

TABLE OF CONTENTS

13-01	UTAH MEDICAID PROVIDER STATISTICAL AND REIMBURSEMENT (PS&R) REPORT.....	2
13-02	PHYSICIAN AND VFC ENHANCEMENT PAYMENTS	2
13-03	HIPAA VERSION 5010 IMPLEMENTATION.....	3
13-04	FDA PREGNANCY RISK CATEGORIES TO BECOME OBSOLETE.....	4
13-05	2013 CPT AND HCPCS CODES	5
13-06	PROVIDER E-PRESCRIBING PORTAL.....	13
13-07	CPT CODE COVERAGE.....	13
13-08	ICD-9-CM CODES.....	15
13-09	PHYSICIAN SERVICES UPDATES	16
13-10	PRIOR AUTHORIZATION (PA) CHANGES.....	18
13-11	MEDICAL SUPPLIES MANUAL.....	18
13-12	MEDICAL SUPPLIES LIST	20
13-13	PROVIDER PREVENTABLE CONDITIONS LIST CHANGES	20
13-14	ANESTHESIOLOGY MANUAL (SECTION 3) UPDATED	21
13-15	PHYSICAL THERAPY/OCCUPATIONAL THERAPY CHANGES	21
13-16	DENTAL SERVICES UPDATES.....	22
13-17	ORAL MAXILLOFACIAL SURGEON SERVICES UPDATES.....	24
13-18	VISION MANUAL UPDATES	25
13-19	AUDIOLOGY MANUAL UPDATES	26
13-20	SPEECH MANUAL UPDATES.....	27
13-21	MEDICAL TRANSPORTATION MANUAL UPDATES.....	27
13-22	PODIATRY MANUAL UPDATES	27
13-23	PSYCHIATRIC CPT CODES 90801 AND 90862.....	28
13-24	ATTN: PROVIDERS OF OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	29
13-25	ATTN: PREPAID MENTAL HEALTH PLANS, MENTAL HEALTH CENTERS, SUBSTANCE ABUSE AGENCIES, AND THE UNIVERSITY OF UTAH'S HOME PROGRAM	32
13-26	VACCINES AS A MEDICAL BENEFIT	33
13-27	MEDICAID PREFERRED DRUG LIST (PDL)	33
13-28	CORRECTION TO NOVEMBER INTERIM MIB ARTICLE 12-121	33

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

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PO Box 143106, Salt Lake City, UT 84114

13-01 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.

13-02 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>

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, physicians must:

1. Provide self-attestation that they have a specialty designation in family medicine, general internal medicine, pediatric medicine or a sub-specialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA).

OR,

2. 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.

These enhanced payments will not begin for a provider until the provider's self-attestation is received and is complete. For example, a physician completing his/her self-attestation on March 5, 2013, will not receive enhanced payments for services before that date. As such, it is critical that you complete your self-attestation as soon as possible.

The attestation form can be accessed through the following link:

[Utah Medicaid Physician Enhancement Attestation](#), or for a detailed link:

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

Providers qualifying under #1 above 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, and a contact phone number.

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

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

Please note that self-attestation to either of these criteria is subject to audit.

VFC Enhanced Payments

Qualifying providers may receive payments up to the new maximum allowed by the new rule.

Payment Methods

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.

13-03 HIPAA Version 5010 Implementation

Effective January 14, 2013, Utah Medicaid will process an electronic real time eligibility inquiry (5010 270

transaction) in addition to batch inquiries. Electronic eligibility allows a provider to send patient information and receive coverage information (i.e. copayments, benefit limitations, accountable care organization (ACO), restriction provider, etc.). With implementation of the real time eligibility, access to eligibility inquiries through Medicaid Online (HLRP access through Blue Zone) will be eliminated.

Currently, Medicaid offers the 276 batch claim status inquiry (5010 276 transaction). By January 31, 2013, real time processing of this transaction will also be available. Claim status responses provide payment information, status of the claim, error messages, etc. To ensure accurate matching and reporting of claim status, remember to submit the same billing NPI/Provider ID on your request that was submitted on the claim initially.

Both Real Time and Batch transactions must be submitted through Medicaid's Fee-For-Service trading partner number (HT000004-001). Batch transactions will no longer be processed hourly, but will be processed nightly. Providers should contact their system programmers/vendors to ensure the ability to utilize the real time transactions. Batch transactions will be limited in size (99 recipients). Real time transactions are for single requests.

The 999 (acknowledgment) transaction in 5010 was delayed and should be available sometime early 2013.

If you have any questions or need further information regarding electronic transactions, please contact Medicaid EDI at (801) 538-61555 or (800) 622-9651, option 3, option 5, option 2.

13-04 FDA Pregnancy Risk Categories to Become Obsolete

For decades, the Food and Drug Administration (FDA) has been aware of significant problems with the system used to categorize medications for use in pregnancy. In 1992, the Teratology Society expressed concerns and noted that the Category system, or 'CAT' system, led to unnecessary terminations of wanted pregnancies¹. The FDA Pregnancy Labeling Initiative is recommending elimination of the CAT system, changing the labels to include risk statements, and mandating that drug inserts be updated when human information is known.

Currently, when a medication is approved for marketing in the U.S., it must be labeled with one of five pregnancy CATs: A, B, C, D, or X. **A** means the drug is well-studied and poses no threat to a developing fetus; **B** is less-studied, but probably still low-risk; **C** has not been studied and therefore the risk is unknown; **D** class drugs, based on animal or human data, may pose a risk; and the **X** classification means the drug, based on animal or human data, causes birth defects and is contraindicated during pregnancy.

More than 90 percent of new medications are categorized as either CAT C or D, with the vast majority being C. Drug manufacturers are legally required to update the category if adverse events are reported; however, no such requirement exists for amending the category when studies show no problems in pregnancy. Most medications on the market continue to be listed as CAT C, when in fact the majority of them warrant a CAT A or B.

Manufacturers recognize that 3 percent of pregnancies will result in a child with a major birth defect and may recognize they are better insulated from litigation if listed as CAT C, D, or X. Hence, a disincentive exists for moving medications from those categories up to A or B. The rule change would require the manufacturers to upgrade a medication when the studies warrant the change.

The Pregnancy Risk Line does not recommend providers rely on the current CAT system for risk assessment and welcomes your questions about the system, as well as questions about specific medications in pregnancy and breastfeeding. Please call (801) 328-2229 in the Salt Lake City area, or 1-800-822-2229 throughout Utah. The Pregnancy Risk Line is a joint effort between the Utah Department of Health and University of Utah Health Care and has been educating health care providers and families about exposures in pregnancy and breastfeeding for 30 years.

