UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin
October 2013

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TABLE OF CONTENTS

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13-87 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 accountable care organization claims data would need to be requested of the appropriate accountable care organization.

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

13-88 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 recently published FAQ documents. The link to these documents is as follows:

http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

Physician Enhancement and Self-Attestation

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

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

   Or, if not board certified in a sub-specialty above,
      i. Self-attest to a specialty designation in family medicine, general internal medicine, or pediatric medicine and demonstrate that 60% or more of all Medicaid services they bill (including Medicaid

managed care environments) are for the following codes: 99201 - 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474.

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

Please note that self-attestation is subject to audit.

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

Clarification and guidance regarding eligible providers

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

ABMS

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

AOA

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

ABPS

The ABPS does not certify subspecialists. Therefore, eligible certifications are:
American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no Board certification specific to Pediatrics.

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

Third, these payments will be retroactive to the begin date of the quarter in which the self-attestation process is completed assuming that the board certification date spans the full period and is not expired. Also, for physicians attesting based on eligible board certification, continuing program eligibility is subject to continued board certification. 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 between 1/1/2013 and 12/31/2014.

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 between 2/1/2013 and 12/31/2014.

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 between 4/1/2013 and 12/31/2014.

Example 4
A provider who self-attests on 2/1/2013 and who is certified from 1/1/2006 to 12/31/2013 will be eligible for enhanced payments for service dates between 1/1/2013 and 12/31/2013.

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

These payments will be made as quarterly lump sum payment amounts to each qualifying provider based on the paid date of the claims data. These payments will be made to the billing provider based on the qualifying servicing provider(s)' applicable services rendered.

Details related to these payments (e.g. breakout of quarterly payments by servicing physician) can be found on the Utah Medicaid website. The link to this site is as follows:

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

Utah Medicaid Accountable Care

Providers that only serve clients through an Accountable Care Organization (ACO) must still self-attest through the above process as Utah Medicaid will collect all of this information.

Utah pays capitation rates without the ACA enhanced primary care payments. On a quarterly basis, Utah Medicaid will calculate the total non-risk reconciled payments for each ACO and distribute payments as noted below. The ACO or H.O.M.E will ensure that their eligible providers receive payments up to the Medicare rate (or the provider's billed charges if less), using a method of their choice, as required in 42 CFR 438.6.

This quarterly non-risk reconciled payment will ensure sufficient reimbursement to ACOs to in turn pay their qualified physicians at the Medicare rates for the applicable services provided in a given quarter.

On 7/1/2009, all Utah Medicaid health plans had a non-risk contract and payments were based on the prevailing Utah Medicaid rate at that time. The current risk-based, capitated ACO rates include a two percent increase to the 7/1/2009 rates.

In determining the enhancement amount for the ACOs, Utah Medicaid will compare the Medicare rate in effect as of January 1 of the calendar year in which the service was incurred to 102 percent of the 7/1/2009 rate to determine the appropriate enhancement amount. Utah Medicaid will sum the enhancement amounts by ACO and make quarterly non-risk reconciled payments for the enhanced amounts. Each quarterly non-risk reconciled payment will be based upon the prior quarter's received encounter data with service end dates on or after 1/1/2013 and not later than 12/31/2014.

It is important to note that the amount Medicaid pays the ACOs does not necessarily equate to the amount the providers may expect to receive from the ACO. It is not a pass-through amount. The ACOs must calculate the amount needed to pay the providers to ensure that the provider is reimbursed in accordance with 42 CFR 447.405.

Newly Enrolled Providers

For new providers that enroll over time, the process for the completion of the self-attestation process will need to be completed as explained above.

VFC Enhanced Payments

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

Details related to these payments (e.g. breakout of quarterly payments by servicing physician) can be found on the Utah Medicaid website. The link to this site is as follows:

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

13-89 Medicaid Autism Waiver Update

Utah Medicaid is submitting an amendment for the Medicaid Autism Waiver to allow a Board Certified Assistant Behavior Analyst (BCABA) as a qualified provider of Intensive Individual Support – Consultation Services (IIS-CS). The amendment will also change the IIS-CS to 15 minute units, from 1 hour units.

