# SECTION 2

**PHYSICIAN SERVICES MANUAL**

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1 General Information

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

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General Information.

1-1 Physician Services

The physician services program provides a scope of service to meet the basic medical needs of eligible categorically and medically needy individuals.

With the cooperation and advice of the Utah Medical Care Advisory Committee, the Department has established standards and regulations governing care for which payment will be made and has formulated general policies and procedures to be followed. 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.

Physician services are a mandatory Medicaid, Title XIX program authorized by sections 1905(a) and 1861 (r) of the Social Security Act, 42 CFR 440.50, and Sections 26-1-5 and 26-18-3, Utah Code Annotated.

In addition to this provider manual, reference Utah Administrative Code Title R414. Health Care Financing, Coverage and Reimbursement Policy, for more information on Utah Medicaid Policy. For specific information regarding Physician Services, see Utah Administrative Code R414-10. Physician Services. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

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

Physician services involve direct patient care and securing and supervising appropriate diagnostic ancillary tests or services, within the parameters of established Medicaid policy, to diagnose the existence, nature, or extent of illness, injury, or disability. In addition, physician services involve establishing a course of medically necessary treatment designed to prevent or minimize the adverse effects of human disease, pain, illness, injury, disability, defect, or other impairments to a member’s physical or mental health. For more information on policy regarding Physician Services coverage, see Utah Administrative Code R414-10-5. Physician Services. Service Coverage. For general information on Medicaid programs other than Physician Services, refer to Section I: General Information, Chapter 8, Programs and Coverage and Utah Medicaid Provider Manuals Parent Directory. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

8-1 Definitions

Definitions of terms used in multiple Medicaid programs are in Section I: General Information, Chapter 1-9, Definitions and Utah Administrative Code R414-1, Utah Medicaid Program. Definitions particular to Physician Services are found in Utah Administrative Code R414-10-2, Physician Services. Definitions.

8-2 Emergency Services Program for Non-Citizens

For information on federal regulations, criteria, documentation, and billing, refer to Section I: General Information, Chapter 8-2.11, Emergency Services Program for Non-Citizens.
8-3 Anesthesia Services

Prior Authorization

Prior authorization (PA) is required for certain anesthesia services. Providers must determine if a PA is necessary before providing services. Failure to obtain a PA may result in payment denial by Medicaid. The surgeon is expected to obtain prior authorization for all codes with a prior authorization requirement. When PA is issued for a procedure that requires authorization, associated anesthesia codes that also require authorization are added to the PA.

When an anesthesia provider bills for an ASA code associated with a CPT procedure code that requires prior authorization, the claim must include the prior authorization number issued to the surgeon. If the surgeon did not obtain a prior authorization, the anesthesia provider may request prior authorization retroactively. The anesthesia provider should submit a completed PA Request Form, the operative report, and any applicable consent forms required by Utah Medicaid. Authorization is not issued for any services in conflict with federal or state law, Medicaid policy, or for procedures in which prior authorization was requested and denied.

General prior authorization information is in Section I: General Information, Chapter 10 Prior Authorization. Code specific coverage and prior authorization requirements are on the Medicaid website Coverage and Reimbursement Lookup Tool.

Billing

Refer to Section I: General Information, Chapter 11 Billing Medicaid and Utah Medicaid Anesthesia Fee Schedule for detailed billing instructions.

Anesthesia entails pre-anesthesia evaluation, intraoperative, and post-anesthesia care. It includes all services associated with the administration and monitoring of the anesthetic/analgesic care (MAC). Postoperative pain management services may begin preoperatively, intraoperatively, or postoperatively.

Anesthesia Time Reporting

Report anesthesia time in minutes.

- Electronic claims
  - Enter total time in minutes in the “minutes” field with the correct MJ (anesthesia minutes) qualifier
- Paper claim forms
  - CMS-1500
    - Enter the minutes in Box 24G.
    - Put an “M” before the minutes
    - Example: M531
  - If a claim is submitted without minutes or the correct MJ qualifier, Medicaid pays one time unit, i.e., 12 minutes or less

Obstetrical Anesthesia - Time Reporting

Obstetrical neuraxial anesthesia for planned vaginal delivery is unique in that the anesthesiologist may attend more than one patient concurrently under continuous regional anesthesia. There is a reduction in the unit value after the first hour of anesthesia time. Example: For the first hour, 5 time units is calculated; for the second hour, 2.5 units; for the third and each succeeding hour of anesthesia, 1.25 units.
When billing obstetrical anesthesia, indicate total time in minutes. The Medicaid Management Information System (MMIS) calculates the appropriate reduction in unit value.

