UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

October 2017

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

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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

17-69 HIPAA Training

The HIPAA rules are flexible and scalable to accommodate the enormous range in types and sizes of entities that must comply with them. This means that there is no single standardized program that could appropriately train employees of all entities.

Providers are encouraged to access free CME training to become better educated about the HIPAA Right of Access in order to help implement privacy and security protections.

Online training resources can be found at: https://www.hhs.gov/hipaa/for-professionals/training/index.html

17-70 MotherToBaby Utah Program Information for Members

The MotherToBaby Utah program, a joint Utah Department of Health and University of Utah program, is available free of cost to Medicaid members. Women can learn about the affects of herbs, dietary supplements and alternative treatments during pregnancy and lactation, as well as other prenatal and postnatal health care topics of concern.

Medicaid members may contact MotherToBaby Utah, Monday through Friday, 8:00 a.m. – 5:00 p.m., MST, at 1-800-822-2229; email at expertinfo@mothertobaby.org; or chat at www.mothertobaby.utah.gov.

17-71 Web-Based Statewide Provider Training

Utah Medicaid will conduct the annual 2017 Statewide Provider Training via webinars in the coming months. Rather than on-site visits throughout the state, our trainers are working on a web-based training and outreach program. This new forum will provide current information with frequent updates, and should reach a larger, more diverse group of providers and participants.

Providers will be notified when more information becomes available on our training page at https://medicaid.utah.gov/medicaid-provider-training and in a future MIB.

17-72 Physician Services Provider Manual Update

The Physician Services Manual will be updated, effective November 1, 2017. Providers are encouraged to become familiar with the manual noting:

- Policy coverage information has been moved to the Administrative Rule R414-10 Physician Services.
- As part of the Physician Services Manual revision, information regarding specific code coverage has been removed from this provider manual.
- The provider manual will continue to be a reference for criteria and reporting instructions.
- Radiation therapy has been removed from manual review.

17-73 Anesthesiology Services Provider Manual Update

The Anesthesiology Services Manual has been updated and is found in the Physician Services Provider Manual. The Anesthesiology Services Manual will be archived effective November 1, 2017.

Specific coverage on CPT or HCPCS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup Tool.

17-74 Hospital Services Provider Manual Update

The Hospital Services Provider Manual will be updated, effective December 1, 2017. Providers are encouraged to become familiar with the manual noting:

- The manual has undergone a major revision, noting a change in the structure, formatting, and content of the manual.
- Policy coverage information has been moved to the Administrative Rule UT Admin Code R414-2A. Inpatient Hospital Services and Rule R414-3A. Outpatient Hospital Services.

Information regarding Long Term Acute Care (LTAC) hospitalizations is currently located in the Utah Medicaid Hospital Services Manual. Providers are encouraged to become familiar with the manual noting:

- Documentation requirements regarding a LTAC request.
- Timely submission of requests for preadmission and continued stay in a LTAC.
- Negotiated rate letter submission.
- Denials of LTAC admission, continued stay, or retroactive requests.

As part of the Hospital Services Provider Manual revision, information regarding specific code coverage has been removed from this provider manual. The provider manual will continue to be a reference for criteria and reporting instructions.

17-75 Hospitals Required to Obtain Prior Authorization

Effective November 1, 2017, hospitals will be required to obtain a prior authorization (PA) for any inpatient or outpatient hospital procedure where a PA is required. Facilities will need to verify a PA is in place or obtain a PA before a procedure is performed in order to receive reimbursement for the service.

If a facility submits a claim for a service requiring a PA and one was not approved, the procedure requiring PA will be denied (e.g., MRI). To review procedures that require a PA, refer to the Coverage and Reimbursement Code Lookup at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

To verify or request a PA, contact Medicaid at:

- In the Salt Lake City area, call: (801) 538-6155
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call: toll-free 1-800-662-9651
- From other states, call: (801) 538-6155

Additional information related to requesting a PA may be found in the Utah Medicaid provider manuals and Medicaid Information Bulletins at https://medicaid.utah.gov/utah-medicaid-official-publications.

