

SECTION 2

DENTAL, ORAL MAXILLOFACIAL, AND ORTHODONTIA SERVICES

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1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to [Section I: General Information, Chapter 1, General Information](#).

1-1 Dental Services

Dental services, whether furnished in the office, a hospital, a skilled nursing facility, or elsewhere, means covered services performed within the scope of the Medicaid dental provider's license as defined in Title 58, Occupations and Professions. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a member's oral or general health. In addition, orthodontics is defined as a corrective procedure for functionally handicapping conditions.

According to Medicaid's policies and procedures, all services must maintain a high standard of quality and be provided within the reasonable limits of those customarily available and provided to most persons in the community.

In addition to this provider manual, reference [Utah Administrative Code Title R414. Health Care Financing, Coverage and Reimbursement Policy](#), for more information on Utah Medicaid Policy. For specific information regarding Dental, Oral and Maxillofacial Surgeons and Orthodontia Services see [Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia](#). Coverage and reimbursement information by procedure code is found in the [Coverage and Reimbursement Code Lookup](#).

References: 42 CFR §§440.100, 440.120, 440.225, 440.50, 483.55; and [Administrative Rule R414-49](#).

2 Health Plans

For more information about *Fee-for-Service and Managed Care* refer to [Section I: General Information, Chapter 1-7](#).

For more Information about Dental Plans, refer to [Section I: General Information, Chapter 2-10](#)

Managed care plans are not responsible for covering the following Medicaid State Plan or waiver services. These services are "Carved-Out Services" and should be reported directly to Medicaid on a fee-for-service basis:

Any dental service for a Medicaid eligible member who is:

- a non-pregnant adult, except for an EPSDT enrollee;
- in the custody of the Department of Human Services and covered by Foster Care Medicaid;
- in a nursing home or an intermediate care facility; or
- enrolled in Utah's Premium Partnership for Health Insurance (UPP);
- Facility charges for hospital and ambulatory surgical centers;
- Medical and dental surgical services that include general anesthesia performed at a hospital or ambulatory surgical center;

- Emergency services performed in an emergency department of a hospital or an urgent care facility;
- Services performed at Indian Health Services, any tribal facility, or an Urban Indian facility;
- Services performed at the Utah State Hospital or Utah State Developmental Center; and
- Surgical repair services performed by a dentist or oral surgeon for craniofacial anomalies, cleft lip, or palate.

3 Provider Participation and Requirements

Refer to [Section I: General Information](#), Chapter 3, *Provider Participation and Requirements*.

4 Record Keeping

Refer to [Section I: General Information](#), Chapter 4, *Record Keeping*.

5 Provider Sanctions

Refer to [Section I: General Information](#), Chapter 5, *Provider Sanctions*.

6 Member Eligibility

Refer to [Section I: General Information](#), Chapter 6, *Member Eligibility*, to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Eligible Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member Responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to [Section I: General Information](#), Chapter 7, *Member Responsibilities*.

8 Programs and Coverage

For information on policy regarding dental, oral and maxillofacial surgeons and orthodontia coverage, see [Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia](#). For general information on Medicaid programs, refer to [Section I: General Information](#), Chapter 8, *Programs and Coverage*, and [Utah Medicaid Provider Manuals Parent Directory](#). Specific coverage and reimbursement information by procedure code is found in the [Coverage and Reimbursement Code Lookup](#).

For Medicaid members that are enrolled as Targeted Adult Medicaid (TAM) members undergoing substance use disorder (SUD) treatment, Aged, or Blind and Disabled, dental services must be provided through the University of Utah School of Dentistry (UUSOD) or their associated state-wide provider network. Providers must be paneled with the UUSOD for dental services to be covered for the TAM SUD, Aged, or Blind and Disabled populations.

For provider network access questions, see [Dental Coverage and Plans](#) on the Medicaid website, or contact the UUSOD at (801) 587-7174.

