21. The *CPT Code List* will be corrected to reflect this coverage.

80104 Multiple drug classes, other than chromatographic method, each procedure. See Laboratory Manual. Payment will not be made for testing of the same drug class by urine and serum testing.

**PA Removed**

65756 Keratoplasty (corneal transplant); endothelial

**PA Required**

54162 Lysis or excision of penile post-circumcision adhesions. Written: PA required. Limited to EPSDT clients who meet criteria.

59525 Subtotal or total hysterectomy following cesarean delivery. As part of the PA process, a *Hysterectomy Consent Form* will be required.

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**11 - 88 ICD-9-CM Codes**

Corrections have been made to the E codes in the MMIS Reference File. Correct coding does not allow an E code to be paid as the primary or stand-alone code. All E codes have been closed.

Some claims were incorrectly billed with the V code as the first or only code on the claim. These V codes have been closed to reflect correct coding as addressed in the CMS V Code Table in the 2008 HCPCS manual. V codes are not to be the first or only code on the claim for Medicaid, with the exception of V codes mentioned in the General Information Section I related to EPSDT preventive health screening, contraceptive management, and screening in pregnancy.

Abortion diagnosis codes have a PA placed and require review prior to payment of hospital claims in the following code ranges: 635.00-635.92 and 637.00-637.92.

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**11 - 89 Hospital Surgical Procedures Attachment**

The *Utah Medicaid Hospital Surgical Procedures*, an attachment to the *Hospital and Physician Manual*, has been archived.

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**11 - 90 Post Operative Days Updated**

The *Post Operative Days by CPT Code* attachment to the *Physician and Anesthesiology Provider Manual* has been updated.

See the updated attachment at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid).

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## 11 - 91 Certified Nurse Midwife Manual Updated

### Covered CPT Codes

59300 Episiotomy or vaginal repair, by other than attending physician

### Covered CPT Codes - For those with hospital privileges

99231 Subsequent hospital care per day

99232 Subsequent hospital care per day

99233 Subsequent hospital care per day

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## 11 - 92 Laboratory Manual Updated

Please see the *Utah Medicaid Laboratory Manual* for minor corrections and updates to addresses and phone numbers.

CPT codes 80100 and 80101 are used for serum drug testing. CPT code 80104 is open for urine drug class testing using a kit.

The code S3854, gene expression profile panel for use in management of breast cancer treatment, will be used for Oncotype DX testing. Oncotype DX testing in women with breast cancer may be used to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy. For reimbursement of the service, documentation must be submitted for medical review and approval of the test, prior to testing.

BRCA1/BRCA2 is covered when the client meets criteria for using the covered molecular diagnostic codes 83890-83914 (excludes 83907 and 93913) and the client can best be served by having a screening panel customized to follow panels completed on other family members. When the client requires complete BRCA1/BRCA2 testing the code S3820 is used. For reimbursement of the service, documentation must be submitted for medical review and approval of the testing prior to testing.

For BRCA1/BRCA2 testing consideration, documentation showing the client meets either of the two requirements (a or b) below is required:

- a) A cancer affected client with one of the following:
  1. Women who are affected with breast cancer, ovarian cancer, cancer of the fallopian tube, or primary peritoneal cancer, and are from families with a high risk of BRCA1 or BRCA2 mutation as defined in the policy guidelines.
  2. Women who at 50 years of age or less (regardless of family history), are affected with one of the following:
    - early onset breast or ovarian cancer
    - multiple primary breast or ovarian cancers
    - bilateral breast, ovarian, or fallopian tube cancers
    - breast with ovarian cancer, fallopian tube cancer, or primary peritoneal cancer
  3. Men affected with breast cancer at any age.
- b) An unaffected adult may be considered under one of the following circumstances:
  1. Unaffected individuals (male or female) from families with a known BRCA1 or BRCA2 mutation.
  2. Unaffected individuals from families with a high risk of BRCA1 or BRCA2 mutation based on a family history where it is not possible to test an affected family member for a mutation.
  3. Unaffected individuals in populations at risk for specific founder mutations due to ethnic background (e.g., Ashkenazi Jewish descent, Norwegians, Dutch, and Icelanders with one or more relatives with breast or ovarian cancer at any age).

