UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin
October 2012

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12-86 Utah Medicaid Provider Statistical and Reimbursement (PS&R) Report

The Utah State Plan Attachment 4.19-B, page 1, which is incorporated into Utah Administrative Rule R414-1-5 by reference states, "In-state hospitals, beginning with the providers' fiscal year ending on or after January 1, 2012, shall complete the Title XIX sections of their Medicare Cost Report." The Medicaid-specific cost report information will be used to calculate a Medicaid CCR that will then be used in place of the Medicare CCR for outpatient hospital reimbursements as applicable.

Utah Medicaid will provide, upon request, a Provider Statistical and Reimbursement (PS&R) report for the fee-for-service claims data. This report provides summary statistical data including: total covered charges, units, and reimbursement (including supplemental payments) by fiscal period. This report provides data to aid in the provider cost reporting relative to Utah Medicaid reimbursement.

Please note that the data in this report only includes fee-for-service information. Any managed care plan claims data would need to be requested of the appropriate managed care organization.

To request a fee-for-service report, contact Andrew Ozmun at aozmun@utah.gov, or (801) 538-6733.

12-87 Medicaid Hospice Rates

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

These rates are effective October 1, 2012. 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 fiscal years (e.g., September/October billings). The FY 2012 rates will be used if the hospice chooses not to split the claim, and Medicaid will perform no subsequent adjustments to these claims.

12-88 Provider Enrollment Inactivity

Utah Medicaid may close providers who are inactive for one or more years without notification.

12-89 Urgent Care Services for the Restricted Client

Utah Medicaid will authorize payment for clients enrolled in the Restriction and Care Coordination Program to utilize all in-network urgent care clinic centers. In the past, the name of an urgent care clinic has been listed on the Medicaid medical card for a restricted individual. This designation has been removed from the restricted medical card.

Restricted Medicaid clients are no longer restricted to a single urgent care clinic. Medicaid encourages clients to go to the nearest urgent care clinic, in their health plan network, when necessary medical care is not an emergency and/or their primary care physician is not available.

A list of authorized urgent care clinics can be found at: http://health.utah.gov/safetowait/. If an urgent care clinic would like to update or change the information found on this website, please call (801) 538-9045, or 1-800-662-9651, ext. 900.

As a reminder, urgent care services are not covered for Primary Care Network (PCN) clients. Please refer these clients to the primary care provider listed on their medical card.

12-90 HIPAA Version 5010 Implementation

Utah Medicaid discontinued accepting and processing 4010 276 (claims status inquiry) transactions on September 4, 2012. The 4010 837s (health care claims) and 270 (eligibility request) transactions will also be terminated beginning November 1, 2012. Please call your software vendor in order to transition over to the 5010 format for the 837, 270, and 276 transactions. For UHINt and Proclaim users, contact UHIN at (801) 716-5901 for assistance.

REAL TIME TRANSACTION

Currently, Utah Medicaid is developing real time transaction for the 270/271, 276/277, 278, and 999 transactions. Real time testing is scheduled for late November. 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 1-800-662-9651, 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 transaction, Utah Medicaid is no longer accepting access applications to Medicaid Online.

PAPER BILLERS

With the implementation of HIPAA 5010, and in order to meet specific requirements, Medicaid requires the billing provider address to be a street address with a valid nine-digit zip code. P.O. Box and/or Lock Box addresses are no longer allowed. Effective immediately, paper claims with P.O. 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 email list serve at medicaidops@utah.gov. You may also sign up to receive the UHIN Alerts for notifications and payer's availability at: http://www.uhin.org/pages/membership/newsletter-alerts.php.

12-91 Emergency Room Billing for Pharmaceuticals

Effective October 1, 2012, all pharmaceutical claim lines without a valid NDC will be denied. Previously, this denial did not apply to emergency room billing with revenue codes 450 and 459. All pharmaceutical claim lines with dates of service after October 1, 2012, will now be subject to NDC validation and a denial will be made if a valid NDC is not present on the claim.

12-92 Physician Administered Injectable Medication Coverage

Current Utah Medicaid policy requires that certain injectable medications administered by a physician in office will only be reimbursed after obtaining a prior authorization. These medications include: Amevive, Avastin, Krystexxa, Orencia, Remicaid, Soliris, Tysabri, Vectibix, Vivtrol, and Xolair.

