Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Hospital Services

Division of Integrated Healthcare

Updated November 2024

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1 General information

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

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 members 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 Managed Care 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 verifying 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 Human Services and Division of Integrated Healthcare, Office of Healthcare Policy and Authorization (OHPA) for medical necessity and appropriateness of the admission according to R414-1-12 Utilization Review and R414-1-14 Utilization Control.

8-1 Emergency services program for non-citizens

For information on federal regulations, criteria, documentation, and billing, refer to Section I: General Information, Chapter 8, Emergency services program for non-citizens.

8-2 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.

8-3 Organ transplant services

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

8-4 Modifiers

Refer to Section I: General Information, Chapter 12-7.3, Modifier used in a claim.

8-5 Complications due to non-covered 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.

8-6 Inpatient hospital intensive physical rehabilitation services

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

Inpatient intensive physical rehabilitation services are covered for acute conditions from birth through any age and are available one time per event.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible members with chronic conditions may be considered for age-appropriate developmental training. All services are subject to post-payment review by the Office of Inspector General (OIG).

Inpatient intensive physical rehabilitation services are intended to provide the therapy necessary to allow the patient to function without avoidable follow-up outpatient therapy. Therefore, the hospital should provide the maximum therapy services the patient could receive under the Diagnosis Related Group (DRG). Outpatient therapy services requested following inpatient intensive physical rehabilitation services in which the maximum therapy services were not provided, and those services could have been appropriately provided in the inpatient setting, will not be approved without the appropriate committee review.

8-6.1 Non-covered services with limitations

Rehabilitation services are non-covered when:

1. The patient's condition and prognosis meet the requirements of placement in a long-term facility, skilled nursing facility, or outpatient rehabilitation service.
2. The admission is for deconditioning (e.g., cardiac, or pulmonary rehabilitation).

8-6.2 Medical necessity documentation

The clinical record must be maintained on file in accordance with any federal or state law or state administrative rule and made available for state or federal review upon request. Based on CMS and other documentation guidelines, a patient admitted for inpatient intensive physical rehabilitation, the medical record should support the admission as reasonable and necessary. The following items and the information contained in the Quick Reference for Rehabilitation Services table will assist in supporting the admission; however, providers should adhere to all applicable standards in preparing medical documentation:

1. If it is the first admission for this medical event.
2. Appropriate standardized measurement tool scores, including an audiology record for admission, that include speech-language pathology services.
3. The member requires rehabilitation evaluation and management services of intensity, frequency, and duration that qualify them for

inpatient rehabilitation, based on the FIM score or Primary Children's Medical Center score (for EPSDT eligible patients), and other appropriate measurement tools (e.g., ASIA score, Rancho score, Disability Rating Scale (DRS), Walking Index for Spinal Cord Injury (WISCI), Agitated Behavior Scale (ABS) or other equivalent standardized measurement tool scores).

4. The member is medically/surgically stable and requires 24-hour nursing care or supervision by a registered nurse with specialized training in rehabilitation.
5. The member has a reasonable expectation of improvement in activities of daily living appropriate for chronological age and development that will be of significant functional improvement when measured against the member's documented condition at the time of the initial evaluation.
6. The member is mentally and physically ready to learn adaptive techniques, transfer skills, and equipment use appropriate for the level of injury.
7. The member's physical, cognitive, and sensory capacity allows active and ongoing participation in intense, multiple therapy disciplines (physical, occupational, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy, designed to restore function rather than maintain existing function.
8. The generally accepted standard by which the intensity of these services is typically demonstrated in an inpatient intensive physical rehabilitation hospital is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated. The intensity of services may vary. For example, a patient admitted for a hip fracture and undergoing chemotherapy for an unrelated issue may have less intense therapy on those days chemotherapy is administered (Also refer to the CMS Brief Exceptions Policy).

