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MEDICAID INFORMATION BULLETIN

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22-86 Utah Medicaid Provider Manuals

The Utah Medicaid Provider Manuals have been redesigned and are available on the Medicaid website at https://medicaid-manuals.dhhs.utah.gov/.

The manuals are current as of July 2022. Archived copies of the provider manuals, prior to July 2022, will be available on the website at https://medicaid.utah.gov/utah-medicaid-official-publications/. Questions may be sent to medicaidops@utah.gov.

22-87 Multiple Procedure Payment Reduction Updates

Section I: General Information Manual, Chapter 12 *Coding,* is updated to include information regarding the Multiple Procedure Payment Reduction policy as follows:

Chapter 12-7.4 Multiple Procedure Payment Reduction

Each CPT, HCPCS, and PCS code has a designated rate and is weighted based on Relative Value Units (RVUs). These values are established based on the concept that the services reported are

standalone procedures. In some instances, providers will perform multi-staged procedures that are separate but related to one another. In these instances, the expense of performing the associated procedures is reduced as they do not require a different surgical session, incisions, anesthesia, etc. This is known as Multiple Procedure Payment Reduction (MPPR). Multiple procedures performed during the same provider's service session are reported using modifier 51. Even if a modifier is not used, MPPR can be applied for services performed on the same date.

The MPPR applies to procedures when:

- Two or more procedure codes are subject to reductions (i.e., two or more codes on the Multiple Procedure Reduction Codes list)
  - If two codes are reported, but only one is subject to reduction, no reduction will be taken on either procedure
- A single code subject to the MPPR is submitted with multiple units
  - *For example, CPT code 11300 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less) is submitted with three units, then MPPR would apply to the second and third units*

The MPPR will be applied using the pricing method outlined below:

- 100% of the allowable amount for the primary/major procedure
- 50% of the allowable amount for the secondary procedure
- 25% of the allowable amount for all subsequent procedures

Multiple Procedure Payment Reduction (MPPR) for Assistant Surgeon Services

Multiple procedures performed by an assistant surgeon or a nurse practitioner/physician assistant are subject to the MPPR concept defined above when performed by the same physician on the same date of service. There are instances when a surgical procedure requires and allows for reporting an assistant surgeon. In these circumstances, the assistant surgeon reimbursement will be 20% of the allowable amount for each procedure.

Refer to Chapter 12-7.3 *Modifier used in a Claim* of Section I: General Information provider manual for additional details related to reporting assistants to surgery.

Multiple Procedure Payment Reduction (MPPR) for Co-Surgeon/Team Surgeon Services

Multiple procedures performed by a co-surgeon or team surgeon are subject to the MPPR when performed by the same physician or other qualified health care professional on the same date of service. Co-surgeon and team surgeon services are considered separately and independently of any other co-surgeon or team surgeon services.

22-88 Removal of PA Requirements from Select Personal Care Services and Nutritional Services

Personal Care Services

- Effective September 1, 2022, prior authorization requirements have been removed from personal care services reported under code T1019.

The Personal Care Services provider manual has been updated to reflect this change. Specifically, Chapter 10, *Prior Authorization,* has been updated to remove information reflecting PA requirements for services reported under code T1019.

Nutritional Services for EPSDT Eligible Individuals

- Effective September 1, 2022, prior authorization requirements have been removed from enteral formula products for members enrolled in the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program. This includes products reported under the following HCPCS codes:
  - B4149—EF blenderized foods
  - B4150—EF complete w/intact nutrient
  - B4152—EF calorie dense>/=1.5Kcal
  - B4153—EF hydrolyzed/amino acids
  - B4154—EF spec metabolic non-inherit
  - B4155—EF incomplete/modular
  - B4157—EF special metabolic inherit
  - B4158—EF ped complete intact nut
  - B4159—EF ped complete soy based
  - B4160—EF ped caloric dense>/=0.7kc
  - B4161—EF ped hydrolyzed/amino acid
  - B4162—EF ped spec metabolic inherit

The Medical Supplies and Durable Medical Equipment provider manual has been updated to reflect this change. Specifically, Section 8-9, *Nutritional Services,* has been updated to remove information reflecting PA requirements for enteral formula for EPSDT members.

22-89 Home Health: Private Duty Nursing Hours

Effective August 1, 2022, Private Duty Nursing (PDN) maximum daily hours are increased in the Home Health Services provider manual and PDN Acuity Grid forms.