For a complete listing of prior authorization criteria, see the *Injectable Medications Attachment* located with the Physician and Anesthesiology provider manual at: http://www.health.utah.gov/medicaid.

12-93 Synagis Reimbursement Change Coming

Utah Medicaid's Respiratory Syncytial Virus (RSV) season has historically been defined as November 1 through April 30. In response to recommendations from the Utah Medical Association and the Medicaid Drug Utilization Review Board, Utah Medicaid will change the current system and allow enrolled pharmacy providers to dispense Synagis (palivizumab) and bill Medicaid.

Beginning December 1, 2012, Synagis (palivizumab) will be provided through pharmacy billing for Medicaid clients. This product will now be reimbursed at our standard AWP – 17.4% rate. Synagis (palivizumab) will still require a clinical prior authorization, but will now be supplied through any willing Medicaid-enrolled pharmacy provider. This is a change from the current method, in which physicians must buy Synagis (palivizumab) and then bill Medicaid only for the portion used for Medicaid clients.

To prevent accidental or other duplicative billing, physician providers will no longer be able to buy and bill for Synagis (palivizumab) under Medicaid. The Current Procedural Terminology (CPT) code 90378 for Synagis (palivizumab) will no longer be payable to a medical provider as of December 1, 2012. After a prior authorization (PA) is obtained, pharmacy providers will bill using Synagis' National Drug Code (NDC) through the Point of Sale Medicaid billing system.

The process for obtaining a clinical authorization will remain the same. Physicians are required to obtain the authorization using the Utah Department of Health, Prior Authorization Request Form for Synagis (palivizumab). This form is available on our website at: www.health.utah.gov/medicaid/pharmacy.

12-94 Drug Criteria and Limits/Prior Authorization Updates

Periodically, the Drug Utilization Review (DUR) Board reviews prior authorization criteria. See below updates:

1. In July, the DUR Board reviewed the Synagis criteria for prior authorization and updated the criteria. The updated criteria now reflects the recommendations of the American Academy of Pediatrics found in the 2012 Redbook and reads as follows:

- **Infants Eligible for a Maximum of Five (5) Doses:**
- < 24 months of age -AND- chronic lung disease of prematurity (formerly bronchopulmonary dysplasia) requiring ongoing medical therapy.
- < 24 months of age -AND- congenital heart disease requiring ongoing medical therapy.
- Premature birth, defined as ≤ 31 weeks, 6 days gestation.
- Infants < 24 months with congenital abnormalities of the airway and/or neuromuscular disease that compromise respiratory secretions.
- **Infants Eligible for a Maximum of Three (3) Doses:**
- Birth ≥ 32 weeks, 0 days, and ≤ 34 weeks, 6 days -AND- born after September 1st -AND- at least one of the following two risk factors:
- Child care attendance.
- ≥ 1 child in the home ≤ 5 years of age.
- **Please Note:**

- The Utah Medicaid Synagis season is December 1st through April 30th. A maximum of five monthly Synagis doses may be given during this five-month period.

-Synagis is not available to any child with active RSV.
-No approval will be given to a child of 24 months or older.
-When an infant begins a Synagis series late in the season, they may receive monthly doses until April 30th, as appropriate, according to the criteria above. A child who begins the series and then turns two may receive monthly doses until April 30th, as appropriate, according to the criteria above.
-The DUR Board, accepted recommendations from the American Academy of Pediatrics, the manufacturer, and the FDA approved indications, in developing these criteria. Therefore, prescribers seeking approval outside the above criteria must provide literature that demonstrates support for the requested use. Consideration of the request will not proceed without it. NO EXCEPTIONS.

2. Low Molecular Weight Heparins (for Non-Traditional Medicaid clients), Stimulants, and Suboxone/Subutex prior authorization criteria were not reviewed by the DUR board but have had wording revisions and clarifications that do not change the overall criteria.

Low Molecular Weight Heparins (for Non-Traditional Medicaid clients):

- Arixtra:
- Pre-operative to stop Coumadin prior to surgery, maximum of 3 days.

AND/OR

- Post-operative bridging to Coumadin (to therapeutic INR); maximum 5 days.