8-6.3 Quick Reference for Rehabilitation Services

Diagnosis	Disease-specific documentation
Spinal injury resulting in paraplegia	The patient has paralysis of two limbs or half of the body related to trauma or disease of the spinal cord. The ASIA score or other standardized measurement tool score must be present in the medical record. May be complicated by: 1. Pressure sores 2. Urological complications (e.g., UTI, dysreflexia) 3. Respiratory complications 4. Contractures 5. Spinal/skeletal instability
Spinal injury resulting in quadriplegia	The patient has paralysis of all four limbs. The ASIA score or other standardized measurement tool score must be present in the medical record. It may be complicated by: 1. Pressure sores 2. Urological complications (e.g., UTI, dysreflexia) 3. Respiratory complications 4. Contractures 5. Spinal/skeletal instability

Traumatic brain injury	The Rancho Classification scale must be in the medical record and must have two or more neurological deficits documented: 1. Dysphagia 2. Dysphasia 3. Paralysis 4. Visual disturbances 5. Cognitive deficit Note: Documentation of well-defined treatment goals for functional improvement. The patient is an evolving Rancho 3 or Rancho 4-6 with behavior management issues.
Stroke (cardiovascular accident)	Treatment must begin within 60 days after onset of stroke, and: 1. The patient has sustained focal neurological deficit. 2. The rehabilitation service is for a separate focal CVA site than a previous admission
Other conditions which may require an intensive inpatient rehabilitation program:	Patients with other conditions must have physical impairment secondary to various problems such as trauma, surgery, chronic disease, and malnutrition. The combination of factors can be expected to improve with a comprehensive physical restoration program. The FIM score or the Primary Children's Medical Center score must be in the record. In addition, other standardized measurement tool scores may be required depending on the diagnosis.
Neurological Defect:	

1. **Amyotrophic lateral sclerosis (ALS)** 2. **Guillain-Barre Syndrome**	
Other Conditions	
Neurological disorders: 1. **Multiple Sclerosis** 2. **Myelopathy (transverse myelitis infarction)** 3. **Myopathy** 4. **Parkinson's Disease**	
Congenital deformity (e.g., following dorsal rhizotomy)	
Complex fractures (e.g., hip) or fracture with complicating condition	
Amputation with complication or multiple amputations	The patient must have been mobile before the injury. Supportive documentation must substantiate a rehabilitation stay will be beneficial to the patient. The stump must be healed so that the patient can accomplish physical therapy and rehabilitation education.
Post neurosurgery of brain or spine (e.g., tumor)	Must have a complicated medical condition requiring a physician's close medical supervision with a resulting muscular-skeletal deficit.
Burns	Disability due to burns involving at least 15% of the body
Major multiple trauma (e.g., fractures, amputation)	
Post meningoencephalitis	

8-6.4 Multidisciplinary treatment team

The multidiscipline treatment team may consist of:

1. A rehabilitation physician with specialized training and experience in rehabilitation services.
2. A registered nurse with specialized training or experience in rehabilitation.
3. A social worker or a case manager (or both).
4. A licensed or certified therapist from each therapy discipline involved in treating the member.

Each member of the treatment team must have current patient knowledge as documented in the medical record at the inpatient intensive physical rehabilitation hospital. A rehabilitation physician responsible for making the final decisions regarding the member's treatment plan in the inpatient intensive physical rehabilitation hospital leads the team.

Within five days of the member's admission to the facility, the following should be complete and documented in the members' medical record:

1. The team evaluation;
2. An estimated length of stay; and
3. Initiation of appropriate discharge planning, including home care assessment.

8-6.5 Billing for inpatient rehabilitation services

Providers submitting claims for inpatient rehabilitation services must report those services per the Medicaid policies in place on the date of discharge. As with all Medicaid policies, this requires providers to know changes in the reporting requirements on the date of discharge, which may vary from the policies in effect on the date of admission.

8-7 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, coinsurance, or co-payments.

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

8-8 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.

8-9 Ambulatory surgical centers coverage and reimbursement

Ambulatory surgical centers are reimbursed as outlined in the Utah State Plan.

Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

8-10 Laboratory services

CLIA requires entities that perform even one test, including waived tests, to meet certain federal requirements and obtain the appropriate level of certification. If an entity performs laboratory tests, they must register with the CLIA program and can only perform those tests as authorized by their level of certification.

CMS has made available the Clinical Laboratory Improvement Amendments (CLIA) Application For Certification form, CMS-116.