**Dental Services**

Ambulatory Surgical Centers (ASC) and outpatient hospitals report dental services using CPT 41899. Anesthesia providers directly rendering services should bill CPT 00170. For coverage details, refer to *Section 2: Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual* and the Coverage and Reimbursement Lookup tool at.

**Procedure Codes**

Anesthesia procedure codes with accompanying criteria and limitations are found on the Medicaid website [Coverage and Reimbursement Lookup Tool](#).

**Anesthesia Modifiers**

Report all anesthesia services with the appropriate anesthesia CPT code(s) plus the physical status modifier. Refer to *Section I: General Information, 12-7.3 Modifier used in a Claim* for additional modifier information.

**Physical Status Modifiers**

Physical Status modifiers distinguish between the levels of complexity of the anesthesia service provided. If no physical status modifier is reported, the modifier indicating a normal healthy patient is used in adjudication.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Medicaid Unit Value</th>
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<tr>
<td>P1</td>
<td>A normal healthy patient</td>
<td>0</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>1</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>3</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>4</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>6</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purpose</td>
<td>Not Payable</td>
</tr>
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</table>

**8-4 Surgical Procedures**

The services of an assistant surgeon are specialty services to be provided only by a licensed physician and covered only on very complex surgical procedures.

If there are extenuating circumstances involved in a case, a physician may request a review of the case by the Utah Medicaid physician consultant for consideration for payment of an assistant. In such cases, a copy of the history and physical exam, the operative report, and the discharge summary must be submitted for review.
The AS modifier, indicating the assistant surgeon is a PA or NP is not covered under Medicaid, modifier 80–assistant surgeon is payable strictly to a qualified surgeon. Physician Assistants and Nurse Practitioners may not be reimbursed as the assistant surgeon through the physician’s provider number as an incident to service.

CRNAs may provide services independently or under the supervision of an anesthesiologist or operating practitioner.

8-5 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.

8-5.1 Immunizations

Most immunizations for both adults and children, when administered in-office, are a covered benefit. When a provider performs an evaluation and management (E & M) service and administers a covered immunization, both services are covered. For specific coverage, refer to the Coverage and Reimbursement Code Lookup.

Prescribers may participate in the Vaccines for Children (VFC) program, in which drug products are supplied to the provider at no cost. Prescribers who participate in the VFC program are reimbursed for E & M services and immunization administration, but not the drug product. The VFC program is administered by the Centers for Disease Control and Prevention (CDC).

8-5.2 IV Infusions and Injections, including Chemotherapy Administration

When a visit to the physician’s office is for administration of a medication or chemotherapy agent, only the provider administered drug (“J-code”) for the medication and the administration code (96400-96549) will be paid. An office visit will not be paid. The administration fee covers the skill, evaluation, and management required to administer the chemotherapy agent. However, when there are significant separately identifiable services, those services must be reported using modifier 25. Reporting the E/M service with modifier 25 requires review of supportive documentation for significant separately identifiable service beyond the E/M services expected with chemotherapy administration.

When administering multiple infusions, injections, or combinations, only one initial service code should be reported, unless protocol requires that two separate IV sites must be used. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within a group of services, then a subsequent or concurrent code from the appropriate section should be reported.

Hydration therapy requires a diagnosis and medical record documentation supporting the therapy for electrolyte imbalance and/or dehydration for reimbursement coverage.

IV-line flush between drugs is considered part of the drug administration service and not reimbursed separately.
One payment for a heparin flush is covered at the conclusion of the infusion.

8-6 **Telemedicine Services**

Telemedicine or telehealth services are an additional method of delivering health care to patients. Refer to Section I: General Information, Chapter 8-4.2, Telemedicine.

8-7 **Diabetes Self-Management Training**

HCPCS S9455, Diabetes Self-Management Training, is available for use by authorized diabetes self-management programs.

**Requirements**

Diabetic self-management training services are limited to an initial 10 sessions per year and must be provider through a:

- Nationally recognized American Diabetes Association (ADA) certified diabetes educator [refer to http://www.diabetes.org](http://www.diabetes.org) or
- An educator certified by the American Association of Diabetes Educators (AADE) [refer to http://www.diabeteseducator.org](http://www.diabeteseducator.org)

Note: Self-management training for the sole use of glucose monitoring or nutritional counseling is not covered through this program.

