SECTION I: GENERAL INFORMATION

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1 OVERVIEW OF THE UTAH MEDICAID PROGRAM

The Utah Medicaid Program pays medical bills for people who have low incomes or cannot afford the cost of health care and who are found eligible for the program. The program is based on a medical need. The Utah Medicaid program is administered by the Utah Department of Health, Division of Medicaid and Health Financing. Benefits are paid with federal and state funds, administered differently state to state.

1 – 1 Applying for Medicaid

Persons seeking assistance to pay for medical services may apply at the Department of Workforce Services (DWS) or outreach offices in most major hospitals and many area public health clinics. People may call DWS Customer Relations: 801-526-0950 or 1-866-435-7414, or visit http://jobs.utah.gov/jsp/officesearch to locate an office in their location. People who want to apply for multiple services, such as medical and financial assistance, food stamps, or child care, may do so at the DWS office.

Individuals with Special Needs (transportation, language)
Persons who need assistance with Medicaid applications due to transportation or language barriers may call the above DWS Customer Relations number for more information. DWS accepts Medicaid applications by telephone or mail when a person cannot travel to a site where applications are usually processed. Medicaid may provide interpretive services for a person who wants to apply for a federal or state medical assistance program. Refer to Chapter 12, Medicaid Information, for phone numbers and hours.

Information Brochure
An information brochure titled "Medicaid Member Guide" is available to explain the Medicaid program. The brochure explains rights and responsibilities, the selection of a health care provider, and health care services covered by Medicaid. A copy of the brochure may be obtained from the Medicaid website at www.health.utah.gov/medicaid, or a Health Program Representative at 801-526-9422 (Salt Lake County) or 1-866-608-9422. Rural areas may also contact their Local Health Department.

Eligibility Determination
An eligibility worker located at the Department of Workforce Services (DWS) determines eligibility and issues written notice of the determination. Clients who disagree with the determination may contact the local office supervisor for a conference, call DWS Customer Relations 801-526-4390 or 1-800-331-4341 or visit http://jobs.utah.gov/, or file for a Fair Hearing.

Constituent Services
For general client concerns, the Division of Medicaid and Health Financing Constituent Services Representative for the Utah Department of Health may be reached at 801-538-6417 or 1-877-291-5583 or email randapickle@utah.gov.

1 - 2 Medicaid Program Requirements

To be eligible for Medicaid, an applicant must first qualify for a category of Medicaid established by federal regulations. Each category has requirements concerning citizenship, resources (assets), and monthly income. Medicaid eligibility is redetermined each month for each individual.

A brief summary of Medicaid requirements is given in the subsections which follow.

Categories of Medicaid
Each person applying for Medicaid must qualify under one of the following categories:

- Age 65 or older
- Legally disabled or blind
- Pregnant woman
- Child under age 18
- Parent or caretaker of a child under age 19
- Woman with breast or cervical cancer

A person who does not qualify for a category of Medicaid is considered for the Primary Care Network (PCN) Program. Refer to Chapter 13 - 10, Primary Care Network Program.

Citizenship
Full Medicaid benefits are available only to U.S. citizens and legal residents. A person who is not a citizen or a legal resident may qualify for Emergency Services Program. This program limits benefits to emergency medical services only. Refer to Chapter 13 - 8, Emergency Services Program For Non-Citizens.

Resources
Federal regulations limit an individual's resources to $2,000. For a family, the limit starts at $3,000. There are exceptions to the resource limit for a pregnant woman and for a person whose spouse is a resident of a nursing home.

Income
Federal regulations require the state to set monthly income standards which vary based on the category of Medicaid. The income standards are usually associated to the annual Federal Poverty Level (FPL) for the household size. (The FPL is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml.) Here are examples of the income standards:

Category of Medicaid	Income as Percent of FPL
Age 65 or older	100%
Blind	100%
Legally disabled	100%
Working legally disabled	250%
Pregnant woman	133%
Child up to age 6	133%
Child from age 6-18	100%
Parent or caretaker relative of a child	4% to 60%
Woman with breast or cervical cancer	250%

The Federal Poverty Level is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml.

Medicaid Medically Needy Program (Spend down)
An applicant who has monthly income which is more than the monthly income standard, but less than the amount needed to pay his or her medical bills, may be considered for the Medicaid Medically Needy program. The program is also referred to as the "spend down" program. To qualify for Medicaid coverage of medical bills, the person agrees to "spend down" his or her monthly income to the Medicaid income standard. The person may choose to either pay "excess" monthly income to the state or to pay a portion of his or her monthly medical bills directly to the medical provider. A provider is notified of the

patient's agreement to pay a portion of medical bills. Refer to Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 2. Spend down applied medical bills are printed on the back of the Medicaid Identification Card.

Medicaid enrollees who choose to spend down to the income limits do this by sending a payment to the Department of Workforce Services (DWS) office equal to the difference between their countable income and the income limit, or by incurring medical bills equal to that difference. In the past, some Medicaid providers have paid the spend down for certain enrollees.

Effective December 1, 2007, Medicaid can no longer accept payments of an enrollee's spend down when the source of the funds is from a Medicaid provider's own funds, or if a Medicaid provider has loaned the money to the enrollee. Federal laws do not let providers pay a client's spend down or loan money to a client for the spend down payment. This policy also includes payments of a premium under the Medicaid Work Incentive Program, payment of the asset copayment for the Prenatal Medicaid Program, and payment of the enrollment fee for the Primary Care Network (PCN).

Instead, enrollees must pay the spend down themselves. Another option is for a Medicaid provider to allow an enrollee to incur the medical expense. The enrollee can present the bills to the Medicaid agency to meet the spend down. The enrollee is responsible to pay medical bills directly to the provider when the bills are used to meet a spend down. The provider and the enrollee can work out a repayment plan together. This does not work for enrollees who are enrolled in an Accountable Care Organization (ACO) (including a mental health care plan); however, those enrollees can use old medical bills to meet a current month's spend down when the bills are from months they did not have Medicaid coverage and the enrollee still owes the bill.

The premium owed for the Medicaid Work Incentive, the asset-copayment for the Prenatal Program, and the fee owed for the PCN program cannot be met with medical bills. However, a pregnant woman who must pay a spend down because she is over the income limit for the Prenatal Program can use incurred medical bills to meet the spend down.

The practice of a provider using a provider's own funds to pay an enrollee's spend down could place the provider in jeopardy of legal penalties such as fines or imprisonment.

Medicaid providers may continue to act as representative payee for Medicaid clients so long as they comply with 20 CFR section 404 subpart U.

Third Party Liability
The Medicaid client must identify any liable third party who may be responsible for payment of medical services rendered to the client. A liable third party includes any person or entity such as health insurance, a health plan, or Medicare.

1 - 3 Retroactive Medicaid

The eligibility worker may approve Medicaid coverage for a client prior to the first of the month in which the client applied for Medicaid. The eligibility period prior to the month of application is called the retroactive period. Effective August 1, 2001, the retroactive coverage period for Medicaid is limited to a three month time period immediately preceding the date of application. Coverage may begin on the calendar day which matches the day of the month in which the application was filed. For example, a client applies on May 16 for Medicaid and asks for retroactive coverage for services in February. Retroactive Medicaid may be approved back to February 16. Services prior to that date would not be covered.

If approved for retroactive Medicaid coverage, the client receives a Medicaid Identification Card for each eligible month. A patient who received medical, dental or mental health services and subsequently qualifies for Medicaid may return to each provider with a Medicaid Identification Card for the month in which service was provided. A provider who has already rendered services may subsequently choose to accept Medicaid as payment in full or refuse to seek Medicaid payment because the patient had not been determined eligible for Medicaid at the time of service.

Note: A Medicaid client may be retroactively enrolled in a Prepaid Mental Health Plan. A Medicaid client cannot retroactively enroll in a health plan nor retroactively select a Primary Care Provider through Medicaid.

1 - 4 Choice of Health Care Provider

Once an applicant is determined eligible for Medicaid, he or she must select a health care provider. Along the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties), the client must enroll in an Accountable Care Organization (ACO). In other areas of Utah, Medicaid clients may select a Primary Care Provider who accepts Medicaid, or a health plan if one is available.

1 - 5 Restriction Program

Medicaid clients who inappropriately utilize health care services may be referred to and enrolled in the Medicaid Restriction Program. This program provides safeguards against inappropriate and excessive use of Medicaid services. Clients are identified for enrollment through:

A. Quarterly review of patient profiles to identify exceptional utilization of medical services.

B. Verbal and written reports of inappropriate use of services generated by one or more health care providers. These reports are verified through a review of the patient's claim history by Medicaid staff and medical consultants.

C. Referral from Medicaid staff.

Clients selected for enrollment in the Restriction Program are informed of the reasons, counseled in the appropriate use of health care services, and assisted in selecting a Primary Care Provider or Accountable Care Organization (ACO) and to a particular pharmacy. Clients are issued a Restriction Medicaid Identification Card. These clients must receive all health care services through either the assigned provider or health plan, or receive a referral from those providers, and all pharmacy services from the assigned pharmacy. Medicaid will only pay claims for services rendered by the providers listed on the card and by providers to whom the client has been appropriately referred. However, emergency services are not restricted to these providers.

Verification
An example of the Restriction Medicaid Identification Card is included with the examples of cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

1 - 6 Woman with Breast or Cervical Cancer

The Breast and Cervical Cancer Prevention and Treatment Act allows states to provide full Medicaid benefits to a qualified woman in need of treatment for breast and cervical cancers, including precancerous

conditions and early stage cancer. The Utah Cancer Control Program (UCCP) will refer the woman for Medicaid coverage.

The woman must meet all of the following requirements:

A. Diagnosis after April 1st, 2001, by ANY health care provider in Utah, of breast or cervical cancer which requires treatment, including precancerous conditions.
B. Under the age of 65.
C. No insurance to cover the treatment needed.
D. A U.S. citizen or qualified alien.
E. Income is at or below 250% of the Federal Poverty Level (The FPL is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml.

For more information, call the Utah Department of Health, Utah Cancer Control Program: (801) 538-6990 or (801) 538-6491. Please have the patient's complete name and telephone number(s).

1 - 7 Program Monitoring

The State is responsible for monitoring all medical assistance programs, including Medicaid, with respect to medical need, extent and appropriateness of care, and program effectiveness. Monitoring includes audit procedures, on-site reviews, quality assurance and utilization reviews.

2 COVERED SERVICES

Services available under the Medicaid State Plan are listed in Chapter 2 - 1, Medicaid Services. Services are reimbursed either directly by Medicaid or by an Accountable Care Organization (ACO) with which Medicaid contracts to provide the covered services. When the Medicaid patient has a Primary Care Provider, this provider must provide an appropriate referral for medical services received from any other provider.

Covered services are generally limited by federal guidelines as set forth under Title XIX of the federal Social Security Act, Title 42 of the Code of Federal Regulations (CFR), and the Utah Administrative Code, Rule R414-1-5, Services Available. SECTION 2, Scope of Service, has conditions of coverage for specific types of services.

2 - 1 Medicaid Services *(Updated 1/1/14)*

Covered services include:

1. Hospital Services:
   A. Inpatient hospital services with the exception of those services provided in an institution for mental disease.
   B. Outpatient hospital services
   C. Outpatient surgical centers
   D. Free-standing birth centers

2. Rural health clinic services.

3. Laboratory and x-ray services.

4. Skilled nursing facility services, other than services in an institution for mental diseases, for individuals 21 years of age or older.

5. CHEC Services: Early and periodic screening and diagnoses of individuals less than 21 years of age and treatment of conditions found are provided in accordance with Federal requirements for the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. In Utah, this program is called the **C**hild **H**ealth **E**valuation and **C**are (CHEC) Program. *Children under age 21 with a current Medicaid Card are automatically enrolled in CHEC.*

   There are three major components to CHEC: Preventive Health Care, Outreach and Education, and Expanded Services.

   A. Preventive Health Care

   A CHEC screening is a **well-child exam** which includes the following:

   - Complete health and developmental history
   - Comprehensive unclothed physical examination, including vision and hearing screening
   - Appropriate immunizations
   - Appropriate laboratory tests
   - Health education

   Children may also receive preventive dental care.

   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.

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:

   - 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.

The CHEC screening is described in SECTION 2, CHEC SERVICES. This section contains recommended protocols and a periodicity schedule based on American Academy of Pediatrics recommendations. It also contains information regarding fluoride varnish as part of a well-child exam.

B. Outreach and Education

When children are newly eligible for Medicaid or due for a periodic exam, the family receives a letter and a phone call about the importance of preventive health care and the availability of screening services. Families are offered assistance in scheduling an appointment and transportation, if needed. The Department of Health contracts with local Health Departments for outreach and education.

C. Expanded Services

Medicaid recipients under age 21 may receive **medically necessary** services that are not available to adults. The definition of medical necessity may be less restrictive for children. However, a written prior authorization request must be submitted to document the medical necessity of the CHEC services. Refer to Chapter 9, Prior Authorization, for more information.

6. Family planning services and supplies for individuals of childbearing age.

7. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

8. Podiatric services.

9. Optometry services.

10. Psychology services for individuals under age 21.

11. Home health services including intermittent or part-time nursing services provided by a home health agency, home health aide services, and medical supplies, equipment, and appliances suitable for use in the home.

12. Private duty nursing services indicated to prevent prolonged institutionalization in medically categorically and needy, eligible, EPSDT clients.

13. Clinic services.

14. Dental services.

15. Physical therapy, occupational therapy and related services.

16. Services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist.

17. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

18. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the State Plan.

19. Services for individuals age 65 or older in institutions for mental diseases:

20. Inpatient hospital services for individuals age 65 or older in institutions for mental diseases.

21. Skilled nursing services for individuals age 65 or older in institutions for mental diseases.

22. Intermediate care facility services for individuals age 65 or older in institutions for mental diseases.

23. Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined, in accordance with section 1902(a)(31)(A) of the Social Security Act, to be in need of such care, including those furnished in a public institution or a distinct part thereof for people with intellectual disabilities or other related conditions.

24. Inpatient psychiatric facility services for individuals less than 22 years of age.

25. Nurse-midwife services and free-standing birth centers.

26. Hospice care in accordance with section 1905(o) of the Social Security Act.

27. Case management services in accordance with section 1905(a)(19) or section 1915(g) of the Social Security Act, as to the group or groups.

28. Enhanced services for pregnant women in addition to services for uncomplicated maternity cases and Certified Nurse Midwife services. Enhanced services include:

A. Medical or remedial care or services, provided by licensed practitioners, other than physician's services, within the scope of practice as defined by state law;

B. Medical transportation;

C. Skilled nursing facility services for patients less than 21 years of age;

D. Emergency hospital services; and

E. Personal care services in the patient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse.

29. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider in accordance with section 1920 of the Social Security Act.

30. Extended services to pregnant women including pregnancy-related and postpartum services for 60 days after the pregnancy ends, including additional services for any other medical conditions that may complicate pregnancy with increases of service.

31. Other medical care and other types of remedial care recognized under State law, specified by the Secretary of the United States Department of Health and Human Services, pursuant to 42 CFR §440.60 and 42 §440.170, include:

A. Medical or remedial care or services, provided by licensed practitioners, other than physician’s services, within the scope of practice as defined by state law;

B. Medical transportation;

C. Skilled nursing facility services for patients less than 21 years of age;

D. Emergency hospital services; and

E. Personal care services in the patient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse

32. Medical interpretive services for clients with limited English proficiency or disabilities. Refer to Chapter 6 - 12, Medical Interpretive Services.

33. Third party insurance premiums, including the Medicare Part A and/or Part B payments. Payments for Medicare clients are covered under the Buy-in Program. Other third party health care premium(s) may be covered under the Buy-Out Program if continued third party coverage for the eligible recipient is determined to be cost-effective.

2 - 2 Limiting Amount, Duration or Scope of Services

The Division of Medicaid and Health Financing has the authority to limit the amount, duration, or scope of services or to exclude a service or procedure from coverage by Medicaid. Policy recommendations are based on medical necessity, appropriateness, and utilization control concerns (42 CFR §440.230). Recommendations consider the following:

- Existing policy for non-covered cosmetic, experimental or non-proven medical practices.
- Information available from the Special Coverage Issues Bureau, Centers for Medicare & Medicaid Services, Department of Health and Human Services. Information and recommendations from physician consultants employed by the Utah Department of Health, Division of Medicaid and Health Financing.
- Consultation with appropriate groups or individuals from various professional organizations.
- Legal counsel.
- Consultation with policy staff of the local Medicare carrier.
- Consultation with policy staff of Medicaid programs in other states (selected).

2 - 3 Out-of-State Services

Medical services are furnished out-of-state to Utah Medicaid clients, in accordance with 42 CFR §431.52. The same services available within the state are available out-of-state from any provider who is or will be enrolled with Utah's Medicaid program.

2 - 4 Group Health Insurance and Medicaid: Certificate of Coverage

Medicaid recipients, current and previous, may benefit from the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The law offers more protections for working people who move from one group health insurance plan to another or who have been covered by any health plan, including Medicaid or Medicare, just prior to enrolling in a group health plan. The law is especially helpful for people who have a preexisting medical condition and want to enroll in an insurance plan.

HIPAA stipulates that when a person changes from one health plan to another, the length of time the person has had recent, continuous group health coverage must be considered as 'credit' toward the exclusion for a pre-existing condition. This credit may allow the client to reduce or eliminate the months he or she would otherwise have to wait for medical treatment of a pre-existing condition under the health plan. (HIPAA defines a pre-existing condition as a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date in any new health plan.) The months a client was eligible for Medicaid coverage count as credit.

The group health insurer will need proof of the months the client was eligible for Medicaid. Acceptable proof includes a Certificate of Coverage from the Department of Health. The certificate verifies the client had Medicaid eligibility which can be used as credit toward any pre-existing condition exclusion.

Client Information or Questions
Medicaid clients who want more information about the Certificate of Coverage or want to request a certificate for himself/herself and family members may call Medicaid Information. (Refer to Chapter 12, Medicaid Information.) The caller will be transferred.

Conditions of Coverage
The Department of Health determines whether the client's coverage under Medicaid qualifies under the provisions of the law. If so, a Certificate of Coverage is created and sent to the client's home. To qualify, coverage must have been recent and continuous. If the client has a lapse in coverage for more than two months in a row, the prior period of coverage will not be counted. However, the client may have received coverage under more than one plan, and as long as there were no gaps in his or her coverage, months of prior coverage do count.

For example, if the client was covered by a health plan or Medicaid in January, February, and March, and then enrolled in another health plan in April, the client could use the three months of coverage (January - March) to reduce the exclusion period by three months. If the exclusion period was six months, the client would only have a three-month exclusion period.

2 - 5 Inmates Not Entitled to Medicaid Services

When a Medicaid client is an "inmate of a public institution" (including jail), Medicaid services is not a benefit even though the client has a Medicaid Card. The penal facility is responsible for all medical expenses incurred during the client's stay including medical treatment, medical supplies and prescriptions. It is not appropriate for a third party to use the Medicaid Card to pick up medications/supplies for someone that is in jail and deliver them to the inmate. Medicaid may recover funds paid under these circumstances. Reference: 42 CFR 435.1008.

3 FEE-FOR-SERVICE MEDICAID

Fee-for-Service means services covered directly by Medicaid and not by an Accountable Care Organization (ACO). A fee-for-service Medicaid client is defined as either of the following:

1. The client is not enrolled in an Accountable Care Organization (ACO), or

2. The client is enrolled in an ACO, but the service that is needed is covered by Medicaid, not by the plan. Services not included in the Medicaid contract with an individual ACO are referred to as 'carve-out' services.

Medicaid clients who are not enrolled in an ACO will not have a health plan or a Prepaid Mental Health plan on their Medicaid Identification Card. These clients may receive services from any provider who accepts Medicaid. When the client is enrolled in a health plan, all pharmacy and dental services are paid through Medicaid and not the health plan. The Medicaid Identification Card states "a participating pharmacy" under Pharmacy and "a participating dentist" under Dental. The client must use a participating dentist and pharmacy for **all** related services.

