UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin
April 2013

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PO Box 143106, Salt Lake City, UT 84114

13-31 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.

13-32 Physician and VFC Enhancement Payments

This update provides the latest information based on the most recent federal guidance and supersedes any previous communication. Specifically, this provides an update of the type of attestation that must be provided by ***physicians*** *in order to qualify for the enhanced physician payments.*

Physician and VFC Enhancement Payments

On November 6, 2012, the Centers for Medicare and Medicaid Services (CMS) published a final rule (CMS-2370-F) titled, *Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program*. In short, the rule, beginning January 1, 2013, and continuing through December 31, 2014, will allow the state to increase payments to qualifying physicians for E&M services up to the Medicare rates and also increase the VFC admin rate allowed.

The rule publication may be reviewed on the Federal Register page. The link is as follows:

> http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf

On December 14, 2012, the Centers for Medicare and Medicaid Services (CMS) published a document that corrects technical errors (CMS-2370-CN) that appeared in the final rule published November 6, 2012 (CMS-2370-F) titled, *Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program; Correction*. A summary of the changes noted by CMS in the publication are as follows:

> In the November 6, 2012 final rule (77 FR 66670), we inadvertently published technical errors in § 447.400(a) and § 447.405 listed on page 66701. One correction ensures consistency between two

sentences in the same paragraph and the other restores text inadvertently omitted from the final rule that had been included in the May 11, 2012 notice of proposed rulemaking (77 FR 27671) on pages 26789–90. Thus, we are correcting page 66701 to reflect the correct information…

IV. Correction of Errors
In FR Doc. 2012–26507 of November 6, 2012 (77 FR 66670), make the following corrections: 1. On page 66701, in the first column; in the last full sentence, in the first partial paragraph, the sentence reads, ''A physician self-attests that he/she:''. Correct the sentence to read, ''Such physician then attests that he/she:''.
2. On the same page, in the same column; in the last full paragraph, paragraph (a) reads, ''For CYs 2013 and 2014, a state must pay for physician services described in § 447.400 based on:''. Correct the sentence to read, ''For CYs 2013 and 2014, a state must pay for physician services described in § 447.400 based on the lower of:''.

The rule publication may be reviewed on the Federal Register page. The link is as follows:

http://www.gpo.gov/fdsys/pkg/FR-2012-12-14/pdf/2012-29640.pdf

Additionally, CMS has provided further guidance in a recently published FAQ document. The link to this document is as follows:

http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Q-and-A-on-Increased-Medicaid-Payments-for-PCPs.pdf

Physician Enhancement and Self-Attestation

The enhanced rate will be available during the program period as noted above. In order to qualify for the enhanced rate, a **physician** must:

1. Provide **self**-attestation that they have:
   a. A primary care designation in:
      i. family medicine,
      ii. general internal medicine, or
      iii. pediatric medicine.
   b. **In addition**, they must be board certified in a sub-specialty recognized by:
      i. The American Board of Medical Specialties (ABMS),
      ii. The American Board of Physician Specialties (ABPS), or
      iii. The American Osteopathic Association (AOA).

   Or, if not board certified in a sub-specialty above:
      i. Self-attest to a specialty designation in family medicine, general internal medicine, or pediatric medicine and demonstrate that 60% or more of all Medicaid services they bill (including Medicaid managed care environments) are for the following codes: 99201 - 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474.

Providers qualifying with a board certification in one of the sub-specialties noted must also fax a copy of their board certification and any subspecialty certifications to (801) 536-0484 in order to complete the self-attestation. The fax cover sheet should include the provider's name, NPI, email address, and a contact phone number. Please be certain to submit the most current certification covering the calendar year 2013 and 2014 time periods.

Please note that self-attestation is subject to audit.

In order to validate the information that is submitted by physicians, Utah Medicaid will review all self-attestations to ensure, among other things, that: the NPI provided is valid, there is a current board certification for the submission, and that the attestation was a **self**-attestation submitted by the physician. The results for this review will then be posted on the Utah Medicaid website (http://health.utah.gov/medicaid/stplan/bcrp.htm) which will allow physicians to verify they have properly submitted, or where problems are identified, a list will be provided noting those problems. It is the provider's responsibility to submit all needed documentation to the agency. Providers should review this information to ensure that their self-attestation information is complete.