1. Friedman, J. *Teratology* 1993: 48: 506

13-05 2013 CPT and HCPCS Codes

Covered

- 23473 Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
- 23474 . . . humeral and glenoid component
- 24370 Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
- 24371 . . . humeral and ulnar component
- 33990 Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
- 33991 . . . both arterial and venous access, with transeptal puncture
- 33992 Removal of percutaneous ventricular assist device at separate and distinct session from insertion
- 33993 Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion
- 36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation, and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
- 36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation, and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

- 36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 35226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation, and all associated radiological supervision and interpretation (add on code)
- 36228 Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation, and all associated radiological supervision and interpretation (e.g. middle cerebral artery, posterior inferior cerebellar artery (add on code)
- 43206 Esophagoscopy, rigid or flexible; with optical endomicroscopy
- 43252 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy
- 52287 Cystourthroscopy, with injection(s) for chemodenervation of the bladder
- 78012 Thyroid uptake, single or multiple quantitative measurement(s) including stimulation, suppression, or discharge, when performed
- 78013 Thyroid imaging including vascular flow, when performed;
- 78014 . . . with single or multiple uptake(s) quantitative measurement(s) including stimulation, suppression, or discharge, when performed)
- 78071 Parathyroid planar imaging (including subtraction, when performed; with tomographic SPECT
- 78072 with tomographic (SPECT) and concurrently acquired computed tomography (CT) for anatomical localization
- 81235 EGR (epidermal growth factor receptor) (e.g. non-small cell lung cancer) gene analysis, common variants (e.g. exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)
- 81508 Fetal congenital abnormalities, biochemical assays of two proteins (PAPPA-A, hCG {any form}), utilizing maternal serum algorithm reported as a risk score
- 81510 Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG {any form}), utilizing maternal serum, algorithm reported as a risk score
- 82777 Galectin-3
- 86711 JC (John Cunningham) virus
- 87631 . . . respiratory virus (eg. adenovirus, influenza virus, corona virus, metapneumonia virus, para influenza virus, respiratory syncytial virus, rhinovirus), multiplex, reverse transcription, and amplified probe technique, multiple types or subtypes, 3-5 targets
- 87910 Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus
- 87912 . . . Hepatitis B

- 88375 Optical endoscopic image(s), interpretation and report, real-time or referred, each endoscopic session
- 90653 Influenza vaccine, inactivated, subunit, adjuvanted for intramuscular use
- 90672 Influenza vaccine, quadravalent, live, for intranasal use
- 90739 Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use
- 92920 Percutaneous transluminal coronary angioplasty; single major coronary artery or branch
- 92921 . . . each additional branch of a major coronary artery (add on code)
- 92924 Percutaneous transluminal coronary atherectomy, with coronary angioplasty; single major coronary artery or branch
- 92925 . . . each additional branch of a major coronary artery (add on code)
- 92928 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
- 92929 . . . each additional branch of a major coronary artery (add on code)
- 92933 Percutaneous transluminal coronary atherectomy, with intracoronary stent; single major coronary artery or branch
- 93934 . . . each additional branch of a major coronary artery (add on code)
- 92937 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous) any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel
- 92938 . . . each additional branch subtended by the bypass graft (add on code)
- 92941 Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery, coronary artery branch, or coronary artery bypass graft any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel
- 92943 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel
- 92944 . . . each coronary artery, coronary artery branch or bypass graft (add on code)
- 93653 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source or atrial re-entry

- 93654 . . . with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed
- 93655 Intracatheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (add on code)
- 93656 Comprehensive electrophysiologic evaluation including transeptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation
- 93657 Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (add on code)
- 95017 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests
- 95018 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests
- 95076 Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug, or other substance); initial 120 minutes of testing
- 95079 . . . each additional 60 minutes of testing (add on code)
- 95782 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
- 95783 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
- 95907 Nerve conduction studies; 1-2 studies
- 95908 . . . 3-4 studies
- 95909 . . . 5-6 studies
- 95910 . . . 7-8 studies
- 95911 . . . 9-10 studies
- 95912 . . . 11-12 studies
- 95913 . . . 13 or more studies
- 95924 Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt

- 95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (add on code)
- 95941 Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (add on code)
- 95943 Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic adrenergic function testing with at least 5 minutes of passive tilt
- 99488 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month
- 99489 . . . each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (add on code)

Non-Covered

- 31647 Bronchoscopy with balloon occlusion, when performed, assessment or air leak, airway sizing, and insertion of bronchial valve(s), initial lobe
- 31648 Bronchoscopy with removal of bronchial valve(s) initial lobe
- 31649 . . . with removal of bronchial valve(s) each additional lobe (add on code)
- 31651 . . . with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (add on code)
- 31660 Bronchoscopy, rigid or flexible, including fluoroscopic guidance with performed; with bronchial thermoplasty, 1 lobe
- 31661 . . . bronchial thermoplasty, 2 or more lobes
- 32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
- 32555 . . . with imaging guidance
- 32556 Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
- 32557 . . . with imaging guidance
- 32701 Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam); entire course of treatment
- 33361 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
- 33362 . . . open femoral artery approach
- 33363 . . . open axillary artery approach
- 33364 . . . open iliac artery approach
- 33365 . . . transaortic approach (e.g. median sternotomy, mediastinotomy) approach

- 33367 . . . cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (e.g. femoral vessels) (add on code)
- 33368 . . . cardiopulmonary bypass support with open peripheral arterial and venous cannulation (e.g. femoral, iliac, axillary vessels) (add on code)
- 33369 . . . cardiopulmonary bypass support with central arterial and venous cannulation (e.g. aorta, right atrium, pulmonary artery) (add on code)
- 37197 Transcatheter retrieval, percutaneous, or intravascular foreign body (e.g. fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed
- 37211 Transcatheter therapy, arterial infusion or thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day
- 37212 Transcatheter therapy, venous infusion or thrombolysis, any method, including radiological supervision and interpretation, initial treatment day
- 37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;
- 37214 . . . cessation of thrombolysis including removal or catheter and vessel closure by any method
- 38243 Hematopoietic progenitor cell (HPC); HPC boost
- 44705 Preparation of fecal microbiata for instillation, including assessment of donor specimen
- 64615 Chemodenervation of muscle(s) muscle innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g. for chronic migraine)
- 81203 . . . duplication/deletion variants
- 81252 GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (e.g. nonsyndromic hearing loss) gene analysis; full gene sequence
- 81253 . . . known familial variants
- 81254 GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (e.g. nonsyndromic hearing loss) gene analysis, common variants (e.g. 309kb {del(GJB6-D13S1830)} and 232kb {del (GJB6-D13S1854)})
- 81321 PTEN (phosphatase and tensin homolog (e.g. Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis
- 81322 . . . known familial variants
- 81323 . . . duplication/deletion variants
- 81324 PMP22 (peripheral myelin protein22) e.g. Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis
- 81325 . . . full sequence analysis