For complete criteria for this service, refer to Utah Administrative Code R414-90. Diabetes Self-Management Training.

To enroll as a Medicaid-authorized diabetes self-management program, visit New Provider Enrollment Web Based Trainings or contact The Bureau of Medicaid Operations Provider Enrollment.

8-8 **Nutritional Counseling**

Nutritional counseling is covered with a maximum of 1 hour for the initial assessment and intervention. For coverage limitations on re-assessment and intervention, please refer to the Coverage and Reimbursement Code Lookup.

Nutritional counseling and an evaluation and management are not covered for the same provider on the same date of service. Physicians and other qualified providers who may report evaluation and management services may be bill with a prolonged service code to include the time for nutritional counseling.

8-9 **Tobacco Cessation Counseling**

Tobacco cessation counseling is covered with a maximum of 4 intermediate sessions and 3 intensive sessions per 12-month period.
8-10 Maternity Services

Maternity services are available as pregnancy related or postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Maternity Care is a global service reported with an appropriate CPT code at the time of delivery. Unbundled services are expected to be reported by more than one provider/group.

8-10.1 Global Maternity Care

Global maternity care includes services normally provided in uncomplicated maternity cases during the period of pregnancy. Services include antepartum care, labor and delivery, postpartum care, and laboratory services as defined below. These are not reported as separate services.

Antepartum care

Antepartum care includes usual prenatal services. The initial visit must be included as part of antepartum care and is not reported as a separate service. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical analysis, hematocrit, maternity counseling, monthly visits up to 28-week gestation, biweekly visits to 36-week gestation, and weekly visits until delivery. Also included is the treatment of routine complaints that accompany pregnancy. Diabetic glucose monitoring is part of the maternity global payment. Additional billings for an office visit, diabetes self-management training, or nutritional medical counseling for diabetic glucose monitoring in pregnancy is not appropriate.

Labor and delivery services

Labor and delivery services include admission to the hospital, admission history, physical examination, management of uncomplicated labor, vaginal delivery, and cesarean section delivery.

Postpartum care

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, a six-week postpartum visit, and obtaining a Pap smear. Medicaid covers postpartum services up to the end of the month in which the 60 days post-delivery occurs. Family planning services are covered separately.

Laboratory Services

Laboratory tests, such as hematocrit and urinalysis, provided during routine visits are included in the global care fee. Other antepartum and postpartum diagnostic services that have medical indication are reported separately.
8-10.2 Ultrasound in Pregnancy

Medicaid covers up to 10 ultrasounds in a 12-month period when diagnostic information is needed.

Incompetent cervix must be diagnosed with a transvaginal ultrasound.

Ultrasounds completed for obtaining a picture of the fetus or sex determination are not covered.

8-10.3 Billing for Maternity Care

Group practices are not allowed to report codes separately regardless of the number of providers delivering care. When the same physician or group practice sees the patient throughout the pregnancy, the global delivery code is to be reported. For reimbursement information refer to Utah Medicaid State Plan Attachment 4.19-B.

8-10.4 Coding for Maternity Care

Gestational Age

Providers are required to report the gestational age of the fetus by using the appropriate ICD-10 diagnosis codes Z3A.00 through Z3A.49 on all delivery claims.

Modifier UC

Providers are required to append modifier UC on claims of deliveries 39 weeks or less that are medically necessary or on deliveries 39 weeks or more, whether spontaneous or elective. If the modifier “UC” is not appended to the claim, it is understood that the claim was for an early elective delivery less than 39 weeks and 0 days and will be denied. Providers are responsible for ensuring that the codes (and modifiers when applicable) submitted for reimbursement accurately reflect the diagnosis and procedure(s) reported.

Modifier 22

All obstetrical and delivery procedure codes submitted with modifier 22 require submission of documentation (e.g., operative report) for review prior to payment. Services for enhanced payment with the 22 modifier include multiple gestations or complications during the delivery which place the mother or fetus at risk of adverse outcome.

