UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

July 2013

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

TABLE OF CONTENTS

13-60 UTAH MEDICAID PROVIDER STATISTICAL AND REIMBURSEMENT (PS&R) REPORT 2

13-61 PHYSICIAN AND VFC ENHANCEMENT PAYMENTS 2

13-62 MEDICAID DENTAL SERVICES 6

13-63 IMPLEMENTATION OF STATE SECURITY STANDARDS FOR PERSONAL INFORMATION 7

13-64 MEDICAID AUTISM WAIVER AGE ELIGIBILITY UPDATE 8

13-65 STATEWIDE PROVIDER TRAINING 2013 8

13-66 CODE COVERAGE 9

13-67 CONSENT FOR STERILIZATION FORM INSTRUCTIONS MODIFIED 11

13-68 LABORATORY SERVICES – LIPID STUDIES 11

13-69 LABORATORY SERVICES – ONCOTYPE REVIEW 11

13-70 RESISTANT ORGANISM ADDED TO PRIVATE ROOM PAYMENTS 11

13-71 DIABETES SELF-MANAGEMENT TRAINING 12

13-72 ANESTHESIA SERVICES FOR POST-OPERATIVE PAIN MANAGEMENT 12

13-73 MEDICAL SUPPLIES POLICY UPDATES 12

13-74 HOME HEALTH AGENCIES PROVIDER MANUAL 13

13-75 DENTAL SERVICE UPDATES 14

13-76 PODIATRIC COVERAGE 14

13-77 VISION COVERAGE 14

13-78 HOSPICE CARE 14

13-79 MEDICAL TRANSPORTATION MANUAL UPDATE 15

13-80 TRIBAL NON-EMERGENCY TRANSPORTATION MANUAL 15

13-81 PHARMACY POLICY UPDATES 15

13-82 ADDITION OF SAN JUAN COUNTY TO THE MEDICAID PMHP 16

13-83 ATTN: PREPAID MENTAL HEALTH PLANS, MENTAL HEALTH CENTERS AND SUBSTANCE ABUSE PROVIDERS UNDER JURISDICTION OF LOCAL COUNTY MENTAL HEALTH AND/OR SUBSTANCE ABUSE AUTHORITIES, AND UNIVERSITY OF UTAH'S NEUROBEHAVIOR HOME PROGRAM 17

13-84 ATTN: REHABILITATIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER PROVIDERS 17

13-85 HOME AND COMMUNITY-BASED SERVICES 1915(C) WAIVER AMENDMENTS 18

13-60 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 cost-to-charge ratio (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.

13-61 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, **physicians** 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.

Once the State Plan amendment is approved by CMS, quarterly payments will begin to billing providers based on the qualified servicing provider's applicable claims. It is anticipated that any detail related to these payments (e.g. breakout of quarterly payments by servicing physician) will be posted to the Utah Medicaid website. The link to this site is as follows:

http://health.utah.gov/medicaid/stplan/PhysicianEnhancement.htm

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.

13-62 Medicaid Dental Services

Effective September 1, 2013, eligible Medicaid recipients in Weber, Davis, Salt Lake, and Utah counties will be required to enroll in a dental plan. There will be two dental plans available:

- Premier Access
- DeltaCare

Utah Code Annotated Section 26-18-2.6, (HB 256S01, 2011 General Session) directed the Division of Medicaid and Health Financing to, "establish a competitive bid process to bid out Medicaid dental benefits." In compliance with the statue, an RFP was issued in December 2012. As a result, contracts were recently awarded to Premier Access and DeltaCare.

This change in service delivery does not change or expand who is eligible to receive dental services under Utah Medicaid. Full dental services will continue to be available only for pregnant women and children. Emergency dental services and dental services for Primary Care Network (PCN) clients will continue to be paid on a fee-for-service basis directly by Medicaid.

A provider who provides services to Medicaid recipients residing in other counties will continue to bill and be paid by Medicaid directly for those services. Medicaid recipients impacted by this change will be given an opportunity to select a dental plan during the open enrollment period. This will occur between mid-July and mid-August 2013.