The Home Health Services provider manual, 8-11.6 *PDN Acuity Grid Score and PDN Hours* has been updated as follows:

8-11.6 PDN *Acuity Grid Score and PDN Hours*

Score	Hours of care per day of shift care (up to)
21-35	9
36-45	11
46-51	13
56+	15

If 20 points or less:

• And the member is being transitioned off 9 hours, then 832 units will be approved to the home health agency for the certification period. During this time, it is expected that discharge planning occurs.

• When a member's tracheostomy is decannulated, up to 5 hours of daily nursing care may be approved during the first 24-72 hours after decannulation.

22-90 Hospice Services Updates

The Hospice Care Provider Manual and Utah Administrative Code, R414-14A. Hospice Care, has been updated. The following reflects the changes made to R414-14A:

- Policy changes
  - Medicaid has updated the code to reflect the requirements of SB 27 to allow physician assistants to work within their scope of practice and act as the attending physician in the hospice care setting. The physician assistants' professional scope of work is outlined in Utah Code, Title 58: Occupations and Professions, Chapter 70a: Utah Physician Assistant Act.
  - Acting within their scope of practice, nurse practitioners may act as attending physicians in the hospice care setting.

- The "cap period" end date will be updated to align with the parameters outlined in the Code of Federal Regulations (CFR) 42 CFR 418.
- Hospice providers are also required to report the location of where services are rendered to ensure appropriate payment.

- Transferred to another area of the rule and updated
  - R414-14A-2. *Definitions*.
    - Modified "Attending Physician" definition to include physician assistants and nurse practitioners
    - Removed definitions for "Employee" and "Physician"
    - Added definitions for "Consecutive Months," "Palliative Care," "Pediatric," and "Pediatric Hospice Agency"
    - Moved definitions from the body of the rule to the definitions section
  - R414-14A-3. *Member Eligibility Requirements*.
    - Restructured point 1 from R414-14A-6 into two different points and added them to Member Eligibility
  - R414-14A-4. *Program Access Requirements*.
    - Added point 1 to add clarification for providers
    - Simplified point two and made the original point 3 a sub-bullet of point 2
    - Moved the first point from R414-14A-15. to make point 4 in Program Access Requirements
  - R414-14A-10. *Concurrent Care for Members Under 21 Years of Age.*
    - Pertinent information from this section was clarified and placed in the Service Coverage Section.
    - The original point 3 was reworded and placed in the new reimbursement section (R414-14A-6)
  - R414-14A-13. *Extended Hospice Care* was reworded and placed in the program access requirements section
  - R414-14A-15. *Hospice Room and Board Services* was reworded and moved to Service Coverage
  - R414-14A-16. *In-Home Physician Services* was reworded and moved to Service Coverage
  - R414-14A-17. *Continuous Home Care* was reworded and moved to Service Coverage
  - R414-14A-18. *General Inpatient Care* was reworded and moved to Service Coverage
  - R414-14A-19. *Inpatient Respite Care* was reworded and moved to Service Coverage
  - R414-14A-21. *Post-Payment for Services While in Medicaid, Pending Status* was clarified/reduced and moved to the new Reimbursement section (R414-14A-6)
  - R414-14A-22. *Hospice Care Reimbursement* was clarified/reduced and moved to the new Reimbursement section (R414-14A-6)

- R414-14A-25. *Hospice Payment Covers Special Modalities* was clarified/reduced and moved to the new Reimbursement section (R414-14A-6)
- R414-14A-26. *Payment for Nursing Facility. ICF/ID, and Freestanding Inpatient Hospice Unit Room and Board* was clarified/reduced and moved to the new Reimbursement section (R414-14A-6)
- R414-14A-27. *Limitation on Liability for Certain Hospice Coverage Denials* was clarified, reduced, and moved to the new Reimbursement section (R414-14A-6)

- Moved to Manual
  - R414-14A-5. *Service Coverage* was expanded with information from sections that follow
    - Removed the requirement that individuals in hospice care for more than 18 consecutive months require a utilization review from this section of the rule and moved it to the manual under *Chapter 10 Prior Authorization*
  - R414-14A-6. *Hospice Election* was moved to the manual for operational purposes
  - R414-14A-8. *Revocation and Re-election of Hospice Services* was moved to the manual for operational purposes
  - R414-14A-11. *Notice of Hospice Care in Nursing Facility, ICF/ID, or Freestanding Clinic* was moved to the manual for operational purposes
  - R414-14A-12. *Notice of Independent Attending Physician* was moved to the manual for operational purposes
  - R414-14A-20. *Notification and Prior Authorization Grace Periods* was moved to the manual for operational purposes
  - R414-14A-23. *Payment for Hospice Care Categories* was moved to the manual for operational purposes
  - R414-14A-24. *Payment for Physician Services* was moved to the manual for operational purposes
  - R414-14A-28. *Medicaid Health Plans and Hospice* was moved to the manual for operational purposes
  - R414-14A-30. *Medicaid 1915c HCBS Waivers and Hospice* was moved to the manual for operational purposes

