

Section 2

Hospital Services

Table of Contents

| | | |
|-------|---|---|
| 1 | General Information..... | 3 |
| 1-1 | Hospital Services..... | 3 |
| 2 | Health Plans | 3 |
| 3 | Provider Participation and Requirements..... | 3 |
| 4 | Record Keeping | 3 |
| 5 | Provider Sanctions | 3 |
| 6 | Member Eligibility..... | 3 |
| 7 | Member Responsibilities..... | 4 |
| 8 | Programs and Coverage | 4 |
| 8-1 | Definitions..... | 4 |
| 8-2 | Emergency Services Program for Non-Citizens | 4 |
| 8-3 | Pharmacy Services | 4 |
| 8-4 | Organ Transplant Services | 4 |
| 8-5 | Modifiers..... | 4 |
| 8-6 | Complications Due to Non-Covered or Non-Authorized Services..... | 4 |
| 8-7 | Inpatient Intensive Physical Rehabilitation Services | 4 |
| 8-8 | Co-payment Requirements for Hospital Services | 5 |
| 8-9 | Emergency Department Coverage | 5 |
| 8-10 | Ambulatory Surgical Centers Coverage and Reimbursement | 5 |
| 8-11 | Laboratory Services | 5 |
| 8-12 | Mental Health Services | 6 |
| 9 | Non-Covered Services and Limitations | 6 |
| 9-1 | Limited Abortion Services | 6 |
| 9-2 | Experimental, Investigational, or Unproven Medical Practices..... | 6 |
| 9-3 | Sterilization and Hysterectomy Procedures | 6 |
| 9-3.1 | Voluntary Sterilization..... | 7 |
| 9-3.2 | Sterilizations Incident to Surgical Procedures | 7 |
| 9-4 | Reconstructive and Cosmetic Services | 7 |
| 9-5 | Treatment of Alcoholism or Drug Dependency..... | 7 |
| 9-6 | Inpatient Only | 7 |

| | | |
|------|---|----|
| 9-7 | Outlier Days | 7 |
| 9-8 | Readmissions Within 30 Days of Previous Discharge..... | 8 |
| 9-9 | Exceptions to the 30-Day Readmission Policy | 8 |
| 9-10 | Occupational Therapy Services | 8 |
| 9-11 | Outpatient Hospital Services..... | 8 |
| 9-12 | Outpatient Hospital Psychiatric Services..... | 8 |
| 9-13 | Hyperbaric Oxygen Therapy..... | 9 |
| 9-14 | Non-Covered Services | 9 |
| 10 | Prior Authorization | 9 |
| 10-1 | Retroactive Authorization..... | 10 |
| 11 | Billing | 10 |
| 11-1 | Inpatient Hospital Claims with Third Party Insurance..... | 11 |
| 11-2 | Outpatient and Inpatient Hospital Revenue Codes | 11 |
| 12 | Coding..... | 11 |
| 13 | Reimbursement for Inpatient Hospital Services | 11 |
| 13-1 | Outpatient Hospital Services..... | 11 |
| 14 | Long-Term Acute Care (LTAC)..... | 13 |
| | Resource Table..... | 15 |

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 Hospital Services

Hospital services are available to eligible Medicaid clients with surgical, medical, diagnostic, or level of care needs that require the availability of specialized diagnostic and therapeutic services, and close medical supervision of care and treatment directed toward maintenance, improvement, or protection of health or lessening of illness, disability or pain.

For documenting admission and length of stay, the day of admission to an acute care hospital facility is counted as a full day stay and the day of discharge is not counted.

2 Health Plans

For more information about Accountable Care Organizations (ACOs), refer to [Section I: General Information, Chapter 2, Health Plans](#).

For more information about Prepaid Mental Health Plans (PMHPs), refer to [Section I: General Information, Chapter 2-1.2, Prepaid Mental Health Plans](#), and the [Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual](#).

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website [Managed Care: Accountable Care Organizations](#).