17-76 Provider Preventable Conditions (PPC)

Medicaid utilizes the MS-DRG Grouper to identify provider preventable conditions (PPC). In the event of an outlier PPC claim, the provider will receive a Remittance Advice (RA) confirming the occurrence and requesting submission of documentation. In addition, at the time of RA notification, a confirmatory letter may be generated, reiterating the occurrence of a PPC outlier and the need to submit documentation.

Requested records are expected to be submitted within 30 days of RA notification. If the medical records are submitted within the 30-day period, the claim will be reviewed and, if appropriate, processed and paid. If medical records are not submitted within the 30-day period, the claim will be denied for failure to submit the requested documentation in a timely fashion.

All documents are to be submitted with an "Outlier PPC Medical Record Documentation Submission Form." This form has been updated to include specific records requirements:

- Complete medical records from the associated hospital stay.
- An itemized bill (tab-delimited text file or Excel spreadsheet) which summarizes to the Total Charges on the submitted claim (detailing Total Charges and Non-covered Charges).
- An itemized list of PPC-related charges (tab delimited file or Excel spreadsheet). A column with this detail should be added to the itemized bill required above.

17-77 Prior Authorization Requirements

CPT/HCPCS codes requiring Prior Authorization (PA) were reviewed for utilization review efficacy. As a result of the review, PA requirements and/or quantity limits were updated. All changes are reflected on the Coverage and Reimbursement Code Lookup Tool. Refer to this tool for accurate information.

17-78 Home Health Services Manual Update

The Home Health Services Manual has been updated, effective August 22, 2017. Providers are encouraged to become familiar with the manual noting:

- All physical therapy must be provided under physician orders, in accordance with a plan of care, and provided by a licensed, qualified physical therapist or physical therapy assistant employed directly by or on contract to a home health agency, as defined by UCA Title 58, Chapter 24b, Physical Therapy Practice Act and Administrative Rule R156-24b Physical Therapy Practice Act Rule.
- All occupational therapy must be provided under physician orders, in accordance with a plan of care, and provided by a licensed, qualified occupational therapist or certified occupational therapy assistant employed directly by or on contract to a home health agency, as defined by UCA Title 58, Chapter 42a, Occupational Therapy Practice Act and Administrative Rule R156-42a Occupational Therapy Practice Act Rule.

17-79 Section I: General Information Provider Manual Update

Section I: General Information Provider Manual has been updated. Providers are encouraged to become familiar with the manual noting:

- Information regarding quantity limits added to Section I, Chapter 9, Non-covered Services and Limitations.
- Addition to Section 1, Chapter 11-2:
  "*Separate charges for freight, postage, delivery, installation, set-up, instruction, fitting, adjustment, measurement, facility visits or transportation since these services are considered to be all-inclusive in a provider's charge, unless otherwise specified, e.g. shipping costs for hearing aid repair.*"

Emergency Services Program for Non-Citizens Language Update

The language regarding coverage criteria for the Emergency Services Program for Non-Citizens has been updated as follows:

1. Criteria to Identify an Emergency Service.

For emergency services for non-citizens to be covered, ALL of the following criteria must be present:

- The final diagnosed condition for the episode of care manifests itself by sudden onset.
- The final diagnosed condition for the episode of care, including emergency labor and delivery, manifests itself by acute symptoms (including severe pain).
- The final diagnosed condition for the episode of care reasonably requires immediate medical attention.
  - Immediate medical attention means provisions of service within 24 hours of the onset of symptoms or within 24 hours of diagnosis.
  - The final diagnosed condition for the episode of care requires acute care, and is not chronic; does not require any chemotherapy or follow up care.
  - Coverage will only be allowed until the final diagnosed condition for the episode of care is stabilized. A condition is stabilized when the severity of illness and the intensity of service are such that the member can leave the acute care facility, no longer needs constant attention from a medical professional, advances to acute care for supportive care, or begins requiring long term care.
  - The final diagnosed condition for the episode of care cannot be related to an organ transplant procedure.
  - The final diagnosed condition for the episode of care could reasonably be expected to result in:
    - Placing the patient's health in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part.

Services provided during the prenatal or post-partum period are not covered unless the specific criteria listed above are met.

17-80 Medical Supplies and Durable Medical Equipment Manual Update

The Medical Supplies and Durable Medical Equipment Manual has been updated. Providers are encouraged to become familiar with the manual noting:

- Section 1-4 regarding quantity limits has been removed and placed in Section I, Chapter 9, Non-covered Services and Limitations.