Medicaid Provider Manuals and Information Bulletins
Fee-for-service providers must follow the scope of service, policies, procedures and processes in the Utah Medicaid Program Provider Manual and Medicaid Information Bulletins.

Services covered by Medicaid, instead of the ACO, vary according to the individual contracts with ACOs. For example, some ACOs contracts do not include pharmacy and/or dental services. Medicaid refers to services not covered in a contract with an ACO or Prepaid Mental Health Plan as 'carve out' services.

Fee-For-Service Clients
Fee-for-service clients may receive covered services from any Medicaid provider. The provider must follow Medicaid coverage and prior authorization requirements. The provider submits the claim to and obtains payment from Medicaid. All questions concerning services covered by Medicaid **and not** by the ACO should be directed to Medicaid Information. (Refer to Chapter 12, Medicaid Information.)

Medicaid will not pay for services covered by a plan in which the Medicaid recipient is enrolled. Medicaid will deny payment on a fee for service claim when the service is covered under an ACO. Because information as to what plans the recipient must use is available to providers on the Medicaid Card, electronically through *ACCESSNOW* and the electronic eligibility inquiry and response (270/271 ANSI X12N Version 4010), or by contacting Medicaid Information, a fee for service claim will not be paid even when information was given in error by Medicaid agency staff.

When the Medicaid patient has a Primary Care Provider, this provider must provide an appropriate referral before Medicaid will pay for medical services received from any other provider. Refer to Chapter 6 - 9, Physician Referrals.

4 HEALTH PLANS

The Division of Medicaid and Health Financing (DMHF) contracts with managed care plans to provide either physical or behavioral health care (mental health and substance use disorder) for Medicaid clients. A managed care plan that covers:

- Physical health care is called an Accountable Care Organization (ACO).
- Behavioral health is called a Prepaid Mental Health Plan (PMHP).

DMHF pays a monthly premium for each Medicaid client enrolled in the ACO or PMHP. The managed care plan is responsible for all health care services specified in the contract with DMHF. Each managed care plan is responsible to determine which services require prior authorization and the process for providers to request authorization of services to be given to Medicaid clients enrolled in the plan. Services not included in the DMHF contract with a plan are referred to as 'carve-out' services. DMHF pays providers directly for carved out services.

Accountable Care Organizations
The Division of Medicaid and Health Financing (DMHF) contracts with four ACOs:

- HealthChoice Utah
- Healthy U
- Molina
- SelectHealth Community Care

4 – 1 Client Enrollment in ACO Plans

DMHF requires all Medicaid clients living in Davis, Salt Lake, Utah, and Weber counties to enroll in an ACO physical health plan (PHP). (Healthy U, Molina, Health Choice Utah, or Select Health Community Care). When a person applying for Medicaid is determined eligible, he or she must select an ACO plan. A Health Program Representative (HPR) employed by DMHF explains the health care choices, including mandatory enrollment in a PHP and the exemption policy for clients whose health care needs cannot be adequately met by a PHP. (See Section 4-6 below.) HPRs also help with problems a client may have related to a PHP.

Medicaid fee-for-service will not pay for services provided by a PHP in which the Medicaid client is enrolled. The information about what PHP the client must use is printed on the client's Utah Medicaid Identification Card (Medicaid Card). Be sure to check the individual's current Medicaid Card. Refer to Chapter 5, Verifying Medicaid Eligibility, for information about how to verify a client's enrollment in a PHP.

Medicaid clients who are not enrolled in a PHP and are not in the Restriction Program may receive services from any provider who accepts Medicaid. Refer to Chapter 1-5, Restriction Program, for information about this program.

4 – 2 Mental Health Services

Prepaid Mental Health Plans
Pursuant to state law the Division of Medicaid and Health Financing contracts with local governmental authorities to provide behavioral health services to Medicaid eligible individuals throughout the state.

In most counties of the state, Medicaid covers outpatient and inpatient mental health services ONLY when provided through a Prepaid Mental Health Plan (PMHP). Medicaid clients who live in these counties **must receive all** mental health services from community mental health centers which have contracted with the DMHF as a PMHP. If a client is in foster care, only inpatient mental health services are covered under the PMHP. Children with adoption subsidies may dis-enroll from the PMHP for outpatient mental health services. Like children in foster care, they remain enrolled in the PMHP for inpatient mental health services. Be sure to check the individual's current Medicaid Card. The specific

PMHP's phone number is listed at the bottom of the card. The card also specifies if the individual is enrolled in the PMHP only for inpatient mental health services.

Physicians or psychologists treating individuals who **may become eligible for Medicaid** should contact the appropriate PMHP to ensure payment or arrange for the individual to be transferred to the PMHP for continued services. Even if the individual is not yet enrolled with a PMHP, he or she may be entitled to retroactive Medicaid eligibility and the PMHP contractor will be responsible for services in the prior eligibility period. (See Chapter 1-3, Retroactive Medicaid.)

A list of PMHPs by county and telephone number is provided in the General Attachments section of the Utah Medicaid Provider Manual.

Inpatient psychiatric admissions, in areas outside of the contracted mental health program, require prior authorization through Medicaid. The HCPCS code G0379, direct admission of patient for hospital observation (Psychiatric Inpatient), will be the code used by the nurse to link the hospital psychiatric inpatient acute admission to prior authorization.

4 – 3 Provider Enrollment in a Managed Care Plan

Providers who are participating providers with a health plan and providing services to a Medicaid enrollee must be enrolled as a full or limited Medicaid provider. Participating providers must follow the requirements of that health plan including prior authorization requirements. The provider obtains payment from the managed care plan. All questions concerning services covered by or payment from a health plan must be directed to the appropriate health plan. A list of the Medicaid health plans, including telephone numbers, is included in the General Attachments section of the Utah Medicaid Provider Manual.

4 – 4 Prior Authorization

Each health plan specifies which services require prior authorization (PA) and the process for providers to request authorization of services to be provided to Medicaid clients enrolled in the health plan. When a provider contacts DMHF to request PA for services to a client covered by a health plan, DMHF must refer the provider to the client's plan. DMHF cannot authorize PA requests for services for clients enrolled in a health plan, unless the services are not included under the DMHF contract with the plan.

Because information as to what health plan the client must use is available to providers, the provider must follow the health plan's procedures for authorization and billing in order to receive reimbursement. When the client is enrolled in a health plan, and DMHF staff prior authorizes a service in error, DMHF cannot pay for the service. If the provider fails to follow the health plan's procedures for authorization and billing, the health plan may also refuse to pay for the service.

4 – 5 Chiropractic Health Plan

Chiropractic providers must contact the Chiropractic Health Plan (CHP) directly for details of provider participation, claim submission, payments and requests for prior authorization. All chiropractic services are covered by a capitated reimbursement contract with CHP. Refer to the Chiropractic Medicaid Provider Manual for program-specific information.

4 – 6 Exemption from Mandatory Physical Health Plan (PHP) Enrollment

A Medicaid client may request an exemption from mandatory PHP enrollment by submitting a request to the DMHF Health Plan Exemption Committee through a Health Program Representative (HPR). The request must include documentation showing:

1. The existence or development of a condition which requires critical care from a specialist or a group of specialists not affiliated with any of the PHPs, **and**

2. The PHP has offered no reasonable alternatives

Before the request is considered by the Health Plan Exemption Committee, the HPR will work with the client to find alternatives to exemption.

1. If a client is currently enrolled in a PHP, the client and HPR will attempt to resolve the request through negotiation with the PHP or transfer to another PHP. If a satisfactory solution is not achieved, the request will go to the Health Plan Exemption Committee for review. A decision will be made within 15 calendar days.

2. If the client is not yet enrolled in a PHP, the HPR may delay PHP enrollment for 60 days. During this time, the client and PHP either work out a satisfactory solution or the request will go to the Health Plan Exemption Committee for review and a decision.

The DMHF Health Plan Exemption Committee may approve the request if there is a reasonable expectation that the client's health would suffer without a PHP exemption. The Committee may grant temporary exemptions for up to one year based on the client's individual circumstances.

As a Medicaid provider, you may be asked by a client, who is requesting an exemption, to furnish information concerning his or her medical condition. If you need additional information to help you respond to the client's request, or want a complete copy of the DMHF's Health Plan Exemption policy and process, call Medicaid Information (Chapter 12, Medicaid Information) and ask for the DMHF Health Plan Quality Assurance Coordinator.

4 – 7 Emergency Services for Clients in an ACO or PMHP

PHPs and PMHPs are responsible for covering all emergency services for enrollees, regardless of where the emergency occurred and was treated. An emergency is any covered service immediately required, due to an unforeseen illness or condition, to avoid endangering the individual or others if immediate treatment were to be postponed. Federal regulations (42 CFR §447.53(b)(4)) state that emergency services are services provided in a hospital, clinic, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that the absence of immediate medical attention could reasonably be expected to result in one of these three conditions:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Providers who render emergency care to a patient enrolled in a PHP or PMHP must obtain payment from the PHP or the PMHP.

The emergency room facility charge is not covered under the PMHP and should be billed to the PHP listed on the Medicaid Card. If none is listed, send the bill to DMHF as a fee-for-service billing.

4 – 8 Complaints and Grievances

Complaints and grievances concerning a PMHP, Healthy U, Molina, Health Choice Utah or Select Health Community Care from either a client or a provider must first go through the appropriate health plan's complaint process. If a client or provider wants to appeal an action taken by a health plan, he or she must first submit the appeal request to the health plan. If the health plan's appeal decision is adverse, the client or provider may then contact DMHF and request a hearing.

4 - 9 Changing Enrollment in an ACO

DMHF has a limited dis-enrollment process for changing PHP enrollment. Clients are allowed to dis-enroll/switch PHPs "with cause." They will work with the Health Program Representative (HPR) for any changes. Once per year, DMHF has an open plan change period during which the client can change to a new PHP effective July 1st of the year.

A client who wants to change the PHP selection should contact their HPR; call Medicaid Information (Chapter 12) for the telephone number for the HPR or call 1(866) 608-9422.

5 VERIFYING MEDICAID ELIGIBILITY

A Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient's eligibility EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in an ACO, Emergency Services or the Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or coinsurance. Eligibility and health plan enrollment may change from month to month. The information needed is printed on the client's Medicaid Identification Card or the Interim Verification of Eligibility (Form 695). The provider may wish to copy the card to substantiate the Medicaid claim.

Information is also available through **electronic eligibility inquiry and response (270/271 ANSI X12N)**, **ACCESSNOW** and **Medicaid Information**. (Refer to Chapter 12, Medicaid Information.) Explanation of the information required for Medicaid and how to access that information is given in the sub-chapters which follow.

NOTE 1: Medicaid staff makes every effort to provide complete and accurate information on all inquiries. However, federal regulations do not allow a claim to be paid even if the information given to a provider by Medicaid staff was incorrect.

NOTE 2: Temporary Proof of Eligibility. When a temporary proof of eligibility expires, Medicaid will no longer pay claims, unless the client has since been issued a Medicaid Identification Card for the month of service. Two temporary proofs of eligibility are the Baby Your Baby Card and the Interim Verification of Eligibility (Form 695).

- When a client's Medicaid Identification number ends with the letter 'V', the client is eligible ONLY for the Baby Your Baby Program. ALWAYS require the Baby Your Baby Card and check the dates of eligibility. Refer to Chapter 13 - 1, Presumptive Eligibility Program (Baby Your Baby).
- When a client's Medicaid Identification number ends with the letter 'X', the client has an Interim Verification of Eligibility (Form 695). Refer to Chapter 5 - 2, Interim Verification of Medicaid Eligibility (Form 695).

5 - 1 Medicaid Identification Card

Each family or individual eligible for Medicaid receives a Medicaid Identification Card each month. The card is typically received on the first of the month. It lists the following information:

- the month of eligibility
- any limitation of benefits, such as Emergency Services Only
- the name of each eligible individual
- the individual's ten digit Medicaid Identification number
- the individual's sex, date of birth and age
- enrollment in an ACO or selection of a Primary Care Provider
- co-payment or co-insurance owed, if any
- the designated Prepaid Mental Health Plan
- the designated dental provider
- the designated pharmacy provider and
- third party liability coverage

Examples of Medicaid Identification Cards and verifications for other medical assistance programs administered by the Department of Health are included in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

5 - 2 Interim Verification of Medicaid Eligibility (Form 695)

Instead of a Medicaid Card, a patient may have an "Interim Verification of Medical Eligibility" (Form 695). This temporary proof of eligibility should contain the same information as the Medicaid Card, except that it will have an expiration date. The eligibility worker issues the Interim Verification form when a client needs proof of eligibility and does not yet have the Medicaid Card. If the client has never been assigned a Medicaid Identification Number, the number on the Form 695 is nine digits followed by the letter **X**. As soon as the client has been assigned a 10 digit Medicaid Identification Number, providers must use the permanent identification number to bill for services, rather than the temporary number ending with the letter X.

When a temporary proof of eligibility expires, Medicaid will no longer pay claims, unless the client has since been issued a Medicaid Identification Card for the month of service.

5 - 3 Medicaid Information System: ACCESSNOW

ACCESSNOW, a touch tone telephone eligibility line, is available to providers at no cost. For information on **ACCESSNOW**, refer to Chapter 12, Medicaid Information.

5 - 4 Pharmacy Point of Sale System

The Point of Sale (POS) system provides pharmacists with the capability to submit pharmacy claims electronically. It allows pharmacies to immediately determine Medicaid client eligibility, verify drug coverage, and have "real time" claims processing. For information about the Point of Sale system, refer to SECTION 2, PHARMACY SERVICES.

5 - 5 Third Party Liability (TPL)

The Medicaid Card lists any third party liable for any type of health care services for the patient. If a patient has Third Party Liability (TPL), the name, policy number and group number are listed on the Medicaid Card below the patient's name. Note that some members of a family may have third party coverage, while others have no coverage or different coverage.

If TPL information is incorrect, advise the patient to call the TPL unit in the Office of Recovery Services at the Department of Human Services. This information is printed on the bottom of the Medicaid Card. Providers may also call the TPL unit about incorrect information. TPL information is corrected by the Office of Recovery Services:

In the Salt Lake area, call..... **801-536-8798**

The toll-free number in Utah is **1-800-821-2237**

Outside Utah, the toll-free number is **1-800-257-9156**

The provider must explore payment from all other liable parties such as insurance coverage, including a health plan, before seeking Medicaid payment. Refer to Chapter 11 - 4, Billing Third Parties, for information on billing the TPL.

5 - 6 Ancillary Providers

Providers who accept a patient covered by Medicaid are asked to ensure that any ancillary services provided to the patient are delivered by a participating Medicaid provider. This includes lab, x-ray, and anesthesiology services. Please give **all** ancillary providers a copy of the patient's Medicaid Identification Card or, at minimum, the patient's Medicaid Identification number. In addition, when the service requires prior authorization (PA) and a PA number is obtained from Medicaid, please give that PA number to any other provider rendering service to the patient. This will assist other providers who may be required to submit the prior authorization number when billing Medicaid.

5 - 7 Health Care Patient Identity Protection

A provider should ask patients for identification, such as picture identification, to assure the individual presenting the card is the same person on the Medicaid Identification Card. Medicaid is a benefit only to eligible persons. Possession of a Medicaid card does not ensure the person presenting the card is eligible for Medicaid. (Utah Code Annotated, Title 26, Chapter 21, Part 25)

6 PROVIDER ENROLLMENT AND COMPLIANCE

This chapter lists general requirements which must be met in order for any provider to participate in the Medicaid Program. SECTION 2 of this manual contains additional requirements for each specific provider type. Medicaid can reimburse a provider who meets all three of the following conditions:

1. Meets all of the credential requirements as listed for each provider type,
2. Completes the Utah Medicaid Provider application and signs the Utah Medicaid Provider agreement, and
3. Receives notice from the Utah Medicaid Program that the credentials have been met and the provider agreement accepted.

Note: Please keep Medicaid informed of any address changes. Returned mail could result in your provider contract being closed. Medicaid may close providers who are inactive for one or more years without notification.

6 - 1 Provider Agreement

A provider enrolls as a Medicaid Provider by completing the Medicaid Provider Application and signing the Provider Agreement. A provider must execute the Agreement before he/she is authorized to furnish Medicaid services. When the State accepts the provider's application and the agreement are signed, the State will notify the provider by approval letter with effective date of enrollment.

The following provisions are part of every Provider Agreement, whether included verbatim or specifically incorporated by reference:

1. The provider agrees to comply with all laws, rules, and regulations governing the Medicaid Program.

2. The provider agrees that the submittal of any claim by or on behalf of the provider will constitute a certification (whether or not such certification is reproduced on the claim form) that:

   A. The medical services for which payment is claimed were furnished in accordance with the requirements of Medicaid;

   B. The medical services for which payment is claimed were actually furnished to the person identified as the patient at the time and in the manner stated;

   C. The payment claimed does not exceed the provider's usual and customary charges or the maximum amount negotiated under applicable regulations of the Division of Medicaid and Health Financing; and

   D. The information submitted in, with, or in support of the claim is true, accurate, and complete.

6 - 2 Ineligibility of Provider

The Division of Medicaid and Health Financing may refuse to grant provider privileges to anyone who has been convicted of a criminal offense relating to that person's involvement in any program established under Titles XVIII, XIX, XXI or XX of the Social Security Act, or of a crime of such nature that, in the judgment of the Department, the participation of such provider would compromise the integrity of the Medicaid Program or puts the client at risk. The Division may terminate any provider from further participation in Medicaid if the provider fails to satisfy all applicable criteria for eligibility.

6 - 3 Title XIX of the Social Security Act

While enrolled as a Medicaid Provider, a provider must comply with the provisions of Title XIX of the Social Security Act and all applicable State and Federal regulations and standards listed in this chapter.

6 - 4 Civil Rights Compliance; Discrimination Prohibited: Provider Self-Limits on Accepting Medicaid Clients *(Updated 1/1/14)*

When providing medical assistance under programs administered by the Utah State Department of Health, a provider must agree to provide services in accordance with Title VI of the Civil Rights Act as well as other federal provisions which prohibit discrimination against any employee or applicant for employment based upon race, age, color, sex, creed, national origin or disability. Other civil rights laws include Section 504 of the Rehabilitation Act, as amended; the Age Discrimination Act of 1975, as amended; the Americans with Disabilities Act of 1990, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. Restrictions to individual patient care, based upon the limits placed upon provider practice by specialty, and because of medically related determinations made within the scope of practice, do not constitute violation of the Civil Rights Act provisions.

A Utah Medicaid provider is under no obligation to accept all Medicaid recipients who seek care, and may limit the number of recipients 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 clients. Some

grounds for denying or dismissing Medicaid claims include: limiting the number or percentage of Medicaid clients, 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.

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that there is no discrimination in CMS programs, including Medicaid and the Children's Health Insurance Program. All beneficiaries shall have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability. The regular program review and audit activities will include: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing CMS publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office of Civil Rights, to initiate orientation and training programs on civil rights. Financial resources will also be allocated to the extent feasible to ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

DHHS seeks voluntary compliance to resolve issues of discrimination whenever possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. To enforce civil rights laws, the Office for Civil Rights may (1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or (2) refer the matter to the Department of Justice for legal action.

6 - 5 Liable Third Parties

A liable third party is any person or entity such as health insurance, a health plan, or Medicare, which may be responsible for services rendered to a Medicaid patient. This information is available from Medicaid and is printed on the Medicaid Identification Card. Refer to Chapter 5 - 5, Third Party Liability.

1. Medicaid and Other Third Party Coverage: Accepting Patients with Dual Coverage

When a Medicaid client also has some other third party insurance, a provider may either accept the patient as having dual coverage OR not accept either type of coverage. Federal Medicaid regulations do not permit a provider to reject Medicaid and accept only the other third party coverage. A provider can only refuse Medicaid and insist the client must be "private pay" IF there's no other third party coverage. Of course, the Medicaid agency urges that providers accept the client as a Medicaid client, then follow the procedures outlined in the Utah Medicaid Provider Manual for billing TPL. Refer to SECTION 1, Chapter 11, Billing Claims.

