UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin
April 2012

Medicaid Information: 1-800-662-9651 | www.health.utah.gov/medicaid

TABLE OF CONTENTS

12-35 MESSAGE FROM THE MEDICAID MEDICAL DIRECTOR 2
12-36 PROVIDER RE-ENROLLMENT PROCESS 2
12-37 STATEWIDE MEDICAID BILLING/PROVIDER SEMINARS 3
12-38 LIMITED MEDICAID PROVIDER ENROLLMENT 3
12-39 HIPAA VERSION 5010 IMPLEMENTATION 3
12-40 SYNAGIS PRIOR AUTHORIZATIONS 5
12-41 CRITERIA UPDATES AND FORM CHANGES 5
12-42 PHYSICIAN MANUAL UPDATED 5
12-43 GENERAL INFORMATION – SECTION I UPDATED 6
12-44 HCPCS AND ICD-9-CM CODE CHANGES 6
12-45 AFTER HOURS CODES 7
12-46 MOBILE ULTRASOUND FACILITIES 8
12-47 ATTN: CERTIFIED NURSE MIDWIFE PROVIDERS 10
12-48 HOSPITAL MANUAL UPDATES 10
12-49 DENTAL MANUAL UPDATES 12
12-50 ORAL MAXILLOFACIAL SURGEON SERVICES 13
12-51 PODIATRIC SERVICES 13
12-52 MEDICAL SUPPLY POLICY 14
12-53 MEDICAL SUPPLIES LIST UPDATED 14
12-54 UPDATES TO HCBS WAIVER PROVIDER MANUALS 15
12-55 HOME AND COMMUNITY-BASED SERVICES 1915(C) WAIVER AMENDMENTS 15
12-56 PHARMACY MANUAL UPDATES 16
12-57 DRUG COVERAGE 17
12-58 NTM MANUAL UPDATES 17

Additional Medicaid Information
Salt Lake City Area: (801) 538-6155
Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, Nevada: 1-800-662-9651
Other States: (801) 538-6155

Request a Medicaid Publication
Send a Publication Request form:
By Fax: (801) 536-0476
By Mail: Division of Medicaid and Health Financing
PO Box 143106, Salt Lake City, UT 84114

12-35 Message from the Medicaid Medical Director

Dear Colleagues,

The following message is a reminder of the importance of dental health in overall human well-being. This is especially true in children. To reinforce that principle, Medicaid has for some time paid an additional amount for application of the fluoride varnish as part of a well child visit. Please see the *Utah Medicaid CHEC Services Provider Manual* for specific information on billing procedures at http://www.health.utah.gov/medicaid/accept.php.

Unfortunately, very few providers have billed for this service over the past 18 months, with the exception of a couple of clinics and a local health department. If fluoride varnish application is not something you currently do in your practices, it would be beneficial and simple to begin.

The 5% fluoride varnish, not gel or rinse, is available through most dental supply houses. The unit dose is approximately $1.00 and can be painted on by a staff member under the direction of the prescribing clinician.

There are several dentists and pediatricians who have volunteered to give instructions on the technique. Dr. Mark Valentine, a pediatrician practicing in Sandy, Utah, is one of those advocates and has even created a teaching video: http://www.youtube.com/watch?v=uqDjKIQHY7Q. It is searchable on YouTube with the keywords “Sandy clinic, fluoride varnish”.

Dr. Neal Davis, a pediatrician at Hillcrest Pediatrics in Murray, Utah, suggests that as you identify Medicaid clients for VFC immunizations, you also select them for the varnish. It should be applied to the erupting teeth at least two times per year, up to but not including the four-year-old visit.

Fluoride varnish products may be available from your medical supply companies. If you have any questions, call the Oral Health Program at (801) 538-9177. Dr. Steven Steed, Director of the state Oral Health Program, can also be reached at stevensteed@utah.gov.

Please let me know if there are any questions, or if you wish to have training. Thank you again for the care and concern you provide to all your patients, particularly those served by Medicaid.

Appreciatively yours,

Joseph G. Cramer, MD, FAAP
Medical Director
UDOH, Division of Medicaid and Health Financing
Phone (801) 538-6316
Cell (801) 448-4635

12-36 Provider Re-enrollment Process

Effective January 1, 2012, due to the CMS mandate defined in CFR 455.104, Utah Medicaid will require all enrolled providers to re-enroll every three to five years depending on the provider type.