8-1 Definitions

Definitions of terms used in multiple Medicaid programs are in [Section I: General Information](#), Chapter 1-9, *Definitions* and [Utah Administrative Code R414-1](#). Utah Medicaid Program.

Definitions particular to Dental Services are found in [Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia](#). Definitions.

8-2 Endodontics

8-2.1 Completed Root Canal

A root canal is to be reported after the canals has been completely obturated with the final filling. Reporting for services that have not been completed is considered fraud.

8-2.2 Billing the Member for Incomplete Root Canal

A dental provider cannot submit a claim to Medicaid for a completed therapeutic pulpotomy when a Medicaid member has the first stage endodontic procedure performed and fails to return for subsequent appointments.

If a written agreement was obtained from the member in advance of treatment, the provider may bill the member for the non-covered pulpal debridement to relieve acute pain before conventional root canal therapy.

The agreement must fulfill ALL FOUR conditions described in the provider manual, [Section I: General Information, Chapter 3-5, Exceptions to Prohibition on Billing Members, Non-Covered Services](#), and also the following:

- The non-covered service, pulpal debridement may only be reported if the member fails to complete endodontic treatment and the required agreement is in place.
- The provider must refund the fee to the member if the root canal is completed and reported to Medicaid.
- A dental provider who fails to comply precisely with the Medicaid process for billing a member is disqualified from billing the patient.

8-3 Prosthodontics

8-3.1 Dentures

Denture services require written prior authorization.

Upper dentures and lower dentures are limited to once every five years. For example, a member that receives an immediate upper denture within the last five years would not be eligible for complete or partial upper dentures within the same five-year period, the same being applicable to lower dentures.

Complete maxillary and mandibular dentures may be allowed for the replacement of permanent teeth under the following conditions when the patient is either:

- edentulous
- has a dental or medical condition that indicates extraction of remaining teeth, or
- documentation of prior appliance

Partial dentures may be allowed when the following criteria are met;

- Prior authorization was obtained before fabricating the partial denture.

- There must be an anterior tooth missing, or the partial denture must restore mastication ability.
- If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if they have two maxillary and two mandibular posterior teeth on the same side in occlusion.
- There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch.
- Medicaid will cover a partial denture if a complete denture opposes it and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch.
- The provider must send the following:
 - Mounted periapical x-rays or Panorex
 - Documentation of the teeth to be replaced

Dental prophylaxis is available for adults and children with dentures through CDT codes D1110 and D1120, respectively. Any enrolled Medicaid dental provider may provide services. All other denture services require written prior authorization.

Additional information on coverage requirements and limitations of denture services is found in the Coverage and Reimbursement Lookup Tool at:
<http://health.utah.gov/stplan/lookup/CoverageLookup.php>.

8-3.2 Loss of Eligibility

A member may lose their Medicaid eligibility before the completion of prosthodontic services. In such instances, Medicaid permits reporting the date of service based on:

- The date of impression related to the prosthodontic service, or
- The date the member had their teeth extracted to receive prosthodontic services and has not yet received impressions.

When reporting prosthodontic services rendered under one of these circumstances, providers must:

- Report the claim with CDT code D5899 in conjunction with the designated prior-authorized prosthodontic code.
- Submit substantiating documentation, including an attestation of having completed prosthodontic services before reporting the claim.

This process does not permit any exceptions to PA requirements. Prosthodontic PAs are for one year from the date of issuance. If the services have not been completed within the PA time frame and a member has lost eligibility, the related claim will be denied.

8-4 Emergency Services

Emergency dental care services are reported globally and include necessary laboratory and preoperative work, placement of sutures, packing, removal of sutures, and office calls.

8-5 Sedation and General Anesthesia

Medicaid requires providers to abide by the current *American Dental Association (ADA)* "[Guidelines for the Use of Sedation and General Anesthesia by Dentists](#)" when performing sedation permitted within their scope of training/licensing. When sedation is provided by another

licensed dentist, anesthesiologist, or certified registered nurse anesthetist, the same requirements apply.

