

SECTION 2

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

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1 EPSDT Services

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, formerly known as Child Health Evaluation and Care (CHEC), is federally mandated, provides comprehensive and preventive health care services for children, and is an integral part of the Medicaid program. Medicaid members who are enrolled in Traditional Medicaid age birth through 20 may receive EPSDT services. Individuals aged 19 through 20 who are enrolled in Non-Traditional Medicaid do not qualify for EPSDT services. **Note:** On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan will end, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.

There are three main components to EPSDT: Prevention, Outreach, and Expanded Services and are provided at no cost to Medicaid eligible children.

Medicaid encourages families to obtain EPSDT Services for children enrolled in Traditional Medicaid.

1 - 1 Prevention and Outreach

The families of Medicaid eligible children are encouraged to seek early and repeated well-child health care visits for their children. These visits should begin as early as possible, ideally at birth, and continue through the child's 20th birthday.

The Utah Department of Health and Human Services contracts with [Local Health Departments](#) (LHD) to provide outreach services to families.

Children born to women enrolled in Medicaid become eligible for a Targeted Case Management Service focused on child development. You may contact the LHD in your area if you feel a child enrolled in Medicaid should receive or would benefit from Targeted Case Management Services. Refer to the [Targeted Case Management-Early Childhood \(ages 0-4\) Manual](#) for additional information.

Services provided through the LHDs include:

- Information to all EPSDT-eligible individuals under age 20, including adults who are pregnant, of all the EPSDT services available, such as age appropriate screenings, well child visits, and immunizations
- Provide or arrange screening services
- Arrange (through referral) for corrective treatment as determined by EPSDT screenings
- Missed appointment follow-up
- Information about transportation assistance to and from EPSDT eligible appointments

1 - 2 Expanded Services

When a Medicaid eligible member requires medically necessary services, those services may be covered by Medicaid. Necessary health care, diagnostic services, treatment or other measures described in [Section 1905 \(a\) of the Social Security Act](#) to correct or ameliorate defects, physical or mental illness or conditions discovered by screening services are available based on medical necessity. Prior authorization may be required before providing services. More information on expanded services is provided throughout this manual.

Individuals aged 19 through 20 who are enrolled in Non-Traditional Medicaid do not qualify for expanded benefits. (**Note:** On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan will end, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.)

1 - 3 Definitions

Federal definitions for the EPSDT program are:

Early means as soon as possible in the child's life.

Periodic means at intervals established for screening by medical, dental and other health care experts to assure that disease or disability has not appeared since the child's last evaluation. The types of procedures performed and their frequency will depend on the child's age and health history.

Screening is the use of quick, simple procedures carried out among large groups of children to sort out apparently well children from those who may have a disease or abnormality and need more definite study of a possible physical, emotional or developmental problem.

Diagnosis is the determination of the nature or cause of physical or mental disease or abnormality through combined use of health history, physical and developmental examinations and laboratory tests and x-rays.

Treatment means physician or dentist services or any other type of medical care and/or services recognized under state law to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

1 - 4 Referrals

Medicaid must track the number of children referred for follow-up services. If you discover a problem(s) or condition(s) that requires follow-up, provide an appropriate referral to the specialty provider.

2 Covered Services

EPSDT covered services include screening, preventive, outreach, and expanded services to include diagnostic and medically necessary treatment.

Medicaid recommends [Bright Futures](#), as developed by the American Academy of Pediatrics, as a screening tool for children

Screening (periodic comprehensive child health assessments) are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth that include all of the following:

- Comprehensive health and developmental history
- Comprehensive unclothed physical examination
- Appropriate vision testing
- Appropriate laboratory tests

- Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age
- Health Education

Each of these screening services is described more fully in the following sources [Bright Futures](#) and [Periodicity Schedule](#) provided by the American Academy of Pediatrics (AAP). Recommended [Immunization Schedule for Children and Adolescents](#) are provided by the Centers for Disease Control and Prevention.

2 – 1 Laboratory Services

2 – 1.1 Genetic Testing

Definitions

Genetic testing: Genetic testing involves the analysis of chromosomes, DNA (deoxyribonucleic acid), RNA (ribonucleic acid), genes or gene products to detect inherited (germline) or non-inherited (somatic) genetic variants related to disease or health.

Germline mutations: Mutations that are present in the DNA of every cell of the body, present from the moment of conception. These include cells in the gonads (testes or ova) and could, therefore be passed on to offspring.

Diagnostic: To confirm or exclude genetic or heritable mutations in a symptomatic person. This refers to a molecular diagnosis supported by the presence of a known pathologic mutation. For the purposes of genetic testing, a symptomatic person is defined as a person with a clinical phenotype that is correlated with a known pathologic mutation.

Prognostic: To determine or refine estimates of disease natural history or recurrence in patients already diagnosed with disease. To predict natural disease course, e.g., aggressiveness, recurrence, risk of death. This type of testing may use gene expression of affected tissue to predict the course of disease.

Therapeutic: To determine that a particular therapeutic intervention is potentially effective (or ineffective) for an individual patient. To determine the probability of favorable or adverse response to medications. To detect genetic variants that alter risk of treatment response, adverse events, drug metabolism, drug effectiveness, etc. e.g., cytochrome p450 testing). To detect genetic mutations that adversely affect response to exposures in the environment that are ordinarily tolerated, such as G6PD deficiency, genetic disorders of immune function, and aminoacidopathies.

Coverage

Genetic testing may require Prior Authorization (PA). Specific coverage on CPT or HCPCS codes are found in the [Utah Medicaid Coverage and Reimbursement Code Lookup](#).

Coverage of genetic testing by Medicaid is determined by using an evidence-based criteria tool and may require review by a Medicaid Consultant.

Genetic tests are laboratory studies of human deoxyribonucleic acid (DNA), chromosomes, genes or gene products to diagnose the presence of a genetic variation associated with a high risk of having or transmitting a specific genetic disorder.