AND/OR

- Post-operative DVT prevention for surgeries of the abdomen or lower extremities (i.e. hip, knee, and ankle not including foot and toes); maximum of 14 days.

OR

- Treatment of acute DVT when administered in conjunction with Coumadin; maximum of 10 days.

OR

- Treatment of acute PE when administered in conjunction with Coumadin, when initial therapy is administered in the hospital; maximum of 10 days.
- Patients diagnosed with cancer will only receive authorization for 6 months of treatment.
- Fragmin and Lovenox:
- Pre-operative to stop Coumadin prior to surgery; maximum of 3 days.

AND/OR

- Post-operative bridging to Coumadin (to therapeutic INR); maximum 5 days.

AND/OR

- Post-operative DVT prevention for surgeries of the abdomen or lower extremities (i.e. hip, acute knee, and ankle not including foot and toes); maximum of 14 days.

OR

- Treatment of acute DVT and/or PE when administered in conjunction with Coumadin; maximum of 10 days.

OR

- Treatment of ischemic complications of unstable angina and non-Q-wave MI patients on concurrent aspirin therapy; maximum of 10 days.

OR

- Treatment or secondary prevention of DVT and/or PE in cancer patients; authorized for 12 months.
- Authorization for Innohep and Fragmin require a trial and failure of or contraindication to the preferred product (generic Enoxaparin).

Stimulants (All criteria remains; only the following statement regarding criteria for children was revised):

- INFORMATION: Children ONLY covered for ADD and ADHD. With the correct ICD-9-CM code for pediatric patients from ages 3 through 18, no prior authorization is needed for immediate release amphetamines Adderall, Dexedrine or Desoxyn. Consideration for patients under 3 requires an evaluation

by a child/adolescent psychiatrist. With the correct ICD-9-CM code for patients ages 6 through 18, methylphenidates and Adderall XR may be approved without prior authorization. Consideration for patients under 6 requires an evaluation by a child/adolescent psychiatrist. When reaching age 19, a letter of medical necessity only is required (see re-authorization criteria).

Suboxone: Any statements referencing Subutex have been removed as it is no longer being manufactured.

12-95 MAC Pricing Inquiries

Utah Medicaid has contracted with Gould Health Systems (GHS) to research and set state Maximum Allowable Costs (MAC). If you have a question regarding the reimbursement received on a pharmacy Point of Sale claim, please contact GHS by telephone at (855) 389-9505, or by fax at (877) 920-1069.

As a reminder, quarterly and annual price surveys will now be conducted by GHS. Your response is important as feedback from the survey directly affects Medicaid reimbursement.

12-96 Online Criteria Updates

The following criteria have been updated effective October 1, 2012. The criteria are located on the Utah Medicaid website under the "criteria" link at www.health.utah.gov/medicaid.

Medical and Surgical Procedures

- Acne Surgery
- Salpingostomy, Laparoscopic/Open
- Salpingectomy, Laparascopic/Open
- Orchiectomy (Pediatric)
- Endothelial Cell Photography AKA Specular Endothelial Microscopy
- Vagal Nerve Stimulator
- Hysteroscopy, Operative
- Bladder Neck Suspension/Sling and Other Pelvic Surgical Procedures, Female
- Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- BSO
- Hysterectomy, Abdominal, +/- BSO
- Hysterectomy, Total Laparoscopic (TLH), +/- BSO
- Hysterectomy, Vaginal, +/- BSO
- Polysomnogram (PSG)
- Spinal Cord Stimulator (SCS) Trial Insertion
- Spinal Cord Stimulator (SCS) Permanent

Criteria for Imaging

- Positron Emission Tomography (PET), PET/CT
- Positron Emission Tomography (PET), PET/CT (Pediatric)
- Nuclear Stress Test, Thallium/Technetium/Sestamibi
- Magnetic Resonance Imaging (MRI), Breast
- Magnetic Resonance Imaging (MRI), Brain