- 81326 . . . known familial variants
- 81500 Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score
- 81503 Oncology (ovarian) biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and pre-albumin), utilizing serum, algorithm reported as a risk score
- 81506 Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting risk score
- 81509 Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG {any form},DIA) utilizing maternal serum, algorithm reported as a risk score
- 81511 Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG {any form}, DIA), utilizing maternal serum, algorithm reported as a risk score
- 81512 Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA), utilizing maternal serum, algorithm reported as a risk score
- 86152 Cell enumeration using immunologic selection and identification in fluid specimen (e.g. circulating tumor cells in blood)
- 86153 . . . physician interpretation and report
- 87632 . . . respiratory virus (e.g. adenovirus, influenza virus, corona virus, metapneumonia virus, para influenza virus, respiratory syncytial virus, rhinovirus), multiplex, reverse transcription, and amplified probe technique, multiple types or subtypes, 6-11 targets
- 87633 . . . respiratory virus (e.g. adenovirus, influenza virus, corona virus, metapneumonia virus, para influenza virus, respiratory syncytial virus, rhinovirus), multiplex, reverse transcription, and amplified probe technique, multiple types or subtypes, 12-25 targets
- 91112 Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report
- 99485 Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient , 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretations and report; first 30 minutes
- 99486 . . . each additional 30 minutes (add on code)
- 99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to face visit, per calendar month
- 99495 Transitional care management services with the following elements: 1) communication (direct contact telephone, electronic- with the patient and/or caregiver within 2 business days of discharge 2) medical decision making of at least moderate complexity during the service period, and 3) face to face visit, within 14 calendar days of discharge
- 99496 Transitional care management services with the following elements: 1) communication (direct contact telephone, electronic- with the patient and/or caregiver within 2 business days of discharge 2) medical

decision making of high complexity during the service period, and 3) face to face visit, within 7 calendar days of discharge

Manual Review

- 81201 APC (adenomatous polyposis coli) (e.g. Familial adenomatous polyposis coli) (e.g. familial adenomatous polyposis (FAP), attenuated (FAP) gene analysis; full gene sequence
- 81202 . . . known familial variants
- 81479 Unlisted molecular pathology procedure
- 81599 Unlisted multianalyte assay with algorithm analysis

Prior Authorization

- 22586 Arthrodesis, pre-sacral interbody techniques, including disc space preparation, discectomy, with posterior instrumentation, with imaging guidance, includes bone graft when preformed, L5-S1 interspace
- 86828 Antibody to human leukocyte antigens (HLA) solid phase assays (e.g. microsphere or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I and Class II HLA antigens
- 86829 Antibody to human leukocyte antigens (HLA) solid phase assays (e.g. microsphere or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I or Class II HLA antigens
- 86830 . . . antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I
- 86831 . . . antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II
- 86832 . . . high definition identification qualitative panel for identification of antibody specificities (e.g. individual antigen per bead methodology) HLA Class I
- 86833 . . . high definition identification qualitative panel for identification of antibody specificities (e.g. individual antigen per bead methodology) HLA Class II
- 86834 . . . semi-quantitative panel (e.g. titer), HLA Class I
- 86835 . . . semi-quantitative panel (e.g. titer), HLA Class II

13-06 Provider E-Prescribing Portal

Utah Medicaid now has a provider e-prescribing web portal available to providers to send the prescriptions they write directly to the pharmacy. With this portal, providers can check eligibility and send a drug prior authorization directly to Medicaid, as well as view drug criteria, diagnosis information, and Medicaid formulary information.

You must be a Utah Medicaid provider/prescriber to have access to use the portal. Please register at www.utahportal.org. For questions, please call (801) 538-6155 or 1-800-662-9651.

13-07 CPT Code Coverage

Opened to OPPS

27477 Arrest epiphyseal, any method, tibia and fibula, proximal (through age 20)

27486 Revision of total knee arthroscopy, with or without allograft, 1 component

64568 Incision for implantation of cranial (vagus) nerve stimulator electrode ray and pulse generator

69714 Implantation osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator, w/o mastoidectomy (PT 01 added)

Opened to Technical Portion

76882 US extremity, non-vascular, w/ real time documentation; limited (added PT 20, 24, 45, 52, 91)

Opened to Ambulatory Surgery Center

12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

20551 Injection(s); single tendon origin/insertion

21931 Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm

24071 Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater

- 29903 Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater
- 30100 Biopsy, intranasal
- 47563 Laparoscopy, surgical; cholecystectomy with cholangiography
- 62311 Injection of diagnostic or therapeutic substance lumbar or sacral (caudal)
- 64634 Destruction by neurolytic agent cervical or thoracic, each added (excludes RF)
- 64635 Destruction by neurolytic agent, lumbar or sacral (excludes RF)
- 64636 Destruction by neurolytic agent, lumbar or sacral, each added (excludes RF)
- 64640 Destruction by neurolytic agent, other peripheral nerve or branch (excludes RF)
- 67041 Vitrectomy with removal reretinal cellular membrane
- 67043 Vitrectomy with removal subretinal membrane includes, if performed intraocular tamponade and laser photocoagulation
- 69424 Ventilating tube removal requiring general anesthesia
- 69610 Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch

Covered Codes

- 43236 Upper GI endoscopy includes esophagus, stomach, and either duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance
- 45335 Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
- 45381 Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
- 68816 Nasolacrimal probing with transluminal balloon dilation (removed from prior authorization)
- 75960 Transcatheter introduction of intravascular stents, percutaneous and/or open, radiological supervision and interpretation
- 76882 US extremity, non-vascular, w/ real time documentation; limited (added PT 20, 24, 45, 52, 91 to technical)
- 95251 Continuous glucose monitoring interpretation and report

Prior Authorization Required

- 58673 Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
- 58770 Salpingostomy (salpingoeostomy)

13-08 ICD-9-CM Codes

The following ICD-9-CM procedural diagnosis code is effective January 1, 2013:

00.95 Injection or infusion of Glucarpidase (open for inpatient and ER)

The following diagnosis codes will be removed from manual review, effective January 1, 2013:

ICD-9-CM 630-634, 640 and sub codes

Note: Although the manual review requirement is being removed from these diagnosis codes, the requirement for prior authorization, if applicable, on the accompanying CPT codes, remains unchanged.