Genetic testing must be medically necessary and ordered by a Medicaid enrolled provider, within the scope of their practice.

- Providers must be able to counsel clients on the particular genetic test ordered and the results of that particular test, as it applies to the member, in consultation with genetic specialist as needed
- If a provider is unable to counsel a member regarding pre- and post-genetic testing, they must refer the member to a provider capable of providing genetic counseling prior to ordering the test

Genetic testing is medically necessary for EPSDT eligible members when there is a reasonable expectation based on family history, risk factors, and/or symptomatology that a genetically inherited condition exists, and any of the following clinical scenarios also exist:

- Clinical presentation fits a well-defined syndrome for which a specific or targeted gene test is available; or
- A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, and/or standard diagnostic studies or tests; or
- There is a clinical syndrome with a broad number of potential diagnoses, and without a specific diagnosis, the medical management will include unnecessary monitoring, testing, hospitalizations, and/or medical setbacks; or
- There is a clinical syndrome with a broad number of potential diagnoses, and a specific diagnosis will determine prognosis and appropriate medical management

Documentation Requirements (see Genetic Testing PA Request Form)

Documentation to support the recommendation(s) for testing must address all of the following:

- Specific risk factors, the clinical scenario, and/or family history that supports the need for the requested test(s); and
- Clinical examination and conventional diagnostic testing that have been unsuccessful in determining the member's specific diagnosis; and
- Medically necessary medical management may not be determined without the genetic testing; and
- How testing, whether positive or negative, may change medical management of the member

Where criteria do not exist, submission of publicly accessible data from peer-reviewed, scientific literature and/or national databases that addresses the clinical validity, predictive value, and/or medical benefit(s) of the specific diagnostic genetic test(s) should be submitted.

Next Generation Sequencing (NGS)

Identifying a molecularly confirmed diagnosis promptly for an individual with a rare genetic condition can have a variety of health outcomes, including:

- Guiding prognosis and improving clinical decision-making that can improve clinical outcome by application of specific treatments as well as withholding of contraindicated treatments for certain rare genetic conditions
- Surveillance for later-onset comorbidities
- Reducing the financial and psychological impact of diagnostic uncertainty
- Eliminating lower-yield testing, and additional screening(s) that may later be proven unnecessary once a diagnosis is achieved

Next-generation sequencing (NGS) includes genetic testing options such as whole exome sequencing (WES) and whole genome sequencing (WGS) and can detect the most significant variant types, meaning genetic alterations with sufficient evidence to classify as pathogenic.

Whole Exome Sequencing (WES)

WES focuses on the genomic protein coding regions (exons). It is a cost-effective, widely used NGS method that requires fewer sequencing reagents and takes less time to perform bioinformatic analysis compared to WGS. Although the human exome represents only 1-5% of the genome, it contains approximately 85% of known disease-related variants.

WES is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in EPSDT eligible members when all of the following criteria are met:

- After all other appropriate diagnostic testing has been performed, and the member remains undiagnosed (e.g., targeted single-gene testing, panel testing, MRI, etc.), and
- Results of such testing are expected to influence medical management and clinical outcomes directly.

Whole Genome Sequencing (WGS)

Whole-genome sequencing (WGS), in contrast to (WES), may detect larger deletions or duplications, triple repeat expansions, and pathogenic variants in deep intronic regions; regulatory regions that are outside of the coding regions; and untranslated gene regions.

WGS is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in members aged less than one year of life and currently admitted to a Neonatal Intensive Care Unit (NICU) or other intensive care setting, when all of the following prior authorization criteria are met:

- Test is ordered by one of the following provider types, who has evaluated the patient and family history, and recommends and/or orders the test:
 - Neonatologist or intensivist in collaboration with a medical geneticist or certified genetic counselor
 - The patient has been evaluated by a board-certified clinician with expertise in clinical genetics and counseled about the potential risks of genetic testing
 - Pre- and post-test counseling is performed by an American Board of Medical Genetics or American Board of Genetic Counseling certified genetic counselor
- Clinical indications:
 - Absence of definitive diagnosis based on standard clinical workup
 - Unclear disease identity based on patient's phenotype, or the patient has phenotypic characteristics outside of, or in addition to, what has been established for the disease
 - A genetic etiology is the most likely explanation for the phenotype or clinical scenario or the affected individual is faced with invasive procedures or testing as the next diagnostic step (e.g., muscle biopsy.)
 - No other causative circumstances (e.g., environmental exposures, injury, infection) can explain the symptoms

Non-Covered Testing

Diagnostic genetic testing, for the sole convenience of information to identify specific diagnoses for which the medical management of the member is not anticipated to be altered

Additional types of diagnostic genetic testing that are non-covered include:

- Experimental and/or investigational (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the “Consolidated Appropriations Act, 2021”)
- Tests for screening purposes only (excluding newborn screening as defined in [Utah Administrative Code R398-2. Newborn Hearing Screening](#)), including:
 - preimplantation genetic diagnosis (PGD); or
 - prenatal genetic screening; or
 - in the absence of signs and/or symptoms
- Tests, for the member or family members, performed solely for the purposes of genetic counseling, family planning, or health screening
- Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
- Direct-to-consumer (DTC) genetic tests
- Tests of a member’s germline DNA to benefit family member(s), rather than the member being tested
- Establishment of paternity
- Genetic testing is considered not medically necessary when performed entirely for non-medical reasons (e.g., a general interest in genetic test results)

Specific coverage on CPT or HCPCS codes are found in the [Utah Medicaid Coverage and Reimbursement Code Lookup](#). The Coverage and Reimbursement Code Lookup allows providers to search for coverage and reimbursement information by procedure code, date of service, and provider type.

Lead Toxicity Screening

The Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend a lead risk assessment and a blood lead level test for all Medicaid eligible children between the ages of 6 and 72 months. All children ages 6 to 72 months of age are considered at risk for lead poisoning and should be screened. Refer to the [Utah Lead Coalition](#) for current criteria information.