If a member is EPSDT eligible, the provider must also abide by the current *American Academy of Pediatric Dentistry* (AAPD) clinical guidelines, "[Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures.](#)"

The member's medical record must reflect adherence to ADA or AAPD guidelines. Documentation must show that there was no other equally effective, more conservative, and less costly level of sedation suitable for the member. Medicaid covers only those services that are medically necessary under Utah Administrative Code R414-1-2(18), which states:

"Medically necessary service" means that:

(a) it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and

(b) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

These guidelines apply to all members, including those with special needs.

Ambulatory surgical centers (ASC) billing for dental services shall use code 41899. Prior authorization may be required. Refer to the Coverage and Reimbursement Lookup tool at: <http://health.utah.gov/stplan/lookup/CoverageLookup.php>.

For information related to billing for services related to sedation, see Chapter 11 "Billing Medicaid."

8-5.1 Oral and Intramuscular Sedation

Medicaid covers intramuscular and intraoral injections for sedation only. Behavior management is not covered. Orally administered medications for sedation are covered under the Medicaid pharmacy program by prescription only.

8-6 Orthodontia

Orthodontia services are available to eligible Medicaid members who have a handicapping malocclusion due to congenital disabilities, accidents, disease, or abnormal growth patterns, of such severity that they cannot masticate, digest, or benefit from their diet.

Orthodontic treatment is limited to one per lifetime.

Prior authorization is required for orthodontia. Send pre-treatment models and photographs, panoramic x-rays, and requested codes on a completed prior authorization form.

Medicaid uses the J.A. Salzmann Handicapping Malocclusion Assessment Record to determine the severity of the malocclusion. Per policy, a tooth must be rotated 30 degrees or more to be included in the assessment. The completed assessment record is used to calculate an index number ("Salzmann Scoring Index"). Members must have a Salzmann Scoring Index of 30 or more to qualify for orthodontia.

Comprehensive orthodontic treatment is a global service that includes banding and adjustments. It is reported at the time of banding. Orthodontic retention is reported upon completion of treatment.

Orthodontia services for Indian Health Services (IHS) are limited to 36 visits for comprehensive treatment and two visits for orthodontic retention. Claims are adjudicated and reimbursed at the all-inclusive rate (AIR).

8-6.1 Non-Covered Orthodontic Services

The following services are non-covered:

- Limited orthodontic and removable appliance therapies
- Re-banding or multistage orthodontic treatment
- Removable appliances in conjunction with the fixed banded treatment
- Habit control appliances
- Orthodontic services for cosmetic or esthetic reasons
- Dental surgical procedures that are cosmetic even when performed in conjunction with orthodontia
- Treatment of any temporomandibular joint condition or dysfunction
- Conditions in which radiographic evidence of bone loss has been documented

Medicaid requires that a licensed orthodontic specialist and a licensed maxillofacial oral specialist be used to treat combined orthodontic/surgical cases. Reimbursement will not be made to general dentists that perform orthodontic or surgical treatment for combined orthodontic/surgical cases.

8-7 Craniofacial Anomalies

The following codes may be allowed with prior authorization approval for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) members with craniofacial anomalies, cleft lip or palate:

- D5936- obturator prosthesis, interim
- D5952- speech aid prosthesis, pediatric
- D5988- surgical splint
- D8210- removable appliance therapy
- D5999- unspecified maxillofacial prosthesis, by report designated for nasal stent/nasal stent activator
- D8999- unspecified orthodontic procedure, by report designated for rapid palate expander

These services are carved out of the Managed Care Entities and billed directly to Medicaid as fee-for-service. Criteria include substantiating the medical necessity of services by describing the medical condition, dentist's treatment plan, and schedule, and radiographs fully depicting existing teeth and associated structures.

8-8 Silver Diamine Fluoride

Silver Diamine Fluoride (SDF) is a liquid substance used to help prevent tooth cavities (or caries) from forming, growing, or spreading to other teeth. Medicaid covers SDF for treatment of primary dentition for EPSDT eligible and pregnant members when:

- Used for treatment of dental caries

- May be applied once per tooth every 6 months

Medicaid does not cover SDF for caries prevention or dental hypersensitivity.