The form should be completed and mailed to the address listed.
Unified State Laboratories:
Public Health Bureau of Laboratory Improvement
4431 South 2700 West
Taylorsville, UT 84129

CLIA regulations require all facilities that perform waived and non-waived testing, to file a separate application for each facility location. Each CLIA certificate represents a facility, and each facility is responsible for complying with the applicable CLIA

requirements. Refer to 42 CFR §493.35(a), §493.43(a) and §493.55(a) for additional information.

Additional information about CLIA and other laboratory services may be found in the Physicians Services Manual, Chapter 8-11, Laboratory services.

8-10.1 Proprietary Laboratory Analysis codes

In accordance with the American Medical Association (AMA) coding guidelines, Proprietary Laboratory Analysis (PLA) codes for propriety laboratory services must be reported, when available, in place of corresponding CPT codes. Do not report PLA codes with corresponding CPT codes. If the PLA code is not available to be used by the billing laboratory, the CPT code should be billed.

8-11 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. Behavioral Health Services, and the Behavioral Health Services Provider Manual.

8-11.1 Psychiatric hospitals considered Institutions for Mental Diseases (IMDs)

Admissions to psychiatric hospitals considered IMDs are covered when medically necessary, for up to 60 days, for members ages 21 through 64. No more than 60 calendar days will be authorized per treatment episode. If treatment exceeds 60 days, no part of the stay is eligible for reimbursement.

Enrollment, licensing and certification or accreditation requirements

Coverage of admissions to psychiatric hospitals requires the hospital to be:

1. Enrolled Medicaid providers.
2. Licensed by the Department of Health.
3. Have Medicare certification or be deemed Medicare-certified through accreditation by The Joint Commission.

Prepaid Mental Health Plans (PMHPs), Utah Medicaid Integrated Care (UMIC) Plans or the Healthy Outcomes Medical Excellence (HOME) Program

Inpatient psychiatric hospitalizations are covered through the PMHPs, UMIC Plans, or the HOME program and require prior authorization.

Medicaid fee for service prior authorization (PA) requirements

Psychiatric hospitals must obtain a PA as notification of admission.

The initial PA request must be submitted to the PA department no later than two business days after the admission date and may be approved for up to seven days.

Inpatient stays that exceed seven days require an additional PA.

For these PA requests, the psychiatric hospital must:

1. Submit the most pertinent and recent comprehensive documentation from the medical record for inpatient psychiatric hospital stays and continued stay reviews that must:
    a) Support medical necessity.
    b) Address evidence-based criteria.
    c) Specify the number of additional days being requested (maximum of up to seven days per request).
    d) Include the anticipated discharge date.
2. Submit each additional request to the PA department:
    a) No later than the first requested date of service indicated on the PA request.
    b) No earlier than four calendar days of and including the first requested date of service indicated on the PA request form.

The PA request form can be found at Psychiatric Hospital Inpatient Services, Individuals Age 21-64 Prior Authorization Request Form.

PA requests may be faxed to the PA Unit at (801) 323-1587, or emailed to mentalhealthservicesprior@utah.gov.

9 Non-covered services and limitations

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

For more information on non-covered services and limitations, see 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

Voluntary sterilization means an individual decision made by the member, male or female, for voluntarily preventing conception for family planning.

1. Prior authorization must be obtained, by the surgeon, before the service are provided, refer to Utah Medicaid Prior Authorization.
2. The Sterilization Consent Form must be properly executed and submitted before the procedure is performed.

9-3.2 Sterilizations incident to surgical procedures

1. Prior authorization requirements must be met.
2. For hysterectomy procedures, a properly executed Utah Medicaid Hysterectomy Acknowledgement Form must be submitted for all hysterectomy procedures.
3. 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.

As defined in Utah Administrative Code R414-1-2 (18), medical necessity shall be established through evidence-based criteria.

9-5 Treatment of alcoholism or drug dependency

1. Inpatient hospital care for treatment of alcoholism or drug dependency is limited to medical treatment of withdrawal symptoms associated with drug or alcohol detoxification.
2. Outpatient continuing therapy for treatment of alcoholism or drug dependency must be accessed under the outpatient mental health or psychiatric services benefit as appropriate.
3. Drug and alcohol rehabilitation are 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 Provider Preventable Conditions

Medicaid will not reimburse inpatient hospital claims for Provider Preventable Conditions (PPC) as identified in claims processing. The MS-DRG Grouper identifies PPCs.