3 Expanded Services

Expanded EPSDT services include vision, dental, hearing, mental health services and may require prior authorization by Medicaid.

3 - 1 Vision Services

Vision services include diagnosis and treatment for defects in vision, including eyeglasses. When needed, refer the child to the appropriate specialist.

3.1.1 Corrective Lenses

Medical necessity is required for corrective lens coverage. Medical necessity includes a change in prescription or replacement due to normal lens wear. Corrective lenses must be suitable for indoor or outdoor, day or night use.

Lenses covered include single vision, bifocal, trifocal, with or without slab-off prism, in clear glass or plastic. If the prescription changes, the same frame must be used if possible.

Separate charges for glasses fitting are not reimbursable when the provider is supplying the frame and lenses. Fitting fees are included in the reimbursement rate for the provided items.

3.1.2 Frames

Medicaid provides one standard frame, plastic or metal. Frames must be reusable and if the lens prescription changes, the same frame must be used when possible. Medicaid reimburses one pair of eyeglasses every 12-month period.

If a member requires lenticular lenses, deluxe frames will be allowed with prior authorization.

3.1.3 Repairs

Medicaid will reimburse for repair or replacement of a damaged lens or frame.

3.1.4 Eyeglasses Replacement

Replacement eyeglasses are allowed for eligible members once every 12-month period. Prior authorization is required to replace frames sooner than 12 months; replacement lenses are covered and do not require prior authorization. If the lenses alone need replacing, the provider must use existing frames.

Prior authorization may be issued for a new pair of eyeglasses, even though 12 months have not passed since a member's last pair was dispensed when one or more of the following reasons for medical necessity are met:

- There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye
- A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
- A change in the recipient's head size warrants a new pair of eyeglasses
- The recipient has had an allergic reaction to the previous pair of eyeglasses
- The original pair is lost, broken, or irreparably damaged; the dispensing provider must obtain a written statement explaining this from the recipient (or the recipient's caretaker) with the prior authorization request

3.1.5 Contact Lenses

Contact lenses require prior authorization.

- Contact lenses may be covered under the following circumstances:
 - Visual acuity cannot be corrected to 20/70 in the better eye with glasses
 - The refractive error is greater than +/- 8D
 - An unusual eye disease or disorder exists that is not correctable with glasses
 - To correct aphakia, keratoconus, nystagmus, or severe corneal distortion
 - Other special medical conditions that medically require a contact lens
- Fitting contact lenses includes determining correction measurements, writing the prescription, fitting and follow-up care necessary for proper wear of the contact lens
 - Medicaid will not reimburse any additional office visits for any of these services

- Soft contact lenses may be approved when medically necessary because of a condition described in “A” above and for either circumstance below:
 - Prescribed by an ophthalmologist or optometrist as a “bandage” to treat eye disease or injury
 - Prescribed for a member who is unable to wear hard contacts due to the shape or surface of the eye and who is unable to obtain the necessary correction with glasses
- Gas permeable contact lenses may be approved when a specific medical need exists that precludes the use of glasses

3.1.6 Low Vision Aids

Low vision aids or materials may be covered. These items require prior authorization. Contact lenses are not covered for moderate visual improvement and/or cosmetic purposes.

3.1.7 Member Chooses Non-Covered Services or Upgrades

- With few exceptions, a provider may not bill a Medicaid member, as the Medicaid payment is considered payment in full. Exceptions may include a member request for service that is not medically necessary and therefore not covered. Examples of services considered not medically necessary: more expensive frames, tinted lenses, lenses of special design.
- For a provider to bill the member the following conditions must be met. (See [Section I: General Information](#), Exceptions to Prohibition on Billing Members for additional information)
 - The provider has an established policy for billing all Medicaid members for services not covered by a third party (The charge cannot be billed only to Medicaid members)
 - The member is advised prior to receiving a non-covered service that Medicaid will not pay for the service
 - The member agrees to be personally responsible for the payment
 - The agreement is made in writing between the provider and the member which details the service and the amount to be paid by the member
- Unless all four conditions are met, the provider may not bill the member for the non-covered service. Further, the provider may not “hold” the member's Medicaid card as guarantee of payment, nor may any other restrictions be placed upon the member.
- If providing upgraded services such as more expensive frames, tinted lenses, or lenses of special design, bill the covered code and charges on the first line. On the second line, bill the non-covered code, including the modifier “GX” (HCPCS “GX” modifier description: Notice of liability issued, voluntary under payer policy) and the charges on the second line. This indicates that the member has signed a memo of understanding of the payment responsibility for the upgrade(s). The code with the GX modifier will be non-payable. The memo of understanding must be kept in the provider’s medical record for the member.
- The amount paid by the member is calculated by taking the difference between the usual and customary charge for the more expensive item and the usual and customary charge for the covered item. For example, if the usual and customary charge for the basic frames were \$35 and the member wanted frames that were presently advertised for \$50, the member would be responsible to pay an additional \$15. Remember, because Medicaid pays \$27.61 for the \$35 basic frame, the provider accepts this as payment in full and cannot bill the member for the \$7.39 difference.

3.1.8 Non-covered Services

The following services are not covered by Medicaid:

- Additional glasses, such as reading glasses, safety glasses, distance glasses, or “spare glasses”
- Extended wear contact lenses
- Contact lenses for moderate visual improvement and/or cosmetic purposes
- Sunglasses, tints, or any other mechanism such as light-sensitive lenses that “darken” or photo grey lenses
- Oversized, exclusive, or specially designed lenses
- Special cataract lenses, unless medically necessary. Only clinical cataract lenses are covered.
- No-line bifocal lenses and no-line trifocal lenses
- Replacement of glasses that are broken or lost due to abuse and neglect of the member
- Repairs due to member neglect or abuse
- Medications dispensed in an office
- Screening examination to determine if member has an eye problem
- Corneal Topography
 - With a non-covered service (e.g., radial keratotomy, Lasix eye surgery)
 - As a screening examination
 - Separate from evaluation & management ophthalmological services
 - Optical Coherence Tomography (OCT) (An ultrasonic method to evaluate ocular structures which is considered investigational)
- Sex characteristic surgical procedures on a member who is less than 18 years of age for the purpose of effectuating a sex change
- Hormonal transgender treatment for a member who is less than 18 years of age

3 - 2 Dental Services

Every child should begin to receive oral health risk assessments by six months of age by a pediatrician or other qualified pediatric health care provider. Dental services for children, at a minimum, include preventive dental services such as preventive dental examinations, prophylaxis, topical fluoride applications, and appropriate prescriptions for fluoride supplements, fluoride treatments and sealants. In addition, the following services are included: relief of pain and infections, restoration of teeth and maintenance of oral health. Orthodontic Treatment is provided in cases of severe malocclusions and requires prior authorization.