Reference: 42 CFR 447.20 (b)

2. Correcting Third Party Information

If information about the responsible third party appears to be incorrect (for example, the TPL denies a claim as "patient not eligible"), the provider should advise the patient to call the TPL unit in the Office of Recovery Services at the Department of Human Services. Providers may also call the Office of Recovery Services to advise them of correct third party liability information. The telephone number is printed on the bottom of the Medicaid Card and also listed in Chapter 5 - 5, Third Party Liability. Refer to Chapter 11 - 4, Billing Third Parties, for information on billing TPL

and coordination with Medicaid.

6 – 6 Billing Medicaid

The provider may bill Medicaid only for services which were medically indicated and necessary for the patient and either personally rendered by him/her or rendered incident to his/her professional service by an employee under immediate personal supervision, except as otherwise expressly permitted by Medicaid regulations. The billed charge may not exceed the usual and customary rate billed to the general public, such as individual patient accounts or third party payer accounts.

As indicated on the *CPT List of Medical and Surgical Procedures*, codes requiring manual review require submission of medical record documentation for staff review. When the exception code (error message on the remittance advice statement), stating documentation required, is reported, the provider should submit the medical record documentation to Medicaid Operations. In cases where the service has been denied after manual review, the remittance advice indicates manually reviewed and denied. This is the point in the process when the provider may consider submitting a request for a hearing.

Unlisted procedures require manual review and often manual pricing. Refer to Section 9 - 1 of this manual.

6 - 7 Medicaid as Payment in Full; Billing Patients Prohibited

A provider who accepts a patient as a Medicaid or Baby Your Baby patient must accept the Medicaid or state payment as reimbursement in full. A provider who accepts a patient enrolled by Medicaid in an ACO must accept the payment from the plan as reimbursement in full. If a patient has both Medicaid and coverage with a responsible third party, do not collect any co-payment usually charged at the time of service. The provider may NOT bill the patient for services covered by either of these programs or an ACO. The payment includes any deductible, coinsurance or co-payments required by any other third party, such as insurance or Medicare. Medicaid claim forms and the completion of the claim forms are considered part of the services provided and cannot be charged to Medicaid patients.

The only exceptions to the general rule of accepting the Medicaid payment as reimbursement in full are in Chapter 6-8, Exceptions to Prohibition on Billing Patients. Providers must follow policies and procedures concerning, but not limited to: medical services covered; medical service limitations; medical services not covered; obtaining prior authorization; claim submission; reimbursement; and provider compliance, as set forth in the Medicaid Manuals, Medicaid Information Bulletins, and letters to providers. If a provider does not follow the policies and procedures, the provider may not seek payment from the patient for services not reimbursed by Medicaid. This includes services that may have been covered if the provider had requested and obtained prior authorization.

A provider who fails to follow Medicaid policy and is not reimbursed for services rendered may NOT subsequently bill the Medicaid patient. For example, if the provider submits a request for prior authorization, and the request is denied pending additional documentation, the provider must submit the documentation and obtain authorization, rather than billing the patient for services rendered.

Providers who serve people with a Qualified Medicare Beneficiary Identification (QMB) Card must accept the Medicare payment and the Medicaid payment, if any, for coinsurance and deductible as payment in full. Providers may not bill patients eligible for the Qualified Medicare Beneficiary Program for any balance remaining after the Medicare payment and the QMB coinsurance and deductible payment from Medicaid. (Federal reference: 42 CFR 447.15)

Exception: Effective July 1, 2002, providers who serve Primary Care Network patients may bill patients for non-covered services set forth in the Primary Care Network Manuals, Primary Care Network Information Bulletins, and letters to providers. A written agreement upon time of service is recommended, but not required.

6 - 8 Exceptions to Prohibition on Billing Patients

The four circumstances explained in this chapter, items 1 through 4, are the ONLY circumstances in which a provider may bill a Medicaid patient. They are non-covered services, spend down medical claims listed on the back of the Medicaid Identification Card; Medicaid co-payments and co-insurance; and broken appointments. The specific policy in each item must be followed before the Medicaid patient can be billed.

1. Non-Covered Services

A non-covered service is a service not covered by a third party, including Medicaid. Since the service is not covered, any provider may bill a Medicaid patient when **four conditions are met:**

A. The provider has an established policy for billing all patients for services not covered by a third party. (The charge cannot be billed only to Medicaid patients.)

B. The patient is advised **prior to receiving** a non-covered service that Medicaid will not pay for the service.

C. The patient agrees to be personally responsible for the payment.

D. The agreement is made in writing between the provider and the patient which details the service and the amount to be paid by the patient.

Unless all conditions are met, the provider may not bill the patient for the non-covered service, even if the provider chooses not to bill Medicaid. Further, the patient's Medicaid Identification Card may not be held by the provider as guarantee of payment by the patient, nor may any other restrictions be placed upon the patient.

2. Client Responsibility Notification Attached to Medicaid Identification Card

The patient's Medicaid Identification Card has the message, "This medical card includes a client responsibility notification" printed in the special instructions. An example of the card is included with the Medicaid Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual. When you see this message, look at the back of the medical card for additional information.

Any provider, whose service is listed under the Client Responsibility Notification section of the card, should collect from the patient the amount the patient is responsible to pay. Information includes the provider's name, date of service, type of service, the total bill for that service, and the recipient's financial obligation, as determined by the eligibility worker at the time the form was issued. Collect from or bill the patient for the amount indicated.

Bill Medicaid the full charge for the service. Do NOT bill a partial charge to Medicaid. If the recipient owes you the full amount of the charge, you may choose not to bill Medicaid.

When your claim is received, Medicaid bases the reimbursement amount on the amount you billed, or the standard reimbursement amount, whichever is less. (This is why a provider should not bill a partial charge. A partial charge might be less than the Medicaid reimbursement amount.) Medicaid deducts the client's obligation from the Medicaid reimbursement amount. The remainder is paid to the provider. When the client's obligation to pay is equal to or more than the Medicaid reimbursement amount, the Medicaid payment will be zero.

For more information on this financial obligation, refer to Chapter 1 - 1, Applying for Medicaid, subsection titled Medicaid Medically Needy Program (Spend down).

3. Medicaid Co-payments, Co-insurance

Many adult Medicaid clients are required to make a co-payment or co-insurance for the types of services listed below. Co-pay refers to either a co-payment or co-insurance. The effective date of the requirement is in parentheses below: pharmacy (July 1, 1997), non-emergency use of a hospital emergency department (January 14, 1994), office visits performed by a physician or podiatrist and for outpatient hospital services (November 1, 2001), rural health clinic services (April 1, 2002), inpatient hospital services (January 1, 2002).

Both health plan and fee-for-service clients can have a patient responsibility. The client's Medicaid Identification Card will state when a co-pay is required. The provider is responsible to collect the co-pay at the time of service or bill the client. The amount of the client's co-pay will automatically be deducted from the claim reimbursement.

Co-Pay Message on Medicaid Card, by Client

The Medicaid Card will have a code under the Co-Pay column by the individual client's name if he or she has a co-pay. View the definition of the codes under the section titled, Co-Pay codes on the medical card. The definition will say what type of co-pay to collect.

NAME Smith, John Q Copay/co-ins for: non-emergency use of the ER, output hosp & physician svcs, pharmacy, inpat hosp

The co-pay message may vary by client and whether the client is in a health plan or is fee-for-service. If there is no co-pay code by a client's name, the client does not have a co-pay. A family may contain an adult with a co-pay and children who are exempt. So you must verify whether the individual patient has a co-pay for the type of service.

No Co-pay for Exempt Services

Some services are exempt from co-pay. It does not matter whether the client has a co-pay or not. Do not collect a co-pay for the following types of service:

1. Family planning services have NO co-pay.
2. Emergency services in a hospital emergency department have NO co-pay. However, non-emergency use of a hospital emergency department may require a co-pay. Refer to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 2 - 1, Co-payment Requirement: Outpatient Hospital and Non-emergency Use of a Hospital Emergency Department.

3. Lab and X-ray services, including both technical and professional components, have NO co-pay.
4. Anesthesia services have NO co-pay.

Collecting a Co-pay

Before you collect a co-pay, be sure the client has a co-pay and that the service requires a co-pay. For more information on the co-pay requirement for specific types of services, refer to SECTION 2 of the appropriate Utah Medicaid Provider Manual:

- Physician Services, Chapter 1 - 5
- Podiatry Services, Chapter 1 - 3
- Hospital Services, Chapter 2 - 1
- Pharmacy Services, Chapter 1 - 8
- Rural Health Clinic Services, Chapter 1 - 5

Please give the client a receipt for the co-pay collected. We will urge clients to keep co-pay receipts in case of delayed billings by providers or discrepancies. If you do not collect a co-pay owed at the time of service, you may bill the client for the amount that should have been paid.

Clients Exempt from Co-pay

- The Medicaid Card states whether an individual client has a co-pay. A client in one of the following groups does not have a co-pay.
- Child under age 18.
- Pregnant woman.
- Total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy
- Families (TANF) standard payment allowance, as determined by an eligibility worker.
- Resident of a nursing home.
- QMB ONLY [Qualified Medicare Benefits]
- Medicaid/QMB clients, except for pharmacy services and non-emergency use of the emergency
- Room as stated on the Medicaid ID Card. 18.
- Co-payment maximum out-of-pocket has been met.

Pregnant Women Exempt from Co-Pay

Do not require a co-pay for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the eligibility worker, who can change her co-pay status to exempt on future Medicaid Cards.

Co-pay Maximums Per Client

There is no maximum on co-pays for non-emergency use of the Emergency Department. Other co-pays and co-insurance have a maximum out-of-pocket per client, per type of service. When a client meets the maximum out-of-pocket payment for a type of service, as determined by Medicaid billing information, the following month the co-pay message will change. For example, a client may meet the maximums for physician and inpatient hospital services and continue to have a co-pay for pharmacy and non-emergency use of the Emergency Department.

4. Broken appointments

A broken appointment is not a service covered by Medicaid. Since the charge is not covered, any provider may bill a Medicaid patient when **three conditions are met**:

A. The provider has an established policy for acceptable cancellations. For example, the patient may cancel 24 hours before the appointment.

B. The patient has signed a statement agreeing to pay for broken appointments.

C. The provider charges all patients in the practice for broken appointments. The charge cannot be billed only to Medicaid patients.

6 - 9 Physician Referrals

Only a Medicaid client's Primary Care Provider can provide a referral to a consulting physician. The Primary Care Provider Physician may make any referral in writing or verbally. However, the patient's medical record must indicate that a referral or consultation was requested.

The consulting physician is responsible for sending the Primary Care Physician a letter describing the consult findings and a summary of the recommendations.

Physicians who make referrals to another provider should consider that Medicaid limits medical transportation to the nearest provider or the nearest appropriate facility which can provide the needed services. Therefore, if the client does not have his or her own transportation, and must use medical transportation covered by Medicaid, the referral must be to the nearest provider or the nearest appropriate facility which can provide the needed services. This limitation includes all medical transportation, in both emergency and non-emergency situations.

Documenting the Referral

Both the referring physician and the servicing provider are responsible for documenting that the Primary Care Physician authorized the referral. When Medicaid conducts a post-payment review, ALL of the following information must be entered in the patient's records to document the referral:

- the date the Primary Care Physician contacted the servicing provider
- Primary Care Physician's name
- Primary Care Physician's number in the format as specified in rule 590-164 on file with the Insurance Commission;
- patient's name;
- patient's Medicaid Identification Number;
- patient's date of birth; AND
- any clinical information that is pertinent to the referral, including a CHEC Well Child follow-up.

Billing claims based on a referral
Follow the CMS-1500 (08/05) instructions for entering the referring provider's number on the claim form. If it is a CHEC Well Child follow-up referral, enter TS in the modifier field.

Follow the Implementation Guides for entering the referring provider's identifier/number on the electronic claim. If the visit is a CHEC Well Child follow-up referral, enter TS in the modifier field.

6 - 10 Physician Ownership and Prohibition of Referrals

A physician or immediate family member of the physician who has a financial interest in a health service should be aware of Federal regulations in Section 13562 of the Omnibus Reconciliation Act (OBRA) of 1993. A physician with a financial interest in a health service may not make a referral to that service when payment would be made as a result. The health service may not send a bill to an individual nor file a claim with a third party for services provided as a result of such a referral.

A financial interest may be through ownership, or through a direct investment interest (such as holding equity or debt), or through another investment which has ownership or an investment interest in the health service.

6 – 11 Ensure All Medically Necessary Services and Medicaid Coverage

A Medicaid provider who accepts a Medicaid client for treatment accepts the responsibility to make sure the client receives all medically necessary services. A provider's responsibilities include making referrals to other Medicaid providers; ensuring ancillary services are also delivered by a Medicaid provider; and ensuring the client receives all medically necessary services at no cost.

A. **Quality of Care** A provider who accepts a Medicaid patient for treatment accepts the responsibility to make sure that the patient receives **all** medically necessary services from enrolled Medicaid practitioners who meet all requirements of the Utah Medicaid program, who agree to abide by Medicaid rules to provide medically necessary services, and who accept the Medicaid reimbursement as payment in full. This includes physicians, surgeons, anesthesiologists, laboratory, X-ray, pharmacy, rehab and other providers on staff.

B. **Appropriate Referrals** When the Medicaid patient has a Primary Care Provider, the provider must provide an appropriate referral before Medicaid will pay for medical services received from any other provider. The other provider must be a Medicaid provider as well. Refer to Chapter 6 - 9, Physician Referrals.

C. **Ancillary Services by Participating Provider.** Make sure ancillary services, such as lab, x-ray, and anesthesiology, are delivered by a participating Medicaid provider. Please give **all** ancillary providers a copy of the patient's Medicaid Identification Card or, at minimum, the patient's Medicaid Identification number. In addition, when the service requires Prior Authorization (PA) and a PA number is obtained from Medicaid, please give that number to other providers rendering service to the patient. This will assist other providers who may be required to submit the prior authorization number when billing Medicaid.

6 - 12 Medical Interpretive Services *(Updated 1/1/14)*

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 clients who have limited English proficiency (LEP). Clients are entitled to an interpreter to assist in making appointments

for qualified procedures and during visits. Providers must notify clients that interpretive services are available at no cost.

Payment for interpretative services will only be made if there is a paid corresponding claim from a Medicaid provider for a Medicaid covered service(s).

LEP clients 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 client 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 clients and/or patients will not be used to interpret, in order to ensure confidentiality of personal health information (PHI).

Clients with Dual Eligibility

If the client 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.

Client Enrolled in an Accountable Care Organization (ACO)

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 1-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.

Fee-for-Service Clients

Medicaid will cover the cost of an interpreter when three conditions are met.

1. Client is eligible for a federal or state medical assistance program. Programs include Medicaid, CHIP, and services authorized on a State Medical Services Reimbursement Agreement Form (MI706).
2. Client is fee-for-service, as defined in SECTION 1, Chapter 3.
3. The health care service needed is covered by the medical program for which the client is eligible. Services covered by Medicaid are listed in SECTION 1, Chapter 2, COVERED SERVICES.

When the three conditions of coverage are not met, the provider may be responsible for the cost of interpretive services. The provider may NOT bill the client for the service except under the conditions stated in SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients.

How to Obtain an Interpreter

Medicaid offers a "Guide to Medical Interpretive Services." The guide lists client eligibility requirements, contractors, languages offered, and information required from the provider. The guide is in the GENERAL ATTACHMENTS Section of this Provider Manual and also available on the Medicaid web site. Look for the link on the Provider Guide at: http://health.utah.gov/medicaid/provhtml/provider.html.

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

6 - 13 Recovery of Payments for Non-Covered Services

When Medicaid pays for a service which is later determined not to be a benefit of the Utah Medicaid Program or not in compliance with State or Federal policies and regulations, Medicaid will make a written request for a refund of the payment. The refund must be made to Medicaid within 30 days of written notification. An appeal of this determination must be filed within 30 days of written notification.

6 - 14 Other Recovery of Payments

When services for which the Medicaid Program provided reimbursement cannot be verified by adequate records as having been furnished, or when a provider unreasonably refuses to provide or grant access to records as described above, either the provider must promptly refund to the State any payments received by the provider for such undocumented services, or the State may elect to deduct an equal amount from future reimbursements.

6 - 15 Administrative Review/Fair Hearing

A provider or client may request a state fair hearing in order to dispute an action taken by the DMHF, in accordance with Utah Code Annotated § 63G-4-201 and Utah Administrative Code R410-14-3(1). Actions taken that may be appealed include:

- Denial of a prior authorization request;
- Claim not paid, as indicated by an explanation of benefits or other remittance document issued by Medicaid;
- Denial of manual review request.

Providers and clients wishing to dispute the decision of an Accountable Care Organization (ACO) must complete the ACO's appeal process before requesting a hearing with DMHF.

A hearing is requested by sending a completed hearing request form to the Office of Formal Hearings. The form must be faxed or postmarked within 30 calendar days from the date DMHF sends written notice of its intended action, unless a different time period is indicated on the denial document. Failure to submit a timely request for a hearing constitutes a waiver of the due process right to a hearing.

A Request for Hearing/Agency Action form is available on the Utah Medicaid website at: http://health.utah.gov/medicaid/pdfs/Forms/HearingRequest2010.pdf, or a copy may be requested from the Hearing Office by calling (801) 538-6576. The form must be filled out and mailed to:

DIVISION OF MEDICAID AND HEALTH FINANCING
DIRECTOR'S OFFICE/FORMAL HEARINGS
BOX 143105
SALT LAKE CITY UT 84114-3105

or use FAX number: (801) 536-0143

The agency is not required to grant a hearing if the sole issue is a Federal or State law requiring an automatic change.

6 - 16 Suspension or Termination from Medicaid

The Department may suspend or terminate from Medicaid participation any medical practitioner or other health care professional licensed under state law who is convicted of Medicaid or Medicare related crime(s) in either a federal or state court.

When a practitioner or other health care professional is convicted and sentenced in a state court of Medicaid-related crime(s), the Department shall promptly notify the Department of Health and Human Services, Regional Sanctions Coordinator, and provide the following information within 15 days after sentencing:

A. name and address of the practitioner;
B. date of conviction;
C. statute(s) violated and number of counts;
D. a copy of the indictment; a copy of the plea agreement (if applicable) and the judgment, conviction, or probation order;
E. current address of the practitioner (if the practitioner is incarcerated, provide the name and address of the penal institution); and
F. name and address of the Director of the State local licensing authority.

The Department may request a waiver of suspension or termination if the sanction is expected to have a substantial negative impact on the availability of medical care in the community or area. The waiver request should contain a brief statement outlining the problem, and be submitted to the Centers for Medicare & Medicaid Services (CMS). CMS will notify the Department if and when it waives the sanction. Waivers should only occur if:

A. the Secretary of the Department of Health and Human Services has designated a health manpower shortage area; and
B. an insufficient number of National Health Services Corps personnel has been assigned to the needs of that area.

6 - 17 Medicaid Audits and Investigations

The following is intended as a useful guide regarding Medicaid audit procedures conducted by the Utah Office of the Attorney General Medicaid Fraud Unit and should not be construed to create any independent rights, duties, or requirements and should not be considered as legally binding upon the State, its agents, or employees. This information is not intended as legal advice. You are encouraged to consult a licensed attorney if you have any questions regarding Medicaid audits or investigations.

I. Definitions

1. **Medicaid Audit**: A civil or administrative process of reviewing Medicaid provider records to ensure accurate billing and payment for Medicaid claims.

2. **Investigation**: An official inquiry conducted by law enforcement officers of the Utah Office of the Attorney General Medicaid Fraud Unit, to prove or disprove evidence of criminal conduct. An investigation may begin by auditing provider records.

3. **Audit Settlement**: An agreement to resolve a civil financial Medicaid overpayment dispute when criminal charges are not currently filed.

4. **Plea Agreement**: An agreement made between a prosecutor to resolve pending criminal charges against a Medicaid provider.