CPT code 87798 should be billed on a separate line for each organism requiring separate payment to expedite payment. Panels receive one payment of 87798 (i.e. H1N1 influenza, multiplex respiratory panel). For panels, you may show one line and the rest of the units on a separate line.

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**11 - 93 Psychiatric Diagnosis Codes**

The ICD-9-CM list for psychiatric codes has been updated to reflect medically necessary inpatient admission. Inpatient diagnosis codes for conditions in remission and some unspecified codes have been closed in the Medicaid and Non-Traditional Medicaid programs.

Outpatient codes for conditions which are not medical (i.e. inability to understand math) and some unspecified codes have been closed in the Medicaid and Non-Traditional Medicaid programs. Mental health care remains a non-covered service in the Primary Care Network program.

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**11 - 94 Pharmacy Manual Updates**

The following Medicaid policies were added to the *Utah Medicaid Pharmacy Provider Manual*:

- The correct prescriber NPI is required on all pharmacy claims.
- Dual-eligible clients must use their Medicaid Part D benefit for all drugs except benzodiazepines, barbiturates, over-the-counter, and select cough and cold medications. These four drug classes will be covered for dual-eligible clients with the same limitations and criteria that apply to all Medicaid clients.
- Coding for home infusion pharmacy dispensing fees was updated.
- Covered days supplies for vitamins were updated.
- Covered days supplies for birth control were updated.
- Pharmacist-administered vaccine policy was updated.
- ICD-9 code policy was updated.
- NDC requirements for J-code claims were clarified.

Additionally, outdated references to protease inhibitor co-pays, over-the-counter anti-ulcer drugs, and H-Pylori treatments were removed from the manual. Outdated information on the pharmacy Point of Sale (POS) system was updated.

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**11 - 95 Medicaid Client ID Required on Pharmacy Claims**

Effective October 1, 2011, Utah Medicaid will no longer accept a client Social Security number on a pharmacy claim in lieu of a Medicaid client ID. If a client does not have a Medicaid card with a Medicaid client ID available, the client ID may be obtained by calling Access Now at (801) 538-6155 or (800) 662-9651, and selecting options 1 and 1 on the phone tree.

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**11 - 96 PDL Update**

The Medicaid Preferred Drug List (PDL) continues to expand on a monthly basis. The Medicaid P&T Committee has recently considered acne therapy and pancreatic enzymes. 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>.

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## 11 - 97 OTC Drug List Updates

The Over-the-Counter (OTC) Drug List has been updated to include benzoyl peroxide (topical) and vitamin D. To view a current OTC Drug List, visit the Utah Medicaid website at: <http://health.utah.gov/medicaid>. This list can also be found as an attachment to the *Utah Medicaid Provider Manual, Section 2 Pharmacy Services*.

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## 11 - 98 Pharmacy Policy Highlights

Updates have been made to the *Drug Criteria and Limits* attachment, found in the *Utah Medicaid Provider Manual, Section 2 Pharmacy Services*.

A section has been added instructing providers how to report the diagnosis code when billing drugs requiring ICD-9 codes. See page 7 of the *Drug Criteria and Limits* for details.

The following cumulative limits have been updated:

- Celebrex - 30 capsules in 30 days
- Diphenoxylate-containing products - 180 tablets in 30 days
- Plan B - 2 kits per month
- Pristiq - 30 tablets in 30 days
- Synera - 5 patches per 30 days

After a review of prior authorization criteria, the following drug criteria have been updated: (Please refer to the *Drug Criteria and Limits* for complete criteria)

