



Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Indian Health

Division of Integrated Healthcare

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Table of Contents

1	General information	3
1-1	General policy	3
1-2	Fee for service or managed care	3
1-3	Definitions	4
1-4	Procedure codes	6
2	Provider participation requirements.....	6
2-1	Provider enrollment.....	6
3	Member eligibility.....	7
4	Program coverage	8
4-1	Covered services	8
5	Non-covered services and limitations.....	8
5-1	Non-covered services.....	8
5-2	Limitations.....	9
6	Billing.....	12
6-1	Prior authorization.....	13
6-2	Timely filing.....	13
6-3	Medicaid/Medicare crossovers	14
7	References.....	14

1 General information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as Section I: General Information and the Physician Services provider manuals at <https://medicaid.utah.gov/utah-medicaid-official-publications/>.

The information in this manual represents available services when medically necessary. Services may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

1-1 General policy

The United States Government has an historical and unique legal relationship with and resulting responsibility to American Indian and Alaska Native (AI/AN) individuals. The health care delivery system for AI/AN tribes with this unique government-to-government relationship consists of Indian Health Services (IHS)-owned and operated health care facilities, IHS-owned facilities that are operated by AI/AN tribes or tribal organizations under 638 agreements (contracts, grants, or compacts), and facilities owned and operated by tribes or tribal organizations under such agreements. Medicaid services are available to AI/AN individual who apply and are found eligible under section 1905(b) of the Social Security Act, 42 U.S.C. 1396d. Centers for Medicare and Medicaid Services (CMS) allows 100 % Federal Medical Assistance Percentage (FMAP) for Medicaid services furnished to Medicaid eligible AI/ANs.

The Utah Medicaid State Plan applies to reimbursement for services provided at IHS facilities, Tribal 638 Programs, and Urban Indian facilities. Additionally, unless otherwise stated, all other Utah Medicaid rules apply to IHS, Tribal 638 Programs, and Urban Indian clinics.

1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members. This manual is not intended to provide guidance to providers for Medicaid members enrolled in a managed care plan (MCP). A Medicaid member enrolled in an MCP (health, behavioral health or dental plan) must receive

services through that plan with some exceptions called carve-out services, which may be billed directly to Medicaid.

Refer to the provider manual, Section I: General Information, for information regarding MCPs and how to verify if a Medicaid member is enrolled in an MCP. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee for service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid member services hotline at (844) 238-3091 for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. Therefore, if a Medicaid member is enrolled in an MCP, a fee for service claim will not be paid unless the claim is for a carve-out service.

Eligibility and plan enrollment information for each member is available to providers on the Eligibility Lookup Tool: <https://medicaid.utah.gov/eligibility>.

1-3 Definitions

Definitions of terms used in other Medicaid programs are available in Section I: General Information. Definitions specific to the content of this manual are provided below.

All Inclusive Rate (AIR): It is based on the rates approved by the Office of Management and Budget (OMB). Each year these rates change based on the negotiated rate between HHS, IHS and OMB. See Federal Register. (AIR is also known as encounter rate)

American Indian/Alaska Native (AI/AN) or "Indian": A member of a tribe, band, or other organized group of Indians, including those tribes, bands or groups terminated

since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree or any such member living on, near, or off a reservation.

Behavioral health services: Professional medical services for the treatment of a mental health and/or addiction disorder(s).

CFR: Code of Federal Regulations

CMS: Centers for Medicare and Medicaid Services

DIH: Division of Integrated Healthcare

DWS: Department of Workforce Services

Encounter: A face-to-face contact between a licensed health care professional and an eligible AI/AN Utah Medicaid member for the provision of medically necessary under Title XIX or Title XXI of the Social Security Act covered services through an IHS, Tribal 638 facility, or urban Indian organization.

Encounter rate: See All Inclusive Rate (AIR)

Indian Health Services (IHS) or service: An agency within the Department of Health and Human Services (DHHS), is responsible for providing federal health services to American Indians and Alaska Natives (AI/AN).

I/T/U: The abbreviation for describing the Indian health system, services and programs (Indian Health Service, Tribal 638, and Urban Indian Organization.)

Physician: A Doctor of Medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the federal Government in an IHS facility or who provides services in an Urban Indian Facility or a 638 Tribal Facility.

Tribal health program or "638" (PL 94-638): an Indian tribe or tribal organization that operates any health program, service, function, activity or facility funded, in whole or part, by the service through, or provided for in, a contract or compact with the service under the Indian Self-Determination and Education Assistance Act (ISDEAA).

Urban Indian Organization (UIO) (PL 94 437, title V): A nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing health activities described in the Indian Health Care Improvement Act (IHCIA).