Clarification and guidance regarding eligible providers

First, further guidance has been provided to show the list of eligible sub-specialties. The list of these eligible sub-specialties is as follows:

ABMS

A. Family Medicine – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine.
B. Internal Medicine – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine; Transplant Hepatology.
C. Pediatrics – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities; Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology; Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

AOA

A. Family Physicians – No subspecialties.
B. Internal Medicine – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.
C. Pediatrics – Adolescent and Young Adult Medicine; Neonatology; Pediatric Allergy/immunology; Pediatric Endocrinology; Pediatric Pulmonology.

ABPS

The ABPS does not certify subspecialists. Therefore, eligible certifications are:

American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no board certification specific to Pediatrics.

Second, non-physician practitioners (e.g., nurse practitioner, physician assistant) should not participate in the self-attestation process. However, services rendered by such providers may be billed through an eligible physician if they are done under the direct supervision of that physician.

Third, these payments will be retroactive to the begin date of the quarter in which they are submitted assuming that the board certification date spans the full period and is not expired. Some examples are provided below:

Example 1
A provider who self-attests on 3/29/2013 and who is certified from 1/1/2013 to 12/31/2020 will be eligible for enhanced payments for service dates starting on 1/1/2013.

Example 2
A provider who self-attests on 1/1/2013 and who is certified from 2/1/2013 to 12/31/2020 will be eligible for enhanced payments for service dates starting on 2/1/2013.

Example 3
A provider who self-attests on 4/1/2013 and who is certified from 1/1/2013 to 12/31/2020 will be eligible for enhanced payments for service dates starting on 4/1/2013.

Self-Attestation Form Link

The attestation form can be accessed through the following link:

https://docs.google.com/a/utah.gov/spreadsheet/viewform?formkey=dG0wVnVZMXh2bmh3bTdDNE9CNmoxVWc6MQ#gid=0

Please be sure to use the individual NPI in the self-attestation as group NPIs will not be accepted in the final determination of eligible physicians.

Utah Medicaid Fee-For-Service Enhanced Payments

The details related to how these enhanced payments will be made are still being finalized with CMS. It is anticipated that these will be made as quarterly lump sum payment amounts to each qualifying provider based on their claims data. These payments will be made to the billing provider based on the qualifying servicing provider(s) individual NPI.

These changes are still pending CMS approval of the State Plan amendment.

Utah Medicaid Managed Care

Providers that only serve Utah Medicaid Managed Care must still self-attest through this process as Utah Medicaid will collect all of this information.

CMS has provided additional guidance related to how these payments may be paid to Accountable Care Organizations. The following describes the general methodology (prescribed by CMS) that Utah Medicaid plans to implement for these payments.

Non-risk Reconciled Payments for Enhanced Rates

Under this method, for 2013, states would prospectively pay capitation rates without enhanced primary care payments. Thus, these capitation rates would not be inclusive of the enhanced rate. At agreed upon intervals (e.g., quarterly) the MCPs would summarize actual encounter data or another reasonable data source to calculate the total payment that eligible providers would need to be paid for eligible services in order to reach the mandated Medicare payment rates. The state would review this report and if found reasonable, the state would pay the MCP the calculated additional payment amount. The MCP would then distribute those payments to the primary care providers using a method of their choosing.

The exact details related to how these enhanced payments will be made are still being finalized with CMS. It is anticipated that these will be made as quarterly lump sum payment amounts to each qualifying provider based on their claims data. These payments will be made to the Accountable Care Organization based on the qualifying servicing provider(s) individual NPI.

These changes are still pending CMS approval of the managed care contracts and state payment methodology.

Newly Enrolled Providers

For new providers that enroll over time, Utah Medicaid Provider Enrollment will request self-attestation information with the enrollment packet.

VFC Enhanced Payments

Qualifying providers, who meet the self-attestation requirements, may receive payments up to the new maximum allowed by the new rule.

These changes are still pending CMS approval of the State Plan amendment.

13-33 Manual Review Process

The manual review claims process will be changing. In an effort to clearly distinguish between client records, Medicaid will no longer accept medical documentation that includes the submission of multiple clients. When submitting documentation, providers must make a physical distinction between Medicaid clients. For example, when sending documentation via fax, a new fax coversheet must be used in order to indicate a new record.