The amendment will modify the BCBA Intern supervision requirements. The supervisory requirements will be reflected as a ratio, rather than a set number of hours per week.

In addition, changes to the unduplicated count have been made following clarification Utah Medicaid has received from CMS. Information on the total projected number of children to be served, and how enrollment to the waivers is conducted, has been revised.

The proposed effective date of the waiver amendment is October 1, 2013, and is pending CMS approval. The full HCBS Waiver Amendment Application can be reviewed at: http://health.utah.gov/autismwaiver.

13-90 ICD-10 Update

Utah Medicaid is currently updating the legacy MMIS System to be able to process ICD-10 diagnosis codes and PCS procedure codes. If you have questions or concerns surrounding this transition, or if your organization has special needs, please submit an e-mail to: utahmedicaidicd10@utah.gov or access the link provided on the Medicaid website at www.health.utah.gov/medicaid.

13-91 Updates to Section I General Information Provider Manual

The *Utah Medicaid Section I General Information Provider Manual* has been updated. A single instance of the term 'mentally retarded' was replaced with the term 'people with intellectual disabilities'. 'People with intellectual disabilities' is equivalent to the term 'mentally retarded' under federal law.

Additionally, private duty nursing services were described to be a covered service when indicated to prevent prolonged institutionalization in medically categorically and needy, eligible, EPSDT clients rather than referring to age 21. This change conforms to recent changes made to the *Utah Medicaid Home Health Agencies Provider Manual*.

The effective date of the updates is October 1, 2013.

13-92 Codes and Coverage

CPT Code Update

88185 Flow cytometry, cell surface, cytoplasmic or nuclear marker, each additional marker. Limited to 24 markers.

93532 Combined RT heart catheterization and transeptal left heart catheterization through intact septum, with or without retrograde, left heart catheterization for congenital cardiac anomalies. Opened to all ages, along with previously opened codes 93530, 93531, and 93533.

HCPCS Code Update

Q4105 Integra dermal regeneration template, per sq cm. Opened to provider type 20, 24, 45, 91 in addition to 01.

Q4108 Integra matrix per sq cm. Opened to provider type 20, 24, 45, 91 in addition to 01.

ICD-9-CM Code Update

649.53 Spotting complicating pregnancy, antepartum condition or complication. Added as a Medicaid covered diagnosis. This code is open to outpatient claims only.

13-93 Physician Manual Updates

Please note that there have been corrections made to the specimen collection codes 36415 and 36416, due to previous typographical errors.

Brachytherapy, for prostate cancer treatment, will be open with manual review under certain criteria. The *Utah Medicaid Physician Manual – Section 2* has been updated as follows:

Z. Brachytherapy for Prostate Cancer

Brachytherapy using permanent transperineal implantation of radioactive seeds may be considered medically necessary in treatment of localized prostate cancer when used as monotherapy or in conjunction with external beam radiation therapy (EBRT).

Medicaid defines prostate cancer risk using the following criteria:

LDR GUIDELINES:

(1) Low Risk: PSA 10 ng/mL or less, Gleason score 6 or less, and clinical stage T1c or T2c
(2) Intermediate Risk: PSA greater than 10 but 20 ng/mL or less, or Gleason score 7, or clinical stage T2b
(3) High Risk: PSA >20 ng/mL, Gleason score 8-10, or clinical stage T2c

HDR GUIDELINES

(1) Low Risk: PSA 10 ng/mL or less, Gleason score 6 or less, and clinical stage T1c or T2c
(2) Intermediate Risk: PSA greater than 10 but 20 ng/mL or less, or Gleason score 7, or clinical stage T2b
(3) High Risk: PSA >20 ng/mL, Gleason score 8-10, or clinical stage T3a for clinical localized disease and T3b-T4 for locally advanced disease