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](#), for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. 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

All hospital inpatient and outpatient services are subject to review by the Department of Health and Health Care Financing, Bureau Coverage and Reimbursement Policy for medical necessity and appropriateness of the admission according to [R414-1-12 Utilization Review](#) and [R414-1-14 Utilization Control](#).

8-2 Emergency Services Program for Non-Citizens

For information on federal regulations, criteria, documentation, and billing, refer to [Section I: General Information](#), *Chapter 8-2, Emergency Services Program for Non-Citizens*.

8-3 Pharmacy Services

For more information on Pharmacy Services, refer to [Utah Administrative Code R414-60. Medicaid Policy for Pharmacy Program](#), and the [Pharmacy Services Provider Manual](#).

8-4 Organ Transplant Services

Organ transplantation services are covered Medicaid services as specified in [Utah Administrative Code. R414-10A. Transplant Services Standards](#).

8-5 Modifiers

Refer to [Section I: General Information](#), *Chapter 12-7.3, Modifier used in a Claim*.

8-6 Complications Due to Non-Covered or Non-Authorized Services

Medically necessary services resulting from complications of non-covered or non-authorized procedures are covered, as appropriate within all other applicable rules and regulations.

8-7 Inpatient Hospital Intensive Physical Rehabilitation Services

Inpatient hospital intensive physical rehabilitation is an intense program of physical rehabilitation provided in an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital.

Prior Authorization

The PA request for inpatient hospital intensive physical rehabilitation services must be submitted within standard timely filing requirements, using the current version of the Request for Prior Authorization Form. PA reviews only serve to determine appropriate DRG assignment.

Quick Reference for Rehabilitation Services

| DRG | Diagnosis |
|------|---|
| 8800 | Spinal injury resulting in paraplegia |
| 8801 | Spinal injury resulting in quadriplegia |
| 8802 | Traumatic brain injury |
| 8803 | Stroke (cardiovascular accident) |
| 8804 | Other condition which may require an intensive inpatient rehabilitation program |

8-8 Co-payment Requirements for Hospital Services

The Medicaid program may require certain members to pay for services or benefits, referred to as cost sharing. Cost sharing amounts may include such items as premiums, deductibles, co-insurance, or co-payments.

Refer to Utah State Plan Attachments 4.18-A through H, for additional cost sharing information.

8-9 Emergency Department Coverage

The “emergency” designation is based on the principal diagnosis (ICD-10-CM code). The diagnosis primarily responsible for the patient’s outpatient service must appear as the principal diagnosis on the claim.

8-10 Ambulatory Surgical Centers Coverage and Reimbursement

Ambulatory Surgical Centers are reimbursed as outlined in the Utah State Plan and [42CFR Part 416, Ambulatory Surgical Services](#).

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

8-11 Laboratory Services

The laboratory services ordered must be medically necessary and appropriate to the patient’s current care and/or condition. Medical necessity must be supported by the documentation in the medical record.

To determine if a laboratory code is covered or requires prior authorization, refer to the [Coverage and Reimbursement Code Lookup](#) and [Utah Medicaid Prior Authorization](#).

Laboratory services are limited to those tests identified by [Centers for Medicare and Medicaid Services \(CMS\)](#) for which the individual provider or laboratory is [Clinical Laboratory Improvement Act \(CLIA\)](#) certified to provide, report, and receive [Medicaid](#) payment.

Certain laboratory tests are paid by CMS out of a separate [Laboratory Fee Schedule](#). The laboratory tests on the Laboratory Fee Schedule are considered technical services. The reading and interpretation of these services are considered bundled into the ordering physician's medical decision portion of the E/M service. Laboratory tests with a professional component within the CMS Laboratory Fee Schedule are the only laboratory services with a separate professional component.

Clinical diagnostic laboratory tests sent to a laboratory must be billed by the laboratory completing the service.