5. **Medicaid Fraud Control Unit** (MFCU), formerly Medicaid Fraud Unit (MFU): The official state Medicaid fraud control unit in the Office of the Attorney General, certified by the federal government, to investigate and prosecute complaints of abuse and neglect of patients, and Medicaid fraud under state laws as required by 42 CFR §§ 1007.7 through 1007.13. The MFCU has state-wide prosecutorial authority.

6. **Search Warrant**: An order signed by a judge and served by a law enforcement officer, which identifies a specific location, items, or person to be searched based upon a judicial finding that probable cause exists to believe that the property or evidence was unlawfully acquired or possessed, used to commit or conceal the commission of a crime, or is evidence of illegal conduct. See Utah Code §§ 77-23-201 and -202. Search warrants are also governed by the Fourth Amendment of the United States Constitution and article I, section 14 of the Utah Constitution.

7. **Criminal Subpoena**: An order signed by a judge obtained pursuant to a pending criminal investigation filed with the court as required by Utah Code § 77-22-2, which requests the named witnesses testimony or documents possessed by the person upon whom the subpoena is served (Subpoena Duces Tecum). A criminal subpoena is not a search warrant and does not provide authority for the serving office to enter a premise or inspect or seize property or persons.

8. **Medicaid Provider Agreement**: A signed contract between a provider and the Utah Medicaid program by which the provider agrees to abide by all state and federal law related to the Medicaid Program, including providing medical and billing records for the purposes of conducting Medicaid and MFCU audits to determine fraud or abuse of the Medicaid program. Through this agreement, the provider also agrees to abide by any subsequent amendments to the Agreement published in the Medicaid Provider Bulletin. This agreement, together with the recipient's Medicaid application, authorizes the release of Medicaid records for Medicaid and MFCU auditing purposes (See attached provider agreement and Medicaid application).

9. **CFR**: Code of Federal Regulations - Federal executive agencies rules, in this context, promulgated by the Centers for Medicare & Medicaid Services [formerly Health Care Financing Administration (HCFA)] which place requirements upon the state Medicaid agency, Medicaid providers, and recipients.

10. **Medicaid Fraud**: Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive some unauthorized Medicaid benefit for any person or entity. See Utah Code Ann. §§ 26-20-1, et seq.; Utah Administrative Rules, R414-22; and 42 C.F.R. § 455.2. Medicaid fraud violations may also be brought under more general state and federal theft and fraud statutes.

11. **Abuse**: Provider practices that are inconsistent with sound fiscal, business, or medical practices resulting in unnecessary Medicaid costs. Reimbursement for services that are not medically necessary, fail to meet professionally recognized standards of care, or any practice that results in increased costs to Medicaid are also considered abuse. Criminal intent need not be alleged or proved to establish abuse. See 42 C.F.R. § 455.2.

12. **Overpayment**: In this context, when a Medicaid provider receives more Medicaid reimbursement than the provider is entitled, regardless what party is at fault.

II. Audits and Criminal Investigations

1. **Identification of Possible Overpayment**: MFCU and the Medicaid Agency identify providers to be audited or investigated through reviews of claims and billing information and referrals and reports from a multitude of sources. Refer to the chart titled "Medicaid Investigations" in the GENERAL ATTACHMENTS Section of this manual.

2. **Initial Review/preliminary investigation**: When MFCU and Medicaid receive information of a possible overpayment, they conduct an initial review. This review may take the form of a civil audit or immediately begin as a criminal investigation.

   A. Medicaid Review: The Medicaid agency performs audits to verify whether an overpayment was made to a provider. This process is always an administrative civil function.
   B. MFCU Review: All MFCU reviews of overpayments are considered part of the criminal investigation process, even at the audit stage. The mere fact that an audit is being performed by MFCU, however, does not suggest that evidence of criminal wrongdoing exists. The audit may tend to prove or disprove potential fraud allegations.

3. **Results of Initial Review/preliminary investigation**:

   A. Medicaid Results: If the preliminary investigation reveals abuse, a full investigation will be conducted if necessary to fully substantiate the extent of the abuse. Medicaid will then proceed through an administrative hearing process to collect the overpayment. However, the matter is referred to MFCU if evidence of fraud is discovered.
   B. MFCU Results: If the initial review indicates substantial potential for criminal prosecution, a criminal investigation will be conducted by MFCU. If the initial review does not substantiate criminal conduct, the matter may be referred to the state Medicaid agency for collection or other action. However, MFCU is authorized to attempt to collect any identified overpayment even in the absence of criminal conduct, but must send claims to the Medicaid Agency if they are unsuccessful in their civil collection efforts (See 42 CFR § 1007.11).

4. **Privacy Rights**: Medicaid and MFCU must safeguard the privacy rights of providers and Medicaid recipients during all aspects of an initial review, audit, and criminal investigation (See 42 CFR § 1007.11(f)).

III. **Obtaining Provider Medicaid Records**:

1. **The Ways to Obtain Records**:
   A. The MFCU may lawfully obtain Medicaid provider records by:
      1. Requesting records for investigative purposes as authorized by the provider agreement and recipient application;
      2. Serving a criminal subpoena upon the provider; and
      3. Serving a search warrant.

   B. Medicaid obtains records through the provider agreement or administrative subpoena.

2. **Access through Medicaid Provider Agreement:** Both Medicaid and MFCU can obtain access to Medicaid medical and billing records as authorized by the Provider Agreement and recipient application. The Medicaid Provider agreement requires a provider to allow access to, or copies of, medical and billing records for at least five years. Providers must allow access, during normal business hours, within 24-hours when "immediate access" is requested by Medicaid or MFCU.[1] Failure to provide records under the Provider Agreement can result in penalties, including exclusion from the Medicaid program. Medicaid and MFCU should give providers a reasonable time period in which to provide access to the records when "immediate access" is not requested. When appropriate, providers will be contacted in writing or by telephone call to give advance notice of records request. Records access sought under the Provider Agreement, rather than through judicial subpoenas and search warrants, is considered the least intrusive means of obtaining records. A provider need not turn over original records, but must allow inspection of the originals or copies to be made. A provider or an employee of a provider may be asked questions, as consented to by the provider or employee, regarding the records and billing practices of a provider. However, the provider and the employee have the right to remain silent if what they say may implicate them in criminal conduct.

3. **Criminal Subpoenas:** Criminal subpoenas are governed by Utah Code § 77-22-1 through 5. Before a law enforcement officer can obtain a criminal subpoena, a criminal investigation case must be opened with, and approved by, a state district court after a showing of "good cause." A prosecutor must apply to the district court for each subpoena prior to it being served.

   A. **Contents of Subpoenas:** The prosecutor must state in each subpoena the time and place of the interrogation or production of records, a description of the records requested if a subpoena duce stecum, that it is issued in aid of a criminal investigation, and that the witness has a right to have counsel present (for any interrogations). Utah Code § 77-222(3). No right to compel testimony or interrogate exists by the mere serving of a subpoena requesting only documents

   B. **Disclosure by Prosecutor for Compelled Testimony:** The prosecutor must personally inform the witness at the beginning of each compelled interrogation of the general subject of the investigation, the right of the witness to refuse to answer any question that may result in self-incrimination, and the right to have counsel present. If the prosecutor has "substantial evidence" that the witness has committed a crime that is under investigation, the prosecutor must so inform the witness and disclose the nature of the contemplated charges prior to the interrogation. Utah Code §§ 77-22-2(4) and (5).

[1] Failure to grant immediate access may result in punitive administrative measures against a provider who does not comply with a reasonable request within 24-hours. A reasonable request means the delivery of a written statement of what records are requested, the authority possessed by the requestor or records, and the penalties for failing to comply within 24-hours of the request.

C. **Witness fees** and expenses such as copy costs and mileage must be paid as required in a civil action. The witness fee should be tendered at the time of serving the subpoena. Utah Code § 77-22-2(6)(b).

D. **Time and Place to Produce Records:** A provider served with a criminal subpoena requesting records, generally need not copy records or provide access when service is made. The subpoena will state the time and place when the documents must be delivered or relevant objections made.

E. **Access to Original Records:** A provider need not provide original records pursuant to a subpoena as long as access to, or copies are made of, the original records.

4. **Search Warrant:** Medicaid documents and any other property in the custody of a Medicaid provider may be seized by a law enforcement officer in the process of executing a valid search warrant. A search warrant must specify the place, location, and the items to be seized. A search warrant is only valid when signed by a judge after a finding of probable cause, which is the same standard necessary to arrest a private citizen for criminal conduct. Patient records seized pursuant to a search warrant must be the original records and a receipt must be provided for the records to the provider by the officer. However, it is the practice of MFCU to provide copies of the records to the provider so that patient care will not be adversely impacted. See Utah Code §§ 77-23-1, et seq. No right to compel testimony or interrogate witnesses exists solely on the basis of a search warrant. A search warrant only authorizes a law enforcement officer to search and seize items as specified in the warrant.

IV. Agreements to Resolve Overpayments

1. **Settlements:** Overpayments identified by a Medicaid or MFCU audit may be settled as any other civil claim. MFCU investigators may not offer to settle an overpayment dispute in exchange for not pressing or filing criminal charges. The agreement should clarify whether it can be used as evidence of fraud or abuse or in collateral actions against a provider's professional licenses or to terminate a provider agreement.

2. **Plea Bargain:** After criminal charges are filed with the district court against a provider, that provider and the prosecutor may enter into a plea bargain agreement. Such an agreement may include paying a fine, penalty, cost of investigation, and overpayment in exchange for a plea, plea in abeyance, or a diversion agreement to the pending charge or a lesser crime. Plea bargains generally resolve all known overpayment issues and purported criminal conduct. Plea bargains may result in a conviction, may serve as a basis to revoke a professional license, association membership, terminate a Medicaid provider agreement, and your name may be added to a federal fraud and abuse data base.

V. Complaints and Appeals

1. MFCU Complaints regarding investigations and personnel misconduct should be directed to:

Director
Division of Criminal Investigations and Technical Services
Office of the Attorney General
Medicaid Fraud Control Unit
5272 South College Drive, Suite 200
Murray, Utah 84123

(801) 281-1252

2. Complaints regarding procedures of the MFCU should be directed to:
   MFCU Director
   Division of Investigations
   Office of the Attorney General
   Medicaid Fraud Control Unit
   5272 South College Drive, Suite 200
   Murray, Utah 84123
   (801) 366-0260 or 1-800-244-4636

3. **Medicaid Administrative Appeals:** Disputes regarding overpayments or audit findings may be appealed through the normal Medicaid administrative hearings process. Call (801) 538-6576 for further information or send appeals to:

   Division of Medicaid and Health Financing
   Medicaid Operations
   Formal Hearings
   P.O. Box 143105
   Salt Lake City, Utah 84114-3105

6 - 18 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. This is true even if the sanctioned individual does not work directly in providing services to individuals under the Medicaid program.

Providers need to be aware that it is their responsibility to verify that the individual is not on a federal sanctions list. If a provider does employ an individual 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 that providers regularly check the federal sanctions list which can be found at: www.oig.hhs.gov/fraud/exclusions/listofexcluded.html. It would be advisable for all providers to check current and potential employees against the list on the federal database to ensure that no sanctioned individuals are working for their organization.

6 - 19 Limiting Medicaid Clientele

A provider may limit the number or percentage of Medicaid clients in his/her practice as long as those limitations are based on non-discriminatory factors. However, a provider may not refuse to accept a client if the reason for not serving the client is one of the prohibited factors identified in Title VI of the Civil Rights Act. Those limitations are race, age, color, sex, creed, national origin or disability. Other

federal laws prohibit discrimination based on specific factors or due to the existence of other third party coverage.

A provider should set up established business guidelines that delineate the limitations on accepting Medicaid patients, and abide by those guidelines. Exceptions that would allow for accepting Medicaid clients outside the established guidelines would be acceptable as long as those exceptions did not violate the prohibited actions identified in this manual.

7 MEDICAL STANDARDS - MEDICAL NECESSITY

A provider must furnish or prescribe medical services to the patient only when, and to the extent that, it is medically necessary. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, or cure conditions in the patient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a disability, and there is no other equally effective course of treatment available or suitable for the patient requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the Department upon request. Services or procedures that are considered experimental or investigational are not considered medically necessary and are not covered by Medicaid.

7 - 1 Determining Compliance with Standards

A provider's failure to comply with medical standards, Federal audit, quality assurance review, or prior authorization requirements may be determined by the Medicaid Program Integrity Unit. Initial determinations as to whether or not a provider has failed to comply will be made by Division of Medicaid and Health Financing employees or consultants. If the determination of a noncompliance is made, the Division of Medicaid and Health Financing will notify the provider in writing pursuant to the notice provisions of the Administrative Hearing Procedures of the failure to comply.

Either the Division of Medicaid and Health Financing or the provider may request to have formal peer review of the determination. A written request by either the Division or the provider for formal review must be made within 30 days following the date of the original notice to the provider of the determination of a noncompliance. The written request from the provider must be submitted by him/her to:

DIVISION OF MEDICAID AND HEALTH FINANCING
BUREAU OF COVERAGE & REIMBURSEMENT POLICY
ATTN: PRIOR AUTHORIZATION UNIT
BOX 143111
SALT LAKE CITY, UT 84114-3111

The written request will be submitted to the Prior Authorization Unit for professional peer review. The informal hearing requirements of Sec. 26-23-2-(1) UCA, (1953) are satisfied by the professional peer review process.

If either the Division Medicaid and Health Financing or the provider is dissatisfied with the results of the informal peer review, they may request a formal hearing before the Department of Health in accordance with the formal hearing procedures set forth by the Division of Medicaid and Health Financing Administrative Hearing Procedures.

In situations of violations of compliance of professionally recognized medical standards, as identified by peer review, the Division of Medicaid and Health Financing may pursue any legal sanction for recovery of overpayments.

If the provider is found at fault, and Federal Financial Participation is disallowed on reimbursements made to the provider, the provider must reimburse to the State the total amount the State paid for the services disallowed.

7 - 2 Experimental or Unproven Medical Practices

Experimental or unproven medical practices are not a benefit of the Medicaid Program. Experimental practices include any services which are investigational or experimental in nature and/or are performed in conjunction with or by persons who are using such services to generate data to support or contribute in any way to research grants, studies or projects, or testing of new processes or products, regardless of sources of support or funding for such projects or any parts of such projects.

Although some services have been shown to provide some medical benefit for certain medical conditions, such services will not be covered for other conditions unless medical efficacy is proven. Examples of such medically unproven treatments include, but are not limited to, plasmapheresis in multiple sclerosis and renal dialysis in schizophrenia.

Unless billed services are proven to be medically efficacious as determined by the Centers for Medicare & Medicaid Services, payment will be denied by Medicaid. Final determination is made by the Department of Health and Human Services.

7 - 3 Payments Recovered

If experimental services or unproven medical practices are billed to and paid by Medicaid, payments for the services in question, along with payments for all supporting services (although though not experimental) will be refunded to the Medicaid Program. Supporting services may include but are not limited to supplies, laboratory, x-ray, inpatient and outpatient hospital services, physician, pharmacy, therapist and transportation.

8 CODING

Medicaid recognizes guidelines in current editions of established coding Manuals or other standard literature. However, those guidelines are adopted only as far as they are consistent with application to Medicaid Policy. The established coding guidance materials consist of the following:

- Physicians' Current Procedural Terminology (CPT) Manual
- Healthcare Common Procedure Coding System, HCPCS Level II
- Healthcare Common Procedure Coding System, HCPCS Level III

- International Classification of Diseases, 9th Edition, Clinical Modification, (ICD.9.CM), Volumes 1, 2, and 3
- Revenue Codes (Uniform Billing Codes - UB-04)

8 - 1 Healthcare Common Procedure Coding System (HCPCS)

The HCPCS System incorporates the American Medical Association, Current Procedural Terminology Manual (CPT) as Level I of the system. CPT represents the major portion of the HCPCS system. CPT uses 5 digit numeric codes and a uniform language to accurately classify medical, surgical, and diagnostic services for effective communication among health care providers, health care facilities, and third party payers. Although the CPT Manual is primarily for physician use, other providers may be authorized by Medicaid policy to use the codes and descriptors if other HCPCS codes are not available or appropriate.

HCPCS Level II codes are alphanumeric codes which are uniform in description throughout the United States. The codes begin with a letter followed by four numbers. The descriptions cover equipment, supplies, materials, injections and other items used in health care services. Although the codes and descriptors are uniform, processing and reimbursement of HCPCS Level II codes is not necessarily uniform throughout all states.

HCPCS Level III codes and descriptors are developed for Medicare carriers for use at the local (carrier) level. These are 5-position alpha-numeric codes in the W, X, Y or Z series represented in the Level I or II codes. Level III codes and their descriptions are available from the local part B carrier.

8 – 2 Classification Coding

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD.9.CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Three to five digit numeric codes are used as identifiers. ICD.9.CM Volumes 1 and 2 provide guidelines for coding and reporting diseases, injuries, impairments, related health problems and their manifestations, and the causes of injury, disease, impairment or other health related problems. Volume 3 identifies procedures or other actions taken to address diseases, injuries, and impairments involving hospital inpatients.

A. **Revenue Codes (Uniform Billing Codes UB-04)**

Uniform billing guidelines are a standard data set and format used by the health care community to transmit charge and claim information on hospital services to third party payers. The guidelines are developed on a national basis by the National Uniform Billing Committee. The Billing Manual is maintained and updates provided locally by the Utah Hospital and Health Systems Association. The approved codes in the Medicaid section of the UB-04 Manual are established consistent with Medicaid policy, reviewed and maintained by Medicaid staff periodically.

B. **Coding Maintenance**

Industry updates to CPT, HCPCS, and ICD.9.CM codes are published toward the end of each year. Medicaid staff review each new edition of the coding manuals. The purpose of the review is to identify new services, eliminated services or procedures, and altered descriptions of service. Where additions, deletions, and/or changes have occurred, research is initiated with subsequent development of appropriate policy recommendations and rulemaking to establish service

coverage and/or limitations consistent with Medicaid policy. Notice of any change is given in the Medicaid Information Bulletin. All codes will be discontinued or added based on the date of implementation set by the standard setting organization.

8 - 3 Classifying Patients as 'New' or 'Established'

Providers must observe CPT and Medicaid guidelines on classifying a patient either as *new* or as *established*. Page 1 of the Physician's Current Procedural Terminology Manual (CPT) defines "New and Established Patient" as follows:

> "A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
>
> An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
>
> In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.
>
> No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department."

Medicaid Guidelines

Medicaid has guidelines in addition to those in the CPT Manual.

A. **Established Patient**

Medicaid considers an established patient as one who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

1. When a physician is on call for or covering for another physician, classify the patient's encounter as it would have been by the physician who is not available.

2. Medicaid considers any physician in the same clinic, group practice or other facility to be "of the same specialty" unless the patient has specifically been referred to another physician of a different specialty for issues related to that specialty.

B. **New Patient**

Providers may bill for a 'new patient' when the person has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, with in the past three years.

C. **Patients Seen in an Emergency Department**

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department. Medicaid considers the term "emergency

department" to be a designated emergency unit of a licensed hospital. No other facility or location will qualify under Medicaid as an "emergency department".

8 - 4 Diagnosis Must Agree with Procedure Code; Use of 'V' Codes

A diagnosis code in addition to the V code must also be on the claim form. Make sure that the diagnosis and procedure codes agree.

Here are two examples:

A. V code V10, personal history of malignant neoplasm, or V10.3, – breast, should be accompanied by other ICD.9 codes indicating the differential diagnoses that led to a decision for CT scans of the brain and spine. Chosen ICD.9 codes should reflect symptoms and/or indications that led to the decision for extensive imaging, laboratory tests, and/or a procedure.

B. When using V code V67, follow up examination, include the code related to the original surgery, injury, or fracture.

Supplying the correct diagnosis and procedure for payment is the responsibility of the provider. The differential diagnosis must support the medical necessity of the procedure for reimbursement. Often, more than one diagnosis is required to explain and support a service. When the diagnosis does not support the procedure, a diagnosis to procedure discrepancy will be reported on the remittance advice. Providers should then resubmit a claim with additional or other appropriate diagnoses.