Additional coverage and reimbursement information by procedure code is found in the [Coverage and Reimbursement Code Lookup](#).

8-9 Dental Hygienists

Dental hygienists enrolled as Medicaid providers may directly report claims for certain dental services provided independently in a public health setting. Public Health setting is defined in the [Dentist and Dental Hygienist Practice Act](#) as:

- an individual's residence, if the individual is unable to leave the residence;
- a school, as part of a school-based program;
- a nursing home;
- an assisted living or long-term care facility;
- a community health center;
- a federally-qualified health center; or
- a mobile dental health program that employs a dentist

In order for a hygienist to be directly reimbursed, the hygienist must work under a written agreement or under the general supervision of a dentist. Services provided must fall within the scope of practice for a dental hygienist as defined in the [Dentist and Dental Hygienist Practice Act](#). The dental hygienist must also have a federally assigned National Provider Identifier (NPI) number.

Dental services that may be reported and billed directly by a hygienist are limited. Refer to the [Coverage and Reimbursement Lookup Tool](#) for additional information concerning CDT code coverage for dental hygienists. All other dental services provided in a public health setting through either written agreement or under general supervision of a dentist must be reported by the supervising dentist.

9 Non-covered Services and Limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see [Utah Administrative Code R414-1. Utah Medicaid Program](#); [Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia.](#); and [Section I: General Information, Chapter 9, Noncovered Services and Limitations](#).

10 Prior Authorization

Prior authorization is obtained by submitting a request for the specific codes of services requested and attaching clinical documentation to support the need or justification for the services requested. When a service requires prior authorization, it is the responsibility of all associated providers to verify whether or not prior authorization has been obtained. Dental and anesthesia providers may require prior authorization as well as the facility where the procedure is to be performed.

If a dental code requires prior authorization, the procedure must be authorized by Medicaid before the service being provided. However, there are limited circumstances in which a provider may request authorization after service is rendered. These limitations are described in [Section I: General Information](#), *Chapter 10-3 Retroactive Authorization*.

Refer to [Section I: General Information](#), Record Keeping and Prior Authorization Chapters for further information.

11 Billing Medicaid

Dental services may be reported using the ADA J430 Dental claim form (same as ADA Dental Claim Form- J431, J432, J433, J434). Medicaid can only accept up to 18 procedure code lines per claim form.

Medicaid accepts dental claims electronically in the ANSI X12N 837d format, version 5010. For additional information concerning electronic reporting, see [Section I: General Information](#), *Electronic Data Interchange*.

11-1 Reporting Supernumerary Teeth

Medicaid supports the nomenclature approved by the ADA for identifying supernumerary teeth.

Please report using the following tooth identifiers for supernumerary teeth:

Upper Right Deciduous Teeth Upper Left

Tooth #	A	B	C	D	E	F	G	H	I	J
Supernumerary #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Right Deciduous Teeth Lower Left

Tooth #	T	S	R	O	P	Q	N	M	L	K
Supernumerary #	TS	SS	RS	OS	PS	QS	NS	MS	LS	KS

Upper Right	Permanent Teeth										Upper Left					
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
“Super “ #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Right	Permanent Teeth										Lower Left					
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
“Super “ #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

11-2 Dental Spend-ups

There are limited dental services where a Medicaid member may choose to upgrade a covered dental service to a non-covered service, which is considered a dental spend-up. However, the member must be willing to assume responsibility for the difference in the covered and non-covered services fees. Refer to [R414-49](#) for the limited services that may be used as a dental spend-up. In addition, when authorized through EPSDT, Utilization Review, or Hearing processes, other covered services may be used as a spend-up.

When a member requests a service not covered by Medicaid, the provider may bill the Medicaid member when ALL FOUR conditions of [Section I: General Information, Exceptions to Prohibition on Billing Members, Non-Covered Services](#), are met.