Manual review claims documentation will be returned to the submitter if distinction between Medicaid clients is not made. The fax number for manual review claims documentation is (801) 536-0463.

13-34 Prior Authorization Request Form Changes

The Prior Authorization Request Form has been updated effective January 1, 2013. SelectHealth has been added as one of the Accountable Care Organizations (ACOs) at the top of the page in bold red.

Since January 1, 2013, SelectHealth Community Care has been processing its prior authorizations. Do not submit requests for prior authorization to Utah Medicaid for clients served by SelectHealth Community Care, Molina, Healthy U, or Health Choice Utah.

Please remember to use the most recent version of the form and complete all required sections legibly and correctly, or the request will be returned without being processed.

Note: Adobe Reader Version 11 is required in order to use the type-able form with Internet Explorer.

13-35 Physician Manual Changes

Information regarding manual review requirements for Intensity Modulated Radiation Therapy (IMRT), CPT codes 77301 and 77418, was added to the Physician Manual. Coverage and documentation requirements are included. For complete information, refer to the Physician Manual, pages 59-61, available on the Medicaid website at www.health.utah.gov/medicaid.

Added – Prior Authorization references to Medicaid Lookup Tool
For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

Changed – Use of Modifier 24
Modifier 24 is only allowed for post-operative pain management as appropriate for anesthesia providers and is recognized for manual review. Otherwise, this modifier is treated the same as modifier 25 and will not be recognized for manual review. Denied claims and unpaid modifiers will continue to have hearing rights.

13-36 General Information – Section I Updated

Updated – Managed Care, Chapter 4, to reflect the January 1, 2013, changes in managed care.

The Division of Medicaid and Health Financing (DMHF) contracts with managed care plans to provide for physical or behavioral health care for Medicaid clients. The model employed for physical health services is called an Accountable Care Organization (ACO).

DMHF requires all Medicaid clients living in Davis, Salt Lake, Utah, and Weber counties to enroll in an ACO such as Healthy U, Molina, Health Choice Utah, or SelectHealth Community Care. The ACO is paid a monthly

premium for each Medicaid client enrolled. The ACO is responsible for all health care services specified in the contract with DMHF.

Changed – Manual Review Process, Chapter 9-1, Modifier 24

Manual Review of Claims – Process, Criteria, and Actions

Modifier 24 can be used for post-operative pain management as appropriate for anesthesia providers and qualifies for manual review. Otherwise, this modifier is treated the same as modifier 25 and not recognized for manual review.

Reminder: Manual Review Process steps outlining how to determine if a claim is eligible for the manual review process are found in Chapter 9-1, Manual Review of Claims, page 45.

13-37 CPT Code Coverage

Covered

68720 Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)

96417 Chemotherapy administration; each additional sequential infusion (different substance/drug), up to one hour

Manual Review

77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, etc… as required during course of treatment, only when prescribed by the treating physician

77301 Intensity modulated radiotherapy (IMRT) plan, including dose-volume histograms for target and critical structure partial tolerance specifications

77418 Intensity modulated treatment (IMRT) delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic, MCL, per treatment

Open to Ambulatory Surgical Centers (ASC)

25606 Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation

25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

25608 Open treatment of distal radial intra-articular or epiphyseal separation, with internal fixation of two fragments

25609 Open treatment of distal radial intra-articular or epiphyseal separation, with internal fixation of 3 or more fragments

Prior Authorization Required

38205 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
Refer to Administrative Rule R414-10A

Non-Covered

81161 DMD (dystropin) (e.g. Duchenne/Becker Muscular Dystrophy) deletion and duplication analysis

90653 Influenza vaccine, inactivated, subunit, adjuvanted for IM use

90672 Influenza vaccine, quadrivalent, live for intranasal use

90685 Influenza virus vaccine, quadrivalent, split preservative free, for 6-35 months of age, IM use

90686 Influenza virus vaccine, quadrivalent, split preservative free, for 3 years and older, IM use

90687 Influenza virus vaccine, quadrivalent, split, for 6-35 months of age, IM use

90688 Influenza virus vaccine, quadrivalent, split, for 3 years of age or older, IM use

90739 Hepatitis B vaccine, adult dose (2 dose schedule) for IM use

13-38 NCCI Modifier Update

Effective April 1, 2013, per CMS, additional modifiers will be added to the list of NCCI-associated modifiers that will allow an edit with modifier indicator of "1" to be bypassed when the modifier is utilized correctly. These modifiers are:

- 24 (unrelated E&M service by the same physician during a postoperative period)
- 57 (decision for surgery)
- LM (left main coronary artery)
- RI (ramus intermedius)

24 Modifier
There may be occasion for a provider to perform and document a separate, unrelated significant E&M service above and beyond that which is medically necessary for managing post-operative care during the global surgical period. Even if a 24 modifier is added, this will be denied in electronic editing. The provider has the right to request a hearing on the matter and submit supporting documentation.