Under direction of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) adopted the term Provider Preventable Condition for use in Medicaid, whereas Medicare retains the use of the term Hospital Acquired Condition (HAC) when describing certain provider preventable conditions for which payment would be prohibited.

To qualify as a PPC, one of the CMS listed HAC diagnoses must develop during the hospitalization. The same diagnoses present on admission are not PPCs. According to correct coding standards, providers must identify each diagnosis Present on Admission (POA) on the claim.

Providers should ensure that all PPC-related diagnoses, services, and charges are noted as “noncovered charges” on the claim. Non-covered charges are not used in calculating hospital reimbursement.

For rural hospitals, non-DRG reimbursed facility claims submitted with an identified HAC code and non-covered charges will be reimbursed. If there are no non-covered charges on the claim, the claim will be denied.

If a DRG reimbursed PPC-related claim results in an outlier payment, it will be denied and medical records will be required. Providers will receive a Remittance Advice (RA) confirming the occurrence of a PPC outlier claim and a request for medical records. Complete medical records for the hospital stay, an “Outlier PPC Medical Record Documentation Submission Form," and an itemized bill (tab de-limited text file or Excel spreadsheet) including a detailed listing of PPC-related charges as non-covered charges, with total charges matching the total charges submitted on the claim, must be submitted within 30 days of the RA notification. In addition, at the time of RA notification, a confirmatory communication may be generated reiterating the occurrence of a PPC and the need for submission of medical records and other required documentation for manual review and claims processing. If the medical

records are submitted within the 30-day period, the claim will be reviewed and, if appropriate, reprocessed and reimbursed. If medical records are not submitted within the 30-day period, the claim will be denied for failure to submit the requested documentation in a timely manner.

Non-outlier claims will continue to be denied with an edit that informs providers that the diagnosis was not Present on Admission (POA). Providers will have the opportunity to submit a corrected claim, selecting the appropriate POA indicator. If the correction is not made, the claim will remain denied.

Providers are required to report PPCs per CMS regulations and Utah Administrative Code R4141. Utah Medicaid Program and R414-2A. Inpatient Hospital Services.

9-8 Outlier days

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

1. Neonatal admissions assigned to DRG's 789, 790, 791 go into outlier status the day after admission. A length of stay of fewer than 20 days does not require review. Payment will automatically be calculated to include the outlier days.
2. If a case with a stay of fewer than 21 days is submitted in error, the entire case will be reviewed for the severity of illness and intensity of service.
3. 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, which benefits both the hospital and the agency.

9-9 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 R414-112 Utilization Review.

9-10 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 R414-112 Utilization Review.

9-11 Occupational therapy services

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

Refer to the Medicaid provider manuals for Early and Periodic Screening, Diagnostic and Treatment Services and Physical Therapy and Occupational Therapy Services.

9-12 Outpatient hospital services

Outpatient hospital services are limited to services that are medically necessary and appropriate for the outpatient setting. Under Utah Administrative Code R414-1-12 Utilization Review, utilization management review determines these services' medical necessity and appropriateness.

Reimbursement is limited to credentialed outpatient hospital departments. For information, refer to the Coverage and Reimbursement Code Lookup.

9-13 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.

9-14 Hyperbaric oxygen therapy

Refer to Utah Administrative Rule R414-2A. Inpatient Hospital Services and Rule R4143A.Outpatient Hospital Services.

9-15 Non-covered services

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for

medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

The general exclusions are listed below:

1. Provider preventable conditions (PPC) refer to Utah Administrative Rule R414-2A. Inpatient Hospital Services and Chapter 9-7.
2. Services rendered during a period the client was ineligible for Medicaid.
3. Services medically unnecessary or unreasonable.
4. Services that fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature (see note below).
5. Services requiring prior authorization, but for which such authorization was not requested, was not obtained, or was denied.
6. Services, elective in nature, and requested or provided only because of the client's personal preference.
7. Third-party payers are primarily responsible for reimbursing services, e.g., Medicare, private health insurance, and liability insurance. Medicaid may make a partial payment up to the Medicaid maximum if the third party has not reached this limit.
8. Services fraudulently claimed.
9. Services that represent abuse or overuse.
10. Services rejected or disallowed by Medicare when the rejection was based on any of the reasons set forth above.
11. 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 from the standard post-operative recovery period.
12. Chemical peeling, dermabrasion, or laser therapy of the face.
13. Tattoo removal.
14. Certain services are excluded as family planning services:
    a) Surgical procedures for the reversal of previous elective sterilization, both male and female.
    b) Infertility studies.
    c) In-vitro fertilization.

d) Artificial insemination.
e) Surrogate motherhood, including all services, tests, and related charges.