Criteria for Durable Medical Equipment

- Insulin Pump, Ambulatory

12-97 Procedure Codes

Covered

33967 Insertion intra-aortic balloon assist device

75960 Transcath intro of intravascular stent percutan, and/or open rad supervise and interp (PT 20, 24, 45, 91 added)

76881 US extremity, non-vascular, complete (added PT 20, 24, 45, 52, 91 to technical)

99354 Prolonged service, outpatient (PT 37 and 47 added)

99355 Prolonged service, outpatient (PT 37 and 47 added)

99356 Prolonged service, inpatient (PT 37 and 47 added)

99357 Prolonged service, inpatient (PT 37 and 47 added)

Covered including OPPS

95012 Nitric oxide expired gas determination

95816 Electroencephalogram (EEG); including awake and drowsy recording

95819 . . . including awake and asleep recording

Opened in OPPS Provider Type 01-Hospitals

43605 Biopsy of stomach by laparotomy

43610 Excision, local; ulcer or benign tumor of stomach

43611 . . . malignant tumor of stomach

44300 Placement, enterostomy or cecostomy tube open for feeding or decompression

51980 Cutaneous vesicostomy (limited to EPSDT)

58700 Salpingectomy, complete or partial, uni- or bilateral

58720 Salpingo-oopherectomy, complete or partial, uni-or bilateral

Covered with prior authorization (PA)

S9455 Diabetes self-management training (DSMT)

10040 Acne surgery (e.g. marsupialization)

71550 MRI chest; without contrast

71551 . . . with contrast material

71552 . . . without contrast material(s) followed by contrast and further sequences

72195 MRI pelvis; without contrast materials

72196 . . . with contrast material

72197 . . . without contrast material(s) followed by contrast and further sequences

74181 MRI imaging abdomen; without contrast material

74182 . . . with contrast material

74183 . . . without contrast material(s) followed by contrast and further sequences

77058 MRI breast without and/or with contrast material(s); unilateral

77059 . . . bilateral

78451 Myocardial perfusion imaging tomographic (SPECT)

78452 . . . multiple studies, at rest and/or stress

78811 PET imaging; limited area (chest, head/neck)

78812 . . . skull base to mid thigh

78813 . . . whole body

78814 PET/CT; limited (chest, head/neck)

78815 . . . skull base to mid thigh

78816 . . . whole body

Covered without PA for EPSDT

70540 MRI orbit, face, and/or neck; without contrast

70542 . . . with contrast

70543 . . . without contrast material(s) followed by contrast and further sequences

70551 MRI brain; without contrast material

70552 . . . with contrast material

70553 . . . without contrast material(s) followed by contrast and further sequences

72141 MRI spinal canal and contents, cervical; without contrast

72142 . . . with contrast material

72146 MRI spinal canal and contents, thoracic; without contrast

72147 . . . with contrast material

72148 MRI spinal canal and contents, lumbar; without contrast

72149 . . . with contrast material

72156 MRI spinal canal and contents without contrast material, followed by contrast material(s) and further sequences; cervical

72157 MRI spinal canal and contents without contrast material, followed by contrast material(s) and further sequences; thoracic

72158 MRI spinal canal and contents without contrast material, followed by contrast material(s) and further sequences; lumbar

73218 MRI imaging, upper extremity, other than joint; without contrast material

73219 . . . with contrast material

73220 . . . without contrast material(s) followed by contrast and further sequences

73221 MRI imaging, upper extremity, any joint; without contrast material

73222 . . . with contrast material

73223 . . . without contrast material(s) followed by contrast and further sequences

73718 MRI imaging, lower extremity, other than joint; without contrast material

73719 . . . with contrast material

73720 . . . without contrast material(s) followed by contrast and further sequences

73721 MRI imaging, lower extremity, any joint; without contrast material

73722 . . . with contrast material

73723 . . . without contrast material(s) followed by contrast and further sequences

75557 Cardiac MRI for morphology and function without contrast

75559 . . . with stress imaging

75561 Cardiac MRI for morphology and function without contrast material, followed by contrast material(s) and further sequences

75563 . . . with stress imaging

75565 Cardiac MRI for velocity flow mapping (add on code in addition to primary procedure)

77084 MRI bone marrow blood supply

Non-Covered (closed in OPPS)

T1000 Private duty nursing (closed in Non-Traditional Medicaid)

43752 Naso or Oro-gastro tube placement, requiring physician skill

64632 Destruction by neurolytic agent; plantar common digital nerve

12-98 Medical Supplies List Updated

Code closed, effective October 1, 2012:

E0983 Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control

Effective October 1, 2012, age limit removed and prior authorization (PA) required:

E2293 Back, contoured, for pediatric size wheelchair, includes fixed attaching hardware

12-99 Audiology Manual Updated

Codes opened to audiologists as an allowed provider type, effective October 1, 2012.