Because this is a major undertaking, Medicaid will begin the process in phases based on provider type. Providers will be notified by letter stating when it is time to re-enroll. Specific required documents will be included with the letter. Providers will have 90 days from the date of the letter to return the required documents to provider

enrollment. Documentation received after 90 days could result in delay of payment or closure of your Medicaid contract.

Please call Provider Enrollment at (801) 538-6155, or toll free (800) 662-9651, option 3, then option 4, with any questions you may have regarding this enrollment process.

12-37 Statewide Medicaid Billing/Provider Seminars

The 2012 Statewide Medicaid training conferences will be held from June through September. We would like to get your input and suggestions on this training. Please submit topics you would like us to address this year to jllittle@utah.gov.

12-38 Limited Medicaid Provider Enrollment

Effective March 25, 2011, CMS has mandated all State Medicaid agencies require all claims submitted for payment contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred, or prescribed such items or services.

All ordering, referring, or prescribing physicians, or other professionals providing services under the State Plan or under a waiver of the plan, must be enrolled as a participating provider. If you are already enrolled to provide services to Medicaid clients, you do not need to enroll again to order, refer, or prescribe.

There are two types of Medicaid enrollment. The standard enrollment allows you to provide medical services, order, refer, and prescribe. The limited enrollment is for providers who only order, refer, or prescribe to Medicaid clients, and who do not wish to provide any other services to Medicaid clients. Under limited enrollment, the provider can neither bill Medicaid nor be paid for services. Enrollment forms for the limited and formal enrollment processes are located on the Medicaid website at http://health.utah.gov/medicaid.

For questions regarding the Medicaid enrollment process, please call Provider Enrollment at (801) 538-6155, or toll free 1-800-662-9651, menu option 3, then 4.

12-39 HIPAA Version 5010 Implementation

Utah Medicaid has fully transitioned to 5010 format on all EDI transactions. Please submit all your EDI transactions in 5010 format only. For questions, call Medicaid EDI at (801) 538-6155 or 800-662-9651, option 3, option 5 and option 2.

EDI reports are also in 5010 format only. Contact UHIN at (877) 693-3071 for assistance in downloading the EDI reports through the Utransend tool.

REMITTANCE ADVICE UPDATES (835)

Providers using Easy Print to read the 835 must bear in mind that the Easy Print has HIPAA Claims Adjustment Reason and Remark Codes hard-coded within the software by Medicare. These codes are not coming from our system nor being returned to you in our 835. These codes may not reflect the real denial reasons from our system. You may open the 835 through Utransend and view the raw data to find the HIPAA codes being relayed through the 835.

For assistance in locating or downloading 5010 835s, call UHIN at (877) 693-3071. Call Medicaid EDI team for discrepancies on the content of 5010 835s.

REAL TIME TRANSACTION

Currently, Utah Medicaid is developing real time transactions for the 270/271, 276/277, 278 and 999. Real time testing is scheduled for mid 2012. Medicaid will invite providers and billers to participate in the real time testing. If you are interested and would like to participate with testing these transactions, contact Medicaid EDI at (801) 538-6155 or 800-662-9651, option 3, option 5 and option 2.

MEDICAID ONLINE (BLUEZONE)

Medicaid Online (HLRP access through BlueZone) will be eliminated with the implementation of real time transactions later this year. Providers using Medicaid Online need to check with their system programmers to assure full utilization of the 270/271 (Eligibility) and 276/277 (Claim Status) transactions.

Due to the impending implementation of the real time transactions, Utah Medicaid is no longer accepting access applications to Medicaid Online.

PAPER BILLERS

With the implementation, and in order to meet HIPAA 5010 requirements, Medicaid requires the billing provider address to be a **street address** with a valid **nine-digit zip code**. The PO Box and/or Lock Box are no longer allowed. Effective May 1, 2012, paper claims with PO Box/Lock Box or partial zip codes on the billing provider field will be returned unprocessed to providers. Contact Medicaid if you have any questions at (801) 538-6143.

NOTIFICATIONS

To receive Medicaid notices of program changes, announcements of MIBs, 5010 real time status updates and other information, please sign up for the Utah Medicaid Newsletter e-mail list serve at http://health.utah.gov/medicaid. You may also sign up to receive the UHIN Alerts at http://www.uhin.org/pages/membership/newsletter-alerts.php for notification and payer's availability.