Anesthesia exception: The 24 modifier is allowed for post-operative pain management as appropriate for anesthesia providers and qualifies for manual review.

57 Modifier
When a provider meets the patient for the first time in the Emergency Department, Critical Care Unit, or preoperative holding area and makes the decision to take the patient to the operating room, a 57 modifier is

usually added to the E&M service. This will be denied in electronic editing. The provider has the right to request a hearing on the matter and submit supporting documentation.

LM and RI Modifiers

NCCI edits are overridden by appending modifier LM or RI to the therapeutic code for the artery undergoing treatment to show work was done in separate coronary arteries. The LM and RI modifiers will be recognized to override the current NCCI bundles when used to show the work was performed in separate coronary arteries. Currently, Medicaid recognizes LC (left circumflex coronary artery), LD (left anterior descending coronary artery), and RC (right coronary artery).

13-39 Dental Services Updates

Fluoride Treatment for EPSDT Eligible Children (Ages 0-18)

Effective January 29, 2013, the following dental code has been opened:
D1208 Topical application of fluoride

Effective April 1, 2013, the following dental code has been closed:
D1206 Topical application of fluoride varnish

Diagnostic Services

Effective January 15, 2013, the following dental codes are open for Traditional Medicaid:
D2392 Resin-based composite, two surfaces, posterior
D2393 Resin-based composite, three surfaces, posterior
D2394 Resin-based composite, four or more surfaces, posterior

Limited Emergency Dental Services

On July 1, 2012, Medicaid's limited emergency dental services for non-pregnant adults on Traditional and Non-Traditional Medicaid were introduced. The following dental codes were opened:
D0140 Limited oral evaluation, problem focused
D0220 Intraoral periapical, first film
D0230 Intraoral periapical, each additional film, if needed
D7140 Extraction, erupted tooth or exposed root
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7510 Incision and drainage of abscess, intraoral soft tissue

Dental Services Provider Manual Changes, Section I – General Information Policy (page 3)

Effective July 1, 2012, limited emergency dental services for non-pregnant adults on Traditional and Non-Traditional Medicaid are covered as described in Chapter 1-16, Limited Emergency Dental Services for Non-Pregnant Adults.

1-16 Limited Emergency Dental Services for Non-Pregnant Adults (page 10)

Effective July 1, 2012, limited emergency dental services for non-pregnant adults on Traditional and Non-Traditional Medicaid will be covered.

Services covered under the Emergency Dental Program are limited. To verify if a service is covered under the Emergency Dental Program, along with procedure codes with accompanying criteria and limitations, go to the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

13-40 Cochlear Device Implantation Policy

The *Utah Medicaid Audiology Provider Manual*, Chapter 2-4, Cochlear Implants, will be modified. Effective April 1, 2013, unilateral cochlear implants will be available to CHEC/EPSDT recipients if the service is determined to be medically necessary. Prior authorization is based on the evidence-based medicine reference tool (EMRT) available at www.health.utah.gov/medicaid, Health Care Provider menu, Criteria (*Instructions*).

The following code will be open with prior authorization, effective April 1, 2013:
69930 Cochlear device implantation, with or without mastoidectomy

13-41 Wheelchair Policy Clarifications

Modifications have been made to the *Utah Medicaid Medical Supply Provider Manual*, Chapter 2-9, Wheelchairs. Providers should carefully review the entire section. The primary purpose of the changes is to clarify how to use the "Motorized Wheelchair Checklist" and the "Motorized or Customized Final Evaluation" forms. Both forms are available at www.health.utah.gov/medicaid, Health Care Provider menu, Forms.