The codes listed below are ONLY covered if the procedure meets criteria, is performed according to the policy, and requires undergoing manual review:

Code Number	
CPT	**Description**
55860	Exposure of prostate, any approach, for insertion of radioactive substance
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55876	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, prostate (via needle, any approach), single or multiple
76873	Ultrasound transrectal; prostate volume study for brachytherapy treatment planning
76965	Ultrasonic guidance for interstitial radioelement application
77326, 77327, 77328	Brachytherapy isodose plan code range
77402, 77403, 77404, 77406	Radiation treatment delivery, single treatment area, code range (used for EBRT)

Refer to the online Coverage and Reimbursement Lookup Tool available on the Medicaid website at: www.health.utah.gov/medicaid.

Effective October 1, 2013, the *Utah Medicaid Physician Manual – Section 2* has been revised and is available at www.health.utah.gov/medicaid. Revisions concerning services to pregnant women, who do not meet United States citizenship requirements, include the following:

O. Services to pregnant women who do not meet United States citizenship requirements as defined in the Medicaid Eligibility Manual §205-6, Emergency Medicaid, are limited only to labor and delivery services.

The following criteria must be met for covering “Emergency Only Services”:

- The condition manifests itself by sudden onset.
- The condition manifests itself by acute symptoms (including severe pain).
- The condition requires immediate medical attention.

  - Immediate medical attention will require attention within 24 hours of the onset of symptoms or within 24 hours of diagnosis whichever comes earlier (no delay for scheduled or convenient time for service).
- The condition requires acute care, and is not chronic (does not include any chemotherapy or follow-up care).
- Coverage will only be allowed until the condition is stabilized sufficient that the patient can leave the acute care facility, or no longer needs constant attention from a medical professional.
- The condition is not related to an organ transplant procedure.
- Prenatal or postpartum care is not covered.

Diagnosed conditions in the prenatal period can arise to a level requiring "immediate medical attention" that can reasonably be expected to result in serious health consequences if not treated. A physician rendering treatment for a diagnosed prenatal emergency condition, if coded appropriately, warrants payment without prior review.

Prenatal testing, observation, pain management, counseling and/or care for any of the following codes are considered as prenatal care and are not a covered benefit unless involving a diagnosed emergency condition.

Medical records may be subject to review if selected during the mandated monthly sample and/or targeted for a focused review.

The following code(s) are approved and may bypass prepayment review when reflecting treatment to resolve a diagnosed emergency medical condition as specified below:

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

2. Vaginal Bleeding – diagnosis codes 641.01, 641.03, 641.11, 641.13, 641.21, 641.23, 641.31, 641.33, 641.81, 641.83.

3. Threatened Abortion – diagnosis code 640.03 - Payable only in the emergent situation defined as uterine bleeding and cramping without cervical change before 20 weeks gestation, but the pregnancy is not terminated.

4. Spontaneous Abortion – diagnosis codes 634.1, 634.2, 634.3, 634.4, 634.5, 634.6, 634.7, 634.8- The appropriate related diagnosis and procedure codes must be on the claim for payment to be made without review.

   Note: An incomplete abortion (code 634.91), which requires a D&C or vacuum extraction to complete, must have medical (manual) record review, including operative and pathology reports, for approval before payment.

5. Missed Abortion – (Fetal death without spontaneous abortion) diagnosis code - 632 CPT codes for physicians - 59820 or 59821. Abortion will inevitably occur, but D&C or D&E may be indicated to prevent any maternal complications.

   Missed abortion, or fetal demise, requires medical staff review, but does not require completion of the abortion consent form. Documentation of fetal demise by ultrasound is required for post payment

review. The abortion consent form is required only in a therapeutic abortion and is part of the required medical record documentation reviewed by medical staff to ensure all legal requirements are met.

A copy of the Abortion Acknowledgement Form can be found under the "Forms" section at: www.health.utah.gov/medicaid.

