UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin
January 2014

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

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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

Request a Medicaid Publication

Send a Publication Request form:

By Fax: (801) 536-0476

By Mail: Division of Medicaid and Health Financing
PO Box 143106, Salt Lake City, UT 84114

14-01 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.

14-02 Physician and VFC Enhancement Payments

This update provides the latest information based on the most recent federal guidance and supersedes any previous communication.

The summaries of the enhancement payments made to date are posted on our website.

Group practices receiving quarterly lump-sum payments may find the breakout of these payments by servicing physician in these summaries.

The status of physician's eligibility based off self-attestation information is available on our website. We strongly encourage all physicians who have submitted the online self-attestation form to check their status on the list.

- Physicians on the list that are deemed eligible for the enhancement payments: Please do NOT fill out the online self-attestation form again. If the *Findings from Review* is noted as "Verified for 2013 only" and you have a valid board certification effective beyond 12/31/2013, please fax in the appropriate documentation in order to continue receiving enhancement payments for the services to be rendered in year 2014. However you do NOT need to re-submit the online self-attestation form.
- Physicians on the list that are NOT deemed eligible due to various attestation issues: Please take appropriate action. For example, when the *Findings from Review* is noted as "NPI Issue (e.g. invalid, group NPI, too short)" and *Provider Action* is "Re-Self-Attest, if not done already, and verify NPI is entered

correctly", providers will need to re-submit the online self-attestation form and fax in any supporting documentation.

Following is a link to more program implementation details:

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

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.

<u>AOA</u>

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.

<u>ABPS</u>

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 Organizations

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.

Questions related to an ACO's payment of this enhancement to eligible providers should be directed to the ACO.

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

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14-03 Closing All Inactive Providers

A performance audit of Utah Medicaid Provider Enrollment, conducted by the Office of Inspector General, (Report 2012-01) recommended that Provider Enrollment close all providers that have been inactive for two or more years. In past years, Utah Medicaid has only had the capability to close providers that have not been affiliated to a group practice. The closure process has now become automated and identifies individual providers, as well as individual providers affiliated to a group practice.

Providers should review billings to Utah Medicaid to be sure that they are billing with the correct NPI numbers to avoid closure of their provider agreement. Any provider that has billed Utah Medicaid within the last two years will not be closed. Provider Enrollment will begin to close providers who are affiliated with a group practice, that have not billed in more than two years, on February 1, 2014.

If a provider agreement is closed due to inactivity, a new application packet will need to be submitted to Provider Enrollment. Contact Provider Enrollment with any questions or concerns at (801) 538-6155 or 1-800-662-9651, menu option 3, then 4.

14-04 MMIS Replacement News

This spring, the first of five planned releases for the new Medicaid Management Information System replacement will debut. This first release will include improvements to the Medicaid website at http://health.utah.gov/medicaid and the addition of a Medicaid beneficiary card look-up tool.

Website Update
The Utah Medicaid website serves as a communication vehicle for the transfer of Utah Medicaid program news, updates, knowledge, and general information for providers, beneficiaries, and the general public. In addition, the Utah Medicaid website will act as a future gateway for pointing providers and members to their respective portals in the new MMIS.

The first release of the new MMIS will provide several benefits for website users. It will reorganize information into more user friendly interfaces and clean-up obsolete links and information. In addition, it will provide significant back-end improvements that will help in timely updates.

Card Look-up Tool
Another important piece of the first release will be the Medicaid card look-up feature. This component of the website provides the functionality for a provider to electronically view a member's Medicaid eligibility information for a specified month and year.

Please stay tuned for future updates in the MIB regarding the MMIS replacement project.