  Disposable Incontinence Products
  Disposable incontinence products are covered for Traditional Medicaid members with documentation of medical necessity.

  The following quantity limits apply to any combination of the covered incontinence supply codes for a one-month supply. If the member's need exceeds these limits, PA is required.
  - Members on Traditional Medicaid programs - 156 per 30-day period
  - Members on an HCBS waiver program do not have a quantity limit

  Disposable incontinence supplies are not covered for:
  - Normal infant use, or
  - Members residing in a long term care facility, as they are furnished by the facility.

Providers may access the manual at Medical Supplies and Durable Medical Equipment Manual.

17-81 Unlisted Codes

Many unlisted CPT codes are closed. Unlisted procedure codes are only reported if an existing CPT Category I code does not describe the procedure being performed. Providers may request a hearing to appeal the denial of an unlisted CPT code.

Per Chapter 1 of the National Correct Coding Initiative Policy Manual for Medicare Services, "A physician should not report a CPT code for a specific procedure if it does not accurately describe the service performed. It is inappropriate to report the best fit HCPCS/CPT code unless it accurately describes the service performed, and all components of the HCPCS/CPT code were performed."

A hearing request to appeal the denial of an unlisted CPT code should include:

- Documentation supporting the use of an unlisted code
- A letter citing 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 member (medical records, operative report, patient history, physical examination report, pathology report, discharge summary)

Additional information may be found in Section I: General Information.

For a list of closed unlisted codes, refer to 17-87 Code Updates below.

17-82 Place of Service Claims Editing

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicaid must comply with HIPAA standards and their implementation guides regarding Place of Service (POS).

To be in full compliance with national POS standards, Utah Medicaid has added an additional module to the existing prepayment editing tool. The new module will affect claims that are billed with an invalid POS. The POS module will detect when services are billed in an inappropriate setting, resulting in a denial.

Place of Service code information can be found on the CMS website at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Telemedicine Place of Service

Providers should immediately begin reporting place of service code 02 when furnishing telemedicine services from a distant site.

17-83 Chiropractic Services Manual Update

The chiropractic services policy has been updated and is now found in the CHEC Services Manual and the Physician Services Manual. The Chiropractic Services Manual will be archived effective October 1, 2017.

Coverage of chiropractic service is limited to spinal manipulation. Chiropractors performing manual manipulation of the spine may use manual devices, however, no additional payment is available for use of the device, nor does Medicaid recognize an extra charge for the device itself. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

Specific coverage on CPT or HCPCS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup Tool.

17-84 Nutritional Counseling

Nutritional counseling is no longer on manual review. Nutritional counseling is covered with a maximum of four units for the initial assessment and intervention.

Nutritional counseling and an evaluation and management are not covered for the same provider on the same date of service. Physicians and other qualified providers who may report evaluation and management services may bill with a prolonged service code to include the time for nutritional counseling.

Specific coverage on CPT or HCPCS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup Tool.

17-85 Speech-Language Pathology and Audiology Services

The Speech-Language Pathology and Audiology Services Manual has been updated. Providers are encouraged to become familiar with the manual noting:

Hearing screening for newborns is a covered service. For more information on newborn hearing screening refer to Utah Administrative Code R398-2. Newborn Hearing Screening and the Utah Department of Health Early Hearing Detection and Intervention Program. For more information on hearing assessments for CHEC eligible members, refer to the CHEC Services Provider Manual.

For specific code coverage, refer to the Coverage and Reimbursement Code Lookup Tool.

17-86 Cost Sharing

The Utah Medicaid State Plan was approved updating cost sharing amounts to align with requirements in 42 CFR §447.50, Sections 1902(a)(14), 1916, and 1916A of the Act.

Effective July 1, 2017, inpatient hospital cost sharing amounts are $75 for each inpatient hospital stay (episode of care).

All other cost sharing amounts will be effective October 1, 2017.