The provider cannot mandate or insist the covered procedure be upgraded. The member makes the choice. Further, the provider as a guarantee of payment by the member may not hold the member's Medicaid Member Card, nor may any other restrictions be placed upon the member.

The amount paid by the member is the difference between the provider's usual and customary charge for the non-covered service and the provider's usual and customary charge for the covered service.

The member is not responsible for paying the difference between the Medicaid payment for the covered service and the usual and customary fee for the requested upgraded service.

When providing an upgraded service, providers report the covered code and charges on the first line. Then, in the description box, indicate it was an upgraded service and reference the upgraded code; this shows that the member has signed a memo of understanding of the payment responsibility for the service. The Memorandum of Understanding must be kept in the provider's medical record for the client.

11-3 Anesthesiologists and Certified Nurse Anesthetists

Anesthesia providers, CRNA or anesthesiologists, billing for dental services shall use code 00170 with the appropriate "P" modifier (Physical Status) and the actual anesthesia time in minutes. For electronic submissions, report anesthesia minutes using the MJ qualifier. For paper claims, report

anesthesia minutes in Box 24G of the CMS-1500 (08/05) claim form by putting an "M" before the number of minutes.

11-4 Timely Filing

A claim must be submitted to Medicaid within 365 days from the date of service. For more information on timely filing, refer to [Section I: General Information](#), *Chapter 11-6.5, Time Limit to Submit Medicaid Claims*.

12 Coding

Medicaid recognizes guidelines in current editions of established coding manuals or other standard literature. However, those guidelines are adopted only as they are consistent with the application to Utah Medicaid policy. The established dental coding guidance material consists of the Code on Dental Procedures and Nomenclature (CDT Code) published by the American Dental Association.

For coverage and reimbursement information for specific procedure codes, see the [Coverage and Reimbursement Code Lookup](#). Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee-for-service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

13 Miscellaneous Information

13-1 Targeted Adult Medicaid Members with Substance Use Disorders

Dental services are available to eligible TAM members actively receiving treatment in a SUD program as defined in [Utah State Code Section 62A-2-101](#), licensed under [Title 62A, Chapter 2, Licensure of Programs and Facilities](#).

Before performing dental services for TAM receiving treatment actively in a SUD program, the UUSOD will verify that the member is receiving active treatment for the SUD. The UUSOD will submit a SUD treatment verification form to Medicaid for each eligible TAM member.

For additional information regarding the TAM program, refer to [Utah Administrative Code R414-31. Targeted Adult Medicaid](#).

13-2 Dental Incentive Programs

13-2.1 Dental Providers in Urban Counties

As an incentive to improve member access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers willing to see 100 or more distinct members during the next year will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less. An agreement for the enhanced payments must be signed and received by Medicaid before the increase is effective.

13-2.2 Dental Providers in Rural Counties

Dentists outside of the Wasatch front (including all counties EXCEPT Salt Lake, Weber, Davis, and Utah Counties) automatically receive a 20% increase in reimbursement. This increase

encourages dentists in rural areas to treat eligible Medicaid members and improve access for members residing outside the Wasatch front areas.

13-2.3 Additional Information

The increases outlined in chapters 13-2.1 and 13-2.2 are mutually exclusive.

A dentist in one of the four Wasatch Front counties can get a 20% increase meeting the requirements of paragraph A. Dentists in other counties will receive a 20% increase regardless of the number of Medicaid patients served.

Bill your usual and customary fee for a dental service provided to a Medicaid client.

If you have signed the Medicaid dental agreement, you will receive either 120% of the amount listed on the reimbursement schedule or the amount you billed for the service provided, whichever amount is less.

If you wish to sign up for the 20% incentive, you may fax a completed copy of the agreement to Medicaid at 1-801-536-0471.