69210 Removal impacted cerumen (separate procedure), 1 or both ears

92551 Screening test, pure tone, air only

92579 Visual reinforcement audiometry (VRA) kids

92582 Conditioning play audiometry

92587 Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)

92588 Comprehensive or diagnostic evaluation (comparison of transient and /or distortion product otoacoustic emissions at multiple levels and frequencies)

92590 Hearing aid examination and selection; monaural

92591 Hearing aid examination and selection; binaural

92625 Assessment of tinnitus (includes pitch, loudness matching, and masking)

12-100 CRNA Anesthesia Codes

Codes opened to CRNA, provider type 38, effective August 1, 2012.

D9220 Deep sedation/ general anesthesia, first 30 minutes

D9221 Deep sedation/ general anesthesia, each additional 15 minutes

12-101 Form Changes

Prior Authorization Request Form

Added - Mandatory question to inform Utah Medicaid if the request is for an inpatient client.

Reminder -

- Use the most recent version of the form.
- Complete all required sections legibly and correctly, or the request will be returned without being processed.

12-102 Physician Manual

Revised statement concerning coverage of E&M and procedure codes page 13, # 11

Payment of E&M and Procedure Codes

Coverage of an E&M code is adjusted when a procedure is completed during the office visit. Medicaid uses editing programs to determine coverage which is affected by the date payment is requested and complexity of the service.

Removed Criteria#40B from page 49, AA:

Now reads: Refer to Criteria for Imaging at http://health.utah.gov/medicaid/pa/index.html.

Removed sentence from page 49, AA:

When MRI, CT, or PET imaging procedures are requested more than once in a year for the same anatomical area, medical record documentation must support the necessity of repeating the procedure.

12-103 Services for Pregnant Women Manual Updates

Changes:

2– 4 Nutritional Assessment and Counseling

2. Nutritional counseling by a Registered Dietitian consists of an individual plan to meet the **protein and caloric** requirements of pregnancy and to address any dietary **issues**. The plan should be documented in the client's record.

12-104 Inpatient Admission List Updated

The *Authorized Emergency Inpatient Diagnosis List* was updated, effective July 1, 2012, and again October 1, 2012.

12-105 Hospital Manual

The following has been added to the Hospital Manual, 1-3 Definitions:

Secondary Diagnosis – Includes all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Secondary diagnosis code(s) are listed after the principle diagnosis. The codes are sequenced in the proper order, not in random order.

Citations: ICD-9-CM, 6th Edition; UHDDS; July 31, 1985, Federal Register (Vol. 50, no, 147), pp. 31038-40; Medicaid Information Bulletin: April 2012, Hospital Services Manual, 1-2 Covered Services.

12-106 Podiatry Manual Updated

Effective October 1, 2012, the following codes will be closed for podiatry to correct discrepancies between the reference file and the policy manual:

17003 Destruction benign 2-14 lesions, any method

17004 Destruction benign 15 or more lesions, any method

99242 Office consultation

29424 is a typographical error in the *Podiatry Manual* (correct code is 29425).

All codes have been removed from the *Podiatry Manual*, except those that indicate a limitation. All other codes open to podiatrists are found online through the "Coverage and Reimbursement Lookup Tool" at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

12-107 Section I – General Information Manual Changes

The following has been added to Section I, 9-1 Unspecified Services and Procedures:

Manual Review of Claims

- Information outlining how to determine if a claim is eligible for the manual review process.

Summary:

- When an explanation of benefits (EOB) is received with a denial, the provider may review the denial reason and, if the criteria are met, may request a manual review of the claim.
- Basic criteria includes: denial codes on the EOB, what type of modifier is used in the claim, and certain diagnosis and CPT codes.

12-108 Long Term Care Manual Updated

The following changes have been made in the *Long Term Care Services in Nursing Facilities Provider Manual*:

1. In compliance with R414-502, the previous term of Intermediate Care Facility for the Mentally Retarded has been replaced with the appropriate term of Intermediate Care Facilities for Persons with Intellectual Disabilities.