630 – Hydatidiform mole

631 – Other abnormal product of conception

632 – Missed abortion

633 – Ectopic pregnancy

Sub-codes of 633

634 – Spontaneous abortion

Sub-codes of 634

640 – Hemorrhage in early pregnancy

For questions regarding prior authorization requirements on CPT codes, refer to the Medicaid website Coverage and Reimbursement Lookup Tool at www.health.utah.gov/medicaid.

13-09 Physician Services Updates

Effective January 1, 2013, the following codes are open to Board Certified Pediatricians, Neonatologists, and Family Practice physicians in rural Utah counties and border towns credentialed to perform critical care services and intensive care services to neonatal and pediatric patients:

- 99468 Initial Inpatient neonatal critical care, per day for neonate 28 days or less
- 99469 Subsequent inpatient neonatal critical care, per day, for neonate 28 days of age or younger
- 99471 Initial inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 29 days through 24 months
- 99472 Subsequent inpatient pediatric critical care, 29 days through 24 months
- 99475 Initial inpatient pediatric critical care, per day for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
- 99477 Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, which require intensive observation, frequent intervention, and other intensive care services
- 99478 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant < 1500 GM

Providers who are credentialed to perform neonatal and pediatric critical care and intensive care services may apply to be approved for these services through Medicaid Provider Enrollment by submitting the **Requisition for Privileges: Neonatal and Pediatric Intensive Care and Critical Care Services** form as a coversheet along with a current copy of **the Physician Privilege Checklist** from hospital(s) of practice. A current Physician Privilege Checklist must be submitted from each facility of practice. All applications will be reviewed by a Medicaid Coverage and Reimbursement Policy Physician Representative.

These services are for a 24-hour calendar day. Critical care codes (per hour) should continue to be utilized when stabilizing a neonate or pediatric patient while waiting for transport to a tertiary care center.

Provider Manual Changes: Effective January 1, 2013, procedure codes, with accompanying criteria and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.



Requisition for Privileges: Neonatal and Pediatric Intensive Care and Critical Care Services

(Print Name)

(Date)

(Provider NPI)

QUALIFICATIONS

A licensed physician (MD or DO) with appropriate education/training, experience and current privileges in neonatology/pediatric services at an accredited hospital(s).

APPLICANTS

Physician must submit the *Requisition for Privileges: Neonatal and Pediatric Intensive Care and Critical Care Services* form as a coversheet with a current copy of the *Physician Privilege Checklist* from hospital(s) of practice. A current *Physician Privilege Checklist* must be submitted from **each** facility of practice.

The provider must submit a separate *Requisition for Privileges form* in conjunction with *the Physician Privilege Checklist* into Medicaid Provider Enrollment for each facility requesting approval.

PRIVILEGES REQUESTED: HOSPITAL/FACILITY

(Facility Name)

(Address)

(Phone number)

I certify that I have been trained and it is within my scope of practice to provide intensive care and critical care to the neonate and pediatric patient in inpatient, outpatient, intensive care units, and Emergency Department settings.

Applicants Signature:

Date:

HOSPITAL REPORT AND RECOMMENDATION: Upon review of all credentialing information available with particular focus on education/training, experience, current competence and ability to perform specific privileges requested, I recommend the applicant as capable of and competent to perform the specific privileges of Neonatal and Pediatric Intensive Care and Critical Care Services.

Signature:

Date:

Hospital Representative

Signature:

Date:

CRP Representative/Approval

*Send request to Medicaid Operations, Attn: Provider Enrollment, PO Box 143106, Salt Lake City, UT 84114-3106

13-10 Prior Authorization (PA) Changes

Medical and Surgical Procedures

The following criteria have been updated effective January 1, 2013. Refer to the Medicaid website Coverage and Reimbursement Lookup Tool at www.health.utah.gov/medicaid.

- Eyelid procedures #19 is being archived and replaced with the subsets below:
Lid Lesion Excision, +/- Reconstruction
Lid Reconstruction
- Dacryoplasty/Dacryocystoplasty for Nasolacrimal Duct Obstruction (CPT codes 68816 and 68720)
Removed from Prior Authorization.

Magnetic Resonance Imaging (MRI) – Billing Process for Professional Component

- **EPSDT (CHEC), Inpatient** clients – Billed with a 26 modifier, receives automatic payment.
- **Adults, Outpatient** clients – Submit a prior authorization request for the professional component. Prior authorization approvals include two (2) units to allow billing for both professional and technical components. These are prior authorized based on current criteria found on the Medicaid website: www.health.utah.gov/medicaid.
- **Adults, Inpatient** clients – Submit a prior authorization request for the professional component. One (1) unit is prior authorized without any additional documentation. The technical component is included in the DRG billed for the client, do not request separately.

13-11 Medical Supplies Manual

Effective January 1, 2013, the Medical Supplies Manual will be combined with the Medical Supplies List. The Medical Supplies List will be archived. Procedure codes, with accompanying criteria, comments, and limitations, will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

Open effective October 1, 2012:

L9900 Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS “L” code. Prior authorization required, manually priced.

Closed for all providers, effective January 1, 2013:

A7017LL Nebulizer, bottle type, not used with oxygen
E0618RR Apnea monitor, without recording feature

Changes - Effective January 1, 2013:

- E0246 Transfer tub rail attachment (not on wall); unit limit changed to 1 every 5 years.
- E0570 Nebulizer with compressor. Available as a capped rental only.
- E0635 Patient lift; electric, with seat or sling. Purchase only. Prior authorization required.
- E0639 Patient lift; electric, with seat or sling. Purchase only. Prior authorization required.
- L0150 Cervical, semi-rigid; adjustable molded chin cup (plastic collar with mandibular/occipital piece). Added additional provider types, 60, 62, 91.
- L1499 Spinal orthosis, not otherwise specified. Added additional provider types 60, 62, 91. Prior authorization required.