These dental plans are full-risk managed care plans. Accordingly, Premier Access and DeltaCare have the flexibility to structure their provider networks and reimbursement methodologies. Dental providers, who would like to join Premier Access and/or DeltaCare provider networks, may contact them at Premier Access (888) 620-2447, and DeltaCare (877) 787-8197.

13-63 Implementation of State Security Standards for Personal Information

Senate Bill 20, State Security Standards for Personal Information, was passed by the Utah Legislature in the 2013 General Session. The bill requires that a health care provider shall, as part of the Notice of Privacy Practices (NPP) required by the Health Insurance Portability and Accountability Act (HIPAA), provide notice to the patient or the patient's personal representative that the health care provider either has, or may submit, Personally Identifiable Information (PHI) about the patient to the Medicaid eligibility database and the Children's Health Insurance Program (CHIP) eligibility database.

In accordance with Senate Bill 20, only providers that include in their NPP a statement that complies with Senate Bill 20 should access the Medicaid and CHIP eligibility databases. Providers that do not have a compliant NPP should not attempt to access the Medicaid and CHIP eligibility databases.

"Access" means an eligibility query either telephonically or electronically. This does not include direct access to databases.

While Senate Bill 20 allows the Department to establish uniform language for the NPP to meet this new requirement, the Department has decided not to do so at this time.

13-64 Medicaid Autism Waiver Age Eligibility Update

Additional legislative guidance has been given on the interpretation of HB 272 (2012 session). Effective May 1, 2013, the age range of the program has been changed from 2 through 5 years of age to now be 2 through 6 years of age.

13-65 Statewide Provider Training 2013

Utah Medicaid Providers are invited to attend the 2013 Medicaid Statewide Billing and Provider Training Seminar. This year's sessions will include important information regarding billing and the new Pharmacy Provider Portal. Presentations will also be provided by Prior Authorization, Managed Health Care, and the Office of the Inspector General. All providers' office staff are encouraged to attend.

Please submit your RSVP by either email to: providertrainingsupport@utah.gov, or telephone (801) 538-6485, 1-800-662-9651 "option 5", or 801-538-6155 "option 5". When leaving information, please indicate which provider office you are representing, how many will be in attendance, and which session you plan to attend. Please provide your contact name and telephone number in order for your group to be confirmed.

Statewide Provider Training Schedule 2013

City	Date	Place	Time
Tooele	08/01/13	Tooele City Health Dept. 151 North Main Room 180	9:30-12:00
Logan	08/02/13	Dept. of Env. Health 85 East 1800 North Rooms 153 & 154	9:30-12:00
Cedar City	08/06/13	Iron County School 2077 Royal Hunt Drive Rooms A, B & C	9:30-12:00
Cedar City	08/06/13	Iron County School 2077 Royal Hunt Drive Rooms A, B & C	1:30-4:00
Monticello	08/08/13	San Juan Hospital 364 West 100 North Conference Room	9:30-12:00

Monticello	08/08/13	San Juan Hospital 364 West 100 North Conference Room	1:30-4:00
Nephi	08/12/13	Central Valley Med Ctr 46 West 1500 North Education Room	9:30-12:00
Nephi	08/12/13	Central Valley Med Ctr 46 West 1500 North Education Room	1:30-4:00
Roosevelt	08/14/13	NE Counseling Ctr 285 West 800 South Conference Room	9:30-12:00
American Fork	08/16/13	American Fork Hospital 170 North 1100 East Education Center	9:30-12:00
Ogden	08/20/13	Ogden Regional Medical Center 5475 South 500 East Cedar Room	9:30-12:00
Salt Lake City	08/23/13	Utah State Library for the Blind & Disabled 250 North 1950 West	9:30-12:00

13-66 Code Coverage

Covered with Prior Authorization

21235 Ear cartilage, autogenous, to nose or ear, includes obtaining graft
29915 Arthroscopy, hip, surgical; with acetabuloplasty (i.e. treatment of pincer lesion)
29916 Arthroscopy, hip, surgical; with labral repair
64575 Incision for implantation or neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
Code was inadvertently removed from prior authorization list. Note: This code requires prior authorization for use in insertion of diaphragmatic electrophrenic neurostimulator and diaphragmatic pacing. The codes

64575, 64590, and L8680 are used to cover both laparoscopic insertion of pacer and open insertion of the diaphragmatic electrophrenic neurostimulator.