12-40 Synagis Prior Authorizations

Providers seeking prior authorization for Synagis, for clients enrolled in a managed care health plan, must contact the managed care plan to obtain prior authorization. Fee-for-service prior authorization staff cannot give prior authorization for enrollees of managed care plans. Providers are responsible to verify if the client is eligible and whether the client is enrolled in a managed care plan.

12-41 Criteria Updates and Form Changes

Medical and Surgical Procedures

The following criteria have been updated effective April 1, 2012. The criteria can be found on the Utah Medicaid Website under the "Criteria" link at www.health.utah.gov/medicaid.

- Hemilaminectomy, Lumbar, +/- Discectomy/Foraminotomy
- Bladder Neck Suspension/Sling and Other Pelvic Surgical Procedures, Female
- Breast Reconstruction

Criteria for Durable Medical Supplies

- Augmentative and Alternative Communication Devices
- Enclosed Hospital Safety Bed

Form Changes

The *Abortion Acknowledgement and Certification Form* was updated in February 2012. Changes were specific to the "internal use" section of the form and do not result in any changes to the current abortion criteria or policy.

12-42 Physician Manual Updated

The Sleep Medicine policy, Item 37, has been updated as follows:

37. Facility payment for the technical portion of the polysomnography is limited to a Utah Medicaid approved sleep center. Medicaid coverage requires physician oversight of the center and a minimum of one registered polysomnography technician at the center. Interpretation and report of the sleep study must be completed by either a board certified Sleep Medicine Diplomat or a board certified Sleep Medicine physician.

    When the physician has completed the training required by the American Academy of Sleep Medicine or sleep medicine training approve by the board in their specialty (e.g. family practice, internal medicine, pediatrics, neurology) and is eligible to take the examination for board certification, the physician may be covered for the up to one year as long as documentation of eligibility is received.

- A letter from the program director that the required training/fellowship in sleep medicine has been completed.
- Board confirmation that the individual has completed training requirements and is eligible for the examination along with the date they are scheduled to take the board examination.

12-43 General Information – Section I Updated

The Physician Referral policy, chapter 6 – 9, has been updated as follows:

6 - 9 Physician Referrals

Only a Medicaid client's Primary Care provider can provide a referral to a consulting physician. The primary care physician may make any referral in writing or verbally. However, the patient's medical record must indicate that a referral for consultation was requested.

The consulting physician is responsible for sending the primary care physician a letter describing the consult findings and a summary of the recommendations.

12-44 HCPCS and ICD-9-CM Code Changes

ICD-9-CM Covered Codes

649.01 Intrauterine pregnancy, with tobacco use, delivered

649.11 Intrauterine pregnancy, with obesity, delivered

Covered in Hospital (Provider Type 01) for Age 20 or Less

27176 Treatment of slipped femoral epiphysis; by single or multiple pinning in situ

27485 Arrest hemiepiphyseal, distal femur or proximal tibia or fibula (e.g. Genu vargus, vargus)

50400 Pyeloplasty (Foley Y-pyeloplasty) plastic operation on ureter, enphropexy, nephrostomy, pyelostomy, or ureteral splinting; simple

51980 Cutaneous vesicostomy

Covered Without Prior Authorization

43279 Laparoscopy, surgical, esophagomyotomy (Heller type) with or without fundoplasty

22842 Posterior segmental instrumentation; 3-6 vertebrae segments in addition to primary procedure

22843 Posterior segmental instrumentation; 7-12 vertebrae segments in addition to code for primary procedure

22846 Anterior segmental instrumentation; 4-7 vertebrae segments in addition to code for primary procedure

22848 Pelvic fixation other than sacrum in addition to code for primary procedure

22851 Application of intervertebral biomechanical device(s) in addition to code for primary procedure

61885 Insert or replace cranial stimulator pulse generator, direct or inductive coupling; with connection to single electrode array. Note: Limited to covered neurostimulator use. Investigational/unproved use non-covered (e.g. depression, gastroparesis)

61886 Insert or replace cranial stimulator pulse generator, direct or inductive coupling; with connection to 2 or more electrode array. Note: Limited to covered neurostimulator use. Investigational/unproved use non-covered (e.g. depression, gastroparesis)

Prior Authorization Required

55650 Vesiculectomy, any approach

57287 Removal or revision of sling for stress incontinence

57288 Sling operation for stress incontinence

57295 Revision (including removal of prosthetic vaginal graft; vaginal approach)

57296 Revision open abdominal approach

Non-Covered Code

58350 Chromotubation of oviduct, including materials

12-45 After Hours Codes

In an effort to increase continuity of care, after hours codes 99050 and 99058 are open for new patient codes 99201-99205 and established patient codes 99211-99215. In addition, coverage of code 99051, which is defined as service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service, is being opened with the following definitions:

"Evening" means after 6:00 PM and "Holiday" means any federal or state-recognized holiday.