Cost sharing amounts are as follows:

$8 for each non-emergency use of the emergency department
$75 for each inpatient hospital stay (episode of care)
$4 for each outpatient services visit (physician visit, podiatry visit, physical therapy, etc.)
$4 for each outpatient hospital service visit (maximum of one per person, per hospital, per date of service)
$4 for each prescription
$1 for each chiropractic visit (maximum of one per date of service)
$3 for each pair of eyeglasses

17-87 Code Updates

Open

81275 KRAS (Kirsten rat sarcoma viral oncogene homolog) (e.g., carcinoma) gene analysis; variants in exon 2 (e.g., codons 12 and 13)

98941 Chiropractic manipulative treatment (CMT); spinal, 3-4 regions – *limited to 12 per 12-month period including any combination of CPT codes 98940, 98941, and 98942*

98942 Chiropractic manipulative treatment (CMT); spinal, 5 regions – *limited to 12 per 12-month period including any combination of CPT codes 98940, 98941, and 98942*

E0244 Raised toilet seat

L6665 Upper extremity addition, Teflon, or equal, cable lining

L6682 Upper extremity addition, test socket, elbow disarticulation or above elbow

L6688 Upper extremity addition, frame type socket, above elbow or elbow disarticulation

L6690 Upper extremity addition, frame type socket, interscapular-thoracic

L7401 Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal)

L7404 Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material

Prior Authorization Required

22856 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical

67915 Repair of ectropion; thermocauterization

81214 BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (i.e., exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)

81215 BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant

81217 BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant

Q4131 EpiFix or Epicord, per sq cm

Q4132 Grafix Core, per sq cm

Q4133 Grafix Prime, per sq cm

Prior Authorization Removed

20931 Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)

20937 Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

20938 Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

49570 Repair epigastric hernia (e.g., preperitoneal fat); reducible (separate procedure)

A4305 Disposable drug delivery system, flow rate of 50 ml or greater per hour

A4306 Disposable drug delivery system, flow rate of less than 50 ml per hour

A8000 Helmet, protective, soft, prefabricated, includes all components and accessories

E0181 Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty

E0935 Continuous passive motion exercise device for use on knee only

E0944 Pelvic belt/harness/boot

L0455 TLSO, flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf

L0456 TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0457 TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf

L0458 Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 2 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0467 TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf

L0469 TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf

L1812 Knee orthosis, elastic with joints, prefabricated, off-the-shelf

L1833 Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf

L1845 Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L1846 Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated

L1932 Ankle-foot orthotic (AFO), rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment

L1945 Ankle-foot orthotic (AFO), plastic, rigid anterior tibial section (floor reaction), custom fabricated

L1951 Ankle-foot orthotic (AFO), spiral, (Institute of rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment

L2005 Knee-ankle-foot orthotic (KAFO), any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated

L3020 Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each

L3906 Wrist-hand orthosis (WHO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L4205 Repair of orthotic device, labor component, per 15 minutes

L6665 Upper extremity addition, Teflon, or equal, cable lining

L6682 Upper extremity addition, test socket, elbow disarticulation or above elbow

L6688 Upper extremity addition, frame type socket, above elbow or elbow disarticulation

L6890 Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment

L7401 Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal)

L7404 Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material

L7520 Repair prosthetic device, labor component, per 15 minutes

S8424 Gradient pressure aid (sleeve), ready made

S8428 Gradient pressure aid (gauntlet), ready made

Manual Review Removed

77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

77402 Radiation treatment delivery, =>1 MeV; simple

86003 Allergen specific IgE; quantitative or semiquantitative, each allergen

92612 Flexible endoscopic evaluation of swallowing by cine or video recording;

92613 Flexible endoscopic evaluation of swallowing by cine or video recording; interpretation and report only

92614 Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording;

92615 Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only

92616 Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;

92617 Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; interpretation and report only

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

99495 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge

99496 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge

Codes Open to Provider Type 32, Speech Language Pathologist

92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording

92612 Flexible endoscopic evaluation of swallowing by cine or video recording;

92614 Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording;

92616 Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;

Quantity Limit Update

86003 Allergen specific IgE; quantitative or semiquantitative, each allergen - *30 units per allergen for 12-month period*

95165 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses) - *30 units per member for 12-month period*

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes – *four units per 12-month period*

97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes – *10 units per 12-month period*

A4305 Disposable drug delivery system, flow rate of 50 ml or greater per hour - *90 per 30 day period*