Provider Type (PT) Coverage Added

50543 Laparoscopic, surgical; nephrectomy (PT 20, 24, 45, 91). Effective March 27, 2013
73206 CT angiography, upper extremity with contrast material(s) including non-contrast images if performed and image post processing (technical PT 70, 91; professional PT 20, 24, 45, 91).

Non-Covered

S9480 Intensive outpatient psychiatric services, per diem
S9485 Crisis intervention mental health services, per diem

Covered to Provider Types 01, 20, 24, 45 and 91 Effective May 8, 2013

62369 Electronic analysis of programmable, implantable pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming
62370 …with reprogramming and refill
Note: These services are used for analysis and refilling of intrathecal pumps for drug therapy such as management of pain for cancer patients or baclofen pumps.

Outpatient Hospital (OPPS) Covered

27036 Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles

Outpatient Hospital (OPPS) Non-Covered

36595 Mechanical removal of pericatheter obstructive material (e.g. fibrin sheath) from central venous device by separate venous access
S0400 Lithotripsy global fee

Ambulatory Surgery Centers Covered Effective April 16, 2013

23071 Excision tumor, soft tissue of shoulder area, subcutaneous; ≥ 3 cm
23073 Excision tumor, soft tissue of shoulder area, subfascial; ≥ 5 cm
49652 Laparoscopy, surgical repair ventral, umbilical spigelian, or epigastric hernia (includes mesh insertion); reducible
49653 …incarcerated or strangulated
49654 Laparoscopy, surgical repair incisional hernia (includes mesh insertion); reducible
49655 …incarcerated or strangulated
49656 Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion); reducible
49657 …incarcerated or strangulated

13-67 Consent for Sterilization Form Instructions Modified

The instructions for the *Consent for Sterilization Form* have been clarified. To access the form and the modified instructions, refer to http://health.utah.gov/medicaid/provhtml/forms.htm, Sterilization Consent.

13-68 Laboratory Services – Lipid Studies

CPT code 83721 (Lipoprotein, direct measurement; direct measurement, LDL cholesterol) describes direct measurement of LDL cholesterol. It should not be used to report a calculated LDL cholesterol. Direct measurement of LDL cholesterol, in addition to total cholesterol (CPT code 82465) or lipid panel (CPT code 80061), may be reasonable and necessary if the triglyceride level is too high (greater than or equal to 400 mg/dl).

CPT code 83721 should be reported with modifier 59 when the LDL is measured and the triglycerides are greater than or equal to 400 mg/dl. In general, Utah Medicaid does not reimburse for calculated measurements.

Reference: NCCI On-Line Manual, Revision Date (Medicare): 1/1/2013 X-7

13-69 Laboratory Services – Oncotype Review

Utah Medicaid Oncotype DX™ Statement of Medical Necessity

Effective May 7, 2013, Utah Medicaid will accept the Utah Medicaid Oncotype DX™ Criteria Verification Form as acceptable documentation for manual review of Oncotype claims.

13-70 Resistant Organism Added to Private Room Payments

Effective July 1, 2013, the *Utah Medicaid Physician Manual*, Section LL (C), has been modified to add Enterobacteriaceae. It now reads, ICD-9-CM Codes 041.85 Other gram negative (Acinetobacter baumanii, Klebsiella oxytoca, Enterobacteriaceae).

13-71 Diabetes Self-Management Training

The diabetes self-management training criterion has been removed from the Physician Manual - Section 2, and is now found in "Criteria" on the Medicaid website at www.health.utah.gov/medicaid.

To enroll as a Utah Medicaid authorized diabetes self-management program, refer to Medicaid provider enrollment at www.health.utah.gov/medicaid.