It is the responsibility of the provider to assure that the code(s) being billed are correct for the diagnosis and procedure performed.

6. Premature Rupture of Membranes – diagnosis code 658.13 requires documentation for review. If delivery occurs within 24 hours of admission; no separate payment is warranted for the ruptured membrane services. Labor and delivery codes only should be billed.

7. Premature Labor -- diagnosis code 644.03. Regular uterine contractions with cervical change after 22 weeks, but before 37 completed weeks of gestation without delivery. Cervical change is defined by vaginal exam or transvaginal ultrasound. Indications of possible early labor with an ER visit that only involves testing, monitoring, counseling or pain management singly or in combination is prenatal care and not an emergency medical condition. The early labor must be advancing at a level where the physician must treat the patient to stall early labor and preserve the pregnancy for further development of the fetus. Any follow up or continuing care following the stabilization will not be covered.

8. Decreased Fetal Movement – diagnosis code 655.73 is subject to review. Decreased fetal movement may be a symptom which may or may not require emergency services. Fetal evaluation and monitoring is required to establish fetal wellbeing. Fetal monitoring includes Non-Stress Test (NST), Amniotic Fluid Index (AFI), Biophysical Profile (BPP), and Contraction Stress Test. All codes associated with evaluating decreased fetal movement with no related emergent condition are inappropriate and will be denied payment.

   If fetal demise occurred then treatment would be under a missed abortion code. Emergent situations that are reimbursable would be indications of and treatment for fetal distress.

9. All services beyond those listed above, must be edited and reviewed before payment.

   Codes which may be associated with the above services are listed below. Codes should be selected carefully based on the condition and the necessary services to stabilize the clients' condition. Documentation must support the billed service(s). Appropriate diagnosis to procedure edits must apply. All codes will not be appropriate for all complaints and may not be associated in the system editing and payment will be denied. Codes including but are not limited to:
   - Physician office visit codes – 99201 – 99205
   - Physician Emergency Department visit codes - 99281 – 99285
   - Ultrasound CPT code - 76805 or 76815
   - CLIA approved CPT lab codes for physician office (diagnosis to procedure edit must agree)
   - Fetal non-stress test – ICD.9 procedure code 75.35 CPT code 59025 (If done in a hospital must have the revenue code plus the CPT code)
   - Fetal Monitor - 59050 – 59051

13-94 Hospital Manual Updates

The following CPT codes have been approved as exceptions to the inpatient only service in OPPS, and have been added to the *Utah Medicaid Hospital Services Manual*:

27036 27176 27477 27485 27486 43605 43610 43611 44300 50400 50543 50780
51980 58700 58720 64568 69714

Clarification of language concerning the "three-day rule" has been made to Chapter 2, Covered Services. Item #3 now reads as follows:

> Services performed for a patient by the admitting hospital or by an entity wholly owned or wholly operated by the hospital within three days of patient admission, are considered inpatient services.
>
> This three-day payment window applies to diagnostic and non-diagnostic services that are clinically related to the reason for the patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

13-95 Laboratory Manual Updates

Effective October 1, 2013, a unit limit of 24 units has been set for CPT code 88185 – flow cytometry, cell surface, cytoplasmic or nuclear marker. Each additional marker is an add-on code to the code 88184. If the 24 unit limit needs to be exceeded, the provider must submit a letter of medical necessity and medical record documentation for manual review.

Please note that there have been corrections made to the specimen collection codes 36415 and 36416, due to previous typographical errors.

The "three-day rule" language has been removed from Section 4, Limitations, in the *Utah Medicaid Laboratory Provider Manual*. Refer to the *Utah Medicaid Hospital Services Manual* for more information.

