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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

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PO Box 143106, Salt Lake City, UT 84114

14-113 Physician and VFC Enhancement Payments

As last noted in the April 2014 MIB article 14-51, once the physician has completed the self-attestation process, program eligibility will be determined based on either board certification or 60% claim history (based on all paid Medicaid services, including managed care) within the approved code set for the Physician Enhancement program. Originally, it was determined that eligibility based on 60% code history would only be tested once (when the provider originally self-attests). Based on recent CMS guidance, it has been determined that eligibility based on 60% testing may be re-evaluated each calendar year if a physician attests/re-attests in calendar year 2014.

With this updated guidance, providers who are not currently approved for these payments may attest/re-attest based on the 60% criteria. Physicians who attested/re-attested prior to June 30, 2014, and who meet or exceed the 60% threshold, as described above, will be eligible for payments for services back to the beginning of calendar year 2014. After June 30, 2014, a provider who attests and passes this 60% threshold will be retro-eligible for enhanced payments back to the beginning of the calendar year quarter in which they completed the self-attestation. For example, if a physician were to attest on July 15, 2014, and met the 60% threshold, the physician would only be eligible for enhanced payments for services rendered on or after July 1, 2014.

This federal program is effective for services provided in calendar years 2013 and 2014 only.

14-114 Employment of Sanctioned Individuals

Federal fraud and abuse regulations, adopted by the Health and Human Services Office of Inspector General in compliance with both HIPAA (Public Law 104-191) and the Balanced Budget Act of 1997 (Public Law 105-33), identify significant civil and criminal actions that may be taken against Medicaid providers who employ federally sanctioned individuals and/or contractors. This is true even if the sanctioned individual does not work directly in providing services to individuals under the Medicaid program.

Utah Medicaid providers must be aware that it is their responsibility to verify that individuals and/or contractors are not on a federal sanctions list. If a provider does employ an individual and/or contractor who is on the federal sanctions list, and that person provides services which are directly or indirectly reimbursed by a federally-funded program, the employer may be subject to legal action which could include civil penalties, criminal prosecution, and/or exclusion from program participation.

It is essential and recommended that providers check the federal sanctions List of Excluded Individuals/Entities (LEIE) at least monthly. It is also advisable for providers to check all current and potential employees on the federal database to ensure that no sanctioned individuals are working for their organization. The LEIE can be found at <http://exclusions.oig.hhs.gov/>.

Laboratories, imaging centers, DME suppliers, pharmacies, etc., should verify that an ordering provider is not on the LEIE, or other acceptable exclusion list. A prescription written by an excluded provider is not valid for Medicaid reimbursement and is a violation of the exclusion policy.

The *Utah Medicaid Section I – General Information Provider Manual*, Chapter 6-18, has been updated with the above information.

14-115 Potential Risks of Non-Secure Email

ATTN: HIPAA-Covered Entities or Business Associates

If Utah Medicaid receives a regular, unencrypted email containing protected health information (PHI), there may be some risk that the information in the email could be intercepted and read by a third party during transmission. This may be a reportable incident under the HIPAA Privacy and Security Rules.

Please follow your organization's incident reporting procedure and notify your compliance officer. If you need to send PHI or other sensitive information to us electronically, we strongly encourage you to use a secure method.

14-116 Electronic Data Interchange (EDI) Transactions on New Server

Utah Medicaid providers should be aware of issues identified in the processing of EDI transactions. The new server system does not process EDI transactions coming in with a "T" for test, nor will we send back acknowledgement for test files. To correct this, in the ISA segment, the Usage Indicator (ISA15) should always be "P" for production, if the claim submission is to be processed for payment.

Secondly, duplicate files submitted by trading partners have been identified and are causing several discrepancies in the system. To eliminate duplication, in the Transaction Control Header (ISA) segment, utilize a unique sequential Interchange Control Number (ISA13) for all EDI claim transmissions. This will improve the identification of files, duplicates and processing of EDI transactions.

Please contact the EDI Department at (801) 538-6155, or toll free 1-800-662-9651, menu option 3, and then option 5, with any questions regarding EDI transactions.

14-117 Transition to 2014 InterQual Criteria

Effective October 1, 2014, all prior authorization reviews currently processed using the 2011 version of InterQual criteria will be processed using the updated 2014 criteria. With the transition to the 2014 version, Utah Medicaid providers will no longer have access to the InterQual Smartsheets, and they will no longer be posted on the Medicaid website.

Providers will be able to access prior authorization requirements at <https://medicaid.utah.gov/utah-medicaid-criteria> or <https://medicaid.utah.gov/> by selecting Health Care Providers > Prior Authorization > Criteria. The Utah Medicaid provider manuals and code-specific special notes in the Coverage and Reimbursement Lookup Tool are also available on the website.