Procedures for Children

When the majority of procedures are basically related to a routine health visit and/or childhood immunizations, V codes related to routine child health examinations, such as V20, V20.0, V20.1, V20.2 will be accepted alone for payment. However, when the child also has a medical condition that requires additional procedures (such as x-rays, laboratory examinations, etc.), place on the claim the ICD.9-CM code which describes the differential diagnoses for the medical condition. The ICD.9 codes assist in explaining the diagnostic test.

Diagnosis and Procedure Incomplete, or Not in Agreement

Past claims reviewed using the clinical claims editor program show numerous instances where the diagnosis does not fit the procedures listed on the claim, or the claim is submitted with only a V-code for the diagnosis. Claims submitted with only a V code will not be paid, with the exception of child health exams. Claims submitted with a diagnosis which does not agree with the procedure completed will be denied. Here is an example: A claim for CT of the abdomen which is submitted with diagnoses of headache and myalgia will not be paid.

Medicaid must have an accurate record of the diagnosis and procedures on submitted claims to evaluate programs and payment trends, and have accurate records. Claim payment to providers is delayed when inaccurate diagnoses are submitted. Other insurance providers including Medicare are using editing programs that review procedure to diagnosis issues. If you have questions, call Medicaid Operations. Staff can assist with training and/or provide a list of procedure-to-diagnoses for a particular issue of concern.

8 - 5 Procedures with Time Definitions

Many procedure codes contain time frames built into the definition. For billing services that fall between the time frames, Medicaid's policy is to round to the nearest full unit or appropriate procedure code. No partial units may be reported.

9 PRIOR AUTHORIZATION

Prior authorization is an approval given by the Medicaid agency, prior to services being rendered, for procedure codes identified in SECTION 2 as requiring prior authorization. Approval must be obtained precedent to service being provided. Prior authorization confirms that services requested are needed, that they conform to commonly accepted medical standards, and that all less costly or more conservative alternative treatments have been considered. Prior authorization does not guarantee reimbursement. All other Medicaid requirements must be met in order for a provider to receive reimbursement.

A. Prior authorization (PA) requirements apply ONLY for services which may be covered directly by Medicaid. These include services for a patient assigned to a Primary Care Provider or services not included in a contract with an Accountable Care Organization (ACO).

B. The PA requirements and process do not apply for services covered by an ACO when the Medicaid patient is enrolled in that ACO. Each plan specifies which services it covers, which require authorization, and the conditions for authorization. Because information as to what plan the client must use is available to providers, the provider must follow the plan's procedures for authorization in order to receive reimbursement.

   Medicaid cannot process requests for prior authorization for services included in a contract with an ACO. Providers requesting services for a client enrolled in an ACO will be referred to that plan. Even if a prior authorization is erroneously given by the Medicaid fee-for-service staff, those authorizations will not be valid if the provider failed to obtain an appropriate authorization from the ACO identified on the card.

C. If a provider is required to obtain prior authorization, fails to do so, provides service anyway, and then bills Medicaid, Medicaid must deny the claim. Because it was the provider's responsibility to obtain authorization, the provider is prohibited from subsequently billing the patient for the unpaid service. Refer to Chapter 6 - 7, Medicaid as Payment in Full; Billing Patients Prohibited.

D. There are specific, limited exceptions to the requirement that approval must be obtained BEFORE service is provided. The exceptions are explained in and limited by Chapter 9 - 7, Retroactive Authorization.

E. FOR PRIOR AUTHORIZATIONS DEALING WITH PHARMACY SERVICES, PLEASE REFER TO THE SECTION 2, PHARMACY SERVICES MANUAL. The remainder of the prior authorization information contained in the following sections and pages below, refer to NON-PHARMACY prior authorization procedures ONLY.

F. In the event there are no pediatric-specific criteria, the default criteria for pediatrics are the adult or general criteria.

9 - 1 Unspecified Services and Procedures

Unspecified services or procedures covered by Medicaid do not require prior authorization. These codes typically are five numbers ending ". . . 99". Do not use unspecified service or procedure codes to provide services which are not a Medicaid benefit. Submit documentation for these codes with the claim for prepayment review. Documentation should include medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary, which provide enough information to identify the procedure performed and to support medical necessity of the procedure.

Unlisted procedures require manual review and often manual pricing. During review of medical record information, medical staff will determine payment based on reimbursement for similar procedures. Additional reimbursement may be considered only when care above similar standard procedures is medically necessary. Additional payment will not be considered when procedures are considered investigational or cosmetic.

Manual Review – Process, Criteria, and Actions

The manual review process is reserved for specific types of cases as described below. Do not submit the claim for manual review if the denial does not fit the criteria below; refer to the tools provided on Utah Medicaid website: www.health.utah.gov/medicaid.

The Utah Medicaid website also has access to the referenced resources and further information on:

- Coverage and Reimbursement Lookup Tool
- 835 Error Codes List
- Forms (includes the Documentation Submission Form)

Throughout this section, supporting documentation consists of medical records that give evidence and support that the claim is correct.

1. Receive the explanation of benefits (EOB) with a denial of all or part of the claim.

2. Note the codes on the non-paid lines on the EOB in this order:
   a. Line Detail Adjustments (adjustments)
   b. Line Detail Remarks (remarks)
      Note: Always use the “adjustments” and “remarks” together to determine the required action.

3. IF the adjustment is CO 16 (Claim/service lacks information which is needed for adjudication)

   AND the remark is N29 (Missing documentation/orders/notes/summary/report/chart)

   THEN go to step 6. The claim meets criteria for manual review.

4. If any other adjustment or remark code is used, go to the home page of the Utah Medicaid website and select the “835 Error Codes List.”

5. On the Error Codes List:

a. Match the codes for the Line Detail Adjustments and Line Detail Remarks with the applicable Adjustment Reason Code Description and Remark Code Description.
b. Go to the Criteria section or step 6, based on these descriptions.
Note: If unable to determine the denial reason, contact Medicaid Customer Service.

Additional Criteria to Determine if the Denial is Eligible for Manual Review

A Modifier is used in a Claim

Modifier 22, 62, or 91
Manual Review is always required for these modifiers. They are flagged by the edit program.

- Modifier 22 – Submit documentation supporting additional time and work required.
- Modifier 62 – Submit claims operative reports from both providers documentation supporting the claim that each surgeon performed separate portions of the procedure(s) that were not those performed by an assistant surgeon.
- Modifier 91 – Submit documentation supporting the claim that separate services were provided for a distinct medical purpose.
  Note: Modifier 91 is typically used for laboratory tests. Acceptable use example: A blood culture is repeated to confirm the presence of the organism in the blood. This modifier is not covered when the code is used to repeat a test for quality control purposes.

Modifier 24, 59, 76, or 77

- Modifier 24 can be used for anesthesia pain management services and qualifies for manual review.
  - Submit documentation showing when the epidural or block injection is given relative to the general anesthesia.
- Modifier 59 is reviewed when the CPT code posts an incidental or mutually exclusive edit to the primary procedure.
  - Submit documentation showing that the procedure is not a component of another procedure, but is a distinct, independent procedure.

  Mutually exclusive edits occur when two or more procedures that are usually not performed during the same patient encounter on the same date of service. The less clinically intense procedure(s) is denied.
  Incidental edits occur when relatively minor procedures are performed at the same time as complex primary procedures, and are considered clinically integral to the performance of the primary procedure.
- Modifier 76 or 77
  When an edit posts that the claim is an exact duplicate of a paid claim, the claim is only manually reviewed when submitted with a 77 or 76 on the denied line.
  - Submit documentation supporting the rational for a repeated procedure or service by the same or another provider.

Codes That Always Require Manual Review

Medicaid policy requires some codes always require manual review.

- "Unlisted" CPT codes require manual review. When an unlisted code is denied:
  - Verify the unlisted code is the most accurate and appropriate.
    - If it is not the most accurate and appropriate code, recode and resubmit the claim.

        - If the code is the most accurate and appropriate for the procedure, submit documentation supporting the use of the code.
- Codes that deny for "No Prior Authorization" that actually require manual review. These codes require manual review, but can only be flagged in the system by indicating prior authorization is required.
    - A claim denied for "Diagnosis requires a prior authorization" requires manual review.
        - To expedite review, submit supporting documentation.
    - CPT code 77300 has a 4 unit limit. When billed for 5 or more units, it will be denied for "Prior Authorization", but it actually requires manual review.
        - To expedite review, submit supporting documentation.

6. If the claim meets the criteria for review, submit the following documentation to the applicable FAX number on the Documentation Submission Form:
    - Completed Documentation Submission Form.
    - Appropriate documentation to support the claim/code under review.

9 - 2 Non-Covered Procedures

Generally, Medicaid does not reimburse non-covered procedures. However, exceptions may be considered through the prior authorization process in the circumstances listed below and when no code that is a Medicaid benefit accurately describes the service to be provided:

1. The patient is a child under 21 years of age. Because of the patient's age, the Child Health Evaluation and Care Program (CHEC) may pay for services which are medically necessary but not typically covered by Medicaid. The CHEC program is based on a preventive health philosophy of discovering and treating health problems before they become disabling and therefore more costly to treat in terms of both human and financial resources. Please refer to SECTION 2, CHEC SERVICES, for additional information. For your convenience, the PA requirements for CHEC services are listed in the Chapter 9 - 3, Prior Authorization Criteria.

2. Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery.

3. Reconstructive procedures to correct serious functional impairments (for example, inability to swallow).

4. When performing the procedure is more cost effective for the Medicaid Program than other alternatives.

9 - 3 Prior Authorization Criteria

In December 1996, Medicaid staff began using the "Medical Review Criteria and System" developed by InterQual, Inc. in conjunction with locally developed prior authorization criteria. Staff were trained in the use and application of the criteria to review prior authorization requests for medical necessity and appropriateness and complete all prior authorization, utilization or post payment reviews. The locally developed criteria used to review a prior authorization request are described in SECTION 2 or listed with each procedure code requiring PA.

When a service is not ordinarily covered by Medicaid, but it is for a child under 21 years of age, Medicaid may authorize the service under the Child Health Evaluation and Care Program (CHEC). For complete information, refer to the Utah Medicaid Provider Manual for CHEC Services. Prior authorization requests for CHEC services must be in writing and include the information listed below:

1. The estimated cost for the service or item;
2. A photocopy of any durable medical equipment item(s) requested;
3. A current comprehensive evaluation of the child's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested;
4. A letter from the physician describing medical necessity and including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be patient specific, indicate the reasons the physician is recommending the service or equipment, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

The physician making the request, the therapist and the provider should communicate directly and work as a team to evaluate the most appropriate services for the child.

9 - 4 Prior Authorization Procedures

Prior authorization (PA) applies to all services which require PA and which are either:

1. Not covered by an Accountable Care Organization (ACO), or
2. In one of the following programs: Psychology, Personal Care Services, Targeted Case Management Services, and Home and Community-Based Waiver Services. Providers of these services should follow the prior authorization process in the applicable provider manual.

A. When prior authorization is required for a health care service, the provider must obtain approval from Medicaid BEFORE service is rendered to the patient. Medicaid can pay for services only if ALL conditions of coverage have been met, including but not limited to, the requirement for prior authorization.

B. A provider must complete a Request for Prior Authorization form and submit it with any required documentation to the Medicaid agency as indicated. A copy of the Request for Prior Authorization form and instructions are in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

1. Any exception to the requirement for written prior authorization is noted in SECTION 2 of this manual for specific provider types and services. A code which requires PA indicates whether the request may be made by telephone or must be in writing.
2. Generally, the provider sends a request for Prior Authorization to the Prior Authorization Unit in the Division of Medicaid and Health Financing. Any exception is noted in SECTION 2 of this manual.

C. The Medicaid agency reviews the request to determine if the service is covered by Medicaid and if it meets the criteria for medical necessity, based on information given by the provider.

1. A service may be covered when it is included in either of these groups:

   a. Within one of the types of service covered by the Utah State Plan for adults, or

   b. Within one of the types of service listed in 42 USC 1396d(a) for children under the age of 21.

2. A service is considered medically necessary when it meets the conditions of Chapter 7, Medical Standards - Medical Necessity.

D. Medicaid sends a written notice to the provider, and a copy to the patient, advising of the request for authorization and the decision. Federal regulations (42 CFR §431.206) require Medicaid to "give notice to the patient" when any action "may affect his claim."

1. When Medicaid denies authorization, the letter of denial includes the following information:

   a. The action the State intends to take;

   b. The reasons for the action, including findings of fact;

   c. Statement of the laws and criteria supporting the action;

   d. The patient's right to a hearing;

   e. The process to request a hearing;

   f. The patient's right to be represented by an attorney or other person;

   g. The circumstances, if any, under which the service is continued pending the outcome of the hearing.

   Attached to the letter are a copy of the laws and criteria supporting the decision and a form and instructions for requesting a hearing.

   The denial letter does not ask for new information. Once a request is denied, the next opportunity to discuss the decision and present additional information for consideration is a prehearing conference.

2. When a provider submits a prior authorization request without complete documentation, the request will be returned. The returned request will indicate the additional documentation required before the prior authorization is acceptable for determination of approval or denial. Please carefully review criteria and policy for all items/services for which prior authorization is required.

E. When a patient submits a request for a hearing, Medicaid follows the policy and procedure under Utah Administrative Code, Section R410.14.

9 - 5 Written Prior Authorization

Send written requests to: MEDICAID PRIOR AUTHORIZATION UNIT

P. O. BOX 143111
SALT LAKE CITY UT 84114-3111

Prior authorization requests may also be faxed to (801) 536-0162, attention "Prior Authorizations"

9 - 6 Telephone Prior Authorization

When policy permits a request for authorization to be made by telephone, call Medicaid Information and follow the telephone menu prompts. Refer to Chapter 12, Medicaid Information.

MEDICAID NON PHARMACY PRIOR AUTHORIZATION UNIT HOURS

Monday, Tuesday and Wednesday .....7:00 A.M. to 6:00 P.M.
Thursday .....(not available in the morning) 1:00 P.M. to 6:00 P.M.
Friday. .....**CLOSED**

MEDICAID PHARMACY PRIOR AUTHORIZATION UNIT HOURS

Monday, Tuesday, Wednesday and Friday. .....8:00 A.M. to Noon and 1:00 P.M. to 5:00 P.M.
Thursday. ..... (not available in the morning) 1:00 P.M. to 5:00 P.M.

9 - 7 Retroactive Authorization

Retroactive authorization is approval given after a service has been provided. Retroactive authorization may be considered ONLY in the circumstances listed in this chapter. The provider must complete a Request or Prior Authorization form and include documentation for the reason service was provided before Medicaid gives authorization. The submitted medical record documentation must comply with Medicaid coverage authorization requirements for coverage of the service retroactively. Refer to Section 2, Physician Services, for documentation guidelines.

A. **Retroactive Medicaid Eligibility**

When a client becomes eligible for Medicaid after receiving services which would have required prior authorization, Medicaid may consider a prepayment review, rather than denying reimbursement solely because prior authorization was not obtained. The provider should explain this circumstance on the Request for Prior Authorization form, with documentation supporting the medical necessity for the service. Even under this condition, the submitted medical record documentation must comply with Medicaid coverage authorization requirements for coverage of the service retroactively.

B. **Medical Supplies Provided in a Medical Emergency**

Certain medical supplies and equipment that require prior authorization may be provided in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment.

It is the responsibility of the medical supplier to substantiate the emergency and provide the necessary documentation to support a prepayment review. Providers must obtain prior authorization for all other services, supplies, and equipment, even if the client's circumstances appear to qualify as an 'emergency."

C. **Surgical Emergency**

Surgical procedures that require prior authorization may be performed in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment. To qualify, the procedure must have been performed in a life-threatening or justifiable medical emergency.

It is the responsibility of the surgeon to substantiate the emergency and provide all necessary documentation to support a prepayment review of the services for all providers concerned, including documentation from the medical record to support the emergent nature of the procedure.

D. **Surgical Exceptions**

For cases in which a surgical procedure requires prior authorization, the associated anesthesia codes are prior authorized as a component of the surgical procedure prior authorization. For cases in which a surgical procedure does not require prior authorization, but the associated anesthesia codes do require prior authorization, retroactive authorization will be granted upon confirmation that the surgery was neither cosmetic, investigational, nor a non-covered service.

For cases in which a surgical code that requires prior authorization is performed during a surgery that does not require prior authorization, retroactive authorization will be granted if the provider is able to demonstrate through written documentation that the need for the additional procedure was unexpected and was discovered during the surgery, that the provider could not have anticipated the need for the procedure prior to the surgery and there was no indication the procedure was anticipated among the differential diagnoses prior to performing the surgery.

E. **Other Exceptions**

When a delay in prior authorization rests with Medicaid, the date of the submission for prior authorization will be considered. However, the submitted documentation must meet the criteria for approval.

9 - 8 Ancillary Services

Providers who accept a patient covered by Medicaid should ensure that any ancillary services provided to the patient are delivered by a participating Medicaid provider. This includes lab, x-ray, and anesthesiology services. In addition, when the service requires prior authorization (PA) and a PA number is obtained from Medicaid, give a copy of the patient’s Medicaid Identification Card or, at minimum, the Medicaid Identification number and the PA number to all providers rendering ancillary services to the patient. This will assist the other providers who may be required to submit the PA number when billing Medicaid.

10 RECORD KEEPING AND DISCLOSURE

Every provider must comply with the following rules regarding records:

1. To maintain for a minimum of five years all records necessary to document and disclose fully the extent of all services provided to Medicaid patients and billed, charged, or reported to the State under Utah's Medicaid Program;

2. To promptly disclose or furnish all information regarding any payment claimed for providing Medicaid services upon request by the State and its designees, the Fraud Control Unit, or the Secretary of the United States Department of Health and Human Services. This includes any information or records necessary to ascertain, disclose, or substantiate all actual income received or expenses incurred in providing services or during the same period as Medicaid services were provided. In addition, all providers must comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B as applicable, except for individual practitioners or groups of practitioners. (A copy of these requirements will be furnished upon request);

3. To allow for reasonable inspection and audit of financial or patient records for non-Medicaid patients to the extent necessary to verify usual and customary expenses and charges.

Upon request, the State will furnish reimbursement to the provider for the cost of making copies of records in compliance with Subsection B, at a rate not to exceed 10 cents per copy when there are 20 or more pages to be copied.

10 - 1 Government Records Access and Management Act (GRAMA)

The Utah Department of Health, Division of Medicaid and Health Financing, follows the provisions of the Government Records Access and Management Act (GRAMA) in classifying records and releasing information. Reference: Utah Code Annotated, Title 63, Chapter 2.

10 - 2 Confidentiality of Records

In accordance with HIPAA and the Government Records Access and Management Act (GRAMA), Utah Code Annotated, Title 63, Chapter 2 et seq., UCA (198653), any information gained from patient records is classified as *controlled* and must be protected pursuant to the guidelines established by law in order to protect the privacy rights of the patients.

Any information received from providers is classified as *private* and will be protected pursuant to the guidelines established by law in order to protect the privacy rights of providers. Records and information acquired in the administration of any part of the Social Security Act are *confidential* and may be disclosed only under the conditions prescribed in rules and regulations of the Department of Health and Human Services, or on the express authorization of the Secretary of the Department of Health and Human Services.

A Medicaid provider may disclose records or information acquired under the Medicaid Program only under conditions prescribed in the rules and regulations of HIPAA and GRAMA.

10 - 3 Access to Records

A provider who receives a request from Medicaid for access to or inspection of documents and records must promptly and reasonably comply with free access to the records and facility at reasonable times and places. A provider must not obstruct any audit or investigation, including the relevant questioning of employees of the provider.

If a provider unreasonably refuses to grant access to records, or cannot provide adequate records for reimbursed services, the services shall be deemed undocumented. The provider must refund all payments for undocumented services. The State may deduct an equal amount from future provider payments

Repeated refusal to provide or grant access to the records as described above will result in the termination of the existing Medicaid provider agreement.