13-42 Medical Supply Code Changes

The following codes are open, effective April 1, 2013:

E0570	Nebulizer with compressor. Available as a purchase or a capped rental.
E1801 LL	Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories. Capped rental, prior authorization required.
E1806 LL	Static progressive stretch wrist device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories. Capped rental, prior authorization required.
E1811 LL	Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories. Capped rental, prior authorization required.
E1816 LL	Static progressive stretch ankle device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories. Capped rental, prior authorization required.
E1818 LL	Static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all components and accessories. Capped rental, prior authorization required.
E1841 LL	Static progressive stretch shoulder device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories. Capped rental, prior authorization required.

The following codes have status changes:

E0670	Segmental pneumatic appliance for use with pneumatic compressor. Added option of rental to this code. Prior authorization required. Effective January 1, 2013.
E2378	Power wheelchair actuator replacement. Prior authorization required. Changed to manual pricing. Effective April 1, 2013.
K0606 RR	Wearable cardiac defibrillator. Opened as a rental, prior authorization required. Effective September 1, 2012.
L1945	Ankle foot orthosis, plastic, rigid anterior tibial section (floor reaction), custom fabricated. Added provider types 60, 62, 91. Prior authorization required. Effective December 4, 2012.
L5649	Addition to lower extremity, ischial/narrow M-L socket. Provider types 60, 62, 91 are now allowed. Prior authorization required. Effective January 8, 2013.
L5651	Addition to lower extremity, above knee, flexible inner socket. Provider types 60, 62, 91 are now allowed. Prior authorization required. Effective January 8, 2013.
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control includes any type of motor(s). Corrected code to include 60, 62, 91 as allowed provider types (previously only showed provider type 01). Changed to manual pricing. Effective January 1, 2013.
L5930	Addition to lower extremity, endoskeletal system, high activity knee control frame. Provider types 60, 62, 91 now allowed. Prior authorization required. Effective January 8, 2013.
L5981	All lower extremity prostheses, flex-walk system or equal. Provider types 60, 62, 91 now allowed. Prior authorization required. Effective January 8, 2013.

13-43 Home Health Agency Provider Manual Updated

Effective April 1, 2013, an updated version of the *Utah Medicaid Home Health Agency Provider Manual* is available at www.health.utah.gov/medicaid. The manual has undergone major revisions. Providers are encouraged to read the manual with the following changes:

- Code tables have been removed from the manual. To access home health services codes, go to the Coverage and Reimbursement Lookup Tool at www.health.utah.gov/medicaid.
- The Private Duty Nursing Acuity Grid has been updated and is available at http://www.health.utah.gov/medicaid/provhtml/forms.htm.

13-44 Laboratory and Pathology Policy Changes

Effective April 1, 2013, the *Utah Medicaid Laboratory Provider Manual* has been revised and is available at www.health.utah.gov/medicaid. Some of the significant highlights include:

- Laboratory Coding Overview, pages 9-11 – Added to help navigate correct coding for prompt reimbursement.
- Non-covered services section, page 19 – Added new reference "R" to reinforce policy that there is no reimbursement for calculated or automated extrapolations of laboratory data.
- Laboratory tests sent to a reference laboratory, pages 19-20 (Chapter 5-3) – Added a new reference regarding billing policy for the tests.
- New attachment: *Detection of Microorganisms Using Nucleic Acid Probes Utilization Guidelines*. This policy is based on Medicare guidelines and contains information regarding utilization of and reimbursement for tests to detect microorganisms using nucleic acid probes.
    - To receive reimbursement for tests to detect microorganisms using nucleic acid probes, all of the following must be true.
    - The test:
        - Is ordered by a physician or eligible provider.
        - Is reported promptly to the physician.
        - Results are used by the physician in the management of the patient ("procedure to diagnosis" editing).
        - Must be considered reasonable and necessary.
            - For a test to be considered reasonable and necessary, the patient's presenting problem and/or symptoms must support the use of the test.