PA removed from the following codes, effective January 1, 2013:

- B9002RR Enteral nutrition infusion pump, with alarm
- B9006RR Parenteral nutrition pump, stationary
- E0779RR Ambulatory infusion pump, reusable, over 8 hours
- E0780RR Ambulatory infusion pump, reusable, less than 8 hours
- E0781RR Ambulatory infusion pump (such as Maxx or microject), single or multiple channels, with administrative equipment, worn by patient
- E0791RR Parenteral infusion pump, stationary single or multi-channel

Effective October 1, 2012:

- A4352 Intermittent urinary catheter, Coude (curved tip), 180 allowed per month.

Correction:

- B4158 Corrected manual typographical error from code B5158 to code B4158.

The following 2013 HCPCS Codes will be opened, effective January 1, 2013:

- A4435 Ostomy pouch, drainable, high output, with extended wear barrier (one piece system), with or without filter, each
- E0670 Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk. Prior authorization required.
- E2378 Power wheelchair component, actuator, replacement only. Prior authorization required.
- L5859 Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)

L8605 Injectable bulking agent, Dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies. Open only to provider type "01". Closed to Medical Suppliers.

The following code will be closed to Medical Suppliers, effective January 1, 2013:

L7902 Tension ring, for vacuum erection device, any type, replacement only, each

13-12 Medical Supplies List

Effective January 1, 2013, the Medical Supplies List will be archived. Procedure codes, with accompanying criteria, comments, and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

All other information is now found in the Medical Supplies Manual.

13-13 Provider Preventable Conditions List Changes

Effective January 1, 2013, The Utah Medicaid Program will adopt the updated CMS 2013 Provider Preventable Events list.

CMS made these changes for calendar year 2013:

New events

- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED).
- Iatrogenic Pneumothorax with Central Venous Catheterization.

ICD-9-CM diagnosis codes

- Several were added to existing conditions.
- A few clarifying statements were added.

For details, refer to the Provider Preventable Conditions (PPC) Diagnosis List at www.health.utah.gov/medicaid.

13-14 Anesthesiology Manual (Section 3) Updated

Effective January 1, 2013, the following information concerning post-operative pain management will be added to the Anesthesiology Manual. Refer to the website at www.health.utah.gov/medicaid.

Post-operative Pain Management

This is a covered service by Utah Medicaid. Prior authorization is not required. Reimbursement for this service requires the following:

- It must be related to the immediate post-operative period (and in some cases the intraoperative period).
- There must be a physician order for post-operative pain management.

Variable rates of reimbursement are applied. This service has a variable rate of reimbursement. Examples of situations affecting reimbursement:

1. Timing of catheter placement.
 - a. Pre or post-operative placement of an epidural catheter (e.g. 62311, 62319) or femoral nerve catheter (64448) reimburses at 100% of the Medicaid allowed amount.
 - b. Intra-operative placement of an epidural or femoral catheter for post-surgical pain management is paid at 50% of the Medicaid allowed amount.
2. Multiple procedure reduction.
 - a. The addition of a pain management to the anesthesia claim creates a multiple procedure situation, and as such, the second or lower paying procedure is paid at 50%.
 - b. When you take 50% of the full rate in as described in 1-a above, you get a total of 50% of the Medicaid allowed amount.
 - c. When you take 50% of the reduced rate indicated in 1-b above, you get a total of 50% of the Medicaid allowed reimbursement. An additional 50% of this reduced rate is taken off for multiple procedure reduction leaving a final reimbursement of 25% of the Medicaid allowed amount.

13-15 Physical Therapy/Occupational Therapy Changes

Effective January 1, 2013, the following codes are opened to Physical Therapy/ Occupational Therapy providers:

L3763 Elbow wrist hand orthosis; rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3806 Wrist, hand, finger orthosis (WHFO); includes one or more non-torsion joints(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustments

L3808 WHFO; rigid without joints, may include soft interface material; straps, custom fabricated includes fitting and adjustment

L3913 Hand finger orthosis, without joints, may include soft interface material, straps, custom fabricated, includes fitting and adjustments

L3921 Hand finger orthosis, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface material, straps, custom fabricated, includes fitting and adjustments

L3933 Finger orthosis, without joints, may include soft interface custom fabricated, includes fitting and adjustment

13-16 Dental Services Updates

Provider Manual Change

Effective January 1, 2013, procedure codes, with accompanying criteria, comments, and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

Effective January 1, 2013, the following dental codes have been opened:

D5931 Obturator prosthesis, surgical

D5955 Mandibular resection prosthesis without guide flange

D7670 Alveolus – closed reduction, may include stabilization of the teeth

Effective October 1, 2012, the following dental code was opened:

D7283 Placement of device to facilitate eruption of impacted tooth

Clients approved for orthodontia treatment, and are currently receiving orthodontia services with prior authorization from Utah Medicaid, will be approved for a prior authorization of D7283.

Effective January 1, 2013, the following dental codes have been deleted:

D1203 Topical application of fluoride – child

D1204 Topical application of fluoride – adult

Providers are to use the following procedure code in place of D1203 and D1204:

D1206 Topical application of fluoride varnish

Effective January 1, 2013, the following dental codes have been revised:

D2980 Crown repair necessitated by restorative material failure

D4210 Gingivectomy or gingivoplasty, four or more contiguous teeth or tooth bounded spaces per quadrant. Performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargement or asymmetrical or unaesthetic or unaesthetic topography is evident with normal bony configuration.

2013 Dental Codes

The following codes are non-covered, effective January 1, 2013:

D0190 Screening of a patient

D0191 Assessment of a patient

D0364 Cone beam CT capture & interpretation with limited field of view of one full dental arch - mandible

D0365 Cone beam CT capture and interpretation with field of view of one full dental arch - mandible

D0366 Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium

D0367 Cone beam CT capture and interpretation with field of view of both jaws with or w/o cranium

D0368 Cone beam CT capture and interpretation for TMJ series. Including two or more exposures.

D0369 Maxillofacial MRI capture and interpretation

D0370 Maxillofacial ultrasound capture and interpretation

D0371 Sialoendoscopy capture and interpretation. Image capture only. Interpretation and report performed by a practitioner not associated with the capture.

D0380 Cone beam CT image capture with limited field of view- less than one whole jaw

D0381 Cone beam CT capture and interpretation with field of view of one full dental arch - mandible

D0382 Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium

D0383 Cone beam CT capture and interpretation with field of view of both jaws with or w/o cranium

D0384 Cone beam CT capture and interpretation for TMJ series. Including two or more exposures.

D0385 Maxillofacial MRI capture and interpretation

D0386 Maxillofacial ultrasound capture and interpretation. Imaging capture performed by a practitioner not associated with interpretation and report.