See the [Dental, Oral Maxillofacial, and Orthodontia Services](#) and the [Coverage and Reimbursement Code Lookup](#) tool for additional coverage information.

Refer the child to a dentist as follows:

- Make the initial referral by six months of age, if determined necessary by a pediatrician, and yearly thereafter
- Make the referral if the child is at least four years and has not had a complete dental examination by a dentist in the past 12 months
- Make the referral at any age if the oral inspection reveals cavities, infection, or significant abnormality

3.2.1 Recommended Dental Services

Fluoride varnish reduces the incidence of dental caries. Fluoride varnish minimizes the risk of inadvertent fluoride consumption and is easy to use on very young children. It forms a deposit on the dental enamel that slowly releases a high concentration of fluoride ions into the dental enamel. It is effective in preventing tooth decay and remineralizes tooth damage caused by the decaying process. Fluoride varnish may be applied to a child's teeth at regular 4 to 6 month intervals starting with primary eruption and continuing through age 4.

3.2.2 Well-child (EPSDT) Procedure Codes for Fluoride Varnish

Medicaid will pay for application of dental fluoride varnish as an optional service for children birth through 4 years as part of a well-child exam. Claims for the application of dental varnish must be submitted using the appropriate CPT code (see section 4-2 for a list of the codes) for the corresponding visit and the CPT code 99188 to indicate the application of fluoride varnish during the visit. For more information, training, or technical advice on the application of the varnish, contact the Oral Health Program at the Utah Department of Health and Human Services at (801) 273-2995. For more information related to claims, payments, or billing codes contact Medicaid Information at (801) 538-6155.

Note: [Recommended Dental Periodicity Schedule](#), is a quick summary of EPSDT dental periodicity requirements. The schedule has been adopted from the Academy of Pediatric Dentistry's recommendations for dental services for the target population (age 0-21) of children. This schedule is provided as a tool and is not intended to replace material in this manual.

3-3 Audiology Services

Audiology services are a covered program for members eligible under EPSDT. Audiology services must have a physician referral, be pre-authorized (as applicable), and be provided by an audiologist. Physician oversight includes:

- Total medical care of each audiology patient is under the direction of a physician
- The provider reviews the plan of care and the results of treatment as often as the patient's condition requires
 - If in their professional judgment, no progress is shown, the provider is responsible for discontinuing treatment and notifying the physician of treatment discontinuance
- The expectation is that services are delivered in an efficient and economical manner and are safeguarded against unnecessary, unreasonable, or inappropriate use

Audiology services include preventive care, screening, evaluation, diagnostic testing, hearing aid evaluation, and prescription for a hearing aid, ear mold services, fitting, orientation and follow-up. A hearing aid battery provision is included in these services. Audiologic habilitation includes, but is not limited to speech, hearing, and gestural communication.

Medicaid reimburses two primary services and one subsequent service for Medicaid members: a diagnostic examination, an assessment for a hearing aid(s) and, when appropriate, a hearing aid or assistive listening device. Medicaid also reimburses repairs on hearing aids.

Diagnostic audiology evaluations require a written physician's order and include procedures that may be used for a hearing aid assessment and any other diagnostic tests appropriate for the specific diagnosis as ordered by the physician.

Hearing screening for newborns is a covered service. For more information on newborn hearing screening refer to [Utah Administrative Code R398-2. Newborn Hearing Screening](#) and the [Utah Department of Health and Human Services Early Hearing Detection and Intervention Program](#). For specific code coverage refer to the [Coverage and Reimbursement Code Lookup](#).

3.3.1 Hearing Aids

Hearing aids require prior authorization. If a recommendation for a hearing aid assessment is made, a written physician's referral or request is required. If subsequent hearing testing shows a change in the hearing thresholds or the need for a new hearing aid, then medical clearance must be obtained before proceeding with the hearing aid refitting. The hearing aid may be provided by an audiologist or by a provider of hearing aid supplies. All services, including conformity evaluation and initial ear molds, are included in each rate to cover a period of 12 months.

- Hearing aids must be guaranteed by the manufacturer for a period of at least one year
- The initial ear mold, fitting of the hearing aid on the recipient, and necessary follow-up procedures (i.e. conformity evaluation, counseling, adjustments, testing batteries, etc.) are part of the global rate and will not be reimbursed separately
 - The global rate covers a period of twelve months
- If a follow-up examination results in a recommendation for a different model of hearing aid, the original aid must be exchanged for another aid within the 60 days allowed by retailers
 - No rental may be charged
- The provider must accept the return of a new hearing aid within 60 days if the physician or audiologist determines that the hearing aid does not meet specifications
- Services requested for patients who reside in an ICF/ID facility are the responsibility of the facility under "active treatment" regulation
 - Exception: This does not include the provision of the hearing aid appliance which may be billed separately to Medicaid
- The physician's statement must be retained on file by the provider of the hearing aid for a period of three years
- Hearing aids may be replaced every three years when medically appropriate
 - Exceptions may be made for unusual circumstances, e.g., accident, surgery, or disease

3.3.2 Replacement

Hearing aid replacement is authorized when medically necessary at an interval of three years for EPSDT-eligible members. When requesting a replacement hearing aid, a new medical examination, referral letter, and audiology evaluation is required. Documentation showing the Manufacturer Suggested Retail Price (MSRP) must be submitted with the prior authorization request.