1-4 Procedure codes

Procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at:

<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

2 Provider participation requirements

Indian Health Services, Tribal 638 Programs, and Urban Indian Organizations (I/T/Us) are considered eligible for participation in the Utah Medicaid Program. To receive reimbursement, an I/T/U must have a current contract on file with the Utah Department of Health and Human Services, Division of Integrated Healthcare (DIH). DIH recognizes that I/T/Us are the payer of last resort and are not considered creditable health insurance.

2-1 Provider enrollment

Refer to provider manual, Section I: General Information for provider enrollment information.

Indian Health Services, Tribal 638 Programs, and Urban Indian Organizations (I/T/Us) are eligible for participation in the Utah Medicaid program.

Non-institutional provider application requirements

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

Note: IHS providers do not require a Utah license, as long as the provider has a valid license in another state.

Professional services requirements (physician, pharmacy, dental, etc.)

Must provide a copy of current professional license, copy from Utah Division of Occupational and Professional Licensing (DOPL) database, or telephone verification from DOPL of professional license from any state. DOPL website: www.dopl.utah.gov.

Hospital services requirements

An IHS hospital must be accredited according to Medicaid requirements.

3 Member eligibility

A Medicaid beneficiary is required to present the Medicaid member card before each service, and every provider must verify each beneficiary's eligibility each time and before services are rendered. For more information regarding verifying eligibility, refer to provider manual, Section I: General Information, Verifying Medicaid eligibility.

For information on how to apply for Medicaid, refer to the provider manual Section I: General Information, Applying for Medicaid, or access the Medicaid website at <https://medicaid.utah.gov>.

Contacting Medicaid

Medicaid contracts with the Department of Workforce Services (DWS) to process applications from tribal members or representatives for medical services. For tribal member eligibility questions:

1. Contact an I/T/U facility benefits coordinator.
2. Go to www.jobs.utah.gov. Tribal members use the application 'myCase'.
3. Call DWS and speak to a worker:
 - a) Call 1-866-435-7414; select option #1; enter the case number. (Once the case has been assigned to the American Indian team, this selection will direct the call to a worker on the AI team.)

4 Program coverage

For additional covered services, refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at:

<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

4-1 Covered services

Encounters - inpatient and outpatient

Encounters whether inpatient or outpatient, must meet the definition found in Chapter 1-3 Definitions and are limited to covered State Plan services. Services include those identified in the State Plan and Title XIX or Title XXI of the Social Security Act.

5 Non-covered services and limitations

Refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php> for additional non-covered services and limitations.

5-1 Non-covered services

The following are excluded from separate coverage, if part of an encounter, and cannot be reimbursed in addition to the encounter. (This list is not all inclusive.)

1. Durable medical equipment or medical supplies not generally provided during the course of a clinic visit (i.e., diabetic supplies)
2. Pharmaceutical or biologicals not generally provided during the clinic visit (i.e., medication samples)
3. Other services that are not defined in the State Plan under Title XIX or Title XXI of the Social Security Act
4. Eyeglasses
5. Emergency ambulance transportation
6. Non-emergency transportation
7. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices
8. Behavioral health rehabilitative services
9. Hearing aids

10. Behavioral health case management service

I/T/U services not reimbursable under outpatient encounters include:

1. Health or group education classes or activities, including media productions and publications
2. Vaccines covered by the Vaccines for Children (VFC) program
3. Group or sports physicals and medical reports
4. Medication samples or other prescription medications provided to the clinic free of charge
5. Administrative medical examinations and report services
6. Gauze, Band-Aids, or other disposable products used during an office visit

5-2 Limitations

Service limitations governing the provision of all Utah Medicaid services apply. In addition, the following limitations and requirements apply to services provided by I/T/U facilities.

Multiple encounters - outpatients

Medicaid will reimburse for one I/T/U encounter per day, per member; however more than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. Documentation must include unrelated diagnosis codes.

Members seen at a single office visit with multiple problems are reported as a single encounter. Similar services, even when provided by two different I/T/U health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

1. Well child check and an immunization
2. Preventive dental screen and fluoride varnish application in a single setting
3. Medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter
4. Mental health and addiction encounter with similar diagnosis

5. Partial service with one medical provider and partial service from another medical provider

Abortion and sterilization

Federal law governs these services:

1. Abortion procedures are limited to those consistent with the Hyde Amendment restrictions. The amendment allows the use of federal funds for abortions to terminate a pregnancy under two conditions:
 - a) A pregnancy resulting from an act of rape or incest, or
 - b) The life of the mother would be endangered if the fetus were carried to term.

(42 CFR 441.203 and Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998).
2. Sterilization procedures are limited to those procedures which meet the requirements of 42 CFR 441 Subpart F.

Refer to Chapter 6-1, Prior authorization, in this Section for PA requirements.

Pharmacy

I/T/U Pharmacy encounters are limited to one per day, per prescriber. If a prescriber issues multiple prescriptions, the reimbursement will be one AIR. If the pharmacy submits a second prescription by a different prescriber on the same day Medicaid will reimburse a second AIR.