For questions, please contact adlucero@utah.gov.

14-118 **Appealing Denial of Unlisted CPT Codes**

Effective October 1, 2014, a description of documentation required when submitting a hearing request to appeal a denial for use of an unlisted CPT code was added to the *Utah Medicaid Provider Manual Section I – General Information*.

A hearing request is required to appeal a denial for use of an unlisted CPT code. When appealing, submit the following documentation:

- Request for Hearing/Agency Action Form (Comes with the denial or is available at <https://medicaid.utah.gov/Documents/pdfs/Forms/HearingRequest2010.pdf>)
 - Documentation supporting the use of an unlisted code
 - A letter citing the methodologies employed
 - Suggested CPT code(s) that is/are most similar in work and malpractice value (for pricing)
 - Clinical publications supporting the methodology under review for safety, outcomes, and cost containment
 - Document a strong case for why this method is the best strategy for the patient (Documentation to support this includes medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary)
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14-119 **CPT Code Update**

Effective May 8, 2014, the age range of the following CPT codes was changed to cover ages 0-45 years.

29914 Arthroscopy, hip, surgical, with femoroplasty
29915 Arthroscopy, hip, surgical, with acetabuloplasty
29916 Arthroscopy, hip, surgical, with labral repair

14-120 **Physician Services Manual Updates**

Allergen Immunotherapy

Effective October 1, 2014, the explanation of reimbursement for CPT code 95165 has been clarified. One unit is defined as one (1) cc aliquot from a single multi-dose vial.

Home Telemetry Policy

Beginning October 1, 2014, CPT codes 93224, 93225, 93226, and 93227 will be placed on manual review with the following criteria:

- Outpatient long-term cardiac (Holter) monitoring must be ordered by a BC/BE neurologist.

- Client must have had a stroke or TIA with no identifiable cause.
 - Client should have already had 24-hour monitoring done previously (either with outpatient long-term cardiac monitoring or as inpatient with telemetry).
 - Client should not be currently anti-coagulated on Warfarin for any other reason.
 - Client should not have a known contra-indication for Warfarin.
 - Outpatient long-term cardiac monitoring may only be authorized for the 30-day test.
 - Data from the test must be reviewed and interpreted by a BC/BE cardiologist.
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14-121 Diagnoses Lists Updated

Effective October 1, 2014, the following updated Utah Medicaid Hospital Services Provider Manual attachments are available on the Medicaid website at <https://medicaid.utah.gov>.

- Utah Medicaid Table of Authorized Emergency Inpatient Diagnoses
 - Utah Medicaid Table of Authorized Emergency Diagnoses
-

14-122 Emergency Services Program

The Emergency Services Program, or Emergency-Only Program (EOP), is a health program designed to cover a limited scope of services for people meeting criteria defined in 42 CFR 440.255(c). Services only cover an “emergency medical condition”. The Utah Medicaid policy definition of emergency medical condition is in *Section I: General Information of the Utah Medicaid Provider Manual, Emergency Services Program for Non-Citizens* at <https://medicaid.utah.gov>.

Claims submitted for EOP consideration must have required documentation attached. If documentation for the episode of care is missing or incomplete, the claim is denied until proper documentation is available for review. To allow for collection of all related documentation and to assure representation of the full episode of care, all claims are held in queue for 60 days before undergoing manual review.

The claims and attachments are then sent to the Bureau of Coverage and Reimbursement Policy (BCRP) for manual review to determine whether the care episode meets EOP coverage criteria. The claim then returns to the Bureau of Medicaid Operations (BMO) for processing. If the claim is approved for payment, BMO completes the payment process. If the claim is denied, no payment is made and a denial remittance advice (RA) is sent to the provider.

A provider who does not agree with Medicaid’s decision should refer to *Section I: General Information of the Utah Medicaid Provider Manual, Administrative Review/Fair Hearing* at <https://medicaid.utah.gov>. Direct inquiries for status update on submitted claims to BMO at (801) 538-6155 or 1-800-662-9651.