13-72 Anesthesia Services for Post-Operative Pain Management

Effective July 1, 2013, post-operative pain management services may be billed with anesthesia services. According to the American Society of Anesthesiologists, the AMA, and now the CMS online NCCI manual, when pain management catheters are placed during anesthesia time, with the sole intent to provide post-operative pain management, the service may be reimbursed. The pain management catheter may not be used to supply any intraoperative analgesia.

Per AMA CPT, anesthesia time starts when the anesthesiologist begins to prepare the patient for the operating room and ends when the patient is transferred to the PACU staff. When the pain management catheter is placed during this time period, documentation must show that anesthesia time stopped for catheter placement and show that time resumed once placed.

In order to bill for this service, modifier 59 is added to the applicable 60,000 series pain management code. This is required to override the NCCI edit. The pain management codes, billed with anesthesia codes, are not reduced with a 51 modifier.

13-73 Medical Supplies Policy Updates

Medical Supply Refills

Effective July 1, 2013, disposable medical supplies that are filled monthly may be refilled between day 25 and 30 to assure the client has the needed product in time for the next 30-day period.

Lookup Tool Changes

Enteral Codes
Lookup tool notes were changed for all enteral formula. The notes now read:

The following criteria apply to ALL Enteral Formula:

1. Diagnosis related to need for enteral nutrition.

2. No other food intake/total nutrition.
3. Enteral nutrition given by NG, NJ, GT, or JT.
4. Function impairment; i.e. missing or nonfunctioning portions of the GI system OR neurological OR psychological impairment that prevents swallowing.
5. Doctor's order: name of product, dose and frequency or total amount per day and expected duration.

Replacement Vest

Added to the lookup tool "Replacement vest allowed every three years":

A7025 High frequency chest wall oscillation system vest replacement

Tracheostomy Supply

Code closed effective July 1, 2013:

S8189 Tracheostomy supply, NOC

Medical Supplies Manual Changes

Disposable Incontinence Products

Clarifying language has been added to the Medical Supplies Manual, Section 2, Scope of Service, 1.A. regarding the issue of unit limits on disposable incontinence products and/or pads. This new language applies to codes T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, and T4543.

Disposable incontinence products are covered for disabled children and disabled adults only. They are not covered for normal infant use or for adult incontinence not related to a disability. They are not covered for residents of a Long Term Care or ICF-ID facility, as they are furnished by the facility.

The unit limit for recipients on the disability Medicaid program is 156 per month. The unit limit for recipients on a waivered program is 312 per month. In both cases, the limit applies to any combination of the above codes for a one-month supply. If more diapers are ordered by the medical provider, a prior authorization must be obtained. The reimbursement rate is based on the appropriate HCPCS code.

Oxygen Concentrators

Clarifying language has been added to indicate the oxygen concentrator contract applies to concentrators that deliver and are adjustable for one-sixteenth to ten liters per minute at 90 to 94 percent oxygen concentration.

13-74 Home Health Agencies Provider Manual

Effective July 1, 2013, the mental health services section of the *Utah Medicaid Provider Manual for Home Health Agencies* has been removed.

13-75 Dental Service Updates

Effective July 1, 2013, dental code D1351 (sealants) will be limited, per tooth, 1st or 2nd permanent molar or premolars (bicuspids) to one every two years. Sealants are available only for EPSDT clients.

13-76 Podiatric Coverage

Effective July 1, 2013, the restriction of services for non-pregnant adults is removed. Any podiatric service, previously available only to children and pregnant women when provided by a podiatrist, is now open to non-pregnant adults eligible for Traditional and Non-Traditional Medicaid.

13-77 Vision Coverage

Effective April 2, 2013, the following code has been modified to add provider type 31 as allowed for the technical component:

92133 Scanning computerized ophthalmic diagnostic imagining

13-78 Hospice Care

Medicaid hospice policy has been updated to reflect a change in reimbursement rates for pediatric hospice room and board. For a client who is under 21 years of age, the room and board rate will be 100% of the amount that Medicaid would have paid to the nursing facility or ICF/ID if the client had not elected to receive hospice care.