14-05 Rehabilitative Mental Health and Substance Use Disorder Providers

Effective January 1, 2014, the Medicaid provider manual entitled *Rehabilitative Mental Health and Substance Use Disorder Services* has been updated as follows:

- Chapter 1-5, Provider Qualifications, has been revised slightly for clarity. The same revisions have been made in the provider sections ('Who' sections) of Chapter 2-3, Mental Health Assessment by a Non-Mental Health Therapist, Chapter 2-4, Psychological Testing, Chapter 2-9, Nurse Medication Management, Chapter 2-10, Therapeutic Behavioral Services, Chapter 2-11, Psychosocial Rehabilitative Services, and in Chapters 3-1 through 3-4 (Prepaid Mental Health Plan 1915(b)(3) services).
- Chapter 1-7, Treatment Plan, Section E, 'mental health services' has been replaced with 'behavioral health services' for consistency in terminology in the manual.
- Chapter 2-1, General Limitations, 2e has been corrected to reflect the current name of the targeted case management target group and the targeted case management provider manual referenced in this section.
- Chapter 2-2, under the 'Limits' section, the reference to the Current Procedural Terminology (CPT) manual has been revised slightly for clarity. Also, in Chapter 2-8, references to the Current Procedural Terminology (CPT) manual have been updated to reflect the current CPT manual.
- Chapter 2-5, Psychotherapy, in the 'Limits' section under group psychotherapy and multi-family group psychotherapy, the term 'co-leader' has been replaced with 'co-provider'. The same change has been made in the 'Limits' section of Chapter 2-10, Therapeutic Behavioral Services.

- Chapter 2-11, Psychosocial Rehabilitative Services, the 'Limits' section has been revised to specify the maximum number of group participants, clarify the requirement for intensive psychosocial rehabilitative programs, and clarify activities that do not constitute Medicaid-covered activities.

Providers can access the revised provider manual at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions about this article, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

14-06 Providers of Targeted Case Management for Individuals with Serious Mental Illness – 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

Effective January 1, 2014, the Medicaid provider manual entitled *Targeted Case Management for Individuals with Serious Mental Illness* has been updated as follows:

- Chapter 1-2, Target Group, has been revised to reiterate that targeted case management is not a covered service for individuals with Non-Traditional Medicaid who have a substance use disorder only.
- Chapter 1-3, General Limitations, Section B, minor corrections in wording have been made regarding outpatient service maximums for individuals with Non-Traditional Medicaid.
- Chapter 1-5, Qualified Targeted Case Management Providers, has been revised slightly for clarity.
- Chapter 2-2, Non-Covered Services/Activities, item N, wording has been corrected.

Providers can access the revised provider manual at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions about this article, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

14-07 Licensed Psychologists

Effective January 1, 2014, the Medicaid provider manual entitled *Psychology Services* has been updated as follows:

- Chapter 1-4, Qualified Providers, Section A, has been revised slightly for clarity.
- Chapter 2-1, reference to the Current Procedural Manual (CPT manual) has been updated.
- Chapter 2-2, the citation in the cross-reference has been corrected to state Chapter 1-2.

Providers can access the revised provider manual at www.health.utah.gov/medicaid. If you do not have Internet access, or have questions about this article, contact Merrila Erickson at (801) 538-6501 or merickson@utah.gov.

14-08 Pharmacy Copay Override

For Traditional and Non-Traditional Medicaid beneficiaries enrolled with an Accountable Care Organization there are instances where the beneficiary may be charged in excess of the $15 maximum monthly copay amount. This will happen when beneficiaries fill both carved-in and carved-out medications on the same date (carved-out medications are not covered by a managed care plan).

Fee-for-service Medicaid has implemented a copay override that pharmacies may use only when they have billed multiple claims and received a beneficiary copay amount in excess of $15 across all claims filled on that date. The override will only work for claims billed to fee-for-service Medicaid. To override the beneficiary copay amount, the pharmacy must submit at the point-of-sale:

- Prior Authorization Type Code (NCPDP field 461-EU) with a value of 4
- Prior Authorization Number (NCPDP field 462-EV) with a value of 111

As a reminder, a provider may not refuse service to a Medicaid beneficiary based on the beneficiary's inability to pay their copayment. See 42 CFR 447.53(e).