3.3.3 Repair

Hearing aid repairs and related services do not require prior authorization.

- Repairs over \$15.00 must be itemized
- Medicaid will only reimburse the actual cost of the parts
- Medicaid reimburses using code V5014 for hearing aid repairs
- If the repair is sent out of a vendor's facility for repair, the vendor will be reimbursed for the manufacturer's invoice plus an additional \$15

- When billing, attach a copy of the manufacturer's original invoice to the request
- If the repair is completed by the vendor directly, the vendor will be reimbursed for the vendor's invoice which must include the cost for time and parts, plus an additional \$15
- Hearing aid repairs are only available to EPSDT eligible members and pregnant women

3.3.4 Rental

Prior authorization is required for hearing aid rental. If a hearing aid must be sent away for repair, Medicaid will pay for a rental hearing aid if a recipient requires a "loaner" hearing aid.

3.3.5 Assistive Listening Device

Assistive listening devices require prior authorization. The hearing loss criteria are the same as that for hearing aids. This device can be provided in lieu of a hearing aid for clients who are not capable of adjusting to a hearing aid. If the client meets the hearing loss criteria, the audiologist shall look at various facts including the client's ability to care for hearing aids, whether the client will wear the hearing aid, whether the client desires a hearing aid, and what are the expected results, in order to determine whether a hearing aid or an assistive listening device would be the most appropriate item, to meet the hearing needs of the client.

3.3.6 Dispensing Fees

With prior authorization, a dispensing fee can be billed once per hearing aid for the operational lifetime of that hearing aid.

Dispensing fee includes:

- Adjusting the hearing aid to the recipient, including necessary programming on digital and digitally programmable hearing aids
- Instructing and counseling the recipient on use and care of the hearing aid
- Fitting and modifications of the hearing aid
- Freight, postage, delivery of the hearing aid
- Maintenance, cleaning and servicing to be provided for the first year of ownership

3.3.7 Prior Authorization

To receive prior authorization all the following are required for EPSDT eligible members:

- A physician's order stating the patient has been medically cleared for hearing aid use
 - Retained in the patient's file
- The results of a comprehensive audiometric exam performed by the audiologist to identify the kind of hearing loss (i.e., conductive loss, sensorineural loss, or mixed loss), speech testing to include the speech reception thresholds and speech discrimination scores, and the pure-tone average
- The kind of hearing loss, conductive loss, sensory-neuro loss, or mixed
- The type of hearing aid requested; monaural or binaural, and the respective code
- An audiogram or form that reports the hearing evaluation test or decibel loss will include for both right and left ears: Hearing thresholds at 250, 500, 1000, 2000, 4000 and 8000 Hz
- Final unaltered purchase invoice of the hearing aid(s) requested
- The high frequency pure-tone average

- If the hearing test shows an average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 hertz for that ear, a monaural aid may be authorized
- Binaural hearing aids are reimbursed only under one of two circumstances:
 - Must be verified with an average hearing loss of 25 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 in both ears
 - The recipient is blind, and a monaural hearing aid may be contraindicated

Note: A binaural hearing aid is one unit for billing purposes

Additional information for EPSDT Eligible Members (18 years and older):

- If the hearing test shows an average hearing loss in one ear of 35 dB or greater, based on the standard PTA (500, 1000, 2000 hertz) for that ear, a monaural aid may be authorized
- Binaural hearing aids are reimbursed only under one of two circumstances:
 - Must be verified with an average hearing loss of 30 dBs based on the standard PTA for both ears
 - The recipient is blind, and a monaural hearing aid may be contraindicated

3.3.8 Brain Stem Testing

When a child cannot be tested by normal audiometric means, generally an Audiological Brain Response (ABR) is administered. This test measures responses in the 2000-4000 Hertz range.

If the ABR results are abnormal or show no response, the results of an Otoacoustic Emissions test (Newborn hearing test) and a Visual Response Audiometry test (or other similar conditioned response audiometry test) will be required to confirm the results of the ABR. All tests must confirm the need for amplification.

3.3.9 Newborn screening

Screening for newborn babies, as authorized by [Rule R398-2. Newborn Hearing Screening: Early Hearing Detection and Intervention \(EHDI\) Program](#), will be reimbursed by the following means:

- If the hospital performing the newborn delivery is a DRG hospital, the auditory screening is included in the DRG and the audiologist is reimbursed by the hospital from the DRG funds paid by Medicaid
- If the hospital performing the newborn delivery is a non-DRG hospital or the delivery occurs in a nonhospital setting, the audiologists may bill Medicaid for the auditory screening
- If the screening does not take place at birth and the infant is screened at a subsequent date, the audiologist may bill Medicaid for the auditory screening

3 - 4 Speech – Language Pathology (SLP) Services

Services include examination, diagnosis, and treatment of speech/ communication disabilities and related factors of individuals with certain voice, speech, hearing, and language disorders. These services treat problems associated with accident, injury, illness, or birth defect. Nonorganic or organically based SLP articulatory deviations, voice disorders, language impairments, or dysfluencies may be included in the treatment plan in some specific instances.

SLP therapy evaluation should consider audiological issues and other physical (organic) conditions restricting proper speech and language development. These must be addressed in a comprehensive treatment plan which includes SLP therapy. SLP therapy without such a plan may be denied until a comprehensive plan is documented and submitted for review.

SLP therapy services must have a physician referral, be pre-authorized (as applicable), and be provided by a speech-language pathologist.

3.4.1 SLP Evaluation

EPSDT eligible members are allowed one speech evaluation per year.

3.4.2 Covered SLP Services

State funds other than Medicaid, support speech and language therapy through Early Intervention for ages 0 to 3 years.