2. 5. Preadmission Screening and Continued Stay Review (page 24)

   R414-501 of the Utah Administrative Code (UAC) defines the preadmission and continued stay review process.

   a. Removed: text of R414-501

   b. Added: "Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-501.htm for the most current information relating to this rule."

3. 5-3 Nursing Facility Levels of Care (page 33)

   R414-502 of the Utah Administrative Code (UAC) defines the levels of care provided in nursing facilities.

   a. Removed: text of R414-502

   b. Added: "Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-502.htm for the most current information relating to this rule."

   c. In compliance with R414-502, a new definition of autism spectrum disorders was incorporated. For information relating to the new definition of autism spectrum disorders, please refer to http://www.rules.utah.gov/publicat/code/r414/r414-502.htm.

4. 5-4 Preadmission Screening and Annual Resident Review (page 37)

   R414-503 of the Utah Administrative Code (UAC) implements requirements for the preadmission screening and annual review of nursing facility residents with serious mental illness, or for people with intellectual disabilities.

   a. Removed: text of R414-503

   b. Added: "Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-503.htm for the most current information relating to this rule."

5. 6-2 Alternative Remedies for Nursing Facilities (page 47)

   R414-7C of the Utah Administrative Code (UAC) provides for the imposition of alternative remedies as the result of on-site inspection findings.

   a. Removed: text of R414-7C

   b. Added: "Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-7c.htm for the most current information relating to this rule."

12-109 Medical Supplies Manual Policy Update

The following is clarification to Section 4, Purchase or Rental of Equipment:

5. Wheelchairs allowed as a rental do not require a prior authorization. The only attachment allowed for rental only wheelchairs is elevating leg rests (Code E0990), when included in the doctor's order. Rental wheelchairs are not allowed when a patient's medical condition, which requires a wheelchair, will be permanent.

12-110 Updates to HCBS Waiver Provider Manuals

The following Home and Community Based Waiver Services provider manuals have been updated: *Acquired Brain Injury, Physical Disabilities*, and *Technology Dependent Waiver*. The updates include the agency name change from the Bureau of Long Term Care to the Bureau of Authorization and Community Based Services. In addition, the policy regarding the termination of HCBS waiver services was updated and the current incident reporting protocol was added. The lists of services and corresponding codes were updated in each manual as well.

Other key updates include the addition of the waiver eligibility requirement that individuals must meet a qualifying ICD-9-CM diagnosis as outlined in Administrative Rule R539-1-8(1)(a) in the *Acquired Brain Injury Waiver* provider manual, and the term "support coordinator" was changed to "administrative case manager" in the *Physical Disabilities Waiver* provider manual.

12-111 New Choices Waiver Provider Manual Updated

The *New Choices Waiver Provider Manual* has been updated. Key updates include:

1. The minimum age for admission was changed from 21 to 18 years old.
2. Language was added to include long term residence (180 days or more) in a licensed assisted living facility to the eligibility criteria.
3. The required disenrollment time frame for participants who have been temporarily admitted to a nursing facility or hospital has been extended from 30 days to 90 days. HCPCS code T2024 will be used to bill for case management services provided during these stays.
4. The incident reporting protocol has been modified and a new incident report form has been created.
5. Waiver contact information has been updated.

Please review the manual in its entirety for other minor revisions.

12-112 Attn: Mental Health Centers/Prepaid Mental Health Plans

Effective October 1, 2012, the Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Mental Health Centers/Prepaid Mental Health Plan Providers* has been updated as follows:

In Chapter 1-12, in the section on the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), a paragraph has been added explaining the NCCI's Medically Unlikely Edits (MUE) module. Providers are responsible to check the NCCI website as CMS can update these modules quarterly.

Providers may access the updated manual at www.health.utah.gov/medicaid.

If you do not have Internet access or have questions about this article, contact Merrila Erickson at (801) 538-6501 or e-mail at merickson@utah.gov.

12-113 Attn: Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse Providers

Effective October 1, 2012, 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 1-11, in the section on the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), a paragraph has been added explaining the NCCI's Medically Unlikely Edits (MUE) module. Providers are responsible to check the NCCI website as CMS can update these modules quarterly.