Reimbursement Limitations

- Medicaid does not reimburse for
    - Non-FDA approved tests. (See Section I – General Information Provider Manual at www.health.utah.gov/medicaid).
    - Laboratory studies currently in clinical trials where the study-related laboratory tests are paid for under a current study grant.
    - A generic test when a CPT code is available for the organism under surveillance.
    - 87797-87799 if there is a specific CPT code. For example, 87510 Direct Probe Technique for Gardnerella vaginalis.
    - Amplified probe technique for Infectious Agent detection.
- 87800-87801 - Should only be used for detection of multiple infectious agents not otherwise specified. For example, Chlamydia and Gonorrhea done together when there is not a specific code for running these together and obtaining a single result. See parenthetical statement under code 87800 in the 2013 Professional CPT book.
- 87797 -In the event there is a need to test for an organism, that is not currently accounted for in the CPT code family 87470-87801, then 87797 can be coded for only one unit as this is designed for each or a singular organism study.

- 87500 –No more than three units of service may be coded and reimbursed for the same date of service. This reflects the fact that no more than three genetic variants (e.g., Van A, Van B and/or Van C) should be necessary for the molecular evaluation of Vancomycin-resistant Enterococcus.
- 87501 –Only reimbursed for typing or subtyping influenza.

Rapid Respiratory Panels
The AMA added a new CPT code to the 2013 CPT for rapid respiratory panels, typically used for patients in the Emergency Department. The test is designed to depict multiple organisms in a multiplex reaction. Since one procedure produces many results, code 87631 is allowed reimbursement for one unit.

87631 Infectious Agent Detection by Nucleic Acid (DNA or RNA); respiratory virus (e.g. adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 3-5 targets

13-45 Physical Therapy Services Updates (Rehabilitation Centers and Independent)

New Physical Therapy and Occupational Therapy Services Provider Manual
Effective April 1, 2013, a new provider manual entitled, *Utah Medicaid Provider Manual for Physical Therapy and Occupational Therapy Services* will take the place of the three existing PT/OT manuals. This new manual includes updated content from all three manuals.

Access the new provider manual, and other associated information, on the Medicaid website at: www.health.utah.gov/medicaid.

Archived
The provider manuals listed below will be archived, effective April 1, 2013:

- *Physical Therapy and Occupational Therapy Services in Rehabilitation Centers*
- *Physical Therapy Services by Independent Physical Therapists (Including Group Practices) Not in Rehabilitation Centers*
- *Occupational Therapy Services by Independent Occupational Therapists (Including Group Practices) Not in Rehabilitation Centers*

13-46 Occupational Therapy Services Updates

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- *Occupational Therapy Services by Independent Occupational Therapists (Including Group Practices) Not in Rehabilitation Centers*

13-47 Neurobehavioral Exam and Neuropsychological Testing

96116 Neurobehavioral status exam
96118 Neuropsychological testing

The above CPT codes are covered for Traditional and Non-Traditional Medicaid and require manual review. There is a maximum of 8 units per year, per client, per code. Refer to the *Utah Medicaid Psychology Manual* or the *Utah Medicaid Rehabilitative Mental Health and Substance Abuse Disorder Services Manual* for information on manual review.

The CPT codes are closed for the Primary Care Network (PCN) program.

13-48 2013 Preferred Drug List

Utah Medicaid has posted the updated Preferred Drug List (PDL) effective for the 2013 calendar year. To view the PDL, please visit the Pharmacy Program website at www.health.utah.gov/medicaid/pharmacy.

13-49 Benzodiazepines and Barbiturates – Medicare Part D Coverage

Effective January 1, 2013, Medicare began covering barbiturates when prescribed for epilepsy, cancer, or a chronic mental health disorder, and benzodiazepines. Clients who are dual eligible (covered by both Medicare and Medicaid) will no longer receive coverage for these classes of medication through their Medicaid benefit.

13-50 Indian Health Services Pharmacies

Indian Health Services (IHS) pharmacies will continue to bill all POS pharmacy claims to fee-for-service Medicaid, regardless if the client is enrolled in an Accountable Care Organization (ACO).

13-51 Coverage of Medication Kits and Combination Products

The Medicaid Drug Utilization Board reviewed kits and combination products in January of 2011. Medicaid accepted the DUR Board recommendation that, unless economically beneficial to Medicaid, kits and combination packets are not reimbursable. For kits and combination products that are exceptions to this policy, refer to Utah Medicaid's Preferred Drug List at: http://www.health.utah.gov/medicaid/pharmacy/PDL/directory.php.

Please note that this policy applies to fee-for-service benefits, and not to benefits administered by Accountable Care Organizations (ACOs). Refer to the pertinent ACO's policy via Utah Medicaid's ACO directory at: http://www.health.utah.gov/medicaid/pharmacy/aco/directory.php.