14-09 340B Billing Requirements

When submitting claims to Medicaid for 340B eligible beneficiaries, pharmacies are required to submit a value of 20 in the Submission Clarification Code (NCPDP field 420-DK). This requirement is for claims submitted to fee-for-service Medicaid, as well as any of the Accountable Care Organizations. This is a minimum requirement. Accountable Care Organizations may require additional field values to be submitted.

14-10 Brand Over Generic Reference

Drug manufacturers enter into rebate programs for many brand name products. These programs result in rebates

that make the cost of some brand name drugs less expensive than their generic counterparts for Utah Medicaid. See Utah Code 58-17b-606(5).

A reference of drugs, where the brand name product is preferred over the available generic, is available to assist pharmacies in maintaining inventory and providing care to Medicaid patients. This reference can be found at: http://www.health.utah.gov/medicaid/pharmacy/coverage/files/Brand_Over_Generic_Reference.pdf.

14-11 Utah Medicaid Payer Sheet Updated

The Utah Medicaid NCPDP Version D.0 Payer Sheet has been updated. To view the payer sheet, go to http://health.utah.gov/hipaa/pdfs/comguides/NCPDP_10-13.pdf.

14-12 Codes and Coverage

The 2014 HCPCS and CPT codes will be published in an interim January MIB, due to the delayed release of the codes by CMS.

Open in OPPS

36660 Catheterization, umbilical artery, newborn, for diagnosis or therapy (PT 01 opened). Effective October 1, 2013.

Prior Authorization Required

91110 Gastrointestinal tract imagining, intraluminal (e.g. capsule endoscopy), esophagus, with interpretation and report. See InterQual criteria.

The following codes requiring PA were corrected from “I” to “L” in the professional component:

70551 MRI brain w/o contrast
70552 MRI brain w contrast
72146 MRI thoracic w/o contrast
72147 MRI thoracic w contrast
72148 MRI lumbar w/o contrast
72149 MRI lumbar w contrast
72157 MRI thoracic spine w/w/o contrast
72158 MRI lumbar spine w/w/o contrast
73220 MRI upper extremity w/w/o contrast
73221 MRI joint w contrast

73222 MRI upper extremity w/o contrast
73223 MRI joint w/o contrast
73718 MRI lower extremity O/T joint w/o contrast
73725 MRA lower extremity w/w/o contrast

Corrected to "P" Non-Traditional Medicaid only; already correct in Traditional Medicaid

78814 PET/CT limited anatomical area

Non-Covered

90460 Immunization administration through 18 years of age, any route, with counseling, first vaccine or toxoid (use 90471 through 90474)
90461 …each additional vaccine or toxoid (use 90471 through 90472)

Non-Covered Ambulatory Surgery

92018 Ophthalmology examination under general anesthesia

14-13 Updates to Criteria for Medical and Surgical Procedures

The *Criteria for Medical and Surgical Procedures* provider manual attachment has been updated, effective January 1, 2014.

14-14 Medical Supplies - Coding Updates

Code Changes

E2402RR Negative pressure wound therapy, electric pump. Prior authorization increments will be increased to 30 days, up to four times.
A6550 Dressing set for negative pressure therapy for electric pumps, each. Limit per wound increased to 22 per NPWT cycle.
A7000 Canister, disposable, used with suction pump, each. Limit per wound increased to 15 per wound, per NPWT cycle with E2402, or two per month with E0600.

New HCPCS Codes

Effective October 1, 2013. Non-covered by Medicaid:
C1841 Retinal prosthesis, includes all internal and external components

Effective January 1, 2012. Prior authorization requirement removed:
E1092RR Wide heavy duty wheelchair, rental

14-15 High Flow Concentrators

High flow concentrators (concentrators with flow greater than or equal to 10 liters) are not a part of the Oxygen Concentrator Contract with Alpine Medical. When a high flow concentrator is needed, it may be provided by any willing Medicaid provider for fee-for-service beneficiaries or beneficiaries enrolled with Select Health Community Care. A prior authorization must be obtained through the Medicaid Prior Authorization Unit.