Treatment with medication(s) during a clinic visit is included in the encounter rate. The medication or medication sample are included in the encounter rate.

Prescriptions for medications that are to be filled by a pharmacy are not included in the encounter rate and must be billed by a qualified enrolled pharmacy through the pharmacy program.

Dental

I/T/U Dental encounters are limited to one per day, per client; however, multiple encounters may be reimbursable if due to an emergency and/or the same member returns on the same day for a second visit with a different diagnosis.

More than one dental visit with a dental professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U dental encounters.

For example, a member comes to the clinic in the morning for a dental examination, and in the afternoon, the member returns to the office with a broken tooth due to a fall. These are two separate dental encounters and can be billed as two encounters.

Dental claims do not provide diagnosis information therefore the second encounter is denied as a duplicate service. If a second encounter meets the definition above and the claim is denied, contact Medicaid customer service. A customer services agent will review the claim, if approved the claim will be reimbursed through manual override of the claim denial.

Customer service hotline

Salt Lake City area,
Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and
Nevada toll-free
From other states

Telephone number

801-538-6155
1-800-662-9651
1-801-538-6155

From all telephone numbers select option 3, then option 9

Laboratory procedures

Laboratory procedures performed by an I/T/U outpatient facility (this does not include the independently certified enrolled laboratory) are included in the I/T/U encounter rate.

Behavioral health services

I/T/U behavioral health professional outpatient encounters are limited to one per day. Multiple encounters may be reimbursable if due to an emergency and/or if the same member returns on the same day for a second visit with a different diagnosis. Each service must have distinctly different diagnoses in order to meet the criteria for

multiple I/T/U encounters. Behavioral health services are limited to those services furnished to members at or on behalf of the I/T/U facility.

6 Billing

Refer to the provider manual, Section I: General Information, for detailed billing instructions.

Reimbursement

To receive the All-Inclusive Rate (AIR) reimbursement an I/T/U facility must have a current contract on file with the Utah Department of Health and Human Services, Office of Healthcare Policy and Authorization.

I/T/Us are the payer of last resort and are not considered credible coverage. I/T/Us must meet one of the following:

Directly employ or contract the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to Utah Medicaid.

OR

I/T/U Physicians may meet all requirements for employment by the federal Government as a physician and be employed by the Federal Government in an IHS Facility, Urban Program Facility or affiliated with a 638 Tribal Facility.

IHS and Tribal 638 facilities are reimbursed as shown in this table.

Service/Claim	Reimbursement
Inpatient Services	Inpatient All Inclusive Rate per episode per day
Outpatient Services	Outpatient All Inclusive Rate per episode per day
Inpatient Physician Services	Medicaid fee schedule, plus the rural enhancement (i.e., for physician visits to a member that is inpatient in a hospital)
Pharmacy Services	All Inclusive Rate per episode per day
Dental Services	All Inclusive Rate per episode per day
Crossovers Claims	Utilize the methodology above AIR/fee for service and the Medicare payment to calculate the reimbursement

Urban Indian Organizations are excluded from the above reimbursement types. UIOs are enrolled as Federally Qualified Health Centers and reimbursed accordingly.

6-1 Prior authorization

All Medicaid prior authorization requirements are applicable for these services: orthodontic, physician inpatient, pharmacy, abortion, and sterilization. For prior authorization information, refer to the Medicaid website Coverage and Reimbursement Lookup Tool,

<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php> or Section I: General Information, Prior authorization at <https://medicaid.utah.gov>.

1. Medicaid providers must verify whether PA is necessary and comply with applicable requirements. Failure to obtain prior authorization may result in a payment denial.
2. I/T/U outpatient encounters for eligible AI/AN Utah Medicaid members whether medical, dental, or behavioral health, are not subject to prior authorization.
3. Abortion and sterilization procedures are governed by federal law. Refer to Chapter 5-1, Limitations, abortion and sterilization for details.

Receipt of prior authorization for abortion or sterilization services requires compliance with specific criteria and special consents obtainable at <https://medicaid.utah.gov/utah-medicaid-forms>.

6-2 Timely filing

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

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

6-3 Medicaid/Medicare crossovers

Medicare claims will “crossover” to Medicaid when an IHS provider is enrolled in the Utah Medicaid program. If a different NPI is used to bill Medicare than to bill Medicaid, contact the Medicaid provider enrollment team.

Do not send a claim if claims are crossing over from Medicare. Claims will pay Medicaid allowed (fee for service or AIR) minus TPL amount. Submit the claim to Medicaid the same as you submitted it to Medicare. For physician inpatient services that were paid line by line by Medicare, submit the claim to Utah Medicaid showing TPL line by line.

7 References

1. 1905(b) of the Social Security Act, 42 U.S.C. 1396d
2. 42 CFR 441 Subpart F
3. 42 CFR 441.203 and
4. Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998