The goal is to help parents prepare their child for preschool and kindergarten if there is a speech or language disorder present. The State Office of Education, not Medicaid, funds speech and language services provided in the education system for children from preschool (age 3 years) through grade 12.

- Services for children ages 2 years through 5 years are covered, if the child's speech or language deficit is at, or greater than one and one-half standard deviations below the mean as measured by an age appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 7th percentile. One and one-half standard deviations below the mean equals a standard score of 78
- Services for children ages 6 years through 20 years are available through the educational system, but additional Medicaid services may be approved if the child's speech or language deficit is at, or greater than two standard deviations below the mean as measured by an age appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 2nd percentile. Two standard deviations below the mean equals a standard score of 70
- Services for children under age 2 are not covered unless a specific medical diagnosis and the documentation supports the need and efficacy of early intervention for speech therapy. There must be a medical reason requiring such early intervention. The criteria found in the first bullet point (ages 2-5 years) applies if testing is possible
- Services for voice anomalies such as pitch, tone, or quality, are limited to velopharyngeal inadequacies due to cleft palate, submucous cleft palate, congenital short palate, palatopharyngeal paresis/paralysis, neuromuscular diseases (myasthenia gravis, multiple sclerosis, ALS, etc.)
- Services for voice disturbances related to vocal cord pathology or vocal cord dysfunctions are limited to 5 visits. This includes vocal cord nodules, polyps, web, mucosal edema, or granulomatosis or vocal cord dysfunctions of paralysis/paresis, hyper and hypokinesis, laryngeal dystonia, or paradoxical vocal fold dysfunction
- Therapeutic services for the use of a speech generating device are covered
- All therapeutic services are limited to a combined total of 24 sessions in a 6-month period

3.4.3 Plan of Care Required

A written plan of care established by the speech-language pathologist is required. The plan of care must include:

- Patient information and history
- Current medical findings
- Diagnosis
- Previous treatment (if applicable)
- Planned treatment
- Anticipated goals
- The type, amount, frequency and duration of the services to be rendered
- Scores of appropriate tests that measure the disability or dysfunction must be submitted with the plan of care annually

3.4.4 Speech Augmentative Communication Devices

Speech augmentative communication devices are covered in accordance with the [Coverage and Reimbursement Code Lookup](#).

3.4.5 Voice Prosthetics and Voice Amplifiers

Voice Prosthetics and Voice Amplifiers are covered in accordance with the [Coverage and Reimbursement Code Lookup](#).

A speech-language pathologist may provide necessary training for utilization of the device. The regular speech therapy codes must be used.

3.4.6 Medical Necessity

Under State law, speech-language services may not be considered medically necessary if an EPSDT eligible member can receive services funded by the State Office of Education.

3.4.7 Limitations

These services are limited as described below.

- Home health speech therapy, unless the recipient is unable to leave the home for outpatient speech therapy
- Communication disabilities solely associated with behavioral, learning, and/or psychological disorders, unless documented as part of a comprehensive medical treatment plan
- Treatment for clients who have reached maximum potential for improvement or who have achieved the stated goals, or now test above the stated threshold requirements for treatment
- Treatment for CVA or TBI which begins more than six months after onset

3.4.8 Non-Covered

The following services are not Medicaid benefits, except when related to accident, illness, birth defect, or injury:

- Recipients with no documented evidence of capability or measurable improvement
- Residents of an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) (included in the per diem resident rate)

- Non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board, such as a PECS, or picture board or other procedures that may be carried out effectively by the patient, family, or care givers
- Continued training beyond the initial instruction to use a communication board, such as a PECS, or picture board
- Self-correcting dysfunctions that are within normal limits for the recipient's age. For example: slow speech development, developmental dysfluencies, or developmental articulation errors
- Dysfluencies such as stuttering or stammering or rhythm abnormalities
- Articulation problems, such as "lispings" or the inability to provide certain consonants

3-5 Mental Health Services

Services that support young children's healthy mental development can reduce the prevalence of developmental and behavioral disorders which have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems. Broadly defined, screening is the process by which a large number of asymptomatic individuals are evaluated for the presence of a particular trait that may be indicative of a behavioral developmental issue.

Medicaid recommends [Bright Futures](#), as developed by the American Academy of Pediatrics, as a screening tool for children

Screening accompanied by referral and intervention protocols can play an important role in linking children with and at-risk for developmental problems with appropriate interventions.

Medicaid encourages providers to refer children with suspected mental health needs for mental health assessment.

Refer the child to the mental health provider listed on the Medicaid Identification Card. If no provider is listed on the Medicaid Card, refer the child to a Medicaid Mental Health Provider in the child's home area. Mental Health Services, at a minimum, include diagnosis and treatment for mental health conditions.

Refer to the [Rehabilitative Mental Health and Substance Use Disorder Services Manual](#) and the [Coverage and Reimbursement Code Lookup](#) tool for policy on covered mental health services.

3.5.1 Maternal Depression Screening

Maternal depression can have a strong impact on parenting and child outcomes, primary care health providers can contribute to their pediatric patients' health and support by screening and assisting mothers with referrals for depression.

Medicaid recommends [Bright Futures](#), as developed by the American Academy of Pediatrics, as a screening tool for children

Screening accompanied by referral and intervention protocols play an important role in linking depressed mothers with appropriate interventions. Medicaid encourages providers to refer depressed mothers with suspected mental health needs for mental health assessments.

Refer the child's mother to the mental health provider listed on the Medicaid Identification Card. If no provider is listed on the Medicaid Card, refer the child's mother to a Medicaid Mental Health Provider in

the child's home area. Mental Health Services, at a minimum, include diagnosis and treatment for mental health conditions. Refer to the [Rehabilitative Mental Health and Substance Use Disorder Services Manual](#) and the [Coverage and Reimbursement Code Lookup](#) tool for policy on covered services.

3-6 Chiropractic Services

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

Specific coverage on CPT® or HCPCS® codes may be found in the Utah Medicaid [Coverage and Reimbursement Code Lookup](#).