8-12 Mental Health Services

Refer to [Section I: General Information, Chapter 2, Prepaid Mental Health Plans, Utah Administrative Code R414-10. Physician Services, Utah Administrative Code R414-36. Rehabilitative Mental Health and Substance Use Disorder Services](#), and the [Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual](#).

9 Non-Covered Services and Limitations

Certain services have been identified to be non-covered for the Medicaid program because medical necessity, appropriateness, and cost effectiveness cannot be readily identified or justified for the purposes of 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 [R414-2A. Inpatient Hospital Services, Rule R414-3A. Outpatient Hospital Services, Utah Administrative Code R414-1. Utah Medicaid Program](#), and [Section I: General Information, Chapter 9, Non-Covered Services and Limitations](#).

9-1 Limited Abortion Services

Refer to [Section I: General Information, Chapter 9-1, Limited Abortion Services](#), and [Utah Administrative Code R414-1B. Payment for Limited Abortion Services](#).

9-2 Experimental, Investigational, or Unproven Medical Practices

Refer to [Section I: General Information, Chapter 9-3.3, Experimental, Investigational, or Unproven Medical Practices](#) and [Utah Administrative Code R414-1A. Medicaid Policy for Experimental, Investigational or Unproven Medical Practices](#).

9-3 Sterilization and Hysterectomy Procedures

Sterilization and hysterectomy procedures are limited to those that meet the requirements of [42 CFR 441, Subpart F](#).

9-3.1 Voluntary Sterilization

This means an individual decision made by the member, male or female, for voluntarily preventing conception for the purpose of family planning.

- A prior authorization must be obtained, by the surgeon, prior to the service being provided, refer to [Utah Medicaid Prior Authorization](#)
- The [Sterilization Consent Form](#) (Form 499-A) must be properly executed and submitted prior to procedure being performed

9-3.2 Sterilizations Incident to Surgical Procedures

- Prior authorization requirements must be met
- For hysterectomy procedures, a properly executed [Utah Medicaid Hysterectomy Acknowledgement Form](#) must be submitted for all hysterectomy procedures
- Refer to the [Coverage and Reimbursement Code Lookup](#) for specific codes which require the hysterectomy consent form

9-4 Reconstructive and Cosmetic Services

For additional information, refer to Utah Administration Code [R414-1-29. Medicaid Policy for Reconstructive and Cosmetic Procedures.](#)

Medical necessity, as defined in [Utah Administrative Code R414-1-2 \(18\)](#), shall be established through evidence-based criteria.

9-5 Treatment of Alcoholism or Drug Dependency

- Inpatient hospital care for treatment of alcoholism or drug dependency is limited to medical treatment of withdrawal symptoms associated with drug or alcohol detoxification
- Outpatient continuing therapy for treatment of alcoholism or drug dependency must be accessed under the outpatient mental health or psychiatric services benefit as appropriate
- Drug and alcohol rehabilitation is not a covered service

9-6 Inpatient Only

Under the current Outpatient Prospective Payment System (OPPS), there are procedure codes that are designated as only payable on inpatient claims. Utah Medicaid follows Medicare's Addendum E to determine which codes are considered inpatient-only. Utah Medicaid may determine that procedures currently listed as inpatient-only may be provided in an outpatient hospital setting.

9-7 Outlier Days

Review of inpatient "outlier days" is limited to cases where full payment of the DRG has been made to the hospital. The following exceptions apply:

- Neonatal admissions assigned to DRG's 789, 790, 791 go into outlier status the day after admission. A length of stay less than 20 days does not require review. Payment will automatically be calculated to include the outlier days.
- If a case with stay of less than 21 days is submitted in error, the entire case will be reviewed for severity of illness and intensity of service
- When the stay for a Medicaid patient eligible for Emergency Services Only goes into outlier days, the entire record must be submitted with a transmittal sheet for one review. The emergency circumstances and the outlier days can be evaluated in the same review – a benefit to both the hospital and the agency.