- Adult acne
- Amitza
- Antibiotics (injectable) for Non-Traditional Medicaid clients
- Cimzia for rheumatoid arthritis
- Kineret
- Botulinum toxins
- Brand-name antiepileptics
- Clobetasol topical (Olux)
- Colcrys
- Depo-Provera (Non-Traditional Medicaid clients only)
- Embeda
- Gabapentin extended release products (Gralise, Horizant)
- Growth hormone (children)
- Hydroxyprogesterone Caproate (extemporaneous compounds and Makena)
- Increlex
- Influenza medications - Tamiflu
- Lamisil
- Pulmonary anti-hypertensives - Adcirca, Tyvaso
- Relistor
- Sabril
- Uloric
- Zovirax ointment

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## 11 - 99    **Injectable Medications List Updates**

After a review of prior authorization criteria, the drug criteria for Kristexxa, Tysabri, and Vivitrol have been updated on the *Injectable Medications List*. For full criteria, see the *Injectable Medications List* attachment to the *Utah Medicaid Provider Manual, Section 2 Physicians Services*.

Additional instructions for billing injectable medications have been added. See page 2 for full details.

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## 11 - 100    **NTM Pharmacy Update**

The *Injectable Medications List* has been updated to cover the following drug in the Non-Traditional Medicaid Program:

Medroxyprogesterone Acetate 150mg will be covered through the pharmacy benefit when used for family planning.

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## 11 - 101    **PCN Pharmacy Updates**

The *Injectable Medications List* has been updated to cover the following drug in the Primary Care Network plan:

Medroxyprogesterone Acetate 150mg will be covered through the pharmacy benefit when used for family planning.

The *PCN Drug Criteria and Limits* attachment, found in the *Utah Medicaid Provider Manual for Primary Care Network (PCN) Plan*, has been updated. A section has been added to notify providers how to report the diagnosis code when billing drugs requiring ICD-9 codes. Also, see page 5 of the *PCN Drug Criteria and Limits* for details.

The following cumulative limits have been updated for the Primary Care Network plan:

- Celebrex - 30 capsules in 30 days
- Diphenoxylate-containing products - 180 tablets in 30 days
- Plan B - 2 kits per month
- Pristiq - 30 tablets in 30 days
- Synera - 5 patches per 30 days
- Fentora - 120 units in 30 day

After a review of prior authorization criteria, the following drug criteria have been updated for the Primary Care Network plan: (Please refer to the *PCN Drug Criteria and Limits* for complete criteria)

- Adult acne
- Amitza
- Clobetasol topical (Olux)
- Colcrys
- Combunox
- Depo-Provera (Non-Traditional Medicaid clients only)
- Embeda
- Gabapentin extended release products (Gralise, Horizant)
- Influenza medications - Relenza, Tamiflu
- Lamisil
- Pulmonary anti-hypertensives - Adcirca, Tracleer, Tyvaso

- Sabril
- Uloric
- Zovirax ointment

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## 11 - 102 Criteria for Medical and Surgical Procedures

The following criteria have been updated effective October 1, 2011. The criteria can be found on the Utah Medicaid website under the "criteria" link at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid).

- Septoplasty
- Fusion, Cervical Spine
- Fusion, Thoracic Spine
- Fusion, Lumbar Spine

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## 11 - 103 Inpatient Hospital Update

Effective October 1, 2011, Utah Medicaid will update its DRG calculator to MS-DRG version 29.

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## 11 - 104 Medical Supplies List Updated

Please note, if there is a need to exceed the quantities listed below, the provider must obtain a prior authorization.