14-16 Medical Supplies Provider Manual Changes

The Medical Supplies Provider Manual has had some minor updates and wording changes, in addition to the changes in Section 6 shown below. Please see the manual for the changes.

Section 6, Prior Authorization, #10:
For beneficiaries who have Medicare and Medicaid benefits, prior authorization for medical supplies, durable medical equipment, prosthetic devices, or braces will no longer be necessary if it is a Medicare-covered item. The claim will go through the cross-over claims process.

For information on billing Medicare/Medicaid cross-over claims, refer to *Section I – General Information*. Note: If the item is not a Medicare-covered benefit, and/or the beneficiary resides in a nursing home, prior authorization from Medicaid is required.

14-17 Orthotic and Prosthetic HCPCS Codes

Utah Medicaid has reviewed the orthotic and prosthetic HCPCS code groups, and has opened the majority of these codes to provider types 62 and 91. These codes were previously limited to outpatient hospitals.

To verify allowed provider types, and other criteria or limitations that are applicable to the codes, access the Coverage and Reimbursement Look-up Tool located at www.health.utah.gov/medicaid.

14-18 Podiatry Services – Code Changes

Effective October 1, 2013, the following procedure codes have been opened for podiatrists, with no beneficiary age restrictions:

28297 Correction, hallux valgus; lapidus type procedure
28705 Arthrodesis; pantalar
28715 Arthrodesis; triple
28725 Arthrodesis; subtalar
28730 Arthrodesis; midtars/tarsmetatrs mult/trnsv
28737 Arthrodesis; w tend length, midtarsal navicular-cuneiform
28740 Arthrodesis; midtars/tarsometatars, sngl
28750 Arthrodesis; gr toe, M-P joint
28755 Arthrodesis; I-P joint
28760 Arthrodesis; w ext hallucis long, great toe, intrphaln

14-19 Speech-Language Services Provider Manual Changes

The Speech-Language Provider Manual has had some minor updates and wording changes. Please see the manual for the changes.

14-20 Speech Code Change

Effective October 25, 2013, the following procedure code is open to all ages:

92610 Evaluation of oral and pharyngeal swallowing function

14-21 Audiology Services Provider Manual Changes

The Audiology Services Provider Manual has had some minor updates and wording changes. Please see the manual for the changes.

14-22 Audiology Services Updates

Please note the following audiology policy updates:

- Policy clarification: Audiology services not related to determination of need for hearing aids are allowed for non-pregnant beneficiaries.
- Hearing aid replacement has been reduced to an interval of three years for EPSDT-eligible beneficiaries when medically appropriate.
- When requesting hearing aid replacement, documentation showing the MSRP must be submitted with the prior authorization request.
- Coverage for cochlear implants will be expanded to allow for bilateral placement.

14-23 Dobbs Bar – Dynamic Orthotic Devices

Effective November 12, 2013, the following codes have had provider types 62 and 91 added:

L2768 Orthotic side bar disconnect device, per bar
L2300 Addition to lower extremity, abduction bar (bilateral hip involvement, jointed, adjustable)
L3201 Orthopedic shoe, Oxford with supinator or pronator, infant
L3202 Orthopedic shoe, Oxford with supinator or pronator, child

L3203 Orthopedic shoe, Oxford with supinator or pronator, junior
L3204 Orthopedic shoe, hightop with supinator or pronator, infant
L3206 Orthopedic shoe, hightop with supinator or pronator, child
L3207 Orthopedic shoe, hightop with supinator or pronator, junior

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14-24 Laboratory Services Manual Update

Utah Medicaid will allow Oncotype DX testing for both men and women. Current guidelines consider medical necessity to include newly diagnosed patients whose breast cancer is stage I or II, node-negative, and estrogen receptor positive.