3-7 Inpatient Intensive Physical Rehabilitation Services

EPSDT eligible members with chronic conditions may be considered for age appropriate developmental training.

3-8 Medical Supplies and Durable Medical Equipment (DME)

The EPSDT program may approve medically necessary medical supplies and DME for children enrolled in Traditional Medicaid and are age birth through twenty. For information on Medical Supplies and Durable Medical Equipment service, refer to the [Medical Supplies and Durable Medical Equipment Manual](#).

3-9 Expanded Services: Other Necessary Health Care

Medicaid does not reimburse non-covered procedures. However, other necessary health care, diagnostic services, treatment and other measures described in [Section 1905 \(a\) of the Social Security Act](#) to correct or ameliorate defects, physical or mental illness, or conditions discovered by the screening services are available based on medical necessity. Such exceptions are considered through the prior authorization process.

Prior authorization confirms services requested are medically necessary, conform to commonly accepted medical standards, and less costly or more conservative alternative treatments have been considered.

Medicaid prior authorization requirements apply only for services to be provided for an EPSDT eligible member not enrolled in a managed care plan.

The prior authorization process described in this chapter applies for services that may be covered directly by Medicaid because the services are not included in a contract with a managed care plan. For more information about the Prior Authorization Process, please refer to [Section I: General Information](#), Chapter 10 Prior Authorization.

3-9.1 Prior Authorization

Coverage may be available for EPSDT eligible members when a service is not covered by Medicaid for an adult. To obtain prior authorization, the provider must complete a current copy of the appropriate prior authorization request form and submit it, with all required documentation, to the Prior Authorization Unit

at the Division of Integrated Healthcare. The appropriate forms are found at [General PA Forms or Pharmacy Criteria Forms](#).

Prior authorization requests for EPSDT services must be in writing and include all applicable information listed below:

- Estimated cost for the service or item
- Photocopy of any durable medical equipment item(s) requested
- 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
- 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
- All providers involved in the diagnosis, evaluation or treatment of the patient, should communicate directly and work together as a team to evaluate the most appropriate services for the child

When prior authorization is required for a health care service, the provider must obtain approval from Medicaid before service is rendered to unless the program specific Section of the provider manual states that there are exceptions to obtaining authorization prior to service delivery. Medicaid can pay for services only if all conditions of coverage have been met, including but not limited to, the requirement for prior authorization. Failure to obtain prior authorization may result in a denial of payment. Providers are responsible for determining whether prior authorization is required.

When a prior authorization request is submitted without complete documentation, the request is returned without processing. Medicaid returns the request and indicates what additional documentation is required before the request can be reviewed to determine medical necessity. A returned request is not a denial and has not accrued hearing rights. When a prior authorization request is returned for lack of documentation, the provider is required to resubmit the entire request including the additional documentation. Upon receipt of the resubmitted request, Medicaid staff reviews the PA request to determine if the service is covered by Medicaid and if the service is medically necessary. The date in which a complete request, with all necessary supporting documentation, is received will be the date posted for the PA request.

When a prior authorization request is denied, Medicaid sends a written notice of decision to the member, and a copy to the provider. Either or both may appeal the denial.

Medicaid will make the determination of medical necessity on a case-by-case basis after considering input from the EPSDT committee.

Prior Authorization Submission Methods

FAX Requests:

FAX the PA request to the appropriate number listed on the applicable prior authorization request form. The prior authorization request forms are found at <https://medicaid.utah.gov/prior-authorization>, General PA Forms or Pharmacy Criteria Forms.

Mail PA requests to:

Medicaid Prior Authorization Unit
P. O. Box 143111
Salt Lake City, UT 84114-3111

Telephone Submission:

When policy permits, submit a request by calling:

(801) 538-6155 or
1(800) 662-9651
Select option 3, option 3 and then select the appropriate program.

Medicaid PA unit hours are:

M, W, Th, F, 8:00 a.m. to 5:00 p.m.
Tuesday 11:00 a.m. to 5:00 p.m.

3-10 Fertility Preservation

Fertility preservation services are covered for members undergoing gonadotoxic cancer treatments or other medically necessary treatment that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment. Qualifying members must meet the following criteria:

- The member is post-pubertal through 40 years of age
- Diagnosis by a qualified healthcare professional (QHP) of a condition requiring treatment which, in the QHP's professional judgment, may pose a substantial risk of sterility or lead to iatrogenic infertility (infertility caused by treatment).
- The member's current state of health is sufficient to undergo fertility preservation procedures.
- The member has received infertility counseling as well as psychotherapy, when medically indicated.
- Collection and storage of embryos, eggs or sperm is consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine (ASRM) or the American Society of Clinical Oncology (ASCO).

Coverage

Collection and storage of embryos, reproductive tissues, eggs, and sperm must use collection and storage processes that are consistent with established medical practices or professional guidelines published by the ASRM or the ASCO.

Coverage includes the following fertility preservation services:

- Mature oocyte cryopreservation
- Ovarian tissue cryopreservation
- Ejaculated/surgically extracted sperm cryopreservation
- Embryo cryopreservation

Limitations

- Reimbursement for cryopreservation storage is covered as a single payment and includes up to a five-year storage increment.
 - Post cryopreservation procedures for use of eggs, sperm, or embryos are not covered.

- Additional five-year storage increments may only be requested for member's that retain Medicaid eligibility.

Non-covered Services

- Cryopreservation of embryos or eggs or sperm for fertility preservation purposes other than chemotherapy or other treatments that may render an individual infertile.
- Cryopreservation of embryos or eggs or sperm for reciprocal IVF
- Sperm storage/banking for males requesting this service for convenience or “back-up” for a fresh specimen.

For additional code specific policy information providers may refer to the [Coverage and Reimbursement Code Lookup](#).