- Removed as duplication to CFR
  - R414-14A-3. *Member Eligibility Requirements* removed the "face to face" and "90-day requirement" as it is stated in 42 CFR 418.21
  - R414-14A-7. *Change in Hospice Provider* removed from rule due to information existing in 42 CFR 481.30
  - R414-14A-9. *Rights Waived to Some Medicaid Services for Adult Members* removed from rule due to information existing in 42 CFR 481.30.42 CFR 418.24 (f)

- R414-14A-14. *Provider Initiated discharge from Hospice Care* removed from rule due to information existing in 42 CFR 418.26
- R414-14A-29. *Marketing for Hospice Providers* removed from the rule because there are no federal regulations on hospice solicitation

The Hospice Care Services Provider Manual and Utah Administrative Code, R414-14A. Hospice Care have been updated to meet new style guide requirements with additional updates and clarifications as needed.

22-91 Pharmacy Policy, Coverage, Prior Authorization and HCPCS Codes

The Utah Medicaid Preferred Drug List is updated monthly and is the most up-to-date source of information pertaining to drug specific pharmacy coverage, limitations, and policies, in addition to the Utah Medicaid State Plan, Utah Administrative Rule, Utah Medicaid Provider Manuals and Medicaid Information Bulletins, and Pharmacy prior authorization forms.

Pharmacy prior authorization forms and pharmacy related HCPCS codes are reviewed and updated at a minimum annually, but may be updated more frequently as drug labels are expanded.

Per the Utah Medicaid Provider Manual Section I: General Information, 2-3 Member Eligibility Verification, providers who administer and bill Utah Medicaid for pharmacy related HCPCS codes shall verify member eligibility. Pharmacy-related HCPCS code coverage and the HCPCS NDC Crosswalk shall be used together to verify coverage, reimbursement, and covered NDC's for pharmacy-related HCPCS.

To access the most recent pharmacy resources, go to https://medicaid.utah.gov/, click on Healthcare Providers, Medicaid Pharmacy Program.

22-92 Pharmacy Prior Authorization Processing

Pharmacy prior authorization requests received for pharmacy services, including pharmacy related HCPCS codes, must be complete upon submission. An incomplete submission means required information is missing, which may result in the prior authorization being denied. The Utah Medicaid pharmacy team attempts to contact providers to obtain additional information for the prior authorization request at least two times. Providers and their staff are encouraged to complete the prior authorization request to include the exact medication name the member will be using, or indicate if a substitution is not permissible.

Medication Name/ Strength:	Dose:
❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider's intent is for a member to use a brand product, they will check "Do Not Substitute". In the example below, the request would be reviewed for the non-preferred name brand Percocet 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☒ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider submits a prior authorization request without indicating "Do Not Substitute", the request will be processed for the preferred Generic/Brand equivalent. In the example below, the request would be reviewed for the preferred generic equivalent, Oxycodone/APAP 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

In all cases, providers should submit prior authorization requests using the most current form available on the Utah Medicaid Pharmacy Website, complete all fields legibly, and include all supporting documentation required for the pharmacy service requested.

22-93 DUR Board Updates

The Drug Utilization Review (DUR) Board met in July 2022 to review guideline treatments for insomnia in adults. The review included evidence-based non-pharmacologic and pharmacologic treatments recommendations. The DUR Board also reviewed Ophthalmic Corticosteroid Intravitreal Implants/Injections prior authorization criteria.

The DUR Board met in August 2022 to review drafted 2022 Clinical Practice Guideline for Prescribing Opioids.

DUR Board meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/.

22-94 Pharmacy Update for Section I: General Information Provider Manual

The Section I: General Information provider manual has been updated to remove language regarding the coverage of weight gain and hair growth drugs.

For more detailed information, refer to Section I: General Information of Utah Medicaid Provider Manual, Chapter 9-2 *Services Not Covered Regardless of Medical Necessity,* and Utah Administrative Rule, R414-60, *Medicaid Policy for Pharmacy Program*.