12-46 Mobile Ultrasound Facilities

Some ultrasound codes will be open to mobile ultrasound facilities (provider type 71) to provide ultrasounds for rural areas with limited access requiring long distance travel. The new site to be open is located in a fixed site. Payment of transportation of equipment for this service is not covered. The requirements for becoming a provider type 71 include:

- Complete non-institutional provider application.
- Signed provider agreement.
- Statement from physician indicating a willingness to assume responsibility of providing general supervision of personnel and equipment for the ultrasound provider.
- Physician requirements:
  - Copy of current physician professional license from DOPL, or a copy from DOPL database, or telephone verification from DOPL professional license.
  - Physician reading the professional component ultrasound to provide information describing their area of expertise to support reading and interpretation of the ultrasound (e.g. radiologist, obstetrician, cardiologist, urologist).
- Technician coverage requires:
  - Statement from the supervisor or diploma program director showing successful completion of 12 months of clinical ultrasound experience for the type(s) of ultrasound(s) performed.
  - Certificate showing successful completion of the certification examination as an ultrasound technician or ultrasound sonographer. (There is no licensure requirement in Utah).

The following CPT codes will be open to mobile ultrasound facilities (provider type 71):

76376 3D rendering with interpretation and report of CT, MRI, US, or other tomographic modality; not requiring imaging post-processing on an independent work station.

76775 Ultrasound, retroperitoneal; limited

76801 Ultrasound pregnant uterus, fetal and maternal evaluation first trimester

76802 . . . each additional gestation

76805 Ultrasound pregnant uterus, fetal and maternal evaluation after first trimester, $\geq$ 14 weeks, transabdominal approach, single or first gestation

76810 . . . each additional gestation

76811 Ultrasound pregnant uterus, fetal and maternal evaluation plus detailed fetal anatomical examination, transabdominal approach, single or first gestation

76812 . . . each additional gestation

76813 Ultrasound pregnant uterus, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach, single or first gestation

76814 . . . each additional gestation

76815 Ultrasound pregnant uterus, limited, 1 or more fetuses

76816 Ultrasound pregnant uterus, follow-up, transabdominal approach, per fetus

76817 Ultrasound pregnant uterus, transvaginal

76819 Fetal biophysical profile without non stress testing

76820 Doppler velocimetry, fetal; umbilical artery

76821 Doppler velocimetry, fetal; middle cerebral artery

76825 Echocardiography, fetal, cardiovascular system, with 2D documentation, with or without M-mode recording.

76826 . . . repeat or follow-up study

76827 Doppler echocardiography, fetal, pulse wave and/or continuous wave with spectral display; complete

76828 . . . repeat or follow-up study

76830 Ultrasound, transvaginal

76831 Saline infusion sonohysterography, including color Doppler flow when performed

76856 Ultrasound, pelvic, non-obstetrical; complete

76857 . . . limited or follow up study

76946 Ultrasonic guidance for amniocentesis, imaging supervision and interpretation

93325 External electrocardiographic recording up to 48 hours by continuous rhythm; recording (includes connection, disconnection)

93975 Duplex can or arterial flow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs, complete study

93976 . . . limited study

12-47 Attn: Certified Nurse Midwife Providers

Beginning January 1, 2012, Utah Medicaid has provided coverage and reimbursement information for HCPCS and CPT codes through a new web-based lookup tool.

Located at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

The website allows providers to search for coverage and reimbursement information by procedure code, date of service, and provider type. With the introduction of this new website, we will be removing the coverage information from our provider manuals; however, the provider policy manuals will still be a reference for criteria, comments, and instructions, including unit limits.