14-123 Family Planning Benefits for Medicaid Accountable Care Organization Members

The following requirements provide clarification to providers about the way Utah Medicaid processes family planning service claims and authorization requests for Accountable Care Organization (ACO) members:

Medicaid Requires:

- a) ACOs to accept and process family planning service claims when services are rendered by a provider within the ACO's network.
- b) Fee-for-service Medicaid to accept and process family planning service claims when services were rendered by a provider outside of the ACO's network.
 - i. In these cases, the provider will be required to submit the following documentation to the Medicaid prior authorization reviewer:
 1. For tubal ligations and vasectomies: The completed *Sterilization Consent Form*. If the form was completed properly and meets the requirements, staff will issue an authorization. (Reviewers will process requests submitted either before or after the procedure has taken place.)
 2. For Hysteroscopic Tubal Occlusive Device (such as Essure®): Documentation to demonstrate that the clinical prior authorization requirements were met prior to the procedure and the completed *Sterilization Consent Form*. If the clinical prior authorization requirements are met, and the form was completed properly and meets the requirements, staff will issue an authorization. (Reviewers will process requests submitted either before or after the procedure has taken place.)

14-124 Dental Manual Update

Beginning October 1, 2014, when assessing the handicap malocclusion, Medicaid policy will require a tooth to have a 30-degree or greater rotation to be scored on the Salzman Index. The change has been made to the policy in Chapter 4B-16, Orthodontia.

14-125 Pharmacy 340B Policy Updates

Effective October 1, 2014, all 340B pharmacy claims should be submitted to Utah Medicaid at the provider's 340B discounted actual acquisition cost. Claims submitted incorrectly will be subject to an edit and may be rejected.

The pharmacy should bill the claim using the NCPDP submission clarification code of “20” to identify the claim as 340B. In addition, the pharmacy should bill all 340B claims with the basis of cost determination value of “8” (NCPDP Field 423-DN) which verifies to Utah Medicaid that the pharmacy is billing for the 340B discounted actual ingredient cost on the claim. 340B claims with a date of service on or after October 1, 2014, that do not have both of these identifiers will reject. Utah Medicaid pharmacy 340B claims that are billed correctly, with date of service of October 1, 2014, or later, will receive a dispensing fee of \$12.39.

The billing pharmacy is responsible for determining and ensuring that its claims are properly billed. 340B billed pharmacy claims will not be invoiced to the manufacturer for Medicaid rebates. Pharmacy claims billed without the submission clarification code value of “20” and the basis of cost determination value of “8” will be invoiced to the manufacturer for rebates and are assumed to not be 340B related.

It is important that billing pharmacies verify the correct 340B coverage status for claims submitted to Medicaid for adjudication. As with all Medicaid claims, 340B pharmacy claims are subject to audit, and claim submission detail will be reviewed to ensure that Utah Medicaid is being billed at the discounted actual 340B ingredient cost by eligible providers.

340B covered entities must ensure compliance with all applicable federal and state rules and regulations.

14-126 Correction of July 2014 MIB Article 14-104

In the July 2014 MIB, an incorrect reference was included in the 340B Improper Billing article. The reference should have directed individuals to the *Utah Provider Manual Section I, Chapter 11-11* (Rebill Denied Claims with Corrected Information).

14-127 Hepatitis C Update

During the Drug Utilization Review Board (DURB) monthly meeting in July, new Hepatitis C drugs were discussed and the board decided on prior authorization criteria for the new drugs Sovaldi and Olysio. The criteria follow guidelines established by professional organizations and the FDA recommendations.

To find the new prior authorization criteria sheets, or to learn more about the DURB, visit the Utah Medicaid Pharmacy website at <https://medicaid.utah.gov/pharmacy/>.

14-128 Pharmacy Co-pay Split

Effective October 1, 2014, pharmacy co-pays for clients enrolled in an Accountable Care Organization (ACO) will be split between Fee-For-Service (FFS) Medicaid and the ACO plan. For drugs that are covered by the ACO, the maximum co-pay out-of-pocket will be \$9.00 per month. For drugs that are covered by FFS Medicaid, the maximum co-pay out-of-pocket will be \$6.00 per month.

Each individual prescription will still have a co-pay limit of \$3.00. The co-pay limits will accumulate concurrently in each plan. After the \$9 co-pay maximum in an ACO is met, additional ACO-paid prescriptions filled in the month will have no co-pay. Similarly, after the \$6 co-pay maximum in FFS Medicaid is met, additional FFS Medicaid-paid prescriptions filled in the month will have no co-pay. These co-pay limits will reset at the start of each calendar month.

For clients with no ACO benefit, the co-pay out-of-pocket will remain at \$15.00 per month.

14-129 Pharmacy Co-pay Override

The co-pay override function will be disabled for pharmacy claims effective October 1, 2014. This override was put in place to prevent a client from being overcharged co-pays during a month. With the implementation of the co-pay split, the co-pay override is no longer needed.

If a provider believes that a co-pay is incorrectly applied to a claim, please call the ACO or Utah Medicaid at (801) 538-6155 or 1-800-662-9651, and follow the prompts to reach the pharmacy helpdesk.