9-8 Readmissions Within 30 Days of Previous Discharge

See Utilization Control and Review Program for Hospital Services in Utah Administrative Rule [R414-2A. Inpatient Hospital Services](#), [Rule R414-3A. Outpatient Hospital Services](#), and [R414-1-12 Utilization Review](#).

9-9 Exceptions to the 30-Day Readmission Policy

See Utilization Control and Review Program for Hospital Services in Utah Administrative Rule [R414-2A. Inpatient Hospital Services](#), [Rule R414-3A. Outpatient Hospital Services](#), and [R414-1-12 Utilization Review](#).

9-10 Occupational Therapy Services

Limited to those cases identified and approved for children through a CHEC/EPSDT screen, or to a special group of services identified and approved through a cooperative occupational therapy/physical therapy program.

Refer to the Medicaid Provider Manuals for [Child Health Evaluation and Care](#) and [Physical Therapy and Occupational Therapy Services](#).

9-11 Outpatient Hospital Services

Limited to services that are medically necessary and appropriate for the outpatient setting. Determinations of medical necessity and appropriateness are based on utilization management review and medical review criteria as outlined in Utah Administrative Code [R414-1-12 Utilization Review](#).

Reimbursement is limited to credentialed outpatient hospital departments.

For information, refer to the [Coverage and Reimbursement Code Lookup](#).

9-12 Outpatient Hospital Psychiatric Services

Outpatient hospital psychiatric services are limited to services provided in an outpatient unit of a general acute care hospital that is licensed and approved for psychiatric care.

9-13 Hyperbaric Oxygen Therapy

Refer to Utah Administrative Rule [R414-2A. Inpatient Hospital Services](#) and [Rule R414-3A. Outpatient Hospital Services](#).

9-14 Non-Covered Services

Certain services have been identified to be non-covered by the Utah Medicaid Program because medical necessity, appropriateness, and cost effectiveness cannot be readily identified or justified for the purposes of medical assistance under Title XIX of the Federal Social Security Act and Title 42 Code of Federal Regulations (CFR). The general exclusions are listed below:

- Provider preventable conditions (PPC) refer to Utah Administrative Rule [R414-2A. Inpatient Hospital Services](#)
- Services rendered during a period the client was ineligible for Medicaid
- Services medically unnecessary or unreasonable
- Services which fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature
- Services requiring prior authorization, but for which such authorization was not requested, was not obtained, or was denied
- Services, elective in nature, and requested or provided only because of the client's personal preference
- Services for which third party payers are primarily responsible, e.g., Medicare, private health insurance, liability insurance, Medicaid may make a partial payment up to the Medicaid maximum if limit has not been reached by third party
- Services fraudulently claimed
- Services which represent abuse or overuse
- Services rejected or disallowed by Medicare when the rejection was based on any of the reasons set forth above
- When a procedure or service is not covered for any of the above reasons or because of specific policy exclusion, all related services and supplies, including institutional costs will be excluded for the standard post-operative recovery period
- Chemical peeling, dermabrasion or laser therapy of the face
- Removal of tattoos
- Certain services are excluded as family planning services:
 - Surgical procedures for the reversal of previous elective sterilization, both male and female
 - Infertility studies
 - In-vitro fertilization
 - Artificial insemination
 - Surrogate motherhood, including all services, tests, and related charges
- Surgical procedures that are unproven or experimental are non-covered Medicaid services

10 Prior Authorization

Prior authorization must be verified before service is rendered. The hospital claim must be submitted with the prior authorization number that was issued to the provider. Facility charges will not be paid when prior authorization is required and there is no valid prior authorization approval on file. For information regarding prior authorization, see [Section I: General](#)

[Information](#), *Chapter 10, Prior Authorization*. Additional resources and information may be found on the [Utah Medicaid Prior Authorization](#) website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the [Coverage and Reimbursement Code Lookup](#).