Resource Table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	<ul style="list-style-type: none"> • Utah Administrative Code Table of Contents • Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49. • Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A. • Physician Services. R414-10
General information including: <ul style="list-style-type: none"> • Billing • Fee for Service and Managed Care • Member Eligibility • Prior Authorization • Provider Participation 	<ul style="list-style-type: none"> • Section I: General Information • Claims • Managed Care: Accountable Care Organizations • Utah Medicaid Prior Authorization <p><i>Administrative Rules</i></p> <ul style="list-style-type: none"> • Eligibility Requirements. R414-302. • Medicaid General Provisions. R414-301. • Program Benefits and Date of Eligibility. R414306. • Utah Medicaid Program. R414-1.
Information including: <ul style="list-style-type: none"> • Anesthesia Fee Resources • Coverage and Reimbursement Resources • National Correct Coding Initiative • Procedure codes with accompanying criteria and limitations 	<ul style="list-style-type: none"> • Bureau of Coverage and Reimbursement Policy • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: <ul style="list-style-type: none"> • Medicaid Information Bulletins (Issued Quarterly in January, April, July, and October) • Medicaid Provider Manuals • Utah State Bulletin (Issued on the 1st and 15th of each month) 	<ul style="list-style-type: none"> • Utah Medicaid Official Publications • Utah State Bulletin

Laboratory Services	<ul style="list-style-type: none"> • Social Security Act §1833 - Payment of Benefits • PART 493—LABORATORY REQUIREMENTS • Clinical Labs Center • Clinical Laboratory Improvement Amendments (CLIA) and Medicare Laboratory Services • CMS Clinical Laboratory Improvement Amendments (CLIA) • State Operations Manual • How to Obtain a CLIA Certificate
	<ul style="list-style-type: none"> <input type="checkbox"/> FDA Clinical Laboratory Improvement Amendments (CLIA) <input type="checkbox"/> CDC Clinical Laboratory Improvement Amendments (CLIA) <input type="checkbox"/> Utah Public Health Laboratory Clinical Laboratory Certification (CLIA) <input type="checkbox"/> Medicare Claims Processing Manual Chapter 16 - Laboratory Services <input type="checkbox"/> Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report <input type="checkbox"/> State Laboratories
Medicaid forms including: <ul style="list-style-type: none"> • Hearing Request • Hospice Prior Authorization Form • PA Request 	<input type="checkbox"/> Utah Medicaid Forms
Modifiers	<input type="checkbox"/> Section I: General Information
Patient (Member) Eligibility Lookup Tool	<input type="checkbox"/> Eligibility Lookup Tool
Pharmacy	<ul style="list-style-type: none"> <input type="checkbox"/> Drug Criteria Limits <input type="checkbox"/> Medicaid Pharmacy Program <input type="checkbox"/> OTC Drug List <input type="checkbox"/> Pharmacy Provider Manual <input type="checkbox"/> Medicaid Policy for Pharmacy Program. R414-60.
Prior Authorization	<ul style="list-style-type: none"> <input type="checkbox"/> Prior Authorization Form <input type="checkbox"/> Utah Medicaid Prior Authorization
Provider Portal Access	<input type="checkbox"/> Provider Portal Access
Provider Training	<input type="checkbox"/> Utah Medicaid Provider Training
Other	<input type="checkbox"/> Medicaid.gov

	<ul style="list-style-type: none"> <input type="checkbox"/> RHC-FQHC Provider Manual <input type="checkbox"/> Women, Infants and Children (WIC)
<p>References including:</p> <ul style="list-style-type: none"> • Social Security Act • Code of Federal Regulations • Utah Code 	<ul style="list-style-type: none"> <input type="checkbox"/> 42 CFR 440.50 <input type="checkbox"/> Social Security Act 1905(a) <input type="checkbox"/> Social Security Act 1861 (r) <input type="checkbox"/> Utah Annotated Code Title 58
Tobacco Cessation Resources	<ul style="list-style-type: none"> <input type="checkbox"/> Utah Tobacco Quit Line (1-800-QUIT-NOW) <input type="checkbox"/> Way to Quit