### DME Quantity Limits

- A7005 Administration set, pneumatic nebulizer, non-disposable, one allowed every 3 months
- A7030 CPAP, full face mask, 2 per year
- A7031 Replacement face mask interface, 1 every 6 months
- A7034 Nasal application device, 1 every 6 months
- A7035 Positive airway pressure headgear, 1 every 6 months
- A7037 Positive airway pressure tubing, 1 every 6 months
- A7038 Positive airway pressure filter, 1 every 90 days
- A7039 Filter, non-disposable with pap, 1 every year
- L5000 Part foot, shoe insert, 1 per year
- L5666 Addition to lower extr, BKA, cuff suspension, 2 per year
- L5668 Addition to lower extr, BKA, molded distal cushion, 1 per year
- L5673 Addition to lower extr, AKA, BKA, cushion fabricated from existing mold, use with locking mechanism, 2 per year
- L5679 Addition to lower extr, AKA, BKA, cushion fabricated from existing mold, not for use with locking mechanism, 2 per year
- L5681 Addition to lower extr, AKA, BKA, cushion fabricated socket insert for congenital or atypical trauma, with or without locking (for other than initial, use code L5673 or L5679), 2 per year
- L5683 Addition to lower extr, AKA, BKA, cushion fabricated socket insert for other than congenital or atypical trauma, with or without locking (for other than initial, use code L5673 or L5679), 2 per year
- L5685 Suspension/sealing sleeve, with or without valve, 3 per year
- L6660 Addition to upper extr, heavy duty control cable, 1 per year
- L6675 Addition to upper extr, harness, single cable, 1 per year

L8400 Prosthetic sheath, BKA, each, 12 per year  
L8410 Prosthetic sheath, AKA, each, 12 per year  
L8420 Prosthetic sock, multiple ply, BKA, each, 24 per year  
L8430 Prosthetic sock, multiple ply, AKA, each 24 per year  
L8435 Prosthetic sock, multiple ply, upper limb, each, 24 per year  
L8440 Prosthetic shrinker, BKA, each, 8 per year  
L8460 Prosthetic shrinker, AKA, each, 8 per year  
L8470 Prosthetic sock, single ply, BKA, each, 12 per year  
L8480 Prosthetic sock, single ply, AKA, each, 12 per year  
L8485 Prosthetic sock, single ply, upper limb, each, 12 per year

### **HCPCS Code Closed**

A4264 Permanent implantable contraceptive intratubal occlusion device(s) and delivery system.

This code has been closed in Traditional Medicaid, Non-Traditional Medicaid, and PCN. The cost of this item is included as a global fee for CPT code 58350.

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## **11 - 105 Medical Transportation Forms**

Two new forms have been developed to assist providers with the prior authorization process for the following:

- Out of State Travel Cover Sheet
- Food and Lodging Reimbursement

These forms will be available on the Medicaid website under the "Forms" link at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid). Information regarding these forms will also be added to sections 5-1 and 5-2 of the provider manual. The purpose is to assist providers in efficiently providing all the needed information with the request for the above services.

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## **11 - 106 Home Health Policy Updates**

### **Private Duty Nursing**

The *Utah Medicaid Home Health Agency Provider Manual*, Section 4-8 Private Duty Nursing (PDN), reflects clarifying language. The purpose of this change is to clarify Medicaid policy on the number of private duty nursing hours that a patient may receive. The number of hours is based on the score a patient receives on the PDN Acuity Grid.

Refer to the Medicaid website at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid) for all provider manual changes.

### **Home Health Manual**

Amended to state (page 7):

- S. Home Health services requiring minimal time (e.g., filling a medication box under code T1003, home health aide codes under T1021 or S9122) and being performed for multiple persons in the same location shall be billed with the appropriate modifier as follows:

UN for two patients served  
UP for three patients served

UQ for four patients served  
 UR for five patients served  
 US for six or more patients served

The units billed to each patient should be calculated as follows:

The total number of units is divided by the total number of patients served. The resulting number of units should be billed to each patient along with the appropriate modifier to indicate the service was shared. If the units do not divide among the patients served into whole numbers, then allocate and bill the remainder units among the patients until used. For example: Four patients having received a total of eleven units would calculate and bill as follows:

$11 / 4 = 2.75$   
 Patient 1 = 3  
 Patient 2 = 3  
 Patient 3 = 3  
 Patient 4 = 2

In addition to the above for services given to multiple persons, when only one person is in the home, two medicine boxes should be filled to cover a two-week period unless there is a documented medically necessary reason for weekly visits.