Beginning July 1, 2013, the pathway for submitting hospice prior authorization requests will be the same process that providers currently use to submit home health service prior authorization requests. Hospice providers will continue to use the Prior Authorization Request Form they are currently using until further notice. The fax number to submit hospice prior authorization requests is (801) 323-1562.

Beginning July 1, 2013, if hospice providers need additional assistance with hospice prior authorization, they will be required to use the Medicaid Information Line at (801) 538-6155 or toll-free (800) 662-9651, option 3, option 3, option 8.

13-79 Medical Transportation Manual Update

Clarification to policy has been made in sections 1, 2, and 3 of the *Utah Medicaid Medical Transportation Provider Manual*. The manual is available at www.health.utah.gov/medicaid.

13-80 Tribal Non-Emergency Transportation Manual

Effective October 1, 2013, the Division of Medicaid and Health Financing has added a new provider manual entitled, *Tribal Non-Emergency Transportation*. The manual is available at www.health.utah.gov/medicaid.

13-81 Pharmacy Policy Updates

Flu Vaccine Billing Limit

Flu vaccines will be limited to 0.5ml per claim. This limit is noted in the *Drug Criteria and Limits* attachment to the *Utah Medicaid Pharmacy Provider Manual*, available online at www.health.utah.gov/medicaid.

Medication Not Received By Medicaid Client

If a Medicaid client has not received a medication billed to Medicaid within ten (10) days of the date it was filled, the pharmacy provider must reverse the claim and credit back the billed amount.

340B Billing Requirements

Pharmacies that submit point-of-sale claims for 340B-eligible clients need to submit a value of 12 in NCPDP field 522-FM, or a value of 20 in the submission clarification code (NCPDP field 420-DK). The billing provider is responsible for identifying which claims were dispensed using 340B stock. Identifying 340B claims is required whether billing fee-for-service or an Accountable Care Organization (Health Choice Utah, Healthy U, Molina, or Select Health).

13-82 Addition of San Juan County to the Medicaid PMHP

Effective July 1, 2013, there will be a change in how Medicaid pays for mental health and substance use disorder services in San Juan County. San Juan County will become part of Medicaid's Prepaid Mental Health Plan (PMHP). Northeastern Counseling Center will administer PMHP-covered services in San Juan County and services will be provided through San Juan Counseling Center. This means Medicaid recipients must get mental health and substance use disorder services through San Juan Counseling Center, except under the following circumstances:

- This change does not affect American Indian Medicaid recipients. American Indians can obtain services from San Juan Counseling Center or an Indian Health Program.
- This change does not affect Federally Qualified Health Centers (FQHCs). Medicaid recipients can obtain services from San Juan Counseling Center or an FQHC.
- Also, this change does not affect physicians who are not part of San Juan Counseling Center who prescribe medication to a Medicaid recipient for a substance use disorder problem, methadone maintenance providers providing the methadone maintenance service covered by Medicaid, or hospitals providing medical detoxification for a substance use disorder. These providers will continue to obtain Medicaid reimbursement as usual.

Children in foster care or state custody are enrolled in the PMHP only for inpatient mental health care in a hospital. They are not enrolled for outpatient mental health or substance use disorder services. Department of Human Services caseworkers will continue to help children in foster care obtain needed outpatient services from qualified providers. Qualified providers will continue to obtain Medicaid reimbursement as usual.

The following table shows PMHP coverage by county:

Prepaid Mental Health Plan (PMHP)	Counties	Inpatient & Outpatient Mental Health	Outpatient Substance Abuse
Bear River Mental Health	Box Elder, Cache, Rich	Yes	No
Southwest Utah Behavioral Health	Beaver, Garfield, Kane, Iron, Washington	Yes	Yes
Four Corners Community Behavioral Health Center	Carbon, Emery, Grand	Yes	Yes
Northeastern Counseling Center	Daggett, Duchesne, Uintah and San Juan*	Yes	Yes
Davis Behavioral Health	Davis	Yes	Yes
Central Utah Counseling Center	Piute, Juab, Wayne, Millard, Sanpete, Sevier	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
Weber Human Services	Weber, Morgan	Yes	Yes