13-52 OTC List Updated

The over-the-counter (OTC) medication list has been updated. It is important to note that over-the-counter medications are only covered when:

1. the medication is listed on the OTC list,
2. the medication is ordered on a written prescription, and
3. the manufacturer has entered into a rebate agreement with CMS.

There are a few OTC medications that Utah Medicaid has chosen to cover, although they do not offer CMS rebates. These have been identified at the bottom of the OTC list. The OTC list is found on the Utah Medicaid Pharmacy Program website at: http://www.health.utah.gov/medicaid/pharmacy/coverage/directory.php.

13-53 Technology Waiver Prior Authorization Change

Effective January 1, 2013, Technology Dependent Waiver service providers are no longer required to use a prior authorization number when billing code T1005, Community Based Respite. Providers must still obtain written service authorization through the RN Waiver Coordinators with the Bureau of Children with Special Health Care Needs (CSHCN).

13-54 Attn: Licensed Psychologists

Effective April 1, 2013, the *Utah Medicaid Psychology Services Provider Manual* has been updated in its entirety. The updated provider manual specifies the services available to individuals who exhibit intellectual disabilities, developmental disabilities or related conditions, and individuals with a condition that requires chronic pain management services. The updated provider manual also includes procedures for manual review by Medicaid for neuropsychological testing (procedure codes 96116 and 96118).

For services to individuals with mental health and/or substance use disorders, including service coverage and limitations, please refer to the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

Providers may access the revised provider 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.

13-55 Attn: Mental Health and Substance Use Disorder Treatment Providers

Effective April 1, 2013, the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated as follows:

- Chapter 1-2, Definitions, a definition for the University of Utah's HOME Program and for enrollees has been added.
- Chapter 1-3, Medicaid Behavioral Health Service Delivery System, clarifications have been made regarding individuals enrolled in the University of Utah's HOME Program.
- Chapter 1-4, Scope of Services, clarification has been made that services must be provided to the Medicaid individual or directed exclusively toward the treatment of the Medicaid individual.
- Chapter 1-5, Provider Qualifications, clarifications have been made regarding supervision of certified psychology residents, and regarding providers exempted from licensure who are qualified to provide services.
- Chapter 2-1, General Limitations, #3, has been updated to include procedures for manual review by Medicaid for services that require manual review.
- Chapter 2-2, Psychiatric Diagnostic Evaluation, the definition has been clarified.
- Chapter 2-4, Psychological Testing, the definition has been updated, clarification has been made regarding supervision of certified psychology residents, and the 'Limits' section has been updated to reference the manual review requirement for neuropsychological testing, procedure codes 96116 and 96118.
- Chapters 2-2, 2-8, 2-9, 2-10, 2-11, and in Chapter 3, for Prepaid Mental Health Plans, Chapter 3-2 and Chapter 3-3 have been updated to clarify services are provided face-to-face.
- Chapters 2-3, 2-9, 2-10 and 2-11, and in Chapter 3, for Prepaid Mental Health Plans, in Chapters 3-1, 3-2, 3-3 and 3-4, qualifications of registered nursing students have been clarified.

Providers may access the current and revised provider 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.

13-56 Accountable Care Organization (ACO) Update

Select Access and SelectHealth Community Care

Effective January 1, 2013, SelectHealth Community Care (SHCC), a new Accountable Care Organization (ACO), replaced Select Access. Prior to January 1, 2013, Select Access was the plan for Medicaid recipients whose claims were paid directly by Medicaid on a fee-for-service basis. Select Access and SelectHealth Community Care are not the same entity. Please note that Select Access no longer exists.

The majority of Medicaid recipients in Weber, Davis, Salt Lake, and Utah counties, who were enrolled in Select Access, are now enrolled in SelectHealth Community Care (SHCC). The remaining Medicaid recipients have enrolled in other ACOs (Healthy U, HealthChoice Utah, and Molina).

Because SelectHealth Community Care (SHCC) has a closed panel of providers, not all providers who previously billed Medicaid directly under Select Access are on SHCC's panel of providers. If a Medicaid recipient is enrolled in SHCC, the Medicaid identification card will show SelectHealth Community Care. Changes are in process to correct this terminology on the Medicaid Access Now system.