10 - 4 Documentation and Signature Requirements

To support its mission to provide access to quality, cost-effective health care for eligible Utahans, the Division of Medicaid and Health Financing requires providers to meet the *Evaluation and Management Documentation Guidelines* developed jointly by the American Medical Association and the Health Care Financing Administration, effective July 1, 1998. In addition, the Division uses InterQual criteria and criteria developed internally under the guidance of the Prior Authorization Unit. Documentation and signature requirements are as follows:

A. **Documentation requirements**

The General Principles of Medical Record Documentation in the *Evaluation and Management Documentation Guidelines* are listed below:

1. The medical record should be complete and legible.
2. There is no specific format required for documenting the components of an E/M service.
3. The documentation of each patient encounter should include:
    a. The chief complaint and/or reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
    b. Assessment, clinical impression, or diagnosis;
    c. Plan for care; and
    d. Date and a verifiable, legible identity of the healthcare professional that provided the service.
4. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
5. To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
6. Appropriate health risk factors should be identified.
7. The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
8. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
9. An addendum to a medical record should be dated the day the information is added to the medical record, not the day the service was provided.
10. Timeliness: A service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record.
11. The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

B. **Signature Requirement**

In keeping with the objectives of 42 CFR 456 Subpart B (to review and evaluate utilization, service, exceptions, quality of care, and to promote accuracy and accountability), providers and the service they provide must be clearly recognized by name and specialty. Any professional providing service and entering documentation in the patient record must include a verifiable, legible signature and professional specialty designation following all entries.

A. **Physician Responsibilities**

The physician has the major responsibility for the patient's medical record and services provided. A recognizable signature, customary to the way in which the physician identifies himself, should be found throughout the record on all direct service entries, consultations or reports.

When service to the patient is provided "incident to" or "under the supervision" of the physician and documented by non-physician personnel, the medical record entry must have sufficient documentation to show active participation of the physician in planning, supervising or reviewing the service.

The physician's signature must accompany every documented patient encounter if the service is being billed with the physician provider number.

B. **Other Professional Services**

Other professionals working in group practices, clinics or hospitals such as nurses, physical therapists, occupational therapists, dietitians, social workers, etc., providing service under a plan of care or following orders of a physician, must provide appropriate documentation, signature and professional designation following entries in the patient's medical record

C. **Accepted Alternative Signature**

Electronic signatures, by federal law, are acceptable. Record documentation made by electronic means has the same legal weight as signatures on paper.

When a service note is dictated and subsequently transcribed into the record over the typed name of the provider, legible initials of the provider next to the typed name are acceptable and imply review and agreement with the documentation.

D. **Unacceptable Signature**

A signature stamp affixed to an entry in the patient's medical record is not sufficient to assure physician review and agreement that the documentation is an adequate representation of the service. Initials alone following an entry are not appropriate, unless that is the customary way a signature is provided.

NOTE: Since July 1, 1998, audits have been completed using the 1997 Evaluation and Management guideline developed by the Centers for Medicaid and Medicare Service (CMS). Effective January 1, 2008, the Department will include the 1995 Evaluation and Management guideline as an alternative in an audit. The provider must stipulate at the time of an audit whether they are submitting evaluation and management services under the 1995 or the 1997 Evaluation and Management CMS guideline. Auditing will proceed under the one guideline named by the provider.

11 BILLING CLAIMS

Procedures and regulations for billing Medicaid follow. Medicaid providers should be aware of Federal regulations which limit use of business agents, prohibit the use of factors, and unacceptable billing practices.

11 - 1 Business Agents

A billing or business agent is a person or an entity that submits a claim for a provider and receives Medicaid payments on behalf of a provider. Payments may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of a provider, if the agent's compensation for this service meets three conditions:

1. Is related to the cost of processing the claim;
2. Is not related on a percentage or other basis to the amount that is billed or collected; and
3. Is not dependent upon the collection of payment.

Reference: 42 CFR §447.10(f).

11 - 2 Factoring Prohibited

As a reminder to all providers, Federal Regulations prohibit the use of a factor to obtain payment from Medicaid for any service furnished to a Medicaid patient. The regulations define a factor as an individual or an organization, such as a collection agency or service bureau, which advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a business representative. Reference: 42 Code of Federal Regulations §447-1(b).

Payment for any service furnished to a Medicaid patient by a provider may not be made to or through a factor, either directly or by power of attorney. Reference: 42 Code of Federal Regulations §447.10(h).

11 - 3 Unacceptable Billing Practices

The use of any device or strategy that may have the effect of increasing the total amount claimed or paid for any service beyond the maximum allowable amount payable for such service is not allowed. Following are examples of unacceptable billing practices.

A. Duplicate billing or billing for services not provided, overstating or mis-describing services, and similar devices;

B. Submitting claims for services or procedures that are components of a global procedure;

C. Submitting claims under an individual practitioner’s provider number for services performed by the practitioner as an employee of or on behalf of a group practice or clinic when the service has been billed under the group or clinic number;

D. Use of more intensive procedure code than the medical record indicates or supports.

11 - 4 Billing Third Parties

Before submitting a claim to Medicaid, collect ONLY the applicable Medicaid co-payment usually charged at the time of service. The provider should include the primary Insurance co-pay as part of the submitted charges to Medicaid. A provider must explore payment from all other liable third parties such as insurance coverage, a health plan and Medicare Part A and B, if applicable. The provider must submit and secure payment from all other liable parties before seeking Medicaid payment. The Medicaid payment is made after all other liable third parties have made payment or sent a denial.

A. If the client has Medicare A & B as Primary Insurance and also has Medicaid, or if the client has Qualified Medicare Benefits (QMB), or QMB with Medicaid, do not collect the Medicaid co-pay amounts EXCEPT the co-pay and co-insurance for pharmacy services.

B. Bill the responsible third party, then Medicaid, as follows:

1. Submit the claim to the third party or parties.
2. If the third party pays the claim, submit a claim to Medicaid and show the TPL payment according to instructions. Medicaid bases any subsequent reimbursement on the Medicaid fee schedule.

   a. Medicaid will not make an additional payment if the amount received from the insurance company is equal to or greater than the Medicaid reimbursement amount. In this case, the TPL payment is considered payment in full. A provider will not bill the patient for any difference between the amount charged and the TPL payment received.

   b. If a provider receives a third party payment and does not bill Medicaid for the balance because he or she anticipates the Medicaid payment to be zero, the TPL payment is considered payment in full, and the provider will not bill the patient.

   c. Medicaid will make an additional payment to a provider for services rendered if the payment received from the insurance company is less than the Medicaid reimbursement amount.

   d. An exception is inpatient hospital claims with third party insurance. Refer to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 5 - 1, Inpatient Hospital Claims with Third Party Insurance.

3. If the third party denies the claim for any reason (non-covered benefit, patient not eligible, etc.) submit a claim to Medicaid. The claim may be filed electronically, and written documentation on the TPL response. Documentation sent separately goes to the Office of Recovery Services; use Fax number 801-536-8513.

   Send a copy of the denial from the responsible third party if the denial was written. If the denial was given verbally, include the name of the person who said the claim was denied, the date of the denial, and the reason for the denial.

   If the TPL information appears to be incorrect, please advise the patient to call the TPL unit in the Office of Recovery Services at the Department of Human Services. The telephone number is printed on the bottom of the Medicaid Identification Card. Providers may also call

the Office of Recovery Services to advise them of correct third party liability information. Telephone numbers are listed in Chapter 5 - 5, Third Party Liability.

4. If the third party pays less than reported on the Medicaid claim, submit a replacement claim showing the correct amount received from the TPL.
5. When a Medicaid claim is suspended for third party liability information, you can expedite the processing of the claim by faxing the complete Explanation of Benefits (EOB) directly to the Health Claims team in the Office of Recovery Services. Include the second page which usually has the definitions of coded reasons for not paying the claim. Use FAX number **(801) 536-8513.**

   You do not need to send the EOB to Medicaid Claims Processing. Any EOB's received by Medicaid are forwarded to the Office of Recovery Services.

11 - 5 Billing Services for Newborns

Bill all services for newborns with the baby's own (unique) Medicaid Identification number. The baby's identification number can be found on the mother's Medicaid Identification Card, often with the name "Unborn" and the expected date of birth. You may also obtain the baby's Medicaid number by calling Medicaid Information. Refer to Chapter 12, Medicaid Information.

If the baby does not have a unique Medicaid Identification number, the mother must notify her eligibility worker immediately. The worker determines the child's eligibility, and a unique Medicaid Identification number is assigned to the child.

NOTE: A newborn infant is NOT covered when his or her mother is eligible only for the Baby Your Baby Program. In this case, the mother must apply for Medicaid on behalf of the child if she needs assistance in paying the child's medical bills.

11 - 6 Medicare/Medicaid Crossover Claims

If the provider accepts assignment for Medicare Part A or Part B, the Crossover claim is sent to Medicaid Crossovers automatically from the intermediary. If the provider does not accept assignment, a claim is not sent automatically, and the provider must submit the claim directly to Medicaid Crossovers.

Payment is reported on the Crossover section of the Medicaid Remittance Statement. The Medicare and Medicaid payment is considered payment in full.

11 - 7 Filing Crossover Claims

Submit claims directly to Medicaid Crossovers. Instructions are on-line at http://health.utah.gov/medicaid under Coordination of Benefits.

To ensure prompt processing, the Medicaid provider's NPI must be on the claim. The deadline for filing a Crossover claim is one year from date of service or six months from the date of the Medicare payment.

PAPER CLAIMS

Submit to:
Medicaid Crossovers
P.O. Box 143106
Salt Lake City, Utah 84114-3106

ELECTRONIC CLAIMS
It is not necessary to submit an EOMB for $0 payment or denials. Complete the other payer payment information, including payer paid amount, patient liability and reason codes.

Submit to:
HT000004-005 Utah Medicaid Crossovers

11 - 8 Non-Covered Medicare Services

Bill claims for non-covered Medicare services, such as non-durable medical supplies, drugs, and ICF nursing home care provided to Medicare/Medicaid eligible patients directly to Medicaid.

11 - 9 Billing Medicaid

1. Paper Claims

As defined in the Rule R590-164, Medicaid accepts the following paper claims:

- CMS-1500 (08/05) Professional Claim,
- UB-04 Institutional Claim,
- ADA Dental Claim (2006), and
- NCPDP Universal Pharmacy Claim.

Claim Form Instructions

Medicaid does not provide instructions for the use of each box on the paper claim forms.

The Utah Insurance Commissioner maintains standards to clearly describe the use of each box (for print images) and its crosswalk to the HIPAA transactions. The Utah standards to describe the use of each box on the Profession Claim CMS-1500 (08/05), the ADA Dental Claim (2006) and the Institutional Claim UB-04 claim forms are available from the UHIN web site: www.UHIN.org or the insurance commissioner's web site at http://www.insurance.utah.gov/legalresources/currentrules.html, (Access Rule R590-164 and accompanying "Standards".)

NCPDP maintains instructions for the pharmacy claim form at
http://www.ncpdp.org/pdf/Basic_guide_to_standards.pdf#search="universal claim form"

2. Electronic Claims

In Utah, a coalition of insurers, providers, the Utah Medical Association, the Utah Hospital Association, and State Government developed the Utah Health Information Network or "UHIN". UHIN is a centralized secure electronic network through which health care transactions (typically health care claims, remittance advice, eligibility inquiries and other administrative messages) pass in Utah. Providers can send claims, etc. through UHIN instead of electronically connecting to each payer. UHIN is the receiving point for health care transactions for Medicaid.

Electronic Data Interchange (EDI) means a provider sends and receives health-related information, including claims, electronically. For an overview of Electronic Data Interchange (EDI), please see Section 11-15 at the end of this chapter.

Utah Medicaid promotes the use of electronic transactions. The Medicaid EDI team is available to provide direction, answer questions, and assist providers or billing agents with the submission of electronic transactions.

Transactions/files that are sent to Medicaid via UHIN are immediately placed in the MMIS for processing during the next claim cycle.

Becoming an Electronic Claims Submitter

The first step to becoming an electronic claims submitter is to complete an EDI application form. The form is found on the Medicaid website at http://health.utah.gov/medicaid/index.html . Providers may take advantage of the EDI process by using a billing agency, clearinghouse or VAN/third party vendor. Refer to Section 11-1, Business Agents.

The second step to becoming an electronic claims submitter is to contact UHIN at 801-466-7705 and complete the membership enrollment process to submit through the UHIN network. Membership information and forms are available at UHIN's website at www.UHIN.org . UHIN provides software needed to bill electronically. The billing software packages are listed below:

1. UHINt: UHINt is an internet based product that can be used to interface between a medical billing system and UHINet (UHIN's internet portal). It can also be used to directly type in claims, eligibility inquiries, etc.

   UHIN offers UHINt at no charge to members who need a way to exchange administrative messages (claims, remits, eligibility, claim attachments, etc). For more information, visit the UHIN website at www.UHIN.org, under products.

2. Other Acceptable Software: Providers who are considering adding computer software support for submitting claims, reporting third party liability, and reporting encounter data should make sure that the software conforms to ANSI standards for the electronic transmission of health information. As a member of UHIN, Medicaid supports the development of national standards and requires the use of the national ANSI standards for receiving and returning electronic information.

   Acceptable software meets all file and data specifications contained in the ANSI X12 implementation standard.

Your software vendor can advise you as to systems which use the ANSI standards in compliance with HIPAA and the UHIN requirements.

Trading partners, whether individual providers or provider groups, have responsibilities to adequately test all business rules appropriate to their type and specialty. If using a third-party vendor (clearinghouse), it is the obligation of the trading partner to ensure the vendor has adequately tested all business rules appropriate to each provider type and specialty.

NCPDP Pharmacy Point of Sale (POS) System

The Point of Sale (POS) system accepts standardized claims for pharmacy services to be submitted through an electronic data exchange. For information about acceptable software for submitting inquiries, transmitting claims, and electronic procedures and messages, refer to Section 2, Pharmacy Services. As electronic data interchange features become available, Medicaid will notify providers in the Medicaid Information Bulletin.

EDI Resources

ASC X12 Implementation Guides are available from the Washington Publishing Company at www.wpc-edi.com .

Utah Medicaid-specific Companion Guides to the X12 Implementation Guides and National Council of Prescription Drug Programs (NCPDP) payer sheets are available on the Medicaid website at http://health.utah.gov/medicaid/index.html .

Utah Medicaid EDI Help Desk

Telephone 800-662-9651 or (801) 538-6155, option 3, option 5

Written correspondence can be sent to:
Bureau of Medicaid Operations
PO BOX 143106
Salt Lake City, UT 84114-3106

11 - 10 Time Limit to Submit Medicaid Claims

A claim must be submitted to Medicaid within 365 days from the date of service. The date of service, or “from” date on the claim, begins the count for the 365 days to determine timely filing. For institutional claims that include a span of service dates (i.e., a “from” and “through” date on the claim), the “through” date begins the count for the 365 days to determine timely filing. Any adjustments or corrections must also be received within the 365-day deadline.

Medicare/Medicaid Crossover claims must be submitted within six months from the date of Medicare payment stated on the Medicare Explanation of Medical Benefits (EOMB).

References: Code of Federal Regulations 42 (CFR), Section 447.45(d) (1).

11 - 11 Rebill Denied Claims with Corrected Information

If a claim has been denied for incorrect information, correct the claim and resubmit it, rather than calling Medicaid Information. Until the claim is billed correctly, it cannot be processed.

11 - 12 Denial of Payment for Patients Not Eligible for Medicaid or Enrolled in an Accountable Care Organization (ACO)

Medicaid is a benefit only to eligible persons. Medicaid will not pay for services rendered to a client who is not eligible for Medicaid benefits on the date the service is rendered, nor will Medicaid pay for services covered by an Accountable Care Organization (ACO) or Prepaid Mental Health Plan, in which the patient is enrolled. Because Medicaid makes available information as to what medical or mental health plans the patient must use, a fee for service claim will not be paid even when information was given in error by Medicaid staff. Staff make every effort to provide complete and accurate information on all inquiries.

11 - 13 Requesting Review of Claim That Exceeds Billing Deadline *(Updated 1/1/14)*

It is to your advantage to submit claims and follow-up on unpaid balances within the billing deadline. Claims received by Medicaid after the billing deadline will be denied. Providers may request the change to correct a claim outside of the timely filing deadline; however, no additional funds will be reimbursed. Any exception to the 365-day limit is stated below.

(Reference: Chapter 11 - 10, Time Limit to Submit Medicaid Claims)

When Payment Can Be Made on 'Late' Claims

If Medicaid denied a claim for exceeding the billing deadline, you may request a review for payment. The situations listed below may be considered for review, provided specific, appropriate documentation is submitted.

1. Provider is under investigation for fraud or abuse.
2. Court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.
3. Situations involving a provider who conforms with Medicaid requirements by billing a third party payer first, resulting in non-payment after the one-year billing deadline, have been allowed as an exception to the filing deadline in hearing decision numbers 13-078-02 and 13-239-03. In accordance with 42 CFR 447.45(d)(4)(iv) and paragraph 2 above, if a provider files a claim beyond one year in such a situation, it is a "same situation" as to prior agency hearing decisions and may be processed.
4. Situations involving agency error in processing a timely clean claim resulting in the provider having to again file the claims beyond the one-year deadline have been allowed as an exception to the filing deadline in hearing decision numbers 13-212-08 and 13-212-22. In accordance with 42 CFR 447.45(d)(4)(iv) and paragraph 2 above, if a provider files a claim in such a situation, it is a "same situation" as to prior agency hearing decisions and may be

processed.

Requesting Review For Payment

If you have documentation to prove one of the situations stated, send the documentation with a copy of the Medicaid remittance to:

Medicaid Operations
PO Box 317106
Salt Lake City, Utah 84114-3106
or fax (801) 536-0164

When the documentation is received, the request is reviewed. If Medicaid finds that one of the situations listed above is met, Medicaid will waive the time limit and initiate processing of the claim.

11 - 14 Claim Corrections Through Re-Submission

The following data elements are required to identify the claim as a replacement or void of an original claim:

Claim Frequency Code
Acceptable values: 6 or 7 for replacement, 8 for void
Electronic: X12 element 2300 CLM05-3
Paper: UB-04 - Form Locator 4, position 3
CMS 1500 (08/05) - Box 22 (Code)
Dental - Process not available on paper.

Original Reference Number
Transaction Control Number (TCN) of original claim to be replaced or voided
Electronic: X12 element 2300 REF02
Paper: UB-04 - Form Locator 37 A-C (same line as Medicaid in 50A-C)
CMS 1500 (08/05) - Box 22
(Original Ref. No.)
Dental - Process not available on
paper.

Replacement claims will void the original claim and process the replacement claim. Please consult with your programmer to verify the required data elements are available in your software. Claims submitted without a valid original reference number (TCN) will be rejected.

The NPI must be the same on both the replacement/void and the original claim. If providers are different, send a void for the original claim and resubmit an original claim for the correct provider.

11 - 15 Electronic Data Interchange (EDI)

Utah Medicaid follows the HIPAA mandated TCS standards as set forth by DHHS and CMS. Electronic Data Interchange (EDI) is the most efficient method of submitting and receiving large amounts of information within the Utah Medicaid Management Information System (MMIS).

INTRODUCTION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted into law on August 21, 1996. The Administrative Simplification provisions of HIPAA, Part C Title II, Subpart F requires the Secretary of Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting standards improves the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange (EDI) in health care. The Secretary is further instructed to use Standard Setting Organizations (SSO) with standards currently in place. An SSO must be accredited by the American National Standards Institute (ANSI).

HIPAA TRANSACTION AND CODE SET REQUIREMENTS

The Health Insurance Portability and Accountability Act (HIPAA) is a national effort driven by the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) geared toward administrative simplification and electronic submission standardization. The HIPAA influences the way protected health information (PHI) is transferred and sets specific guidelines for protection of PHI used for treatment, payment and business operation.