D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report

D1208 Topical application of fluoride

D2929 Prefabrication porcelain/ceramic crown –primary tooth

D2981 Inlay repair necessitated by restorative material failure

D2982 Onlay repair necessitated by restorative material failure

D2983 Veneer repair necessitated by restorative material failure

D2990 Resin infiltration of incipient smooth surface lesions

D4212 Gingivectomy or gingivoplasmy to allow access for restorative procedure, per tooth or edentulous tooth position in graft

D4277 Free soft tissue graft procedure (including donor site surgery) first tooth or edentulous tooth position in graft

- D4278 Free soft tissue graft procedure (including donor site surgery) each additional contiguous tooth or edentulous tooth position in same graft site
 - D6051 Interim abutment
 - D6101 Debridement of a perimplant defect and surface cleaning of exposed implant surface, including flap entry and closure
 - D6102 Debridement and osseous contouring of a perimplant defect – not including flap entry and closure or when indicated placement of a barrier membrane or biologic materials to aid in osseous regeneration
 - D6103 Bone graft for repair of perimplant defect – not including flap entry and closure or when indicated placement of a barrier membrane or biological materials to aid in osseous regeneration
 - D6104 Bone graft at time of implant placement
 - D7921 Collection and application of autologous blood concentrate product
 - D7952 Sinus augmentation via a vertical approach
 - D9975 External bleaching for home application, per arch. Includes materials and fabrication of custom trays.
-

13-17 Oral Maxillofacial Surgeon Services Updates

Provider Manual Change

Effective January 1, 2013, procedure codes, with accompanying criteria, comments, and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

Effective January 1, 2013, the following dental codes have been opened:

- D5931 Obturator prosthesis, surgical
- D5955 Mandibular resection prosthesis without guide flange
- D7670 Alveolus – closed reduction, may include stabilization of the teeth

Effective October 1, 2012, the following dental codes were opened to provider type 95:

- 40808 Biopsy, vestibule of mouth
- 40810 Excision of lesion mucosa/submucosa; w/o repair
- 40819 Excision of frenum, labial, or buccal
- 40820 Destruction scar/lesion by physical met
- D7410 Radical excision-lesion diameter up to 1.25 cm

Effective January 1, 2013, the following dental codes have been deleted:

D1203 Topical application of fluoride – child

D1204 Topical application of fluoride – adult

Providers are to use the following procedure code in place of D1203 and D1204:

D1206 Topical application of fluoride varnish

Effective January 1, 2013, the following dental codes have been revised:

D2980 Crown repair necessitated by restorative material failure

D4210 Gingivectomy or gingivoplasty, four or more contiguous teeth or tooth bounded spaces per quadrant. Performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargement or asymmetrical or unaesthetic or unaesthetic topography is evident with normal bony configuration.

13-18 Vision Manual Updates

Code opened for pre and post-operative care effective October 1, 2012, for Provider Type “31”, Optometrist:

66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g. irrigation and aspiration or phacoemulsification).

Action taken so pre and post-operative care by an Optometrist can be paid. No prior authorization required.

Coding:

Surgeon

- Use 66984 with modifier -54 Surgical Care only.
- Enter the “to” and “from” dates of service in section 24 a, of CMS-1500 form on the claim. (These are the actual dates of service. Do not include the optometrist’s dates of service.)

Optometrist

- Use 66984
- Pre-operative care only: add modifier -56
- Post-operative care only: add modifier -55
- Enter “to” and “from” dates of service in section 24 a, of CMS-1500 form on the claim. (These are the actual dates of service. Do not include the surgeon’s dates of service.)

- Typically E&M codes are not paid outside the global surgical package, unless for an unrelated issue. Nor should they be utilized to circumvent the global package concept creating a situation for overpayment.
- When the Optometrist provides the pre and/or post-operative care the surgical package is broken down into its components. Medicaid splits the global surgery fee between participants.
- Any pre-operative services (i.e., E&M) performed within 24 hours of the surgery are considered part of the global surgical package, unless the decision to do surgery occurred in the initial encounter within 24 hours of surgery.
- Retrospective auditing of these services will be done to ensure that all parties are working together and no unbundling of the surgical package occurs.

Effective January 1, 2013, codes opened for Provider Type "31", Optometrist:

- 65855 Post-op Trabeculoplasty by laser surgery, one or more sessions
- 66821 Post-op YAG Capsulotomy
- 92284 Dark adaptation examination, with medical diagnostic evaluation
- 92313 Corneoscleral lens
- 92314 Prescription of optical and physical characteristics and management of contact
- 92315 Corneal lens for aphakia, one eye
- 92316 Corneal lens for aphakia, two eyes
- 92317 Corneoscleral lens
- 92326 Replacement of contact lens
- 92342 Multifocal, other than bifocal
- 92352 Fitting of spectacle prosthesis for aphakia, monofocal
- 92354 Treatment with spectacle mounted low vision aid; single-element system
- 92355 Telescopic or other compound lens system
- 92358 Prosthesis service for aphakia, temporary (disposable or loan, including materials)
- 99050 Services requested after office hours in addition to basic service
- 99058 Office services provided on an emergency basis
- 99070 Supplies and materials (except spectacles) provided by the optometrists over and above those usually included with the office visit or other services rendered (list materials provided)

13-19 Audiology Manual Updates

Effective January 1, 2013, procedure codes, with accompanying criteria, comments, and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

Open effective January 1, 2013:

- L8628 Cochlear implant; external controller component, replacement. No prior authorization required.
- L8629 Transmitting coil and cable, integrated for use with cochlear implant device, replacement. No prior authorization required.

The following 2013 HCPCS Codes related to listening devices are closed for Medicaid:

- V5281 Assistive listening device, personal FM/DM system, monaural (1 receiver, transmitter, microphone, any type
 - V5282 Assistive listening device, personal FM/DM system, binaural, (2 receivers, transmitter, microphone, any type
 - V5283 Assistive listening device, personal FM/DM neck, loop induction receiver
 - V5284 Assistive listening device, personal FM/DM, ear level receiver
 - V5285 Assistive listening device, personal FM/DM, direct audio input receiver
 - V5286 Assistive listening device, personal Blue Tooth FM/DM receiver
 - V5287 Assistive listening device, personal FM/DM receiver, not otherwise specified
 - V5288 Assistive listening device, personal FM/DM transmitter assistive listening device
 - V5289 Assistive listening device, personal FM/DM adapter/boot coupling device for receiver, any type
 - V5290 Assistive listening device, transmitter microphone, any type
-

13-20 Speech Manual Updates

Effective January 1, 2013, procedure codes, with accompanying criteria, comments, and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

13-21 Medical Transportation Manual Updates

Effective January 1, 2013, procedure codes, with accompanying criteria, comments, and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

13-22 Podiatry Manual Updates

Effective January 1, 2013, procedure codes, with accompanying criteria, comments, and limitations, will be removed from the Provider Manual and will be found in the Coverage and Reimbursement Lookup Tool on the Medicaid website at www.health.utah.gov/medicaid.