14-25 Provider Self-Limits on Accepting Medicaid Patients

Medicaid Provider Manual, Section I, § 6-4, Civil Rights Compliance; Discrimination Prohibited

This section of the provider manual clarifies a provider's ability to limit the number of Medicaid beneficiaries accepted into his or her practice. For example, a Medicaid provider physician who treats a beneficiary in a hospital emergency room is not required to accept that patient outside that setting. A limitation on access to services must be consistent with federal law concerning civil rights and disabilities, and may be subject to requirements under state licensure requirements and the Medicaid provider agreement. The following language is added to Section 1, § 6-4 of the Medicaid Provider Manual:

A Utah Medicaid provider is under no obligation to accept all Medicaid beneficiaries who seek care, and may limit the number of beneficiaries accepted into his or her private practice. However, the limitation may not be based on prohibited discriminatory factors such as race, color, national origin, disability or age. Limitations are generally permissible if applicable to both Medicaid and non-Medicaid beneficiaries. Some grounds for denying or dismissing Medicaid beneficiaries include: limiting the number or percentage of accepted Medicaid beneficiaries, missed appointments, abusive behavior, or provider lack of training or experience. Providers may wish to consult their respective state licensing rules for definitions of standards of care for any additional limitations.

14-26 Exceptions for Untimely Claims

Medicaid Provider Manual, Section I, Chapter 11-13, Requesting Review of Claim That Exceeds Billing Deadline

Section 11-13 has been revised to include additional grounds for reviewing and processing untimely claims. These situations include (1) when a third party payer denies payment after one year, preventing the provider from

filing a timely claim with Medicaid; and (2) when a provider files a timely clean claim, but an agency error causes delay or failure in the processing of that claim.

14-27 Rural Health Clinics and Federally Qualified Health Clinics

The Utah Medicaid Provider Manual, Rural Health Clinic Services, has been updated to include information on Federally Qualified Health Clinics. The manual will now be entitled "Rural Health Clinics and Federally Qualified Health Clinics." The manual also includes an expanded section on definitions applicable to these types of clinics.

14-28 Evaluation and Management Services – Outpatient Hospitals

When a level of E/M service is assigned and coded (CPT 99201-99215 and 99241-99245), it should never incorporate services that can be separately reported with a CPT code (e.g. ECG, venipuncture, etc.). The facility is permitted to code these services separately. Services documented in the patient medical record must support the level of service billed.

14-29 ICD 10 Update – Medicaid Website Link

Utah Medicaid has launched a new link on the Medicaid homepage with ICD 10 CM implementation updates and frequently asked questions from our providers. This information can be found at http://health.utah.gov/medicaid/pdfs/MedicaidICD-10_FAQ.pdf.

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.

14-30 Correction to October MIB Article 13-103 – Medical Interpretive Services Clarification

The October MIB article "Medical Interpretive Services Clarification" stated the information in the article would be placed in the Utah Medicaid Section I: General Information Provider Manual. This will not be done. The intent was to clarify the information only.

14-31 Section I: General Information Provider Manual Updates

The following changes have been made to Section I: General Information:

6-12 Medical Interpretive Services
Medicaid administrative funding for translation or interpretation services is available only when associated with a Medicaid State Plan covered service. Translation or interpretation services are available to eligible individuals for whom English is not their primary language. This includes individuals whose primary language is American Sign Language or Braille, since these languages are considered distinct and separate languages from English.

Medicaid providers are required to provide foreign language interpreters for Medicaid beneficiaries who have limited English proficiency (LEP). Beneficiaries are entitled to an interpreter to assist in making appointments for qualified procedures and during visits.

Providers must notify beneficiaries that interpretive services are available at no cost. Payment for interpretive services will only be made if there is a paid corresponding claim from a Medicaid provider for a Medicaid covered service(s).