A4306 Disposable drug delivery system, flow rate of less than 50 ml per hour - *90 per 30 day period*

A4602 Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each - *quantity limit removed*

A4614 Peak expiratory flow rate meter, hand held - *quantity limit removed*

A8000 Helmet, protective, soft, prefabricated, includes all components and accessories – *1 every 3 years*

E0181 Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty – *1 every 3 years*

E0935 Continuous passive motion exercise device for use on knee only - *21 units per 30-days*

L0455 TLSO, flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf - *1 every 3 years*

L0456 TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise - *1 every 3 years*

L0457 TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf - *1 every 3 years*

L0458 Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 2 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment - *1 every 3 years*

L0467 TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf - *1 every 3 years*

L0469 TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic,

thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf - *1 every 3 years*

L1240 Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), lumbar derotation pad - *quantity limit removed*

L1833 Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf - *1 per side every 3 years, RT or LT modifiers required*

L1845 Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise - *1 per side every 3 years, RT or LT modifiers required*

L1846 Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated - *1 per side every 3 years, RT or LT modifiers required*

L1932 Ankle-foot orthotic (AFO), rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment - *1 per side every 3 years, RT or LT modifiers required*

L1945 Ankle-foot orthotic (AFO), plastic, rigid anterior tibial section (floor reaction), custom fabricated - *1 per side every 3 years, RT or LT modifiers required*

L1951 Ankle-foot orthotic (AFO), spiral, (Institute of rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment - *1 per side every 3 years, RT or LT modifiers required*

L2005 Knee-ankle-foot orthotic (KAFO), any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated - *1 per side every 3 years, RT or LT modifiers required*

L3906 Wrist-hand orthosis (WHO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment - *1 per side every 3 years, RT or LT modifiers required*

L4205 Repair of orthotic device, labor component, per 15 minutes - *2 units per month*

L6682 Upper extremity addition, test socket, elbow disarticulation or above elbow – *1 every 5 years*

L6688 Upper extremity addition, frame type socket, above elbow or elbow disarticulation – *1 every 5 years*

L7401 Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal) – *1 every 5 years*

L7404 Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material – *1 every 5 years*

L7520 Repair prosthetic device, labor component, per 15 minutes - *2 units per month*

Closed

64555 Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

A4614 Peak expiratory flow rate meter, hand held – *Non-covered for PCN*

E0440 Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing – *as a purchase*

S9470 Nutritional counseling, dietitian visit

01999 UNLISTED ANESTHESIA PROCEDURE(S)
15999 UNLISTED PROCEDURE, EXCISION PRESSURE ULCER
17999 UNLISTED PROC,SKIN,MUCOUS MEMBRANE/SUBCUT TISSUE
19499 UNLISTED PROCEDURE, BREAST
20999 UNLISTED PROCEDURE,MUSCULOSKELETAL SYSTEM,GENERAL
21499 UNLISTED MUSCULOSKELETAL PROCEDURE, HEAD
22899 UNLISTED PROCEDURE, SPINE
22999 UNLISTED PROCEDURE,ABDOMEN,MUSCULOSKELETAL SYSTEM
23929 UNLISTED PROCEDURE, SHOULDER
24999 UNLISTED PROCEDURE, HUMERUS OR ELBOW
25999 UNLISTED PROCEDURE, FOREARM OR WRIST
26989 UNLISTED PROCEDURE, HANDS OR FINGERS
27299 UNLISTED PROCEDURE, PELVIS, HIP OR JOINT
27599 UNLISTED PROCEDURE, FEMUR OR KNEE
27899 UNLISTED PROCEDURE, LEG OR ANKLE
28899 UNLISTED PROCEDURE, FOOT OR TOES
31299 UNLISTED PROCEDURE, ACCESSORY SINUSES
31599 UNLISTED PROCEDURE, LARYNX
31899 UNLISTED PROCEDURE, TRACHEA, BRONCHI
32999 UNLISTED PROCEDURE, LUNGS AND PLEURA
33999 UNLISTED PROCEDURE, CARDIAC SURGERY
36299 UNLISTED PROCEDURE, VASCULAR INJECTION
37501 UNLISTED VASCULAR ENDOSCOPY PROCEDURE
37799 UNLISTED PROCEDURE, VASCULAR SURGERY
38129 UNLISTED LAPAROSCOPY PROCEDURE, SPLEEN
38589 UNLISTED LAPAROSCOPY PROCEDURE, LYMPHATIC SYSTEM
38999 UNLISTED PROCEDURE, HEMIC OR LYMPHATIC SYSTEM
39499 UNLISTED PROCEDURE, MEDIASTINUM
39599 UNLISTED PROCEDURE, DIAPHRAGM
40799 UNLISTED PROCEDURE, LIPS
40899 UNLISTED PROCEDURE, VESTIBULE OF MOUTH
41599 UNLISTED PROCEDURE, TONGUE, FLOOR OF MOUTH
42299 UNLISTED PROCEDURE, PALATE, UVULA
42699 UNLISTED PROCEDURE, SALIVARY GLANDS OR DUCTS