13-23 Psychiatric CPT Codes 90801 and 90862

Attention: Psychiatrists and other qualified medical practitioners using Current Procedural Terminology (CPT) procedure codes 90801 (Psychiatric Diagnostic Interview Examination) and 90862 (Psychiatric Pharmacologic Management)

This article applies to:

Psychiatrists and other qualified medical practitioners in independent or group practices billing Medicaid for psychiatric diagnostic evaluations (procedure code 90801) or psychiatric pharmacologic management (procedure code 90862) provided to children in State custody (foster care) or other children under the jurisdiction of the Department of Human Services who are not enrolled in Medicaid's mental health managed care plan (Prepaid Mental Health Plan) for outpatient mental health services.

2013 CPT Coding Changes in Psychiatry Section

In the 2013 CPT Manual, for service dates on or after January 1, 2013, many procedure codes in this section are deleted and replaced with new codes. Procedure code 90801, psychiatric diagnostic interview examination, and procedure code 90862, psychiatric pharmacologic management, are deleted and replaced as follows:

Psychiatric Diagnostic Interview Examination, Current CPT Code 90801

CPT code 90801 is replaced with two new CPT procedure codes: 90791, psychiatric diagnostic evaluation, or 90792, psychiatric diagnostic evaluation with medical services. Documentation requirements and the billing unit (15-minute unit) remain the same.

The 2013 CPT Manual includes a new add-on code to reflect interactive complexity that can be reported in conjunction with CPT codes 90791 and 90792. There is no additional reimbursement for this add-on code.

Psychiatric Pharmacologic Management, Current CPT Code 90862

In place of 90862, providers must use evaluation and management (E/M) services codes.

Since pharmacologic management is provided subsequent to the initial psychiatric diagnostic evaluation (90791/90792), in place of 90862 use established patient E/M codes in the 'Office or Other Outpatient Services,' 'Nursing Facility' or the 'Home' E/M group. Refer to the 2013 CPT Manual for directions on selecting the appropriate group of E/M codes. Prescribers must directly provide all psychiatric pharmacologic management services to the child (including any services that may qualify for coding under E/M code 99211).

To ensure correct adjudication of psychiatric pharmacologic management claims with the new E/M coding, always use the **CG modifier** with the E/M code on the claim. This modifier will identify that the service provided was psychiatric pharmacologic management.

To ensure continued access to specialized psychiatric pharmacologic management, pending approval from the Centers for Medicare and Medicaid Services (CMS), for services that qualify for E/M coding as 99213, 99214, 99308, 99309, 99310, 99348 or 99349, when only the E/M code is billed payment determination will be based on the fee in effect on December 31, 2012, for procedure code 90862.

Documentation

E/M documentation requirements apply. Please refer to the E/M section of the 2013 CPT Manual. Providers can also refer to CMS' 1997 publication on documenting E/M services entitled *1997 Documentation Guidelines for Evaluation and Management Services* at:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning->

New Medicaid Provider Manual

Also, all outpatient rehabilitative mental health and substance use disorder services are addressed in the new Medicaid provider manual entitled, *Rehabilitative Mental Health and Substance Use Disorder Services*, published January 1, 2013. Providers can access this new Medicaid 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.

13-24 Attn: Providers of Outpatient Mental Health and Substance Use Disorder Services

Coding Changes in the 2013 Current Procedural Terminology (CPT) Manual and New Consolidated Medicaid Provider Manual for Outpatient Rehabilitative Mental Health and Substance Use Disorder Services

This article applies to Prepaid Mental Health Plans (PMHPs), mental health centers, substance abuse agencies, Department of Human Services (DHS) mental health providers serving children in State custody (foster care) or other children under the jurisdiction of DHS who are not enrolled in the PMHP for outpatient services, and other mental health/psychiatric providers serving clients in counties not covered under the Prepaid Mental Health Plan. The table at the end of this article shows PMHP coverage by county.

2013 CPT Coding Changes in Psychiatry Section

In the 2013 CPT Manual, for service dates on or after January 1, 2013, many procedure codes in this section are deleted and replaced with new codes. The table below contains the deleted and the new CPT codes.

Psychiatric Pharmacologic Management (CPT Code 90862) -- Children in State custody (foster care) or other children under the jurisdiction of the Department of Human Services often get psychiatric pharmacologic management from psychiatrists or other qualified medical practitioners in independent or group practices. Procedure code 90862 for psychiatric pharmacologic management is deleted. To ensure correct adjudication of

these providers' claims with the codes replacing 90862, also see Article 13-23 in this Medicaid Information Bulletin.

Psychiatric CPT Code Changes Effective for Service Dates On or After January 1, 2013