12-48 Hospital Manual Updates

Section 1 Hospital Inpatient and Outpatient

The *Utah Medicaid Hospital Provider Manual* has been corrected for minor grammatical errors, dates have been updated for the CFR citations, other references have been updated, and references to HCFA have been changed to Centers for Medicare and Medicaid Services (CMS). Additional changes or additions follow:

1 - 3 Definitions

Bundling
The DRG payment includes the use of hospital facilities, technical portion of clinical laboratory and radiology services, nursing, therapy services, medical social services, and other related services furnished by the hospital as part of the general accommodations for inpatient service.

Fee-for-Service
Reimbursement term for service provided to a client that is not enrolled in a Prepaid Mental Health Plan (PMHP) or Managed Healthcare Organization.

Inpatient Hospital Services
An inpatient stay is defined as an admission which meets established criteria for severity of illness and intensity of service. The patient receives room, board, and professional services in an institution and the physician identifies the patient as inpatient status.

1 - 2 Covered Services

1. Inpatient hospital services encompass medically necessary, therapeutic services and supplies that are ordered by a physician or other practitioner of the healing arts which are appropriate for the adequate diagnosis and treatment of a patient's illness. These services include use of hospital facilities, the technical portion of clinical laboratory and radiology services, nursing, medical social services, and

therapy services. The principal reason for the hospital admission is listed as the primary or first diagnosis on the claim.

Medicaid will pay at least one day stay for an admission meeting one of the above listed situations:

2.c. If the patient leaves the hospital as scheduled after outpatient surgery and is later admitted as an inpatient, the principal diagnosis on the claim must be the ICD-9-CM diagnosis code which is the reason for the admission.

6. False labor . . . Repeated admissions through the final three weeks of pregnancy are subject to review through the post payment review process.

8. The provider must seek authorization for emergency and crisis psychiatric admissions within 24 hours of admission.

10.c(1) The patient's physical condition will allow the patient to participate in the rehabilitation service (e.g. the stump has healed).

10.d(2) Fax (801-536-0955)

3 Limitations

4.B. . . . Such surgical procedures require the following:

4.B(1) Prior authorization must be obtained before the procedure is completed. In the case of an emergency procedure, the authorization should be requested by the physician as soon as possible after the procedure by submitting documentation for review to support the emergency nature of the service.

5.B (1) Diagnosis Code V22.2 - Pregnant state incidental, must appear on every claim as one of the diagnosis codes.

(2) Vaginal Bleeding – Diagnosis codes 641.03, 641.13, 641.23, 641.33, 641.83

(5) Missed abortion – (Fetal death without spontaneous abortion) Diagnosis code - 632 Abortion will inevitably occur, but D&C or D&E may be indicated to prevent any maternal complications. Documentation of fetal demise by ultrasound is required for post payment review.

(6) Premature rupture of membranes – Diagnosis code 658.13 is subject to review. If delivery occurs within 24 hours of admission, no separate payment is warranted for the ruptured membrane services. Labor and delivery codes only should be billed.

(8) Decreased fetal movement – Diagnosis code 655.73 is subject to review. This could be an indication of symptoms which may or may not require emergency service. The evaluation should not require hospital service.

(9) All other services to the undocumented population beyond those listed above, must still be edited and reviewed before payment.

5.C. Fetal non-stress test – ICD.9 code 75.35 to be used with CPT code 59025. Other fetal monitor – ICD.9 code 75.34 to be used with CPT codes 59050 and 59051.

6. Organ transplant services are limited to approved procedures for the specific type of transplant.

14. Certain services or procedures are limited to prior authorization or are non-covered. For code coverage, see the lookup table found at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

When prior approval is required for a surgical or imaging procedure, the requirement must be met whether the procedure is performed on an outpatient or inpatient basis. Approval is not limited to outpatient procedures. Examples of procedures requiring inpatient and outpatient prior authorization include implantation of the neurostimulator for partial epilepsy, autologous bone marrow transplant, and procedures which result in sterilization.

24.A.1. . . . or disseminated Shingles (Herpes Zoster in an immune compromised patient).

24.C. Resistant organisms of concern must be listed with an appropriate V code (V09.0-V09.91) as the secondary diagnosis on the claim.

Section 3 ESRD

Only correction, *Centers for Medicare and Medicaid Services (CMS)*, on page 3.

12-49 Dental Manual Updates

Effective April 1, 2012, clarification and some modifications have been made to the Utah *Medicaid Dental Services Provider Manual*. Please review the following sections for more detailed information on the changes:

1 – 3 Definitions

Prior Authorization: Prior authorization is approval given by the Division of Medicaid and Health Financing prior to dental services being rendered. Prior authorization is obtained by the dental provider submitting a request for the specific codes of services being requested, and attaching medical evidence to support the need or justification for the services being requested.