42999 UNLISTED PROCEDURE, PHARYNX, ADENOIDS, OR TONSILS
43289 UNLISTED LAPAROSCOPY PROCEDURE, ESOPHAGUS
43499 UNLISTED PROCEDURE, ESOPHAGUS
43659 UNLISTED LAPAROSCOPY PROCEDURE, STOMACH
43999 UNLISTED PROCEDURE, STOMACH
44238 UNLISTED LAPAROSCOPY PROCEDURE,INTESTINE
44799 UNLISTED PROCEDURE, INTESTINE
44899 UNLISTED PROCEDURE,MECKEL DIVERTICULUM & MESENTERY
44979 UNLISTED LAPAROSCOPY PROCEDURE, APPENDIX
45399 UNLISTED PROCEDURE COLON
45499 UNLISTED LAPAROSCOPY PROCEDURE, RECTUM
45999 UNLISTED PROCEDURE, RECTUM
46999 UNLISTED PROCEDURE, ANUS
47379 UNLISTED LAPAROSCOPIC PROCEDURE, LIVER
47399 UNLISTED PROCEDURE, LIVER
47579 UNLISTED LAPAROSCOPY PROCEDURE, BILIARY TRACT
47999 UNLISTED PROCEDURE, BILIARY TRACT
48999 UNLISTED PROCEDURE, PANCREAS
49659 UNLISTED LAPAROSCOPY PROC,HERNIOPLASTY,HERNIORRHP
49999 UNLISTED PROCEDURE,ABDOMEN,PERITONEUM & OMENTUM
50549 UNLISTED LAPAROSCOPY PROCEDURE, RENAL
50949 UNLISTED LAPAROSCOPY PROCEDURE, URETER
51999 UNLISTED LAPAROSCOPY PROCEDURE,BLADDER
53899 UNLISTED PROCEDURE, URINARY SYSTEM
54699 UNLISTED LAPAROSCOPY PROCEDURE, TESTIS
55559 UNLISTED LAPAROSCOPY PROCEDURE, SPERMATIC CORD
58578 UNLISTED LAPAROSCOPY PROCEDURE, UTERUS
58579 UNLISTED HYSTEROSCOPY PROCEDURE, UTERUS
58679 UNLISTED LAPAROSCOPY PROCEDURE, OVIDUCT, OVARY
58999 UNLISTED PROCEDURE, FEMALE GENITAL SYSTEM
59898 UNLISTED LAPAROSCOPY PROC,MATERNITY CARE/DELIVERY
59899 UNLISTED PROCEDURE, MATERNITY CARE AND DELIVERY
60659 UNLISTED LAPAROSCOPY PROCEDURE, ENDOCRINE SYSTEM
60699 UNLISTED PROCEDURE, ENDOCRINE SYSTEM
66999 UNLISTED PROCEDURE, ANTERIOR SEGMENT EYE
67299 UNLISTED PROCEDURE, POSTERIOR SEGMENT
67399 UNLISTED PROCEDURE, OCULAR MUSCLE
67599 UNLISTED PROCEDURE, ORBIT
67999 UNLISTED PROCEDURE, EYELIDS
68399 UNLISTED PROCEDURE, CONJUNCTIVA
68899 UNLISTED PROCEDURE, LACRIMAL SYSTEM
69399 UNLISTED PROCEDURE, EXTERNAL EAR
69799 UNLISTED PROCEDURE, MIDDLE EAR
69949 UNLISTED PROCEDURE, INNER EAR