13-96 Medical Supply Code Coverage

The following new HCPCS codes are effective July 1, 2013, and will **not** be covered for Medicaid:
K0008 Custom manual wheelchair base
K0009 Custom durable, other than wheelchair

K0013 Custom motorized/power wheelchair base

Effective July 16, 2013, prior authorization is no longer required on the following code:
K0606 Automatic external defibrillator - rental

13-97 Dental Services Updates

The following changes have been made to the *Utah Medicaid Dental Provider Manual*, effective October 1, 2013:

1-6 Radiographic Services (page 4)

2. A panoramic x-ray performed with one or more of the following services will be re-bundled to D0210:
    - Bitewings
    - 2 or 4 films
    - 2 or more periapicals

1-8 Restorative Services (page 5)

Routine amalgam fillings on posterior teeth and composite resin fillings on anterior and posterior teeth are covered.

Composite resin restorations on anterior and posterior teeth, amalgam restorations, pin retention, stainless steel crowns, core buildups, prefabricated post and core, and re-cementation of crowns are covered services.

1-14 Orthodontia (page 8)

Providers billing for orthodontia services under IHS are reimbursed using code D8080. Prior authorization is required for D8080, and periodic orthodontic treatment visits are limited to 36. Code D8680, orthodontic retention, is limited to two visits with a prior authorization. Claims are adjudicated and reimbursed at the all-inclusive rate (AIR).

2 NON-COVERED SERVICES (pages 12-13)

The following information was deleted from this section:
1. Multiple surface composite resin fillings on posterior teeth.
2. Periodontal scaling, root planing, and periodontal surgery.

3 DENTAL SPEND-UPS (page 13)

The following information was deleted from this section:
- Covered amalgam fillings to non-covered composite resin fillings.

The following policy, effective September 1, 2013, will be added to the *Utah Medicaid Dental Provider Manual*:

1-5 Client Enrollment in a Dental Plan

The Division of Medicaid and Health Financing (DMHF) requires pregnant women and children on Medicaid, living in Davis, Salt Lake, Utah, and Weber counties, to enroll in a dental plan (Delta Dental or Premier Access). When a person applying for Medicaid is determined eligible, he or she must select a dental plan. A Health Program Representative (HPR) employed by DMHF explains the managed care choices, including mandatory enrollment in a dental plan.

Medicaid fee-for-service will not pay for services provided by a dental plan in which the Medicaid client is enrolled, except as otherwise stated in the 'Carved Out Services' section below. The information about what dental plan the client must use is printed on the client's Utah Medicaid Identification Card (Medicaid Card). Be sure to check the individual's current Medicaid Card. Refer to SECTION I: GENERAL INFORMATION Chapter 5, Verifying Medicaid Eligibility, for information on how to verify a client's enrollment in a dental plan.

The dental plan shall agree to cover dental services in accordance with benefits as defined in the Medicaid State Plan and state and federal law. Except as otherwise provided for cases of emergency services, the dental plan is responsible to arrange for all covered services listed in the Coverage and Reimbursement Lookup Tool, the Division's Provider Manuals, and the Division's Medicaid Information Bulletin (MIB).

Carved Out Services

The following services are Medicaid State Plan services in which the dental plan is not responsible to cover. These services are "carved out" and covered by Medicaid fee-for-service (FFS) and/or the client's health plan:

a) Non-pregnant adults
b) Children in custody of the Department of Human Services (DHS) and covered by foster care Medicaid
c) Clients covered by refugee Medicaid
d) Clients covered by nursing home Medicaid
e) Facility charges for hospital and ambulatory surgical center
f) Medical and surgical services of a dentist, including general anesthesia performed at a hospital or ambulatory surgical center
g) Emergency services provided in an emergency department as described in Attachment B, Article 4.3
h) Services performed at an Indian Health Services (IHS) tribal facility, or an Urban Indian Facility (UIF)
i) Services performed at the state hospital or state developmental center

13-98 Flu Vaccine Coverage

All Medicaid clients are eligible for flu vaccines when given in a prescriber's office. Flu vaccines are also covered for Traditional Medicaid clients and Medicaid clients who reside in nursing homes through the outpatient pharmacy program year round.