Failure to obtain appropriate prior authorization for a surgical facility or anesthesiologist will result in the services being denied.

1 – 5 Diagnostic Services

Clarification has been added for codes D0140, D0150, and D0120.

1 – 10 Periodontics

A written prior authorization is now required for a gingivectomy for patients who use anticonvulsant medication.

1 – 15 Emergency Services

Please review the first paragraph where changes have been made.

1 – 18 General Anesthesia

A note has been added to explain that the dental provider is responsible for requesting the prior authorization. Also, direction changes have been made for services rendered in an emergent or urgent situation.

Codes Added (inadvertently left out)

D9420 Hospital call
D7670 Alveolus-open reduction, may include stabilization of teeth

---

12-50 Oral Maxillofacial Surgeon Services

Code Opened to Oral Surgeons

41112 Excision of lesion of tongue w/closure; anterior two-thirds

Correction has been made to all references to Section 3 in the manual. The correct reference should be Section 2.

12-51 Podiatric Services

Codes Opened to Podiatrists

13131 Repair of complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm

28525 Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each

12-52 Medical Supply Policy

Please note the following correction to Oral Nutritional Supplements (without feeding tube):

Page 12, 3 (A), first paragraph in the *Utah Medicaid Provider Manual for Medical Supplies*, now states, “Prior authorization **is** required for medical food supplements that are available through NDC codes in the pharmacy program.”

12-53 Medical Supplies List Updated

Beds

Effective April 1, 2012, Sleep Safer Beds will no longer be identified with code E0255. Codes E0328 and E0329, as purchase and with a prior authorization, will be used to identify a Sleep Safer Bed.

Other beds also assigned to these codes will continue to be available as a capped rental with a prior authorization.

Wheelchairs

During this past quarter, a review of wheelchair pricing was completed. For wheelchair bases that were priced below the Medicare/Medicaid formula, the price increase was made effective January 1, 2012. Below are the codes that will have a decrease in reimbursement rate effective April 1, 2012. Please refer to the Coverage and Reimbursement Lookup Tool at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php for the exact reimbursement rates.

K0822 K0823 K0824 K0826 K0828 K0835 K0836 K0837 K0838 K0839 K0841 K0842 K0843 K0856 K0858 K0860 K0861 K0862 K0864

Rental Codes

Effective January 17, 2012, the prior authorization requirement has been removed from the following rental codes:

B9006RR	Parenteral nutrition infusion pump, stationary
E0791RR	Parenteral infusion pump, stationary, single/multi
E1240	Lightweight wheelchair, detachable arms, (desk or full length), swing away detachable, elevating leg rest
E1260	Lightweight wheelchair, detachable arms, (desk or full length), swing away detachable foot rest
E1295	Heavy duty wheelchair, detachable arms, (desk or full length), swing away detachable foot rest

Code Correction

Effective January 1, 2012, the following code has been corrected:

K0007	Extra heavy duty wheelchair – may be purchased, requires prior authorization

12-54 Updates to HCBS Waiver Provider Manuals

The *Acquired Brain Injury, Aging, Technology Dependent, and Physical Disabilities Waiver* provider manuals have been updated. The updates include agency name changes: The name of Medicaid's Bureau of Long Term Care was changed to Bureau of Authorization and Community Based Services. In addition, the policy regarding the termination of HCBS waiver services was updated. Lists of services and corresponding codes were updated in each manual as well.

In all instances within the manuals, the use of the term Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) or mental retardation (MR) was replaced with the term Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). ICF/ID is equivalent to the term ICF/MR under federal law.

The effective date of the updates is April 1, 2012.

12-55 Home and Community-Based Services 1915(C) Waiver Amendments

The Department has submitted three home and community-based waiver amendments to CMS. The amendments are for the Community Supports, New Choices, and Technology Dependent waivers. The collective purpose of these three amendments is to incorporate quality improvement updates, revise references within each waiver to reflect name and contact information changes, and revise cost estimates of waiver services.

The Department also substituted all instances of the term Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) with the term, Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). ICF/ID is equivalent to an intermediate care facility for persons with mental retardation (ICF/MR) under federal law.

In addition to these global changes, each waiver amendment also includes some unrelated adjustments.