In Chapter 2-3, procedure code H0001 is no longer covered and replaced with H0031 for dates of service on or after October 1, 2012. Under NCCI's MUE module, CMS has set a limit of one unit on H0001 that is payable by Medicaid on a fee-for-service basis. This limit has not been applied to procedure code H0031. Therefore, substance abuse providers will use H0031 in both fee-for-service and encounter data instead of H0001.

Providers may access the updated manual at www.health.utah.gov/medicaid.

If you do not have Internet access or have questions about this article, contact Merrila Erickson at (801) 538-6501 or e-mail at merickson@utah.gov.

12-114 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, 2012, the Medicaid provider manual entitled, *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 1-10, in the section on the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), a paragraph has been added explaining the NCCI's Medically Unlikely Edits (MUE) module. Providers are responsible to check the NCCI website as CMS can update these modules quarterly.

In Chapter 2-3, procedure code H0001 is discontinued. Providers must use H0031 exclusively for dates of service on or after October 1, 2012. Under NCCI's MUE module, CMS has set a limit of one unit on H0001 that is payable by Medicaid on a fee-for-service basis. This limit has not been applied to procedure code H0031; therefore, H0031 will be used for both mental health and substance use-related psychosocial assessments.

Providers may access the updated manual at www.health.utah.gov/medicaid.

If you do not have Internet access or have questions about this article, contact Merrila Erickson at (801) 538-6501 or e-mail at merickson@utah.gov.

12-115 Attn: Psychologists

Effective October 1, 2012, the Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Psychology Services* has been updated as follows:

In Chapters 1-1, 1-2 and 1-4, references to health plans and health plan responsibility for psychologist services have be removed.

In Chapter 1-2, the following changes also have been made:

Revisions have been made to clarify Prepaid Mental Health Plan coverage.

Provision A under the section on exceptions to coverage policy has been deleted as this exception no longer applies.

Provisions B-D have been re-lettered accordingly and other non-substantive wording changes have been made to these remaining provisions.

In Chapter 1-3, under item F, a section explaining the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) has been added.

Providers may access the updated manual at www.health.utah.gov/medicaid.

If you do not have Internet access or have questions about this article, contact Merrila Erickson at (801) 538-6501 or e-mail at merickson@utah.gov.

12-116 Correction to Article 12-83 Published in the July 2012 MIB

Expansion of Prepaid Mental Health Plan (PMHP) to Include Outpatient Substance Use Disorder Services

In Article 12-83, Weber Human Services was inadvertently left off the table below. The table has been corrected.

Effective July 1, 2012, Medicaid's mental health managed care program, the Prepaid Mental Health Plan (PMHP), was expanded in all counties covered under the PMHP (except Box Elder, Cache and Rich counties) to include outpatient rehabilitative substance use disorder services. This means Medicaid recipients must get outpatient substance use disorder services through the PMHP contractor listed on their Medicaid cards.

Medicaid no longer reimburses substance abuse providers directly for dates of service on or after July 1, 2012. If a provider wishes to provide services to Medicaid clients, they must contact the applicable PMHP contractor regarding whether they can become a panel provider.

The following table shows PMHP contractors and coverage by county.

Prepaid Mental Health Plan Coverage by County

Prepaid Mental Health Plan Contractor (PMHP)	Counties	Inpatient & Outpatient Mental Health Services	Outpatient Rehabilitative Substance Use Disorder Services
Bear River Mental Health	Box Elder, Cache, Rich	Yes	No
Southwest Utah Behavioral Health	Beaver, Garfield, Iron, Kane, Washington	Yes	Yes
Four Corners Community Behavioral Health Center	Carbon, Emery, Grand	Yes	Yes
Northeastern Counseling Center	Daggett, Duchesne, Uintah	Yes	Yes
Davis Behavioral Health	Davis	Yes	Yes
Central Utah Counseling Center	Juab, Millard, Piute, Sanpete, Sevier, Wayne	Yes	Yes
Weber Human Services	Morgan & Weber	Yes	Yes
Salt Lake County, Division of Behavioral Health Services/OptumHealth	Salt Lake	Yes	Yes
Valley Mental Health	Summit & Tooele	Yes	Yes
Wasatch Mental Health	Utah	Yes	No
Utah County Department of Drug & Alcohol Prevention & Treatment	Utah	No	Yes

Utah County

In Utah County, there are two PMHP contractors. Wasatch Mental Health continues to be the PMHP contractor responsible for mental health services. The Utah County Department of Drug & Alcohol Prevention & Treatment is the PMHP contractor responsible for outpatient substance use disorder services. Utah County Medicaid recipients' Medicaid cards also have 'Utah County Drug & Alcohol Svcs' listed.