*Services in San Juan County provided through San Juan Counseling Center

---

13-83 Attn: Prepaid Mental Health Plans, Mental Health Centers and Substance Abuse Providers Under Jurisdiction of Local County Mental Health and/or Substance Abuse Authorities, and University of Utah's Neurobehavior HOME Program

Based on approval from the Centers for Medicare and Medicaid Services (CMS), the state has consolidated two targeted case management target groups, the chronically mentally ill and individuals with substance use disorders, into one target group. The combined target group is called "Individuals with Serious Mental Illness".

In conjunction with this consolidation, the two separate targeted case management provider manuals, *Targeted Case Management for the Chronically Mentally Ill* and *Targeted Case Management for Substance Abuse*, have been combined into one new provider manual entitled, *Targeted Case Management for Individuals with Serious Mental Illness*.

Due to the new State Plan amendment and instructions from CMS, changes have been made in policy addressed in Chapter 2-1, C.

Providers may access the new combined 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.

13-84 Attn: Rehabilitative Mental Health and Substance Use Disorder Providers

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

- Chapter 1-3, Medicaid Behavior Health Service Delivery System, has been updated to include San Juan County in the Prepaid Mental Health Plan.

- Chapter 2-8, Pharmacologic Management, clarifying information has been added regarding evaluation and management (E/M) services code selection when more than 50 percent of time is counseling and/or coordination of care.
  Also, the 'Record' section of Chapter 2-8 has been updated to clarify documentation requirements.
- Chapter 2-9, Nurse Medication Management, 5.a. of the 'Record' section has been revised slightly for clarity.
- Chapter 2-10, Therapeutic Behavioral Services, and Chapter 2-11, Psychosocial Rehabilitative Services, the 'Who' sections have been revised to clarify supervision of substance use disorder counselors.

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.

13-85 Home and Community-Based Services 1915(C) Waiver Amendments

The Department is submitting four home and community-based waiver amendments to CMS. The amendments are for the Acquired Brain Injury, Aging, Community Supports, and Physical Disabilities Waivers. During recent communication with CMS, a concern was expressed in how the state explains the number of individuals served on the waiver programs. To best describe how Utah operates the waivers, CMS recommended that in addition to an unduplicated count for each year that the state also implement a "point in time" estimate to clarify how many individuals were intended to be served at any one moment. In conjunction, these two items are able to more accurately reflect the number of people current appropriations can serve as well as to acknowledge the attrition on the waiver programs.

Also, beyond these global changes, each waiver amendment includes some additional adjustments as follows:

The Acquired Brain Injury Waiver Amendment adds approximately 6-8 new individuals to the program, revises language in the personal emergency response system service descriptions to include medication management systems, and describes the new admissions process as outlined and approved during the 2013 legislative session – 85% of any new appropriations is to allow those with critical need onto the waiver; 15% to be used for individuals who are requiring respite only assistance.

The Aging Waiver Amendment provides clarification in the service description for the chore service to allow one-time start-up expenses an individual may require and revises language in the environmental accessibility adaptations service description to allow the use of equipment and/or physical adaptations in a setting outside of a participant's residence.

The Community Supports Waiver Amendment adds approximately 80 new individuals to the program and, similar to the Acquired Brain Injury Waiver Amendment, describes the new admissions process outlined and approved during the 2013 legislative session as previously mentioned and revises language in the personal emergency response system service descriptions to include medication management systems.

The Physical Disabilities Waiver Amendment removes the support coordination liaison service from the waiver because it will now be provided by DSPD staff as an administrative function, adds approximately 6-8 new individuals to the program and also revises language in the personal emergency response system single service description to also include medication management systems.

The proposed effective date of the waiver amendments is July 1, 2013. All four amendments are pending CMS approval. The full HCBS Waiver Amendment Application for each waiver can be reviewed by visiting the following site at http://health.utah.gov/ltc/.