4 Reimbursement

EPSDT screening fee includes payment for all components of the EPSDT Screening. Additional services, such as administration of immunizations, laboratory test and other diagnostic and treatment services, may be billed in addition to the EPSDT screening. Reimbursement for these services for a child enrolled in a managed care plan is based on the provider's agreement with the managed care plan. Reimbursement for oral health or dental services for a child enrolled in a dental managed care plan is based on the provider's agreement with the managed care plan.

4 - 1 Billing for EPSDT Exams

Submit claims for the EPSDT exam and any additional services to the EPSDT population the same as any other health care claim.

4 - 2 Instructions for Entering Procedure Code When Billing for an EPSDT Exam/Service

To report an EPSDT screening, enter the appropriate CPT procedure code (and modifier if needed) listed below. Refer to [Section I: General Information](#), Chapter 11 Billing Medicaid, for billing instructions.

Preventive Medicine Services

New Patient

99381 – Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)

99382 – Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)

99383 – Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)

99384 – Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)

99385 – Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; (18 through 20 years – EPSDT specific coverage)

Established Patient

99391 – Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)

99392 – Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)

99393 – Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)

99394 – Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)

99395 – Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; (18 through 20 years – EPSDT specific coverage)

Other

99460 – initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant

99461 – initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center

99462 - Subsequent hospital care, per day, for evaluation and management of normal newborn

99463 - initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same day

While these CPT codes refer to a healthy child, we encourage you to use these codes each time you complete an EPSDT screening even if the child presents with a chronic illness and/or other health problems.

4 - 3 Children Enrolled in Managed Care Health Plans

Information on billing and prior authorization applies to children not enrolled in a managed care plan. To verify the child’s enrollment, use the [Eligibility Lookup Tool](#), EDI transaction ASC X12N, 270/271 Eligibility Inquiry/Response, or call Medicaid Information (801) 538-6155 to obtain the information.

Children enrolled in health plans must also receive EPSDT screening services. However, billing and authorization for expanded services must be obtained through the plan listed on the child’s card. Children enrolled in an oral health or dental managed care plan must receive EPSDT oral health services from a provider contracted with that plan. The plan is listed on the Medicaid card.

5 Local Health Departments (LHD)

<i>Bear River Health Department</i> 655 East 1300 North Logan, UT 84341-2570 Office: 435 792-6541 Office Fax: 435 792-6600	<i>Central Utah Health Department</i> 70 Westview Drive Richfield, UT 84701-1868 Office: 435 896-5451, ext. 322 Office Fax: 435 896-4353
<i>Davis County Health Department</i> 22 S. State Street Clearfield, UT 84015-1043 Office: 801 525-5202 Office Fax: 801 525-5210	<i>Salt Lake County Health Department</i> 2001 South State Street, S3-700 PO Box 144575, Salt Lake City, UT 84114-4575 Office: 385 468-4150 Office Fax: 385 468-4109
<i>San Juan Health Department</i> 196 East Center Blanding, UT 84511 Office: 435 678-2723 Office Fax: 435 678-3309	<i>Southeast Health Department</i> 28 South 100 East Price, UT 84501-3002 Office: 435 637-3671 Office Fax: 435 637-1933
<i>Southwest Health Department</i> 620 South 400 East #400 St. George, UT 84770 Office: 435 986-2588 Office Fax: 435 628-6425	<i>Summit County Health Department</i> 650 Round Valley Dr., Suite 100 Park City, UT 84060 Office: 435 333-1504 Office Fax: 435 333-1580
<i>Tri-County Health Department</i> 133 South 500 East Vernal, UT 840787-2728 Office: 435 247- Office Fax: 435 781-0536	<i>Utah County Health Department</i> 151 S University Ave. #1610 Provo, UT 84601 Office: 801 851-7050 Office Fax: 801 851-7055
<i>Wasatch County Health Department</i> 55 South 500 West Heber City, UT 84032-1918 Office: 435 657-3257	<i>Weber Morgan Health Department</i> 477 23rd Street Ogden, UT 84401-1507 Office: 801 399-7235

Office Fax: 435 654-2705	Office Fax: 801 399-7256
<u>Tooele County Health Department</u> 151 North Main Street Tooele, UT 84074-2141 Office: 435 277-2303	

6 Resource Table

<i>For information regarding:</i>	
Administrative Rules	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. Transplant Services Standards. R414-10A.
General information including: Billing Fee for Service and Managed Care Member Eligibility Prior Authorization Provider Participation	Section I: General Information Claims Managed Care: Accountable Care Organizations Utah Medicaid Prior Authorization <i>Administrative Rules</i> Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301. Program Benefits and Date of Eligibility. R414-306. Utah Medicaid Program. R414-1.
Information including: Anesthesia Fee Resources Coverage and Reimbursement Resources Procedure codes with accompanying criteria and limitations National Correct Coding Initiative	Bureau of Coverage and Reimbursement Policy Coverage and Reimbursement Code Lookup The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: Medicaid Information Bulletins (Issued Quarterly in January, April, July, and October) Medicaid Provider Manuals Utah State Bulletin (Issued on the 1 st and 15 th of each month)	Utah Medicaid Official Publications Utah State Bulletin
Patient (Member) Eligibility Lookup Tool	Eligibility Lookup Tool
Prior Authorization	Prior Authorization Form Utah Medicaid Prior Authorization
Provider Portal Access	Provider Portal Access
Provider Training	Utah Medicaid Provider Training
Other	Bright Futures Periodicity Schedule Immunization Schedule for Children and Adolescents

	Targeted Case Management-Early Childhood (ages 0-4) Manual Baby Your Baby CDC Vaccines for Children Program. Dental, Oral Maxillofacial, And Orthodontia Provider Manual Hospice Provider Manual Medicaid.gov Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual RHC-FQHC Provider Manual Women, Infants and Children (WIC) Utah Lead Coalition Appendix A, Child Health Evaluation and Care Recommended Dental Periodicity Schedule
References including: Social Security Act Code of Federal Regulations	Section 1905 (a) of the Social Security Act Title 42 → Chapter IV → Subchapter C → Part 441 → Subpart B