10-1 Retroactive Authorization

There are limited circumstances in which a hospital may request authorization after service is rendered. These limitations are described in [Section I: General Information](#), *Chapter 10-3 Retroactive Authorization*.

11 Billing

Refer to [Section I: General Information](#), *Chapter 11, Billing Medicaid*, for more information about billing instructions.

Medicaid requires UB-04 inpatient and outpatient claims to be billed electronically. The Utah Medicaid agency will return UB-04 claims submitted on a paper form to the provider with a cover letter requesting the claim be submitted electronically.

Paper Claim Exceptions:

- Medicaid accepts paper UB-04 claims in three circumstances only:
 - UB-04 claims billed by out-of-state providers
 - Dialysis claims
 - Crossover claims where the Medicare carrier is out of state
 - When necessary and appropriate to file a paper claim, refer to the Utah Uniform Billing Instruction Manual
 - (UB-04 Manual) for the Utah Medicaid UB-04 Billing Instructions

Electronic Billing with AcClaim Software

The Utah Health Information Network (UHIN) provides AcClaim software for billing UB-04 claims electronically. Providers who need AcClaim software and be set up to bill through UHIN may call (801) 466-7705. Providers who need additional assistance may call Medicaid Information, 801-538-6155 or toll-free 1-800-662-9651, and ask for Medicaid Electronic Billing.

The requirement to bill electronically through UHIN is supported by the Administrative Simplification Clause in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). An advantage of electronic billing for providers is that mistakes, such as placement of the provider number, can be corrected immediately. Because billing errors are reduced, claims can be processed immediately. In addition, electronic claims can be submitted until noon on Friday for processing that week.

Crossover Claims with EOMB attachment

Medicaid processes crossover claims in two circumstances only:

- Inpatient claim, Part B Only. After Medicare pays the claim, it is processed as a Medicaid claim with the Medicare payment on the claim. Medicaid then pays the Part A (hospital) charges.
- Out of plan claims such as mammography with the EOMB denial attached.

Manual Adjustments Accepted

When submitting a paper UB-04 claim as an adjustment to an original paid or denied claim, write the seventeen-digit transaction control number (TCN) of the original claim on the paper claim or write **PAR** (Payment Adjustment Request) on the claim. The claim will be adjusted to correct billing errors or add charges.

11-1 Inpatient Hospital Claims with Third Party Insurance

[Section I: General Information Provider Manual](#), *Chapter 11, Billing Third Parties*, states the general policy for patients who have liable third parties such as private insurance, a health maintenance organization, Medicare Part A and B or B only, or Qualified Medicare Benefits (QMB), in addition to Medicaid.

When a patient with third party insurance receives inpatient hospital services, there are two clarifications to the general information, refer to [Section I: General Information Provider Manual](#), *Chapter 11, Billing Third Parties* for additional information.

11-2 Outpatient and Inpatient Hospital Revenue Codes

Medicaid is following the national standard to require CPT codes to be listed with the revenue code. This standard will apply with the exception of the following revenue codes: 0360, 0361, 0451-0452, 0459-0460, and 0469, wherein CPT codes will not be required.

12 Coding

Refer to the [Section I: General Information Provider Manual](#), *Chapter 12, Coding*, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure, codes see the [Coverage and Reimbursement Code Lookup](#).

13 Reimbursement for Inpatient Hospital Services

- Reimbursement for inpatient hospital services is covered in the Utah State Plan
- Providers must ensure that all submitted diagnoses are appropriate and documented in the patient's medical record
- Only covered charges will be included in the calculation of the hospital's reimbursement
- Denied or non-covered charges will be excluded.

13-1 Outpatient Hospital Services

Note: This section does not apply to Long-Term Acute Care hospitals, Ambulatory Surgical Centers, or ambulance claims.