On August 14, 2000, the DHHS issued a Final Rule for Standards for Electronic Transmissions as part of the Administrative Simplification portion of the HIPAA. Find the Final Rule at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. In October 2002, DHHS issued an addendum to the Final Rule, which was accepted in December 2002 and published in February 2003.

The secretary of the Department of Health and Human Services (HHS) has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009.

By establishing a national standard* for electronic claims and other transactions, healthcare providers are able to use consistent procedures and codes when submitting transactions to a health plan anywhere in the United States.

> *Accredited Standards Committee (ASC X12) – An ANSI accredited standards organization responsible for the development and maintenance of electronic data interchange (EDI) standards for many industries. The "X12" or insurance section of ASC X12 handles the EDI for the health insurance industry's administrative transactions. Under HIPAA, X12 standards have been adopted for most of the transactions between health plans and providers.

The rule adopts standards for nine electronic transactions and for code sets to be used in those transactions. These include:

- Claims or Encounter Information
- Eligibility Inquiry and Response
- Payment and Remittance Advice
- Referral Certification and Authorization (Prior Auth)
- Claim Status Inquiry and Response
- Enrollment/Dis-enrollment in Plan
- Premium Payments

PROFESSIONAL CLAIMS (837 PROFESSIONAL)

837 PROFESSIONAL TRANSACTION
The ASC X12N 837 Professional transaction is the electronic equivalent for the CMS-1500 (08/05) paper claim form.

INSTITUTIONAL CLAIMS (837 INSTITUTIONAL)
837 INSTITUTIONAL TRANSACTION
The ASC X12N 837 Institutional transaction is the electronic equivalent of the UB-04 paper claim form.

DENTAL CLAIMS (837 DENTAL)
837 DENTAL TRANSACTION
The ASC X12 837 Dental transaction is the electronic equivalent of the ADA 2006 paper claim form.

ELIGIBILITY INQUIRY/RESPONSE (270/271 Transactions)
270 ELIGIBILITY INQUIRY TRANSACTION (BATCH)
The ASC X12N 270 Eligibility Inquiry Transaction set is used to transmit health care eligibility benefit inquiries from health care providers, clearinghouses and other health care adjudication processors.
271 ELIGIBILITY INQUIRY TRANSACTION
The ASC X12N 271 Eligibility Response Transaction set is used to respond to health care eligibility benefit inquiries as the appropriate mechanism.

CLAIM INQUIRY/RESPONSE (276/277 Transactions)
276 CLAIM INQUIRY TRANSACTION (BATCH)
The 276 Transaction Set is used to transmit health care claim status request/response inquiries from health care providers, clearinghouses and other health care claims adjudication processors. The 276 Transaction Set can be used to make an inquiry about a claim or claims for specific Medicaid members.
277 CLAIM INQUIRY RESPONSE TRANSACTION (BATCH)
The 277 Transaction Set is used to transmit health care claim status inquiry responses to any health care provider, clearinghouse or other health care claims adjudication processors that has submitted a 276 to the Utah MMIS.

ENROLLMENT (834 Transactions)
834 ENROLLMENT TRANSACTION
The 834 Transaction Set is used to transmit health care enrollment into an Accountable Care Organization (ACO). Medicaid uses this transaction to notify the ACOs that a Medicaid recipient has been enrolled in the ACO. The transaction provides the plan with the recipient's demographics and some health data.

REMITTANCE ADVICE (RA) (835 Transactions)
835 REMITTANCE ADVICE
The 835 Transaction Set will only be used to send an Explanation of Benefits (EOB) RA. For Utah Medicaid, payment is separate from the EOB RA and will therefore not be affected by changes to how the provider receives payment. The 835 transaction will be available to the providers and contracted clearinghouses requesting electronic remittance advice (ERA). Providers may choose to receive ERA or paper RA, or both.

PREMIUM PAYMENT (820 Transactions)
820 PREMIUM PAYMENT TRANSACTION
The 820 Transaction Set is used to transmit premium payment data to the ACO.

PRIOR AUTHORIZATION (278 Transactions)
278 REFERRAL CERTIFICATION AND AUTHORIZATION. HEALTH CARE SERVICE REVIEW TRANSACTION

The 278 Transaction Set is used to transmit requests for prior authorization of services.

ELECTRONIC CLAIM/PRIOR AUTHORIZATION WITH ATTACHMENT(S)
Medicaid allows claims or prior authorization request submitters to continue billing their claims or PA requests electronically even if a paper attachment needs to be sent with the claim or PA request. If documentation is required to support the claim, the claim may deny; however, once documentation is received the claim will be reprocessed.

To ensure proper handling of attachments, please ensure the attachment contains the following information:

- A provider assigned attachment control number (ACN) unique to this attachment. Each attachment associated with the claim must display a unique number.
- The attachment control number (ACN) (can be the transaction control number (TCN) of the accepted claim as reported in the 277FE when sending to Medicaid) in the PWK segment in the electronic claim must be identical to the ACN or TCN on paper. Write number reported in 2300 PWK06 (Identification Code) or TCN of accepted claim as reported in the 277FE on documentation before sending to Medicaid.
- All ACNs must be unique.
- The provider and recipient numbers on the claim must match the provider and recipient numbers on the attachment.
- The ACN/TCN number on attachment must be clear and legible.

PHARMACY CLAIMS NCPDP VERSION 5.1
PHARMACY CLAIMS
All interactive electronic pharmacy claims should be submitted using the NCPDP version 5.1 standard. All pharmacy claims submitted electronically in batch must be in NCPDP version 1.1 standard.

12 MEDICAID INFORMATION

Telephone

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

Medicaid Information has a telephone menu to reduce waiting time and the number of transfers for Medicaid providers and clients. A flowchart of the **Medicaid Information Line** menu is included in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual. Customer Service Representatives are available:

Monday, Tuesday, Wednesday, Friday..... 8:00 A.M. to 5:00 P.M.
Thursday ..... .11: 00 A.M. to 5:00 P.M.
Closed on all state and federal holidays.

FAX Numbers

Each Medicaid team has its own FAX line in order to provide better customer service. These FAX numbers are on the back of the ACCESSNOW instructions in the GENERAL ATTACHMENTS Section of this manual.

Mailing Address for Medicaid Claims

BUREAU OF MEDICAID OPERATIONS
BOX 143106
SALT LAKE CITY UT 84114-3106

NOTE: All Medicaid paper claims must be sent via the U.S. Postal Service.

Street Address

Department of Health
288 North 1460 West
Salt Lake City, Utah 84114

NOTE: The Department of Health (the Martha Hughes Cannon Building) is a secure building. Public access is restricted to the lobby area, cafeteria, Vital Records, and a designated conference room, all located on the first floor. Access to other areas of the building requires an employee escort. State and Federal privacy laws do not permit staff at the Martha Hughes Cannon Building's information desk, or any other reception desk in the building, to handle Medicaid claims.

Automated Medicaid Information System: ACCESSNOW

ACCESSNOW, the touch tone telephone eligibility line, is a free information system for Medicaid providers. ACCESSNOW allows you to access information directly and at your convenience.

ACCESSNOW is operated with the use of a touch tone telephone. It provides the following information: client eligibility, including client restrictions, other insurance coverage, health plan enrollment, and primary care physician information where applicable. In the GENERAL ATTACHMENTS section of this manual, there is a step-by-step guide for use of ACCESSNOW. You need a touch tone phone, your 12-digit Medicaid Provider Contract Number followed by the pound sign(#) or your NPI (on or after May 23, 2007) followed by the pound sign(#), and the client's Medicaid Identification Number OR the client's Social Security Number and Date of Birth.

AccessNow is available Monday through Saturday from 6:00 a.m. to midnight and Sunday from noon to midnight. There is no limitation on the number of inquiries you can make. Call Medicaid Information and follow the menu instructions to reach ACCESSNOW.

Electronic Mail Access to Medicaid Staff

Electronic mail (e-mail) messages may be sent to Medicaid staff (employees of the Division of Medicaid and Health Financing, Department of Health) through an Internet provider. All staff - Customer Service Representatives, provider enrollment, pharmacy and transportation team members, publications, policy staff, etc. - have an e-mail address. If you wish to ask a question, provide information needed to process a claim or a prior approval request, request publications (Provider Manuals, Medicaid Information Bulletins, and Amber Sheets), you may send an e-mail as an alternative to a telephone call or FAX. Ask the person to whom you wish to send a message for his or her e-mail address. Due to HIPAA privacy/security regulations, **DO NOT** send personal health information via e-mail.

12 - 1 Internet Site

The Division of Medicaid and Health Financing, Department of Health, has two Internet sites with information for Medicaid providers: Medicaid-specific information: **http://health.utah.gov/medicaid**
HIPAA: **http://health.utah.gov/hipaa/**

Medicaid-specific web site:

There are six selections on the Medicaid home page:

- **Medicaid A – Z.** This web page has a quick reference, alphabetical index linking to subjects and keywords in the Medicaid web site.
- **Programs.** This web page provides general information about the Utah Medicaid Program and eligibility criteria such as income and resource limits.
- **Provider.** This web page has links to the on-line Utah Medicaid Provider Manual, Bulletins and other information for Medicaid providers.
- **Client**. This web page has links to publications, brochures and newsletter with information for Medicaid clients.
- **Questions?** This web page has information on contacting Medicaid, the client advocate, and a local Medicaid office.
- **Español**. This links to language and interpretive services. Spanish is the most commonly requested; services for many other languages are also offered.

HIPAA web site:

This web site contains Utah specific information relating to federal standards imposed on electronic data interchange (EDI) by implementation of the Health Insurance Portability and Accountability Act (HIPAA). Provider links to Utah specific billing instructions (companion guides), privacy notices, EDI enrollment information, crosswalk of Utah Local Codes, etc., are provided.

12 - 2 Information for Clients

Medicaid clients receive information as to the proper and appropriate use of the Medicaid services and benefits covered in several ways. Information sources include eligibility staff; face-to-face and group education; pamphlets, brochures, and newsletters; Medicaid Information; and the client Information Internet site at:
http://health.utah.gov/medicaid/provhtml/clients.htm

13 OTHER MEDICAL ASSISTANCE PROGRAMS

The Department of Health administers or pays claims for medical assistance programs other than the Utah Medicaid Program. Other programs include Presumptive Eligibility (Baby Your Baby), Primary Care Network (PCN), Custody Medical Care, Qualified Medicare Beneficiary, and Emergency Services For Non-Citizens. These programs, eligibility verification and covered services are described in the chapters which follow.

13 - 1 Presumptive Eligibility Program (Baby Your Baby)

The Presumptive Eligibility Program, also known as the Baby Your Baby Program, covers outpatient, pregnancy-related, prenatal care for eligible pregnant women prior to establishing eligibility for Medicaid. Pregnant women apply for this program with a qualified health provider, usually through a community health center or public health department.

Verification

A woman eligible for a Baby Your Baby Identification Card must present the card each time she requests prenatal services. A copy of this card is included with the sample Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual. ALWAYS CHECK ELIGIBILITY DATES on the Baby Your Baby Card. The card has an initial expiration date pending a formal decision of eligibility for Medicaid.

The Medicaid eligibility verification systems, ACCESSNOW, the electronic eligibility inquiry and response (270/271 ANSI X12N Version 4010), and Pharmacy Point of Sale, indicate whether the client's number ends in a 'V'. The 'V' means the provider must VERIFY dates of eligibility on the Baby Your Baby Card. The provider may wish to copy the card to substantiate the claim for services.

When the card expires, Medicaid will no longer pay claims, unless the client has since been issued a Medicaid Identification Card for the month of service. If the woman is determined eligible for Medicaid, she receives a Medicaid Identification Card. If she is not eligible, the Baby Your Baby Card is no longer valid as of the date of the formal Medicaid denial. If Medicaid eligibility cannot be determined before the Baby Your Baby Card expires, the eligibility worker may extend the expiration date.

Note: The name and phone number of the patient's Perinatal Care Coordinator are listed on the back of the Baby Your Baby Card in the lower right-hand corner.

Services Covered

Only outpatient, pregnancy-related medical services are covered. The Baby Your Baby program does NOT cover inpatient care for the woman, and it does NOT cover charges for services for a newborn infant. The mother may apply for Medicaid on behalf of the child if she needs assistance in paying the child's medical bills. NEVER collect a co-payment from a client eligible for the Baby Your Baby Program on the date of service. A co-payment will NOT be assessed by Medicaid.

Enhanced services may be covered with a referral by the patient's Perinatal Care Coordinator. The coordinator's name and phone number are listed on the back of the patient's Baby Your Baby Card in the lower right-hand corner. If the patient has only the Medicaid Identification Card, ask her if she ever had the Baby Your Baby Card and at what clinic she obtained the card. Then call the Community Health Center or local Public Health Department and ask for the perinatal care coordinator.

For more information about application, eligibility, perinatal care coordination and covered or non-covered services under the Presumptive Eligibility (Baby Your Baby) Program, call the Baby Your Baby Hotline, **1-800-826-9662**.

13 - 2 Custody Medical Care Program

The Custody Medical Care Program pays medical bills for a child who is placed in the custody of the State and who has not yet been determined eligible for Medicaid or is not eligible for Medicaid. The program may pay for services not covered by Medicaid and for services from a provider who may not be a current Medicaid provider.

Verification

Medical services are authorized on Form MI-706, STATE MEDICAL SERVICES, by the assigned case manager in the Division of Child and Family Services. The case manager gives the foster parent this form, and it must be presented at the time of the medical visit. A copy of the form and instructions are included with the sample Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Services Covered

Only services identified on the MI-706 form are payable. Every service must be individually authorized before payment is made. Services provided without authorization will **not** be paid by the Division of Child and Family Services nor by Medicaid. Emergency services can be authorized after the fact, as long as the service is within the scope of service of the program, and Form MI-706 is obtained before billing. Services must be billed within twelve months of the date of service or six months of the date Form MI-706 was issued, whichever is later. To bill claims, follow the same instructions as for billing Medicaid claims with one exception: every claim requires a prior approval number. (The prior approval number is the MI-706 number.) Medicaid processes the claim, and the payment method and amount is the same as that for the Medicaid Program, even though the child is not eligible for Medicaid.

For more information, contact Medicaid Information. Refer to Chapter 12. You may also call Julie Moore, CMC Specialist, Medicaid Operations, (801) 538-6085, Email: JMOORE1@utah.gov, FAX: (801) 538-9428.

13 - 3 Children in State Custody (Foster Care)

Medical services for most children placed in state custody (Foster Care) are covered either by Medicaid or the Custody Medical Care Program. The State pays medical bills only when the child is eligible for either of these programs. The State does not automatically pay medical bills for children in Foster Care. BEFORE providing services, determine the child's health care coverage. Find out if the child is eligible for Medicaid and assigned to a Primary Care Provider or ACO.

The information in this chapter is intended to assist providers in determining and providing health coverage for a child in state custody. Please provide services to these children within the time frames outlined in the third section of this chapter, Time Frame for Services. The Division of Child and Family Services contracts with the Department of Health to provide health care case management for children in foster care. You may contact the Fostering Health Children Program with questions about serving children in state custody.

Children in Foster Care Eligible for Medicaid

BEFORE providing services, check (1) Medicaid eligibility and (2) the health care providers identified on the current Medicaid Identification Card. Services will not be reimbursed when the child is not eligible for Medicaid, nor when the child is covered by a health plan or Prepaid Mental Health Plan and the provider is not affiliated with the plan. To check eligibility and provider assignment, use the

Medicaid Identification Card, or the electronic eligibility inquiry and response (270/271 ANSI X12N Version 4010), or call ACCESSNOW.

Many of the children placed in state custody are already eligible for Medicaid and enrolled in an ACO. As with any other enrollee, these children are covered ONLY for services received from providers affiliated with the ACO(s) identified. The provider receives payment from the child's ACO. If a child is taken to a provider who is not affiliated with the child's plan, referred to as 'out of plan', services will not be reimbursed by the plan nor by Medicaid.

The child may be enrolled in a Prepaid Mental Health Plan (PMHP) for inpatient psychiatric services only. The Medicaid Card specifies the name of the PMHP. (Foster care children may obtain outpatient mental health services from any participating Medicaid provider.) The caseworkers in the Division of Child and Family Services are responsible for coordinating any needed outpatient or inpatient mental health services.

For new enrollees, the Division of Child and Family Services (DCFS) chooses an ACO which contracts with the provider(s) the child has seen in the past. Foster parents and Division staff continue to be trained to use providers affiliated with the health plan and PMHP plans in which the child is enrolled.

When the child is eligible on the date of service and not assigned to a health plan nor a PMHP, services may be billed directly to Medicaid as fee-for-service. Some children in state custody come from outside the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties) for medical treatment and are not enrolled in a health plan. Also, when the child is placed in a different household, a new Medicaid Identification Card must be issued. In a very few cases, this change means the child's Medicaid Card does not indicate a health plan for the first month. The provider will receive payment for services either from the child's health plan if the child is enrolled in a health plan or from Medicaid.

When the child is not enrolled in a plan, Medicaid reimburses the provider directly. Payment for services to these children is on a fee-for-service basis.

Children in Foster Care Not Eligible for Medicaid

When a foster child is not eligible or not yet eligible for Medicaid, the child may qualify for the Custody Medical Care Program. A nurse from the *Fostering Healthy Children Program (FHC) may authorize medical services on Form MI-706, STATE MEDICAL SERVICES and give it to the foster parent. This form must be presented at the time of the visit. Services provided without this authorization will not be paid by DCFS or Medicaid. Also refer to Chapter 13 - 4, Children in State Custody. *Fostering Healthy Children is a program within the Department of Health which contracts with the Division of Community and Family Health Services, Bureau of Children with Special Health Care Needs, to provide nurse case manager services.

Time Frame for Services

Children removed from their homes must receive certain services within the specific time frames listed below. Providers are encouraged to do everything possible to provide service to the child placed in state custody within these time frames stated.

1. Children must receive an initial physical exam within five days of removal.
2. Children must have a complete CHEC exam within 30 days of removal.

3. Children must receive a mental health assessment within 30 days of removal.

4. Children must receive a dental exam within 60 days of removal.

13 - 4 Child Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is a medical assistance program for children who do not have other health insurance and who meet the eligibility criteria. A child may qualify when three conditions are met:

1. The child is 18 years or younger

2. Family income is below 200% of the federal poverty level (FPL) and the child is not eligible for Medicaid. The FPL is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml (The Medicaid income standard is 133% FPL for ages 0-5 and 100% FPL for ages 6 - 18.)

3. There is no other insurance plan available, either from employer or individual.

For more information about the CHIP Program, call the CHIP Hotline: **1-888-222-2542.** The CHIP Internet site is **http://health.utah.gov/chip** .

The CHIP Program does not have a premium payment. Refer to the sub-section below titled **Services Covered** for a description of other charges.

Providers enrolled as Medicaid providers are eligible to provide CHIP services. Billing forms, formats, codes, and the billing address are similar or identical to Medicaid's. Services are funded with a $4 or $1 match from the federal government. Funding is in part from an increase in the national cigarette tax and a Utah state hospital assessment.

Verification

Eligible clients have a CHIP Identification Card. Providers may also verify eligibility through the Medicaid information system. Refer to Chapter 5, Verifying Medicaid Eligibility.

Services Covered

Preventive care includes: routine physicals, well baby and well child care, immunizations, vision screening, hearing screening, and basic dental services (cleaning, exam, and x- rays). Preventive services are free. Other benefits include inpatient and outpatient hospital services, physicians' services, office visits, laboratory services, prescription drugs, mental health services, and single surface dental fillings. There are co-payments and deductibles for non-preventative care services. The amount is nominal for families with income under 150% of the federal poverty level and higher for families with income between 150% and 200% of the FPL. (The FPL is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml .)

13 - 5 Qualified Medicare Beneficiary Program (QMB)

The Qualified Medicare Beneficiary Program helps with the cost of the Medicare Program. The QMB program is not a Medicaid program. To qualify, an individual must be entitled to Medicare, have limited financial resources and low income. Refer also to Chapters 11 - 6, Medicare/Medicaid Crossover Claims, and 11 - 7, Filing Crossover Claims, for information on billing claims.