CPT Codes Effective through December 31, 2012	CPT Codes Effective January 1, 2013
90801 Psychiatric Diagnostic Interview Examination; 90802 Interactive Psychiatric Diagnostic Interview Examination	90791 Psychiatric Diagnostic Evaluation 90792 Psychiatric Diagnostic Evaluation with medical services (This code is limited to qualified medical practitioners only.)
Note: See section below this table, 'Centers for Medicare and Medicaid Services' (CMS') National Correct Coding Initiative (NCCI) – Unit Limit on 90791'	
90804-90829 Individual Psychotherapy (All individual psychotherapy codes are deleted and replaced with three codes.)	90832 Psychotherapy with patient and/or family member, 30 minutes 90834 Psychotherapy with patient and/or family member, 45 minutes 90837 Psychotherapy with patient and/or family member, 60 minutes
Note: In accordance with CPT 13, 90832 is billed for 16 through 37minutes, 90834 is billed for 38 through 52 minutes and 90837 is billed for 53 or more minutes. Prolonged services codes (99354 and 99355 if applicable) may be added to 90837 in accordance with CPT rules for therapy services 90 minutes or longer.	
90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90826, 90829 Individual psychotherapy with medical evaluation and management services	Evaluation and Management (E/M) Services (99xxx series) + psychotherapy add-on code Appropriate E/M code and 90833 , 30-minute psychotherapy add-on code Appropriate E/M code and 90836 , 45-minute psychotherapy add-on code Appropriate E/M code and 90838 , 60-minute psychotherapy add-on code;
90862 Psychiatric Pharmacologic Management	Appropriate Evaluation and Management Services (E/M) Code (99xxx series)
Note: Since pharmacologic management is provided subsequent to the initial psychiatric diagnostic evaluation (90791/90792), in place of 90862, use established patient E/M codes in the 'Office or Other Outpatient Services,' 'Nursing Facility' or 'Home Services' E/M group. Refer to the 2013 CPT Manual for directions on selecting the appropriate group of E/M codes. Prescribers must directly provide all psychiatric pharmacologic management services to the client (including any services that may qualify for coding under E/M code 99211).	
To ensure correct adjudication of the claim, always use the CG modifier with the E/M code. This modifier will identify that the service provided was psychiatric pharmacologic management.	
To ensure continued access to specialized psychiatric pharmacologic management, pending approval from CMS, for services that qualify for E/M coding as 99213 or 99214, 99308, 99309, 99310, 99348 or 99349, when only the E/M code is billed payment determination will be based on the fee in effect on December 31, 2012 for procedure code 90862.	
E/M documentation requirements apply. Please refer to the E/M section of the 2013 CPT manual. Providers can also refer to CMS' 1997 publication on documenting E/M services entitled <i>1997 Documentation Guidelines for Evaluation and Management Services</i> at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-	
90857 Interactive Group Therapy	No replacement – see section on Interactive Complexity below.
No code	90839 Psychotherapy for crisis, first 60 minutes
No code	90840 Psychotherapy for crisis, each additional 30-minutes
Note: Use 90832 for crisis contacts 30 minutes or less; or use add-on psychotherapy code 90833 if the crisis service 30 minutes or less is provided with an E/M service.	
No code	90785 Interactive Complexity Add-on Code
Note: The 2013 CPT Manual includes a new add-on code to reflect interactive complexity. In accordance with CPT 13, this add-on code can be reported in conjunction with CPT codes for psychiatric diagnostic evaluation (90791 and 90792), psychotherapy codes (90832, 90834, and 90837), psychotherapy when performed with an E/M service (psychotherapy codes 90833, 90836, 90838), and with group psychotherapy (90853). There is no additional reimbursement for this add-on code.	

Centers for Medicare and Medicaid Services' (CMS') National Correct Coding Initiative (NCCI) – Unit Limit on 90791

CMS recently released new NCCI edits that are effective for dates of service on or after January 1, 2013.

CMS is limiting reimbursement for the new CPT procedure code, 90791, to one unit. Utah Medicaid's current unit is a 15-minute unit, rather than a 'per encounter' unit. Medicaid plans to negotiate with CMS to retain the 15-

minute billing unit. Medicaid will notify providers of the outcome. Until that time, payment for additional 15-minute units (beyond one unit) will be denied.

New Utah Medicaid Provider Manual for Outpatient Rehabilitative Mental Health and Substance Use Disorder Services

All mental health and substance use disorder services are contained in the new Utah Medicaid provider manual entitled, *Rehabilitative Mental Health and Substance Use Disorder Services*.

This new provider manual replaces the following provider manuals:

- *Utah Medicaid Provider Manual, Mental Health Centers/Prepaid Mental Health Plans;*
- *The treatment services section of the Utah Medicaid Provider Manual, Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse;* and the
- *Utah Medicaid Provider Manual, Rehabilitative Mental Health Services for Children Under Authority of Department of Human Services, Division of Child & Family Services or Division of Juvenile Justice Services*

In this new provider manual, policy on treatment plan reviews has also been updated. See Chapter 1-7, Treatment Plans.

As a reminder, rehabilitative mental health and substance use disorder services may be provided to individuals with a dual diagnosis of a mental health or substance use disorder and a developmental disorder when rehabilitative services are directed to treatment of the mental health or substance use disorder.

Providers may access the new 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.

Prepaid Mental Health Plan Coverage by County

Prepaid Mental Health Plan Contractor (PMHP)	Counties	Inpatient Mental Health & Outpatient Rehabilitative 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
NA	San Juan	No	No
NA	Wasatch	No	No

13-25 Attn: Prepaid Mental Health Plans, Mental Health Centers, Substance Abuse Agencies, and the University of Utah’s HOME Program

Consolidation of two targeted case management target groups and unlicensed case manager certification requirements

Pending Centers for Medicare and Medicaid Services (CMS) approval, effective January 1, 2013, Utah Medicaid will combine two targeted case management target groups: the chronically mentally ill and individuals with substance use disorders. This new combined target group will be called the seriously mentally ill target group.

With consolidation of the two target groups, the Department of Human Services, Division of Substance Abuse Health’s (DSAMH’s) training and certification requirements for case managers who are not licensed will also apply to unlicensed case managers who provide targeted case management services to individuals with substance use disorders. Please refer to the section on provider qualifications in the targeted case management provider

manual entitled, *Targeted Case Management for the Chronically Mentally Ill*, Chapter 1-4, #6, and to Chapter 1-5 of this provider manual for training and certification requirements. Also, contact the DSAMH for more information.

To review certification requirements, providers can access the Medicaid provider manual entitled, *Targeted Case Management for the Chronically Mentally Ill*, 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.

13-26 Vaccines as a Medical Benefit

Please note that the coverage of vaccines as a medical benefit has not changed. The Traditional, Non-Traditional, and Primary Care Network Manuals have been updated to better reflect the uniformity in the plans, and to replace outdated information (obsolete billing codes, etc.).

13-27 Medicaid Preferred Drug List (PDL)

The draft Utah Medicaid Preferred Drug List (PDL), effective for January 1, 2013, will be posted on the Utah Medicaid Pharmacy Program website. Important drug product changes will be dated January 1, 2013. Some brand name drug products are less expensive for Utah Medicaid due to manufacturer rebates. This program continues to be extremely effective.

Medicaid prescribers and dispensers are encouraged to check the PDL periodically at www.health.utah.gov/medicaid/pharmacy. Select from the first drop down menu labeled for physicians and pharmacies, select the Preferred Drug List (PDL) option, then select Utah Medicaid PDL draft effective January 1, 2013.

13-28 Correction to November Interim MIB Article 12-121

The contact information for Healthy U – Accountable Care Organization (ACO) should read:

Healthy U
1-888-271-5870
801-587-6480
www.uhealthplan.utah.edu