- A. Effective September 1, 2011, Utah Medicaid began paying outpatient hospital claims like Medicare's Outpatient Prospective Payment System (OPPS) methodology. Hospitals are paid accord to their Medicare-designated facility type. Due to differences in clientele, Utah Medicaid may choose to differ in coverage from Medicare's coverage and edits. Coverage is displayed by the Outpatient fee schedule posted to the Medicaid website. Please refer to Utah State Plan, Attachment 4.19-B for specifics.
- B.
- Critical Access Hospitals (CAH) are paid 101% of costs for covered procedure codes.
- B.1. Costs are determined using the hospital-specific cost-to-charge ratio (CCR) multiplied by the submitted charges.
- B.2. The Medicare CCR will be used for in-state facilities. The CCR will be obtained quarterly from Noridian.
- B.2.1.1.1. The Medicare CCR will be used for out-of-state facilities. The CCR will be obtained from the Healthcare Cost Report Information System (HCRIS)
- B.3. Claims will be edited using the Center for Medicare & Medicaid Service's (CMS) Outpatient Code Editor (OCE). Edits will apply, but reimbursement for CAH facilities is contained within this section.
- C.
- OPPS hospitals are paid on a line-item level based upon the procedure code.
- C.1. Claims will be edited using the Centers for Medicare & Medicaid Services (CMS) Outpatient Code Editor (OCE)
- C.1.1. Line items with a Medicare status indicator 'A' (Paid ...under a fee schedule...) will be paid by the applicable Medicare fee schedule. Fee schedules that apply include Medicare's Lab, DME, DME Penpuf, Physician, and ASP fee schedules (ambulance and ASC fee schedules are not applied for Utah Medicaid). Medicare lab panel methodology applies.
- C.1.2. Line items with a Medicare status indicator shown below will only be paid if Medicaid has the code open for outpatient billing. Such claim lines will be paid based on the Medicaid fee schedule rate.
- 'B' (Codes not recognized by OPPS)
 - 'E1' (Items, codes, & services...Not paid by Medicare)
 - 'E2' (Items, codes, & services...Not paid by Medicare)
 - 'M' (Items & services not billable to the fiscal intermediary)
 - 'Y' (Non-Implantable Durable Medical Equipment)
- C.1.3. Line items with a Medicare status indicator shown below will **NOT** be paid by Medicaid.
- 'C' (Inpatient procedures)
Refer to the Coverage and Reimbursement Lookup Tool for exceptions at:
<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>
 - 'D' (Discontinued)
- C.1.4. Line items with a Medicare status indicator shown below will be paid reasonable cost (charges multiplied by the hospital-specific CCR).
- 'F' (Corneal tissue, Hepatitis B vaccines)
 - 'L' (Influenza, Pneumococcal vaccines)
- C.1.5. Line items with a Medicare status indicator shown below will be paid at the pass-through rate. (Pass-through rate means that the provider's charges reflect the cost of the item only.)
- 'G' (Pass-through drugs & biologicals)
 - 'H' (Pass-through device categories)

- C.1.6. Line items with a Medicare status indicator shown below will be paid the APC-calculated rate.
- ‘J1’ (Hospital Part B services paid through a comprehensive APC)
 - ‘J2’ (Hospital Part B services that may be paid through a comprehensive APC)
 - ‘K’ (Non-Pass-Through Drugs...)
 - ‘N’ (Items and Services Packaged into APC Rates)
 - ‘P’ (Partial Hospitalization)
 - ‘Q1’ (STVX-Packaged Codes)
 - ‘Q2’ (T-Packaged Codes)
 - ‘Q3’ (Codes That May Be Paid Through a Composite APC)
 - ‘Q4’ (Conditionally packaged Laboratory tests)
 - ‘R’ (Blood & blood products)
 - ‘S’ (Significant Procedure, Not Discounted When Multiple)
 - ‘T’ (Significant Procedure, Multiple Reduction Applies)
 - ‘U’ (Brachytherapy Sources)
 - ‘V’ (Clinic or Emergency Department Visit)
 - ‘X’ (Ancillary Services)
- C.2. Rural Sole Community Hospitals (RSCH)
- C.2.1. Receive a 7.1% bonus (or current Medicare rate) for APC-calculated items.
- C.2.2. Lab fees are paid at 62% of base rate. This follows Medicare methodology for a 3.3% increase (base is 60%).
- C.3. Vaccines & Injectables
- C.3.1. Vaccines for children (VFC) payments are reimbursable at Medicaid VFC-established rates.
- C.3.2. Non-VFC Covered vaccines and injectables are paid through OPPS pricing.
- C.3.3. Non-VFC Non-covered vaccines and injectables are not reimbursed, nor are the associated administration charges.