This change does not affect the following:

1. Methadone maintenance services. Methadone maintenance services will not be included under the PMHP. Methadone maintenance providers will continue to bill Medicaid directly for methadone maintenance services.

2. Children in state custody (foster care). These children are not enrolled in the PMHP for outpatient mental health services or outpatient substance use disorder services. Department of Human Services caseworkers will continue to help these children get needed mental health or substance use disorder services from qualified providers. Providers will continue to bill Medicaid directly.

3. Children with state adoption subsidy who are exempted on a case-by-case basis from the PMHP for outpatient mental health services. Exempted children will be exempted for both outpatient mental health and substance use disorder services. Department of Human Services post-adoption workers will continue to help these children get needed mental health or substance use disorder services from qualified providers. Providers will continue to bill Medicaid directly.

4. Independent prescribers prescribing medications for a substance use disorder since the independent prescriber would not be part of a substance abuse treatment agency or program.

12-117 Influenza Vaccine Provided by Vaccines For Children (VFC)

Utah Medicaid is a strong supporter of immunizations and seeks to assist and encourage the medical professionals who provide them.

Physicians and other eligible medical providers are encouraged to administer the VFC influenza vaccine to all eligible Utah Medicaid patients as soon as they receive the vaccine. There is no "start date" before which Utah Medicaid will not reimburse the administration.

Physicians should bill for VFC administration using appropriate procedure codes, and will be reimbursed appropriately. Questions regarding denied or back-dated claims can be addressed to Utah Medicaid Customer Service at (801) 538-6155, or 1-800-662-9651.

This year, a new Utah Medicaid policy extends vaccination reimbursement to pharmacists. Utah Medicaid is pleased to increase access to VFC influenza immunizations via this policy. Beginning October 1, 2012, enrolled

pharmacies may bill Utah Medicaid for the vaccine at the pharmacy's point of sale. A special, enhanced dispensing fee will be paid as a vaccine administration fee.

Please note that Vaccines For Children (VFC) are provided free of charge. Physicians, pharmacists, and other eligible medical providers will not be reimbursed for the cost of the drug.

12-118 Medicaid Autism Waiver Provider Manual

A new Home and Community Based Waiver provider manual has been created for the Medicaid Autism Waiver which will be starting this fall. The manual can be found online at: www.health.utah.gov/medicaid.

Additional information can also be found on the Medicaid Autism Waiver website at: http://health.utah.gov/autismwaiver.

12-119 Ambulatory Surgical Centers

Opened in Ambulatory Surgery Centers

12011 Simple repair superficial wounds of scalp, neck, axillae < 2.5 cm

20551 Injection single tendon insertion

21931 Excision tumor back or flank > 3 cm

22903 Excision of soft tissue tumor abdominal wall > 3 cm

24071 Excision of soft tissue tumor upper arm or elbow > 3 cm

30100 Intranasal biopsy

47563 Cholecystectomy with cholangiography

64634 Destruction by neurolytic agent, paravertebral joint nerve(s) with imaging guidance; cervical or thoracic, each additional facet joint. Radiofrequency method not covered.

64635 . . . lumbar or sacral, single facet joint. Radiofrequency method not covered.

64636 . . . lumbar or sacral; each additional facet joint. Radiofrequency method not covered.

67041 Vitrectomy with removal reretinal cellular membrane. Zion Institute.

67043 Vitrectomy with removal subretinal membrane. Zion Institute.

69424 Venting tube removal under anesthesia

69610 Tympanic membrane repair

In addition, effective October 1, 2012, pricing for Ambulatory Surgical Centers will be rebased using a budget-neutral calculation to ensure that Medicaid's pricing is no more than that of Medicare.