Verification

Qualified persons receive a Qualified Medicare Beneficiary (QMB) Identification Card. A copy of this card is included with the sample Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Services Covered

For people who qualify, the State pays the Medicare premiums (Part A and Part B) and the lesser of either:

a. Medicare deductibles and coinsurance (co-payment) for covered services under Medicare Part A and Part B, up to the amount allowed for reimbursement by Medicaid.

13 - 6 Administrative Physicals

When an administrative physical is required to determine Medicaid eligibility based on the applicant's ability to work, the eligibility worker will give the applicant two forms. The two forms are the administrative physical form (Form 20 or Form 20M) and a reimbursement agreement, Form MI-706, Request for Medical Information. The applicant is told to take both forms to a provider who will accept the State's payment for the physical. A copy of the Form MI-706 and form instructions are included with the examples of Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Administrative physicals are used to determine eligibility for programs other than Medicaid. Providers may receive medical reports and billing forms other than the Form MI-706, Request for Medical Information. Please follow the directions for completing the forms and submitting the bill to the appropriate agency.

13 - 7 Emergency Services Program For Non-Citizens

The Emergency Services Program is a health program designed to cover a limited scope of services for a specific, defined group of individuals.

Authority

The Social Security Act Section 1903(v)(1) and 42 CFR 440.255(c) provides that no payment can be made to the state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence status in the United States. People who meet all Medicaid eligibility requirements except citizenship can receive services only for an "emergency medical condition". The act defines "emergency medical condition" (including emergency labor and delivery) as "manifesting itself by sudden onset of acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

A. placing the patient's health in serious jeopardy,
B. serious impairment to bodily functions, or
C. serious dysfunction of any bodily organ or part."

Such care and service cannot be related to an organ transplant procedure. (Emphasis added.)

I DEFINITIONS

The following is the Utah Medicaid definition of "emergency" as it applies to these services:

Emergency shall mean a medical condition for which the absence of immediate medical attention could reasonably be expected to result in death or permanent disability to the person, or in the case of a pregnant woman, to the unborn child. Emergency services shall be those rendered from the moment of onset of the emergency condition, to the time the person's condition is stabilized at an appropriate medical facility, or death results. The definition of emergency services shall include labor and delivery services, but not pre-natal or postpartum services. Emergency services shall not include prolonged medical support, medical equipment, or prescribed drugs which are required beyond the point at which the emergency condition has been resolved. Emergency services also shall not include long term care or organ transplants.

Medical Identification Card

Individuals who qualify only for Emergency Services have a special card issued by Medicaid which states "EMERGENCY SERVICES". The client is eligible only for the restricted scope of emergency service defined by the Social Security Act and Medicaid's definition of emergency as noted above. These services are covered only until the condition is stabilized. A condition is stabilized when the severity of illness and the intensity of service is such that the patient can leave the facility. Services rendered subsequent to the patient leaving the facility, such as follow-up visits, follow-up treatment or visits scheduled in the future, are not covered by this program.

Documentation

Only labor and delivery services are paid for the Emergency Services client without documentation and review. Pre-natal and post-partum services ARE NOT covered for a non-citizen. Physicians and certified nurse midwives may use only the non-global delivery codes specified in SECTION 2 of the Utah Medicaid Provider Manual for Physician Services and for Certified Nurse Midwife Services.

All other services provided to a non-citizen, eligible only for the Emergency Services Program, require documentation and review before payment to determine that the services meet the definition and limitations of an emergency medical condition as outlined in the Social Security Act and 42 CFR 440.255(c).

Advising Client of Non-Covered Services

Because the Emergency Services Program has a very restricted scope of services, it does not have some of the same restrictions on billing the patient as is the case in Medicaid covered services. If a provider does not receive payment because the provider failed to follow procedure to get a service covered, the provider is prohibited from pursuing payment from the patient. If, however, payment is not made because the

service was not an emergency, or the service is not provided under the program, then the patient can be billed for those services.

When a service to be rendered to an Emergency Services client is not or does not appear to be emergent in nature, the provider would be prudent to inform the patient, prior to the service, that the service will not be covered by Medicaid, and that the patient will be financially responsible for paying the bill. However, if the service meets the Medicaid definition of "emergency", Medicaid will pay for the service.

Criteria to Identify An Emergency Service

For services to be covered under the Emergency Services program, ALL of the following criteria must be present:

A. The condition manifests itself by **sudden onset**.

B. The condition manifests itself by **acute symptoms (including severe pain)**.

C. The condition requires **immediate medical attention**.

1. Immediate medical attention means provision of service within **24 hours of the onset of symptoms or within 24 hours of diagnosis** (whichever is earlier).

2. The condition requires acute care, and is **not chronic**.

3. Coverage will only be allowed **until the condition is stabilized** sufficiently so that the patient can leave the acute care facility or no longer needs constant attention from a medical professional.

4. The condition is **not related to an organ transplant procedure**.

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

A. **Steps to Seeking Payment for Services Provided to an Emergency Services Client**

B. Provider submits a claim to Medicaid with the required documentation. If sending claim electronically, utilize the attachment control number. FAX or mail your documentation. Include the attachment control number, provider name and Medicaid ID, and recipient name and Medicaid ID on your attachment.

C. Medicaid pays a claim for labor and delivery for a qualified client. If no attachment is sent with the claim, the claim will deny. A remittance advice will be sent to the provider.

D. When the remittance advice is received stating payment was denied, FAX or mail to Medicaid a copy of the remittance advice, the medical record **specific to the case in question,** including reports and consultations, and any other documentation in support of the services as a medical emergency. DO NOT rebill the claim. The FAX number for the Emergency Services Program: (801) 536-0475 The Medicaid billing address is in Chapter 12, Medicaid Information. All information to be considered for review MUST be included in this initial submission. A second submission will not be considered for payment. See item 4 and 5 for utilization of the Administrative Review/Fair Hearing.

E. Medicaid staff will review the submitted documentation. If services meet the definitions of an "emergency medical condition" and "immediate medical attention" and are approved as an emergency, the claim will be paid. A remittance advice will be sent to confirm payment. If criteria are not met, a letter will be sent from the Prior Authorization Unit outlining the reasons for denial. Administrative Review and Fair Hearing rights will be explained in the denial letter.

F. A provider who does not agree with Medicaid's decision should refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 15, Administrative Review/Fair Hearing.

G. Any payment made by the Medicaid Agency for a service is considered payment in full. Once that payment has been made to the provider, no additional reimbursement can be requested from the client.

13 - 8 Non-Traditional Medicaid Plan

The Non-Traditional Medicaid Plan (NTMP) provides a scope of service similar to that currently covered by the Medicaid State Plan, but with some additional limitations and reduced benefits. Eligible clients are adults over the age of 19, with children, who receive cash assistance from the Utah Family Employment Program (FEP), or they are transitioning into the workforce and eligible to receive medical assistance during the transition, or they qualify as medically needy.

Verification

Qualified persons receive a blue Non-Traditional Medicaid Plan Identification Card.

Services Covered

As stated, the scope of service is similar to the Medicaid program, but with some limitations. There are limits or benefit reductions in the following types of services: pharmacy, dental services, vision services, mental health services, substance abuse services, physical therapy, occupational therapy, chiropractic services, organ transplants, transportation services, outside medical services in free standing surgical center, emergency center (instep care type), or birthing center if chosen by the plan administrators.

For more information, refer to the SECTION titled "Non-Traditional Medicaid Plan" in selected Medicaid Provider Manuals, or use the on-line version (link at http://www.health.utah.gov/medicaid/provhtml/provider.html .)

13 - 9 Primary Care Network Program

The Primary Care Network serves individuals age 19 to 64 with incomes under 150% of the federal poverty level who are not otherwise eligible for Medicaid through the State Plan and who are eligible only through the Demonstration Waiver.

Verification

Qualified persons receive a yellow Primary Care Network Identification Card.

Services Covered

The Scope of Service is limited to basic medical service of a general nature to provide preventive and palliative care in an outpatient, office setting. The following types of services are covered with limitations: Hospital services, physician services, general preventive services and health education, family planning services, laboratory and radiology services, pharmacy, prescriptions, dental services, vision services, medical supplies and equipment, transportation services.

For more information, refer to the Provider Manual for the Primary Care Network, available through the Medicaid agency.

14 DEFINITIONS

Following is a list of definitions relevant to the administration, policies and procedures of Utah's Medicaid Program:

Abuse: Refer to 'Provider Abuse.'

Accountable Care Organization: ACO; See Health Plans.

Assigned Claim: a claim for which the provider accepts the Medicare assignment of payment.

Audit Settlement: An agreement to resolve a civil financial Medicaid overpayment dispute when criminal charges are not currently filed.

Carve-out services: Services not included in the Medicaid contract with an individual ACO.

Child Health Evaluation and Care or **"CHEC":** The name used in Utah for the EPSDT program. This program is designed to bring comprehensive health care to individuals from birth to 21 years of age who are eligible for Medical Assistance.

Client: a person who applies for Medicaid and may be eligible. "Client" is used interchangeably with "recipient" when the person is eligible for the Utah Medicaid Program. Refer also to "Recipient".

Clinical Laboratory Improvement Amendments (CLIA): The federal Centers for Medicare & Medicaid Services(CMS) program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.

Code of Federal Regulations (CFR): The publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid program. Federal rules promulgated by the Centers for Medicare & Medicaid Services (CMS) place requirements upon the state Medicaid agency, Medicaid providers, and recipients.

Covered Medicaid Service: Service available to an eligible Medicaid client within the constraints of the Utah Medicaid Program and criteria for approval of service.

Criminal Subpoena: An order signed by a judge obtained pursuant to a pending criminal investigation filed with the court as required by Utah Code § 77-22-2, which requests the named witnesses testimony or documents possessed by the person upon whom the subpoena is served (Subpoena Duces Tecum). A criminal subpoena is not a search warrant and does not provide authority for the serving office to enter a premise or inspect or seize property or persons.

Current Procedural Terminology Manual (CPT): The manual published by the American Medical Association that provides a systematic listing and coding of procedures and services performed by physicians and simplifies the reporting of services to third party payers.

Diagnosis Related Group (DRG): The system established to recognize and reimburse for the resources used to treat a client with a specific diagnosis or medical need. The is weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files or from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS).

Division of Medicaid and Health Financing: the organizational division in the Utah Department of Health which administers the Medicaid program in Utah.

Early Periodic Screening Diagnosis and Treatment or "**EPSDT":** Refer to 'Child Health Evaluation and Care'.

Enrolled Provider: A licensed practitioner of the healing arts or an entity providing approved Medicaid services to patients under a provider agreement with the Department.

Explanation of Benefits or **"E.O.B":** the form sent by a liable third party to a provider to explain whether a claim is paid and the amount paid or denied and the reason denied.

Explanation of Medicare Benefits or **"E.O.M.B":** the form received by the provider from Medicare to explain whether a claim is paid, the amount paid, or denied and the reason denied.

Federal Financial Participation or **"FFP":** the amount the federal government contributes to provider reimbursement for Medicaid or other medical services.

Federal Poverty Level (FPL): The poverty guidelines are a simplification of the poverty thresholds for use in determining financial eligibility for certain federal programs. The guidelines are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The Federal Poverty Level is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml .

Fee for Service: Services covered directly by Medicaid and not by an ACO. Reimbursement is an established amount of money paid to a provider in exchange for a specifically defined and coded service provided to a Medicaid client.

Fee-for-Service Medicaid client: A client who (1) is not enrolled in an ACO;or (2) is enrolled in an ACO, but the service that is needed is covered by Medicaid, not by the plan.

Fraud: Refer to 'Medicaid Fraud'.

Healthcare Common Procedure Coding System: The system mandated by the Centers for Medicare &Medicaid Services (CMS) to code procedures and services. This system incorporates the CPT Manual for physicians and individually developed service codes and definitions for non-physician providers.

Intermediary: an entity which contracts with Centers for Medicare & Medicaid Services (CMS) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis and to perform other related functions.

International Classification of Diseases or **"ICD":** the source for coding the diagnosis for which a patient is being treated.

Investigation: An official inquiry conducted by law enforcement officers of the Utah Department of Public Safety's Medicaid Fraud Unit, to prove or disprove evidence of criminal conduct. An investigation may begin by auditing provider records.

Medicaid: the medical assistance program authorized under Title XIX of the Social Security Act.

Medicaid Agency: the Utah Department of Health, Division of Medicaid and Health Financing.

Medicaid Audit: A civil or administrative process of reviewing Medicaid provider records to ensure accurate billing and payment for Medicaid claims.

Medicaid Fraud: Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive some unauthorized Medicaid benefit for any person or entity. Refer to Utah Code Ann. §§ 26-20-1, et seq.; Utah Administrative Rules, R414-22; and 42 C.F.R. § 455.2. Medicaid fraud violations may also be brought under more general state and federal theft and fraud statutes.

Medicaid Fraud Control Unit (MFCU): The official state Medicaid fraud control unit in the Department of Public Safety, certified by the federal government, to investigate and prosecute complaints of abuse and neglect of patients, and Medicaid fraud under state laws as required by 42 CFR §§ 1007.7 through 1007.13. The MFCU has state-wide prosecutorial authority.

Medicaid Information Bulletins: An official, periodic publication of the Division of Medicaid and Health Financing to update the Utah Medicaid Provider Manual or issue information to Medicaid providers.

Medicaid Provider Agreement: A signed contract between a provider and the Utah Medicaid program by which the provider agrees to abide by all state and federal law related to the Medicaid Program, including providing medical and billing records for the purposes of conducting Medicaid and MFCU audits to determine fraud or abuse of the Medicaid program. The provider also agrees to abide by any subsequent amendments to the Agreement published in the Medicaid Information Bulletin. This agreement, together with the recipient's Medicaid application, authorizes the release of Medicaid records for Medicaid and MFCU auditing purposes.

Medical Necessity: A service is "medically necessary" if it is (1) reasonable calculated to prevent, diagnose, or cure conditions in the client that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and (2) there is no other equally effective

course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly.

Medicare: the national health insurance program for aged and disabled persons under Title XVIII of the Social Security Act. Part A includes hospital and nursing home services. Part B pays professional fees, such as physicians, physical therapy, etc.

Overpayment: Refer to 'Provider Overpayment'.

Patient: an individual awaiting or receiving professional services directed by a licensed practitioner of the healing arts.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the state.

Plea Agreement: An agreement made between a prosecutor to resolve pending criminal charges against a Medicaid provider.

Prepaid Mental Health Plan or **"PMHP":** a plan offering coverage for mental health care services.

Prior Authorization or **"PA":** required approval obtained by a health care provider from Medicaid (the Division of Medicaid and Health Financing, Department of Health) before service is rendered.

Provider: An entity or licensed practitioner of the healing arts furnishing medical, mental health, dental or pharmacy services.

Provider Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices resulting in unnecessary Medicaid costs. Reimbursement for services that are not medically necessary, fail to meet professionally recognized standards of care, or any practice that results in increased costs to Medicaid are also considered abuse. Criminal intent need not be alleged nor proved to establish abuse. Refer to 42 C.F.R. § 455.2.

Provider Agreement: Refer to 'Medicaid Provider Agreement'.

Provider Overpayment: An overpayment occurs when a Medicaid provider receives more Medicaid reimbursement than the provider is entitled, regardless what party is at fault.

Recipient: a person who is eligible for the Utah Medicaid Program and eligible to receive covered Medicaid services from an enrolled Medicaid provider.

Reimbursement: an established amount of money paid to a provider in exchange for a specifically defined and coded service provided to a Medicaid client.

Remittance Statement: the explanation from Medicaid as to claims which have been paid, denied or are in process.

Search Warrant: An order signed by a judge and served by a law enforcement officer, which identifies a specific location, items, or person to be searched based upon a judicial finding that probable

cause exists to believe that the property or evidence was unlawfully acquired or possessed, used to commit or conceal the commission of a crime, or is evidence of illegal conduct. Refer to Utah Code §§ 77-23-201 and -202. Search warrants are also governed by the Fourth Amendment of the United States Constitution and article I, section 14 of the Utah Constitution.

Services: The types of medical assistance specified in Sections 1905(a)(1) through (25) of the Social Security Act and interpreted in 42 CFR 440 [October 1, 1996, edition].

Single State Agency: The agency which administers the Medicaid program in the State of Utah is the Utah Department of Health, Division of Medicaid and Health Financing.

Third Party Liability or **"TPL":** the responsibility of an individual, entity, or program which is or may be liable to pay all or part of the medical cost of injury, disease, or disability of a patient.

Title XIX: the Medicaid Program authorized by the Federal Social Security Act.

Utah Department of Health: the Single State Agency designated to administer or supervise the administration of the Medicaid Program under Title XIX of the federal Social Security Act. All references to "the Medicaid agency "mean the Department of Health. Reference: Utah Code Annotated §26-18-2.1 (1953, as amended) and Utah Administrative Code, Rule R414-1-2.

Utah Health Information Network or **"UHIN":** (1) a coalition of insurers, providers, the Utah Medical Association, the Utah Hospital Association, and State Government which developed an electronic data exchange to centralize transactions for providers and payers, including Medicaid. (2) the electronic data exchange, also referred to as UHIN or the UHIN network.

14 – 1 Acronyms

Following is a list of acronyms commonly used in the administration, policies or procedures of Utah's Medicaid Program.

ACO	Accountable Care Organization
ALOS	Average length of stay
ANSI	American National Standards Institute
CDEN	Child Health Insurance Program Dental Claims
CFR	Code of Federal Regulations
CHEC	Child Health Evaluation and Care
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services [formerly Health Care Financing Administration (HCFA)]
CPT	Current Procedural Terminology
DCFS	Division of Child and Family Services
DMHF	Division of Medicaid and Health Financing
DHS	Department of Human Services
DOH	Department of Health
DRA	Deficit Reduction Act

DRG	Diagnosis Related Group
DUR	Drug Utilization Review
DWS	Department of Workforce Services
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early Periodic Screening Diagnosis and Treatment
EREP	Electronic Resource and Eligibility Product
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FR	Federal Register
GRAMA	Government Records Access and Management Act
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration (Federal) [Name changed to Centers for Medicare & Medicaid Services (CMS) in June 2001]
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Health and Human Services (Federal)
HIPAA	Health Insurance Portability and Accountability Act
HPR	Health Program Representative
ICD-9	International Classification of Diseases, Ninth Revision
ICF	Intermediate Care Facility
IPA	Independent Practice Association
LTAC	Long Term Acute Care Hospital
LTCB	Long Term Care Bureau
MCP	Managed Care Plan (Now called Accountable Care Organization or ACO)
MFCU	Medicaid Fraud Control Unit
MFU	Medicaid Fraud Unit, now the MFCU
MMCS	Medicaid Managed Care System
MMIS	Medicaid Management Information System
NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NTM	Non-Traditional Medicaid
OBRM	Omnibus Budget Reconciliation Act
ORS	Office of Recovery Services
ORSIS	Office of Recovery Services Information System
PACMIS	Public Assistance Case Management Information System
PCN	Primary Care Network
PCP	Primary Care Physician
PERM	Payment Error Rate Measurement

PMIP	Prepaid Mental Health Plan
POS	Point of Sale
PPO	Preferred Provider Organization
PRO	Peer Review Organization
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TPL	Third Party Liability
UHA	Utah Hospital Association
UHCA	Utah Health Care Association
UHIN	Utah Health Information Network
UHINT	Utah Health Information Network Transactor
UMA	Utah Medical Association
KUPP	Utah's Premium Partnership
WIC	Special Supplemental Food Program for Women, Infants, and Children

Notes:

- Acronyms are listed separately on the preceding page. Acronyms are not included in the index.
- In the electronic version of SECTION 1 on the Internet (http://health.utah.gov/medicaid/pdfs/SECTION 1pdf). use the Adobe Acrobat FIND function to locate a keyword of interest.
- Where there are multiple page numbers indexed to a keyword, the page numbers(s) in boldface type indicate a chapter heading on that keyword.

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