15. Surgical procedures that are unproven or experimental are non-covered Medicaid services (see note below).

Note: Experimental, investigational, or unproven services do not include 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."

10 Prior authorization

Providers must verify prior authorization requirements before rendering services. 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.

11-1 Paper claim exceptions

Medicaid accepts paper UB-04 claims in three circumstances only:

1. UB-04 claims billed by out-of-state providers.
2. Dialysis claims.
3. Crossover claims where the Medicare carrier is out of state:
   a) When necessary and appropriate to file a paper claim, refer to the Utah Uniform Billing Instruction Manual.
   b) UB-04 Manual for the Utah Medicaid UB-04 Billing Instructions.

11-2 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 to be set up to bill through UHIN may call (801) 466-7705. Providers who need additional assistance may contact Medicaid Information, 801-538-6155, or toll-free 1-800-662-9651, and ask for Medicaid electronic billing support.

The Administrative Simplification Clause supports the requirement to bill electronically through UHIN 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. In addition, because of the reduction in billing errors, claims are processed without delay. Providers can submit electronic claims until noon on Friday for processing that week.

11-3 Crossover claims with EOMB attachment

Medicaid processes crossover claims in two circumstances only:

1. 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.
2. Out of plan claims such as mammography with the EOMB denial attached.

11-4 Manual adjustments accepted

When submitting a paper UB-04 claim as an adjustment to an original paid or denied claim, write the 17-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.

11-5 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 member 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.

11-6 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.

11-7 Reporting and billing covered and non-covered services for acute inpatient hospital claims

Correct coding guidelines encourage providers to include all delivered services on their claim submissions. Therefore, providers should include covered and non-covered services when submitting an acute inpatient hospital claim.

Due to the limitations of Utah's current Medicaid claims processing system, there are instances when an entire claim will deny as a result of a single denied line. For example, a claim is denied when a single line is a non-covered service. This can occur when a claim is submitted for a service requiring prior authorization, but the hospital or other provider did not obtain prior authorization.

To allow payment for covered services, when non-covered services have also been delivered, Medicaid requires acute inpatient hospitals to submit claims that include covered services and exclude non-covered services that would otherwise result in denial of the entire claim. In addition, when a claim is submitted that excludes non-covered services, providers must not include any ICD-10-PCS, CPT, HCPCS, or revenue codes related to the non-covered services.

For example, a member is admitted to an acute care hospital for labor and delivery and elects to have a sterilization procedure performed during the same episode of care. However, the provider does not have prior authorization for the sterilization. In this instance, the sterilization, and the associated services, are non-covered. The facility must exclude the non-covered services from the claim. Note: Providers must be familiar with and adhere to all federal regulations regarding sterilization requirements.

Additionally, if admission to an acute inpatient hospital is primarily to receive services not covered by Medicaid, all services performed for that episode of care are non-covered and will not be reimbursed. This policy applies regardless of whether or not Medicaid would have covered some of the services performed.

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

1. Reimbursement for inpatient hospital services is covered in the Utah State Plan.
2. Providers must ensure that all submitted diagnoses are appropriate and documented in the patient's medical record.
3. Only covered charges will be included in the calculation of the hospital's reimbursement.
4. 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 according 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 Centers for Medicare and 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 and 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 passthrough 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 more expensive 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.

13-2 Inpatient hospital 3-day admission policy

If an admitting hospital furnishes services in an outpatient setting up to three days before an inpatient admission, Medicaid will incorporate the outpatient services into the DRG determination for the inpatient reimbursement. Medicaid defines this as the three-day admission policy.

For example, if a member is admitted to an inpatient hospital on a Wednesday, services performed on the previous Sunday, Monday, or Tuesday would be considered part of the inpatient services.