The Community Supports waiver amendment modifies the routine group respite service. Previously, routine group respite was only available through the Self-Administered Service (SAS) model. The amendment adjusts this service so that it may now be offered through agency-based providers.

The New Choices waiver amendment includes increasing the limit of clients served annually from 1200 to 1400, and reducing the minimum age requirement from 21 to 18 years of age. It also includes expanding special targeting criteria to take account of individuals who at the time of application are receiving assisted living facility services on an extended stay basis of 180 days or greater, or have previously been enrolled in the New Choices Waiver, but were disenrolled from the waiver due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility.

The proposed effective date of the waiver amendments is retroactive to July 1, 2011. All three amendments are pending CMS approval. The full HCBS Waiver Amendment Application for each waiver can be reviewed by visiting the following site at http://health.utah.gov/ltc/.

12-56 Pharmacy Manual Updates

The *Utah Medicaid Pharmacy Provider Manual* has been updated in the following sections:

1 – 2 Federal Upper Limit List

The Patient Protection and Affordable Care Act of 2009 (PPACA) established a new methodology for determining FULs. CMS has not fully implemented these new guidelines. For further information, please go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Federal-Upper-Limits-.html. Medicaid will continue to publish information as it becomes available. Medicaid cannot override a FUL price. A DAW option is not available to override a FUL.

1 – 3 Utah MAC List

MAC prices may be used with certain categories of drugs and may be applied to all elements of each drug class in the category. In these cases, both brand name and generic elements of the class will be classed as preferred agents. If the class is not part of a preferred drug list (PDL), MACs may be applied to just the generic elements of the class. In these cases, a brand name prior authorization will be required in order to be reimbursed for the brand name drugs. No DAW option is available to override a MAC price. MAC prices may be used on drug categories that have FUL prices.

2 – 3 Non-Covered Drugs and Services

The list of cough and cold medications covered by Medicaid is now updated to include the following drugs: Guaifenesin with DextroMethorphan (DM) 600/30 tab, Guaifenesin with Hydrocodone 100/5 liquid, Promethazine with Codeine, Cheratussin AC, Rondec and Rondec DM (generic equivalents only), covered over-the-counter cough and cold remedies are given in the approved OTC list.

3 – 3 Prior Authorization Process

The prior authorization process for medications obtained through the pharmacy has changed. Pharmacy prior authorizations will no longer be specific to one pharmacy; they will be specific to the client and product authorized. Prior authorizations will no longer be issued via telephone calls. Faxed requests with the proper corresponding prior authorization request sheet are required. Sheets are available on the Medicaid Pharmacy Website at http://www.health.utah.gov/medicaid/pharmacy. **The fax number for pharmacy prior authorizations has changed. Requests must now be sent to (855) 828-4992.**

When a prior authorization request is denied, a hearing request form will no longer be faxed back to the requestor. The form can be downloaded and printed from the Medicaid Forms webpage at http://www.health.utah.gov/medicaid/provhtml/forms.htm.

4 – 7 Early Refills

The Early Refill section has additional information added to clarify the early refill process for narcotic analgesic pain medications. These refills will only be authorized 30 days after the previous fill and when 100% of the medication is expected to be used up.

12-57 Drug Coverage

Ferrous Sulfate

Ferrous Sulfate is a covered over-the-counter drug under the Medicaid pharmacy program. Due to drug file updates, there are currently only a few NDCs that are processing for payment. Please dispense the following NDCs for Medicaid clients:

00536-5890-01
63868-0617-01
64376-0809-10

Phenobarbital

Phenobarbital is a covered drug under the Medicaid pharmacy program. In December 2011, the manufacturer of Phenobarbital issued an invalid discontinuation date to CMS. With that discontinuation date in place, Medicaid is not able to reimburse for Phenobarbital. We have contacted the manufacturer and verified the faulty discontinuation date. They have acknowledged this and are actively contacting CMS and drug data source providers to get the information corrected. One the information is updated, Medicaid will resume reimbursement for Phenobarbital.

12-58 NTM Manual Updates

The *Non-Traditional Medicaid Provider Manual* has been updated in the following section:

2 – 19 Pharmacy Services

Drug Product Exclusions and Restrictions: The benefit for injectable medications is limited in scope. Antihemophilia Factor products (only available through University Hospital Home Infusion Services) and Insulin 10ml vials will be covered.