LEP beneficiaries may prefer or request to use family and/or friends as interpreters. The use of family and/or friends as interpreters should occur only after the LEP beneficiary is informed of the right to receive free interpreter services, and the offer for assistance has been declined and documented in the patient's record. Family and/or friends are not reimbursed for interpretive services.

Minor children and other beneficiaries and/or patients will not be used to interpret, in order to ensure confidentiality of personal health information (PHI).

Beneficiaries with Dual Eligibility
If the beneficiary has dual eligibility (Medicare and Medicaid) it is not required that the corresponding claims be reimbursed by Medicaid; however, evidence of a Medicare cross over claim must be available.

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

Beneficiaries Enrolled in a Managed Care Organization
Always verify whether a patient is covered by an Accountable Care Organization (ACO), Prepaid Mental Health Plan, or Dental Plan. If the service needed is covered by a plan, contact the plan directly for more information. References: Utah Medicaid Provider Manual, Section I – General Information, Chapter 4, Accountable Care Organizations (ACOs), and Chapter 5, Verifying Medicaid Eligibility.

Medicaid Eligible Translation Services Documentation Requirements
A Medicaid Interpretive Services contractor is required to maintain documentation as instructed by UDOH to assure reimbursement of federal funds.

For additional information regarding interpretive services, refer to the *Medicaid Member Guide* at http://health.utah.gov/umb/forms/pdf/mg_w_cover.pdf.

Dental Varnish Policy

Fluoride Varnish as Part of a Well-Child Exam

As part of a well-child (CHEC) exam, Medicaid will pay for application of dental fluoride varnish as an optional service for children birth through 3 years.

Claims for the application of dental varnish must be submitted using the appropriate EPSDT CPT code with an EP modifier. See below codes.

Preventive Medicine Services Codes

New Patient

99381 Infant, less than 1 year of age
99382 Early childhood, age 1 through 4 years

Established Patient

99391 Infant, less than 1 year of age
99392 Early childhood, age 1 through 4 years

For more information see:

- Varnish application – training or technical advice: Oral Health Program, Utah Department of Health (801) 538-9177.
- Claims, payments, or billing codes: Medicaid Information (801) 538-6155 or 1-800-662-9651.

For more information regarding fluoride varnish as part of a well-child exam, refer to Section 2, CHEC Services Provider Manual.

14-32 Physical Therapy and Occupational Therapy Services Provider Manual Change

An attachment to the *Utah Medicaid Physical Therapy and Occupational Therapy Services Provider Manual* entitled, *Physical Therapy and Occupational Therapy Decision Tables*, has been added January, 1, 2014. The attachment will provide information used to complete prior authorization requests for outpatient physical therapy (PT) or occupational therapy (OT) services in excess of the allowed annual sessions.

14-33 Dental Policy Updates

Dental Codes Closed to CRNA (provider type 38)
D9220 Deep sedation/general anesthesia, first 30 minutes
D9221 Deep sedation/general anesthesia, each additional 15 minutes

Dental Codes Closed for Traditional Medicaid Beneficiaries
D2392 Resin-based composite, two surfaces, posterior
D2393 Resin-based composite, three surfaces, posterior
D2394 Resin-based composite, four or more surfaces, posterior
*Medicaid beneficiaries in the dental program may use these codes as a dental spend-up.

Dental Manual Update - Preventive Services
A prophylaxis, with or without fluoride, is covered two times a calendar year for children. For pregnant women, only the prophylaxis is covered. Oral debridement may be done once per year and in conjunction with a prophylaxis in cases requiring subgingival scaling.

The following codes are to be used for dental prophylaxis:

- D1120 Prophylaxis – child ages 0-15
- D1110 Prophylaxis – adult ages 16-20

Dental Manual Update - Dental Spend Up
A Medicaid beneficiary in the dental program may choose to upgrade a covered service to a non-covered service if they assume the responsibility for the difference in the fees for the covered and non-covered service. The only dental procedure that a Medicaid beneficiary may choose to upgrade is as follows:

- Covered amalgam filling to non-covered composite resin filling

If providing an upgraded service, such as a porcelain crown in place of a Medicaid-allowed crown, or any other non-covered service:

- Bill the covered code and charges.
- Document that an upgraded service was provided and reference the upgraded code in the description box.