The 3-day admission policy only applies to acute inpatient hospital admissions.

Preadmission services furnished within the admission window that are determined not clinically related to an inpatient admission are not subject to the 3-day admission DRG payment policy.

14 Long-Term Acute Care (LTAC)

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

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

An LTAC request must include:

1. Properly completed Utah Department of Health LTAC document submission cover sheet.
2. A prior authorization request.
3. Current comprehensive documentation to make a preadmission, continued stay, or retroactive determination.

Documentation must include, as applicable:

1. A history and physical.
2. Operative reports.
3. Daily physician progress notes.
4. Consulting physician progress notes.
5. Vital signs.
6. Laboratory test results.
7. Medication administration records.
8. Respiratory therapy notes.
9. Wound care notes.
10. Nutrition notes.
11. Physical, occupational, and speech therapy notes.
12. Any other pertinent information regarding the LTAC request.

14-1 Requirements

1. Payment will be approved for reasonable and medically necessary services and supplies subject to the exclusions and limitations outlined in policy and Utah Administrative Code Title R414-515 Long Term Acute Care.
2. The LTAC must submit a discharge plan with all continued stay reviews.
   a) Failure to properly plan a discharge from the LTAC does not qualify for continued stay in the LTAC.
3. To adjudicate correctly, the billing provider indicator for LTAC in the provider record in PRISM must be a "Y" and claims must be reported using revenue code 0100. This will ensure that the appropriate rate is applied to the claim. All other billing procedures and practices apply to

LTAC claims. These may be found in the General Information: Section I Manual.

4. LTAC providers must utilize value code 80 for covered days and value code 81 for non-covered days on their LTAC claims to ensure proper adjudication.

14-2 Limitations

1. 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.
2. An LTAC will not be reimbursed for denied dates of service or for any subsequent dates of service related to that episode of care.
3. The predominant clinical findings will be used to determine the severity of illness criteria for the primary condition.
4. If the member does not admit within 48 hours of the prior authorization approval, a new prior authorization must be submitted.

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

15 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	• 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	• 42CFR Part 416, Ambulatory Surgical Services
Emergency services program for non-citizens	• Section I: General Information • 42 CFR 440.255
General information including: • Billing	• Section I: General Information • Claims
• Fee for service and managed care • Member eligibility • Prior authorization • Provider participation	• 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	• §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: • Anesthesia fee resources • Coverage and reimbursement resources • National correct coding initiative • Procedure codes with accompanying criteria and limitations	• Office of Healthcare Policy and Authorization (OHPA) • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: • Medicaid Information Bulletins • Medicaid Provider Manuals Utah State Bulletin	• Utah Medicaid Official Publications • Utah State Bulletin
Laboratory services	• 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
Medicaid forms including: • Abortion Acknowledgement • Hearing Request • Hospice Prior Authorization Form • Hysterectomy Acknowledgement • PA Request • Sterilization Consent	• Utah Medicaid Forms
Medical Supplies and DME	• Medical Supplies And Durable Medical Equipment Provider Manual • Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70
Modifiers	• Section I: General Information
Patient (Member) Eligibility Lookup Tool	• Eligibility Lookup Tool
Pharmacy	• Drug Criteria Limits • Generic Prescriptions List • ICD-10 Reference Chart Pharmacy • Medicaid Pharmacy Program • OTC Drug List • Pharmacy Provider Manual • Medicaid Policy for Pharmacy Program. R414-60
Prior authorization	• Prior Authorization Form • Utah Medicaid Prior Authorization
Provider portal access	• Provider Portal Access
Provider training	• Utah Medicaid Provider Training
Other	• 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 • Behavioral Health Services Provider Manual • RHC-FQHC Provider Manual • Vision Care Services Provider Manual • Women, Infants and Children (WIC)
References including: • Social Security Act	• 42 CFR • Social Security Act 1905(a)
• Code of Federal Regulations • Utah Code Utah State Medicaid Plan	• Social Security Act 1861 (r) • Utah Annotated Code Title 58 • Utah State Medicaid Plan
• Tobacco cessation resources	• Utah Tobacco Quit Line (1-800-QUIT-NOW) • Way to Quit