Flu vaccines administered to children under the age of 18 must have the product supplied by the Vaccines for Children (VFC) program and are subject to VFC coverage policies. VFC providers will be reimbursed for the administration of the vaccine only. Adult vaccinations are eligible for coverage of vaccine administration and for the covered product. Flu vaccines administered in a pharmacy 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*. The manuals and attachments are available on the Medicaid website at www.health.utah.gov/medicaid.

13-99 Drug Utilization Review Board and Prior Authorization Updates

The Drug Utilization Review (DUR) Board recently reviewed and established prior authorization criteria for Xifaxan (Rifaximin). The criteria are as follows:

- Traveler's Diarrhea:
  - Age ≥ 12 years
  - For treatment, not for prophylaxis
  - Trail and failure of, or contraindication to, a fluoroquinolone or azithromycin (please describe)
  - Must reasonably be believe to be caused by Escherichia coli (please describe)
  - Maximum 200mg three times daily for three days

- Overt Hepatic Encephalopathy:
  - Age ≥ 18 years
  - For prophylaxis of recurrence (please describe previous occurrences and therapies)
  - Trail and failure of, or contraindication to, properly doses and titrated lactulose (please describe)
  - Maximum 550mg twice daily

Authorization for traveler's diarrhea will be approved for three days. Authorization for overt hepatic encephalopathy will be approved for one year.

The prior authorization criteria sheet for proton pump inhibitors (PPI) has been removed. All proton pump inhibitors, including those over-the-counter, are included on the Preferred Drug List (PDL). If a non-preferred PPI is prescribed, please use the Non-Preferred Drug Authorization form located online at: http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/allentries.php.

13-100 Utah Medicaid PDL Update

The Preferred Drug List (PDL) will be updated with new drug classes. Covered drugs not listed are still considered covered under regular Utah Medicaid pharmacy policy. The PDL is available at www.health.utah.gov/medicaid/pharmacy.

13-101 72-Hour Emergency Supply Override

Utah Medicaid authorizes 72-hour supplies of medications, normally requiring a prior authorization, which are provided in a medical emergency. In these instances, the prior authorization requirements will be waived for the 72-hour period.

To view this policy, see the *Utah Medicaid Pharmacy Provider Manual* at: www.health.utah.gov/medicaid.

13-102 Reporting of Drug Shortages

If a medication becomes generally unavailable from wholesalers or suppliers, a pharmacy may report the shortage to www.ASHP.org/shortages or http://www.fda.gov/Drugs/DrugSafety/DrugShortages/ucm050792.htm. Once a shortage is confirmed, and posted by one of these sources, Medicaid will consider coverage modifications to accommodate the available medication options.

13-103 Medical Interpretive Services Clarification

Effective October 1, 2013, Chapter 6-12, Medical Interpretive Services, of the *Utah Medicaid Section I: General Information Provider Manual* will contain the following clarifications:

1. Clients with Dual Eligibility

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have dual eligibility (both Medicaid and Medicare) and are receiving Medicaid covered services. Medicaid administrative funding for translation or interpretation services is available to the eligible client, whether or not Medicaid reimburses any amount on the claim.

2. Transportation
   Medicaid will not reimburse for an interpreter's mileage unless the interpreter's contract with the state, or Accountable Care Organization (ACO), requires the reimbursement.

13-104 Vision Policy Update

Effective January 1, 2013, group practice (provider type 45) has been added to the optical codes.

13-105 Home Health Agencies Provider Manual Updated

The *Utah Medicaid Home Health Agencies Provider Manual*, section 7-10, C. Billing, has been modified to include the verbiage, TE to pay at 78 percent of the fee schedule.

13-106 Hospice Care

The *Utah Medicaid Hospice Care Provider Manual* has been updated as follows:

For clients under 21 years of age, the hospice room and board rate is 100% of the amount that the Department would have paid to the nursing facility, ICF/ID, or freestanding hospice inpatient unit for that client if the client had not elected to receive hospice care.