14-130 Pharmacy New Drugs Coverage

The following new drugs have been entered in the Medicaid system as closed services:

- C9023 Testosterone Undecanoate, 1mg injection (Aveed™)
- C9025 Ramucirumab, 5mg injection (Cyramza™)
- C9026 Vedolizumab, 1mg injection (Entyvio™)
- C9135 Factor IX Recombinant Antihemophilic Factor, 10 I.U. (Aprolix™)

14-131 Preferred Drug List (PDL) New Drug Classes

On July 1, 2014, the Utah Medicaid PDL was updated with the addition of six new drug classes. The new classes include sulfonyleurea drug agents, first and second generation antihistamine agents, erythropoiesis stimulating agents, inflammatory bowel agents, and phosphate binding agents. In addition, the prenatal vitamin class was updated with different preferred and non-preferred agents.

The current PDL is available on the Utah Medicaid Pharmacy website at <https://medicaid.utah.gov/pharmacy/>.

14-132 DME / Medical Supplies Updates

Manual Pricing for DME

Effective October 1, 2014, prior authorization (PA) numbers issued for manually-priced items considered “miscellaneous” or “not otherwise specified (NOS)” will include a reimbursement amount and a brief description for each item.

Claims submitted for miscellaneous or NOS items must include the PA number issued for the item(s) and a line item invoice with the reimbursement amount and the brief description given with the PA number.

HCPCS Code

E0603 Breast pump, electric (AC and/or DC), any type. Effective July 29, 2014, quantity limit is 1 per year.

Code Quantity Limit Updates - Effective October 1, 2014

A7028 Oral cushions for combo oral/nasal mask replacement, 2 allowed per year

A7029 Nasal pillows for combo oral/nasal mask replacement, 2 allowed per year

A7030 Full face mask, 2 allowed per year

A7031 Face mask interface/cushion, 2 allowed per year

A7032 Nasal pillow/cushion replacement only, 2 allowed per year

A7033 Pillow for use on nasal cannula type interface, 2 allowed per year

A7034 Nasal interface, 2 allowed per year

A7035 Headgear, 2 allowed per year

14-133 Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual Updates

- In Chapter 1-5, Provider Qualifications, C., clarification has been made regarding services other trained individuals may provide.
- In Chapter 1-11, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI), instructions for accessing CMS' website have been updated.

Providers can access the revised provider manual at <https://medicaid.utah.gov>.

14-134 Psychology Services Provider Manual Update

- In Chapter 1-6, Billings, B., Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI), instructions for accessing CMS' website have been updated.

Providers can access the revised provider manual at <https://medicaid.utah.gov>.

14-135 Home Health Agencies Manual Update

Effective October 1, 2014, home health agencies (HHA) may adjust or group private duty nursing (PDN) hours to meet patient staffing needs within a 7-day period. Please note the following policy:

- Any adjustment or grouping of PDN hours must meet the physician's orders and that the physician's order takes precedence in determining the daily care requirements.
- This policy change does not allow an HHA provider to miss a required daily service on one day only to group with another day's services.
- PDN hours cannot be grouped or adjusted for periods that the patient is hospitalized or otherwise under the care of another provider who meets the PDN service requirements.
- To ensure required services are provided in the event of unexpected illness or injury, submit a PA requesting approval to exceed the regular necessary allowance.

The PDN section of the *Utah Medicaid Home Health Agencies Provider Manual* will be updated for January 2015 publication.

14-136 School-Based Skills Manual Updated

The *Utah Medicaid School-Based Skills Development Provider Manual* has been updated October 1, 2014. The manual can be found on the Medicaid website at <https://medicaid.utah.gov>.

14-137 CHEC Manual Updated

Effective October 1, 2014, the *Utah Medicaid CHEC Services Provider Manual* has been updated as follows:

Chapter 1 – CHEC Services has been updated to clarify that individuals birth through 20 years of age enrolled in Traditional Medicaid may receive CHEC Services.

Chapter 4 – Reimbursement has been updated to clarify that reimbursement for oral health/dental services provided to children enrolled in a dental managed care plan must be made through the dental managed care plan on the child's Medicaid card.

Chapter 4-3 – Children Enrolled in Managed Care Health Plans has been updated to clarify that children enrolled in an oral health or dental managed care plan must use providers contracted with that plan.

Providers may access the current and revised provider manual at <https://medicaid.utah.gov>. If you do not have Internet access, or have questions about this article, contact Julie Olson at (801) 538-6764 or e-mail at julieolson@utah.gov.