69979 UNLISTED PROCEDURE,TEMPORAL BONE,MIDDLE FOSSA APPR
76496 UNLISTED FLOUROSCOPIC PROCEDURE
76497 UNLISTED COMPUTED TOMOGRAPHY PROCEDURE
76499 UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE
76999 UNLISTED DIAGNOSTIC ULTRASOUND EXAM
77299 UNLISTED PROC,THERAP RADIOLOGY CLINICAL TREAT PLAN
77399 UNLISTED PROC, EXTERNAL RAD DOSIMETRY
77499 UNLISTED PROC,THERAPEUTIC RADIOLOGY TREAT MANAGMNT
77799 RADIUM/RADIOISOTOPE THERAP, UNLIST PROC
78099 UNLISTED ENDOCRINE PROCEDURE,DIAGNOST NUCLEAR MED
78199 UNLISTED HEMATOPOIETIC R-E LYMPHATIC PRO
78299 UNLISTED GASTROINTESTINAL PROCEDURE
78399 UNLISTED MUSCULOSKELETAL PROCEDURE
78599 UNLISTED RESPIRATORY PROCEDURE
78699 UNLISTED NERVOUS SYSTEM PROCEDURE
78799 UNLISTED GENITOURINARY PROCEDURE
78999 UNLISTED MISCELLANEOUS PROCEDURE
79999 UNLISTED RADIOPHARMACEUTICAL THERAPEUTIC PROCEDURE
81099 UNLISTED URINALYSIS PROCEDURE
85999 UNLISTED HEMATOLOGY AND COAGULATION PROCEDURE
86486 SKIN TEST;UNLISTED ANTIGEN,EA
86849 UNLISTED IMMUNOLOGY PROCEDURE
87999 UNLISTED MICROBIOLOGY PROCEDURE
88199 UNLISTED CYTOPATHOLOGY PROCEDURE
88399 UNLISTED SURGICAL PATHOLOGY PROCEDURE
89240 UNLISTED MISCELLANEOUS PATHOLOGY TEST
90399 UNLISTED IMMUNE GLOBULIN
90749 UNLISTED VACCINE/TOXOID
90899 UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE
91299 UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE
92700 UNLISTED OTORHINOLARYNGOLOGICAL SERVICE/PROCEDURE
93799 UNLISTED CARDIOVASCULAR SERVICE OR PROCEDURE
95199 UNLISTED ALLERGY/CLINICAL IMMUNOLOGIC SRVC/PROCED
95999 UNLISTED NEUROLOGICAL/NEUROMUSCULAR DIAGNOST PROC
96379 UNLSTD THRPTC/PROPH/DIAG INTRA/INTRA-ARTRL INJ/INF
96549 UNLISTED CHEMOTHERAPY PROCEDURE
96999 UNLISTED SPECIAL DERMATOLOGICAL SERVICE/PROCEDURE
97139 THER PROC,1+AREA,15 MIN;UNLISTED THERAPEUTIC PROC
99358 PROLONGED E/M SERVICE BEFORE AND/OR AFTER DIRECT PATIENT CARE; FIRST HOUR
99359 PROLONGED E/M SERVICE BEFORE AND/OR AFTER DIRECT PATIENT CARE; EA ADD 30 MIN
L8499 UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC

17-88 Tables of Authorized Emergency Diagnoses

The tables of authorized emergency inpatient diagnoses and authorized emergency department diagnoses are updated regularly. The current authorized diagnoses lists are available on the Medicaid website at Utah Medicaid Table of Authorized Emergency Department Diagnoses.

17-89 Home and Community Based Waiver Amendments

The following Home and Community-Based Services waiver programs have had amendments submitted to CMS in order to comply with legislation passed in the 2017 General Session:

Acquired Brain Injury Waiver
Community Supports Waiver
Physical Disabilities Waiver

The amendments included rate increases for Financial Management and Non-Medical Transportation Services. The State Implementation Plans were submitted to CMS by June 30, 2017. Implementation plans for the proposed amendments are available on the Medicaid website at http://www.health.utah.gov/ltc.