Updates to coverage and pricing will occur quarterly with Medicare’s release of OCE and pricer software. Medicaid will review coverage to match these releases. Due to software release timing, claims may be held for up to 15 days. If additional time is required, claims will be initially processed to make payments and then reprocessed after updates are made in the system.

Pharmaceutical claims lines without a valid NDC will be denied. This includes services billed with revenue codes 450 and 459.

14 Long-Term Acute Care (LTAC)

Utah Medicaid policy regarding LTAC preadmission, continued stay or retroactive review is located in Utah Administrative Rule R414-515 Long Term Acute Care.

- Members must be Medicaid eligible prior to authorization of any LTAC stay
- Criteria for a preadmission, continued stay, and retroactive review is determined through an evidence-based review process

A LTAC request must include:

- Properly completed Utah Department of Health LTAC document submission cover sheet
- A prior authorization request

- Current comprehensive documentation to make a preadmission, continued stay, or retroactive determination

Documentation must include, as applicable:

- A history and physical
- Operative reports
- Daily physician progress notes
- Consulting physician progress notes
- Vital signs
- Laboratory test results
- Medication administration records
- Respiratory therapy notes
- Wound care notes
- Nutrition notes
- Physical, occupational, and speech therapy notes
- Any other pertinent information regarding the LTAC request

Requirements

- Payment will be approved for reasonable and medically necessary services and supplies subject to the exclusions and limitations set forth in policy and Utah Administrative Code Title R414-515 Long Term Acute Care
- A discharge plan must be submitted with all continued stay reviews
 - Failure to properly plan a discharge from the LTAC does not qualify for continued stay in the LTAC
- In order to adjudicate correctly, LTAC claims must be billed as an outpatient hospital claim using revenue code 760 for the daily rate charges. All other billing procedures and practices apply to LTAC claims. These may be found in the [General Information: Section I Manual](#).

Limitations

- Documentation for preadmission, continued stay and retroactive review must be submitted in a timely manner as outlined in Administrative Rule R414-515 Long Term Acute Care, or the request shall be denied
- A LTAC will not be reimbursed for denied dates of service or for any subsequent dates of service related to that episode of care
- The predominant clinical findings will be used to determine the severity of illness criteria for the primary condition

Rights to the fair hearing process are given to all LTAC denials as outlined in Administrative Rule [R414-301. Medicaid General Provisions](#).

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 • Diabetes Self-Management Training. R414-90. • Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49 • Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A • Payment for Limited Abortion Services. R414-1B • Physician Services. R414-10 • Transplant Services Standards. R414-10A • Podiatric Services. R414-11 |
| Ambulatory Surgical Centers | <ul style="list-style-type: none"> • 42CFR Part 416, Ambulatory Surgical Services |
| Emergency Services Program for Non-Citizens | <ul style="list-style-type: none"> • Section I: General Information • 42 CFR 440.255 |
| 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 • Eligibility Requirements. R414-302 • Medicaid General Provisions. R414-301 • Program Benefits and Date of Eligibility. R414-306 • Utah Medicaid Program. R414-1 |
| Hospital Services | <ul style="list-style-type: none"> • §440.10 Inpatient hospital services, other than services in an institution for mental diseases • 42 CFR 447.26 Prohibition on Payment for Provider-Preventable Conditions • 42 CFR 482 Conditions of Participation for Hospitals • 42 CFR 440.20 Outpatient Hospital Services and Rural Health Clinic Services • Rule R414-2A. Inpatient Hospital Services • Rule R414-3A. Outpatient Hospital Services • R414-1-12 Utilization Review • Utah Administrative Code. R414-10A. Transplant Services Standards • 42 CFR 441, Subpart F Sterilizations • 42 CFR 412, Subpart P Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units |
| Information including: <ul style="list-style-type: none"> • Anesthesia Fee Resources • Coverage and Reimbursement Resources • National Correct Coding Initiative | <ul style="list-style-type: none"> • Bureau of Coverage and Reimbursement Policy • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid |

| | |
|---|---|
| <ul style="list-style-type: none"> • Procedure codes with accompanying criteria and limitations | |
| <p>Information including policy and rule updates:</p> <ul style="list-style-type: none"> • Medicaid Information Bulletins • Medicaid Provider Manuals • Utah State Bulletin | <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 • FDA Clinical Laboratory Improvement Amendments (CLIA) • CDC Clinical Laboratory Improvement Amendments (CLIA) • Utah Public Health Laboratory Clinical Laboratory Certification (CLIA) • Medicare Claims Processing Manual Chapter 16 - Laboratory Services • Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report • State Laboratories |
| <p>Medicaid forms including:</p> <ul style="list-style-type: none"> • Abortion Acknowledgement • Hearing Request • Hospice Prior Authorization Form • Hysterectomy Acknowledgement • PA Request • Sterilization Consent | <ul style="list-style-type: none"> • Utah Medicaid Forms |
| Medical Supplies and DME | <ul style="list-style-type: none"> • Medical Supplies And Durable Medical Equipment Provider Manual • Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70 |
| Modifiers | <ul style="list-style-type: none"> • Section I: General Information |
| Non-Traditional Medicaid Health Plan Services | <ul style="list-style-type: none"> • Non-Traditional Medicaid Health Plan Services. R414-200 |
| Patient (Member) Eligibility Lookup Tool | <ul style="list-style-type: none"> • Eligibility Lookup Tool |
| Pharmacy | <ul style="list-style-type: none"> • Drug Criteria Limits • Generic Prescriptions List • ICD-10 Reference Chart Pharmacy • Medicaid Pharmacy Program • OTC Drug List • Pharmacy Provider Manual |

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| | <ul style="list-style-type: none"> • Medicaid Policy for Pharmacy Program. R414-60 |
| Primary Care Network Plan Services | <ul style="list-style-type: none"> • Primary Care Network (PCN) Provider Manual • Medicaid Primary Care Network Services. R414-100 |
| Prior Authorization | <ul style="list-style-type: none"> • Prior Authorization Form • Utah Medicaid Prior Authorization |
| Provider Portal Access | <ul style="list-style-type: none"> • Provider Portal Access |
| Provider Training | <ul style="list-style-type: none"> • Utah Medicaid Provider Training |
| Other | <ul style="list-style-type: none"> • Baby Your Baby • CDC Vaccines for Children Program. • Dental, Oral Maxillofacial, And Orthodontia Provider Manual • Hospice Provider Manual • Licensed Nurse Practitioner Provider Manual • Medicaid.gov • Podiatric Services Provider Manual • Rehabilitative Mental Health And Substance Use Disorder Services Provider Manual • RHC-FQHC Provider Manual • Vision Care Services Provider Manual • Women, Infants and Children (WIC) |
| References including: <ul style="list-style-type: none"> • Social Security Act • Code of Federal Regulations • Utah Code • Utah State Medicaid Plan | <ul style="list-style-type: none"> • 42 CFR • Social Security Act 1905(a) • Social Security Act 1861 (r) • Utah Annotated Code Title 58 • Utah State Medicaid Plan |
| Tobacco Cessation Resources | <ul style="list-style-type: none"> • Utah Tobacco Quit Line (1-800-QUIT-NOW) • Way to Quit |