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## 11 - 107 New Choices Waiver

The *Utah Home and Community-Based Waiver Services, New Choices Waiver Provider Manual* has been updated. The most significant revisions can be found in the following sections of the manual:

- Waiver of Statewideness
- Disenrollment and Termination of Home and Community-Based Waiver Services
- Provider Reimbursement
- Incident Reporting
- Timely Filing of Claims
- Service Procedure Codes
- Attachment A - Authorized Provider Services

The revised manual can be found online at [www.health.utah.gov/medicaid](http://www.health.utah.gov/medicaid).

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## 11 - 108 Attn: Psychologists

Effective October 1, 2011, the Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Psychology Services*, has been updated as follows:

- Chapter 1-7, Periodic Review of the Treatment Plan; clarifications have been made regarding proper billing of periodic reviews of the treatment plan. Effective October 1, 2011, treatment plan reviews must not be billed as psychiatric diagnostic interview examinations.
- Chapter 1-9, Collateral Services; non-substantive wording changes have been made to clarify these services.
- Chapter 1-10, Billings; has been updated to include information on the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) regarding proper billing of services on the same day by the same servicing provider.
- Effective October 1, 2011, Chapter 2-1, Psychiatric Diagnostic Interview Examination (CPT-4 procedure codes 90801/90802); has been revised to clarify requirements for and limitations regarding the appropriate use and billing of this service.
- Chapter 2-3, Individual Psychotherapy and Individual Psychotherapy with Medical Evaluation and Management

Services; clarifications have been made regarding proper billing when two individual psychotherapy services are provided by the same servicing provider on the same day.

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 email [merickson@utah.gov](mailto:merickson@utah.gov).

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**11 - 109 Attn: 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**

Effective October 1, 2011, 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:

- Chapter 1-4, Provider Qualifications; there is a new Section D that includes the training requirements for 'other trained individuals.'
- Chapter 1-7, Periodic Review of the Treatment Plan; clarifications have been made regarding proper billing of periodic reviews of the treatment plan. Effective October 1, 2011, treatment plan reviews must not be billed as psychiatric diagnostic interview examinations.
- Chapter 1-9, Collateral Services; non-substantive wording changes have been made to clarify these services.
- Chapter 1-10, Billings; has been updated to include information on the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) regarding proper billing of services on the same day by the same servicing provider.
- Effective October 1, 2011, Chapter 2-2, Psychiatric Diagnostic Interview Examination; has been revised to clarify requirements for and limitations on the use and billing of this service (CPT-4 procedure codes 90801/90802).

The 'Limits' and 'Units' sections of this chapter also include guidance on billing additional evaluations that no longer may be billed under the Psychiatric Diagnostic Interview Examination (CPT-4 procedure codes 90801/90802). A different HCPCS code (G0409) is provided for billing additional evaluation activities or periodic reviews of the treatment plan that cannot be performed as a part of service(s) the client is receiving.

- Chapter 2-5, Individual Psychotherapy and Individual Psychotherapy with Medical Evaluation and Management Services; clarifications have been made regarding proper billing when two individual psychotherapy services are provided by the same servicing provider on the same day.
- Chapter 2-8, Pharmacologic Management, the 'Record' section has been revised to specify that the prescriber's NPI must be included on prescriptions.

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 email [merickson@utah.gov](mailto:merickson@utah.gov).

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**11 - 110 Attn: Mental Health Centers / Prepaid Mental Health Plans**

Effective October 1, 2011, the Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Mental Health Centers / Prepaid Mental Health Plan Providers*, has been updated as follows:

- Chapter 1-5, Provider Qualifications; there is a new Section D that includes the training requirements for 'other trained individuals.'
- Chapter 1-8, Periodic Review of the Treatment Plan; clarifications have been made regarding proper billing or reporting of periodic reviews of the treatment plan. Effective October 1, 2011, treatment plan reviews must not be billed or

reported as psychiatric diagnostic interview examinations.