17-90 Home and Community Based Services Waiver for Individuals Age 65 or Older Manual Updated

All Aging Waiver providers are requested to submit claims within 90 days of the delivery of services; however, Medicaid allows for a 12-month claim submission and correction period.

An error was corrected on the Service Procedure Codes Table. The correct billing code for Personal Emergency Response System – Purchase, Rental or Repair is S5162, and the correct code for Personal Emergency Response – Installation, Testing, or Removal is S5160.

If you have any questions, contact Linda Robinson at (801) 538-6132 or lindarobinson@utah.gov.

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

17-91 Drug Utilization Review Board Update

Entresto, Movantik, Selzentry and long-acting insulins, long acting blood factors, and benzodiazepines were recently discussed by the DURB. Mutual exclusivity was established between benzodiazepines and opioids and general prior authorization criteria for new-to-market drugs was approved. Meeting minutes are available online.

17-92 Prescriber Monitoring Requirements

The Utah Medicaid Pharmacy Program launched two (2) new projects that specifically address prescriber monitoring requirements focused on utilization of the psychotropic medications on the Preferred Drug List (PDL). The benchmark is set as fifty-five percent (55%) preferred psychotropic medications utilization.

The first project is the provision of individualized, confidential prescriber report cards. This individualized report card compares his/her psychotropic prescribing patterns to a standard, both established by statute and that of his/her peers. These individualized reports are generated and confidentially sent to each Medicaid prescriber to illustrate the utilization of preferred psychotropic medications from the PDL.

The second project involves prescriber medical education including electronic materials and peer-to-peer education. Education and best practices may be found on the Utah Medicaid Pharmacy web page with hyperlinks to articles: https://medicaid.utah.gov/pharmacy/resource-library.

17-93 Preferred Drug List

The Pharmacy and Therapeutics (P&T) Committee recently reviewed treatments for HIV, gout, parathyroid hormone analogs and combination treatments for COPD. Additions and updates to these classes have been made to the Utah Medicaid Preferred Drug List (PDL) in accordance with P&T Committee recommendations.

Meeting minutes are available on the Utah Medicaid Pharmacy website at https://medicaid.utah.gov/pharmacy/pt-committee.

17-94 Brand Drug Over Generic Drug Reference

Several changes were made to the Brand over Generic reference recently. This reference is available at https://medicaid.utah.gov/pharmacy/resource-library.

17-95 Pharmacy Manual Update

The Utah Medicaid Pharmacy Services Provider Manual is updated in the following sections:

- 4-8 Co-payment Required for Medicaid Prescriptions: Maximum number of copays was clarified.
- 4-12 Compounded Prescriptions: Bulk compounding powders are not covered by Utah Medicaid for compounded prescriptions.
- 6-7 Provider Administered Drug: Additional information and reimbursement rate were added.
- 6-16 Utah Maximum Allowable Cost: NADAC contact information was added.
- 6-17 Dispensing Fees: Please see State Plan, Attachment 4.19-B for current dispensing fee information.
- New Section added: 7 End Stage Renal Disease (ERSD)

17-96 Drug Criteria Limits

Several recent changes were made to the Drug Criteria Limits information. This reference is available at https://medicaid.utah.gov/pharmacy/resource-library.

17-97 ICD-10 Reference Chart

The ICD-10 Reference Chart was updated for the Fee For Service Pharmacy Claims on the processing pain medications for cancer diagnosis. This reference is available at https://medicaid.utah.gov/pharmacy/resource-library.

17-98 Utah Medicaid Documentation Submission Form for the Emergency Services Program for Non-Citizens (ESPN-C)

Effective October 1, 2017, all documentation submitted to support the Emergency Services Program for Non-Citizens claims review shall include a completed Utah Medicaid ESPN-C Documentation Submission Form. The form is available on the Medicaid website at https://medicaid.utah.gov/utah-medicaid-forms.

The form must be the first page of the submitted documentation. The form must be included with all documentation, regardless of submission method (i.e., mail, fax, cHIE, electronic attachment). This form must be filled out completely and include all necessary supporting documentation. All documentation for review must be received within 365 days of the date of service to be considered.

Any documentation submitted without the most current Utah Medicaid ESPN-C Documentation Submission Form will be returned to the provider.