This documentation indicates that the patient has signed a memo of understanding of the payment responsibility for the bill, and the memo will be maintained in the provider's medical record for the beneficiary.

14-34 Physician Services Provider Manual Updates

Non-Pulsed Radiofrequency Rhizotomy

Section C., Epidural and Block Injections, number 4:

4. Non-pulsed radiofrequency rhizotomy of cervical facet joints (C3-4 and below) and lumbar facet joints may be considered medically necessary when all of the following criteria below are met:

- No prior spinal fusion surgery in the vertebral level being treated;
- Cervical or lumbar pain is suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record H&P, and radiographic evaluation performed within the last 12 months;
- Pain has failed to respond to a minimum of three months of conservative treatment with oral pain mediation (e.g. NSAID, analgesics, muscles relaxants).
- Pain has failed to respond to a minimum of three months of at least one of the following therapies within the last six months (as documented in the medical record);
    - Physical therapy, with weekly visits for a period of four weeks; or
    - Trial of manipulative therapy for a period of four weeks.
- A trial of controlled diagnostic medial branch blocks consisting of (2) separate positive blocks under fluoroscopic guidance that have each resulted in at least a 50% reduction in pain;
- Only one treatment procedure per level per side is considered medically necessary in a six-month period;
- Repeat medial branch blocks are not necessary after six months or more since prior radiofrequency rhizotomy if symptoms and treatment are at the same location(s), and presentation is similar to that of initial treatment;
- If no prior diagnostic medial branch blocks have been performed, even if the patient has responded well to radiofrequency rhizotomy prior, the previous radiofrequency rhizotomy treatments are **not** a substitute for an initial trial of nerve block;
- Medial branch blocks must be repeated before radiofrequency rhizotomy is performed.

Note: Utah Medicaid considers pulsed radiofrequency experimental and investigational for all indications, because its effectiveness has not been established.

Dental Varnish Policy

<u>Fluoride Varnish as Part of a Well-Child Exam</u>
As part of a well-child (CHEC) exam, Medicaid will pay for application of dental fluoride varnish as an optional service for children birth through 3 years.

Claims for the application of dental varnish must be submitted using the appropriate EPSDT CPT code with an EP modifier. See below codes.

<u>Preventive Medicine Services Codes</u>
New Patient
99381 Infant, less than 1 year of age
99382 Early childhood, age 1 through 4 years
Established Patient
99391 Infant, less than 1 year of age
99392 Early childhood, age 1 through 4 years

For more information see:

- Varnish application – training or technical advice: Oral Health Program, Utah Department of Health (801) 538-9177.
- Claims, payments, or billing codes: Medicaid Information (801) 538-6155 or 1-800-662-9651.

For more information regarding fluoride varnish as part of a well-child exam, refer to Section 2, CHEC Services Provider Manual.

14-35 Refugee Services Update

The following preventative health codes are open for refugee children and pregnant adults:

- V20.0 Health supervision of infant or child receiving care
- V22.0 Supervision of normal first pregnancy
- V22.1 Supervision of other normal pregnancy
- 99381 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
- 99382 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
- 99383 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
- 99384 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescence (age 12 through 17 years)

Beginning January 1, 2014, the following preventative health codes will be open on manual review for non-pregnant refugee adults:

- V70.5 Health examination of defined subpopulations
- 99385 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years of age

- 99386 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years of age
- 99387 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

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14-36 Anesthesiology Services Update

The following pain management codes have been opened to CRNAs, provider type 38, for postoperative pain management:

Epidural or Nerve Block Analgesia by Continuous Infusion

62318 Injection, including catheter placement, continuous infusion or intermittent bolus, of therapeutic substances, epidural or subarachnoid; cervical or thoracic
62319 Injection, including catheter placement, continuous infusion or intermittent bolus, of therapeutic substances; lumbar, sacral (caudal)
64416 Injection, anesthetic agent plexus, continuous infusion by catheter
64446 Injection, anesthetic agent, sciatic nerve, continuous infusion by catheter
64448 Injection, anesthetic agent, femoral nerve, continuous infusion by catheter
01996 Daily follow-up and management of epidural or nerve block analgesia by continuous or intermittent infusion. Units will be attached to this code, but not time. (A “0” is not an appropriate unit to use in this field.) Payment will be made only once daily, beginning the day after the surgical procedure, unless the epidural catheter has been placed by the surgeon, see B.2 above.

Epidural or Nerve Block Analgesia by Single Injection

62310 Injection, single (not via indwelling catheter) not including neurolytic substances, with or without contrast, epidural or subarachnoid; cervical or thoracic
64415 Injection, anesthetic agent; brachial plexus, single
64417 Injection, anesthetic agent; axillary nerve, single
64445 Injection, anesthetic agent; sciatic nerve, single
64447 Injection, anesthetic agent; femoral nerve, single
64450 Injection, anesthetic agent; other peripheral nerve or branch

14-37 Hospital Services Provider Manual Changes

Critical Access Hospitals (CAH)

Critical Access Hospital (CAH) settlements for outpatient hospital services will no longer be made. This change is based on a State Plan Amendment. The following will be deleted from the Hospital Manual:

B.5 CAH reconciliation for in-state CAH hospitals will occur yearly after the Medicare cost report is filed and made available to the Department.

Exception Codes to Outpatient Hospital Services Removed

Exception codes to outpatient hospital services have been removed from the Hospital Manual. For exceptions, refer to the note for the applicable code in the Coverage and Reimbursement Look-up Tool. Chapter 9, Outpatient Hospital Services, C.1.3., has been updated as follows:

Line items with a Medicare status indicator … will NOT be paid by Medicaid. 'C' (Inpatient Procedures) Refer to Coverage and Reimbursement Look-up Tool for exceptions at www.health.utah.gov/medicaid.

14-38 Limited Medicaid Provider Enrollment

Pursuant to federal regulations, all ordering, referring, or prescribing providers, including physicians, residents, physician assistants, nurse practitioners, or other professionals providing services to Medicaid beneficiaries, including those enrolled in a health, dental, or behavioral health managed care plan, must be enrolled as a participating provider with Utah Medicaid. If you are already enrolled to provide services to Medicaid beneficiaries, you do not need to enroll again to order, refer, or prescribe.

There are two types of Medicaid enrollment. The standard enrollment allows you to provide medical services, order, refer, and prescribe. The limited enrollment is for providers who only order, refer, or prescribe to Medicaid beneficiaries, and who do not wish to provide any other services to Medicaid beneficiaries. Under limited enrollment, the provider can neither bill Medicaid nor be paid for services.

If you are not enrolled with Utah Medicaid and you issue a prescription for a Medicaid recipient, Medicaid will not pay for the prescription. Your patient will have to make other arrangements to pay for the prescription, or your patient may not be able to get the prescription filled.

Enrollment forms for the limited and formal enrollment processes are located on the Medicaid website at www.health.utah.gov/medicaid. For questions regarding the Medicaid enrollment process, call Provider Enrollment at (801) 538-6155 or 1-800-662-9651, menu option 3, then 4.

14-39 Technology Dependent Waiver – Adjustment to Respite Payment Rate

Effective September 23, 2013, the rate for code T1005 U7 (RN Community Based Respite) was increased to $11.09 per 15 minute unit in order to have State Plan home health rates and waiver program rates remain equal. The TE and 52 modifiers, used when this service is performed by LPNs or home health aides, will continue to reimburse providers at their respective payment ratios.