- Chapter 1-11, Collateral Services; non-substantive wording changes have been made to clarify these services.
- Chapter 1-12, Billings; has been updated to include information on the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) regarding proper billing of services on the same day by the same servicing provider.
- Chapter 2-1, General Limitations; clarifications have been made regarding the limitations on mental health benefits for adults in the Non-Traditional Medicaid Plan.
- Effective October 1, 2011, Chapter 2-2, Psychiatric Diagnostic Interview Examination; has been revised to clarify requirements for and limitations on the use and billing or reporting of this service (CPT-4 procedure codes 90801/90802).

The 'Limits' and 'Units' sections of this chapter also include guidance on billing or reporting additional evaluations that no longer may be billed or reported under the Psychiatric Diagnostic Interview Examination (CPT-4 procedure codes 90801/90802). A different HCPCS code (G0409) is provided for billing or reporting additional evaluation activities or periodic reviews of the treatment plan that cannot be performed as a part of service(s) the client is receiving.

- Chapter 2-5, Individual Psychotherapy and Individual Psychotherapy with Medical Evaluation and Management Services; clarifications have been made regarding proper billing or reporting when two individual psychotherapy services are provided by the same servicing provider on the same day.
- Chapter 2-8, Pharmacologic Management, the 'Record' section has been revised to specify that the prescriber's NPI must be included on prescriptions.
- Chapter 2-11, Peer Support Services; clarifications have been made regarding this service. Effective July 1, 2011, qualified providers may also include patents of a child with serious emotional disturbance (SED) or adults who have an ongoing and personal experience with a family member who is a child with SED. A clarification has been made that peer support services may be provided to parents/legal guardians of children with SED when the services are directed exclusively toward the treatment of the Medicaid-eligible child.

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 email [merickson@utah.gov](mailto:merickson@utah.gov).

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## **11 - 111 Attn: Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse Providers**

Effective October 1, 2011, 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:

- Chapter 1-5, Provider Qualifications; there is a new Section D that includes the training requirements for 'other trained individuals.'
- Chapter 1-8, Periodic Review of the Treatment Plan; clarifications have been made regarding proper billing of periodic reviews of the treatment plan. Effective October 1, 2011, treatment plan reviews must not be billed as psychiatric diagnostic interview examinations.
- Chapter 1-10, Collateral Services; non-substantive wording changes have been made to clarify these services.
- Chapter 1-12, Billings; has been updated to include information on the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) regarding proper billing of services on the same day by the same servicing provider.
- Effective October 1, 2011, Chapter 2-2, Psychiatric Diagnostic Interview Examination; has been revised to clarify requirements for and limitations on the use and billing of this service (CPT-4 procedure codes 90801/90802).

The 'Limits' and 'Units' sections of this chapter also include guidance on billing additional evaluations that no longer may be billed under the Psychiatric Diagnostic Interview Examination (CPT-4 procedure codes 90801/90802). A different HCPCS code (G0409) is provided for billing additional evaluation activities or periodic reviews of the treatment plan that cannot be performed as a part of service(s) the client is receiving.

- Chapter 2-5, Individual Psychotherapy and Individual Psychotherapy with Medical Evaluation and Management Services; clarifications have been made regarding proper billing when two individual psychotherapy services are provided by the same servicing provider on the same day.

- Chapter 2-8, Pharmacologic Management, the 'Record' section has been revised to specify that the prescriber's NPI must be included on prescriptions.

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 email [merickson@utah.gov](mailto:merickson@utah.gov).

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## 11 - 112 Medicaid Hospice Rates

The Medicaid hospice rates have been updated and are available at <http://health.utah.gov/medicaid/stplan/hospice.htm>.

These rates are effective October 1, 2011. As in the past, the reimbursement rates are specific to several geographical areas of Utah. Medicaid hospice providers must use the reimbursement rate associated with the geographical area in which the Medicaid client resides, not the geographical area in which the hospice agency is necessarily located.

Also, be aware that Medicaid hospice providers should split claims if dates of service span separate federal fiscal years (e.g., September/October billings). The FY 2011 rates will be used if the hospice chooses not to split the claim and Medicaid will perform no subsequent adjustments to these claims.

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