8-10.5 Services for Pregnant Women not Eligible for Medicaid

Women meeting all Medicaid eligibility requirements except citizenship, may be eligible for the Emergency Services Program for Non-Citizens. If eligible, they may receive services for an “emergency medical condition.” Labor and delivery are considered emergency medical conditions. Prenatal and postpartum care are not considered emergency medical conditions and shall not be reimbursed. Information and criteria for these services are found in Section I: General Information, Chapter 8-2.11, Emergency Services Program for Non-Citizens.
8-10.6 Extended Services for Pregnant Women

The services described in this section are available to pregnant women eligible for Medicaid or for the Presumptive Eligibility (PE) Program. These services are in addition to those normally provided in uncomplicated maternity cases.

Extended services are available as pregnancy related or postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

8-10.6.1 Perinatal Care Coordination

Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psychosocial, nutritional, educational and other services for the pregnant woman.

Perinatal Care Coordination Service Providers must be a licensed provider in Utah and one of the following qualified providers:

- Registered Nurse
- Certified Nurse-Midwife
- Certified Nurse Practitioner
- Social Service Worker
- Certified Social Worker
- Licensed Practical Nurse who works under the supervision of a registered nurse and has additional training and experience to be a perinatal care coordinator
- Health Educator must have either a Bachelor’s degree in health education with a minimum of three years’ experience, at least one of which must be in a medical setting, a Master’s degree with a minimum of one year of experience working in a medical setting or with pregnant women, or a Bachelor’s degree and a certificate showing completion of a certification examination in health education.

The service is reported using HCPCS T1017 Targeted Case Management, each 15 minutes. Limited to four (4) units in a 30-day period.

8-10.6.2 Prenatal and Postnatal Home Visits

Home visits can be included in the management plan of pregnant members when there is a need to assess the home environment and its implications for the management of prenatal and postnatal care; to provide direct care; to encourage regular visits for prenatal care; to provide emotional support; and to determine educational needs.

Visits may be provided by one of the following Utah licensed qualified providers:

- Registered Nurse
- Certified Nurse-Midwife
- Certified Nurse Practitioner
- Social Service Worker
• Certified Social Worker
• Licensed Practical Nurse, who works under the supervision of a registered nurse and has additional training and experience to be a perinatal care coordinator
• Health Educator must have either a Bachelor’s degree in health education with a minimum of three years’ experience, at least one of which must be in a medical setting, a Master’s degree with a minimum of one year of experience working in a medical setting or with pregnant women, or a Bachelor’s degree and a certificate showing completion of a certification examination in health education.

The service is reported using HCPCS H1004 Prenatal Care, At-Risk Enhanced; Follow Up Home Visit. Limited to six visits during a 12-month period.

8-10.6.3 Group Prenatal and Postnatal Education

Group prenatal and postnatal education is classroom learning experience for improving the knowledge of pregnancy, labor, childbirth, parenting and infant care. The objective of this planned educational service is to promote informed self-care, to prevent development of conditions which may complicate pregnancy, and to enhance early parenting and child care skills.

Group Education may be provided by one of the following qualified providers:

• Registered Nurse
• Certified Nurse-Midwife
• Certified Nurse Practitioner
• Health Educator must have either a Bachelor’s degree in health education with a minimum of three years’ experience, at least one of which must be in a medical setting, a Master’s degree with a minimum of one year of experience working in a medical setting or with pregnant women, or a Bachelor’s degree and a certificate showing completion of a certification examination in health education.

The service is reported using HCPCS S9446 Patient Education, Not Otherwise Classified, Non-Physician Provider, Group, Per Session. Group education is limited to eight (8) units during any 12-month period.

8-10.6.4 Nutritional Assessment and Counseling

Women with complex nutritional or related medical risk factors as determined in initial prenatal visits may require intensive nutrition education, counseling, monitoring and frequent consultations and may receive service by referral from a physician, certified nurse midwife, or a certified nurse practitioner to a registered dietitian.

Nutritional Assessment and Counseling may be provided by a Registered Dietitian.

8-10.6.5 Prenatal and Postnatal Psychosocial Counseling

Psychosocial evaluation is provided as a prenatal and postnatal service to identify members and families with high psychological and social risks, to develop a psychosocial care plan and provide
or coordinate appropriate intervention, counseling or referral necessary to meet the identified needs of each family.

Counseling may be provided by one of the following licensed Medicaid providers:

- Licensed Clinical Social Worker
- Clinical Psychologist
- Marriage and Family Therapist

The service is reported using HCPCS H0046 *Mental Health Services, Not Otherwise Specified.* Limited to twelve (12) visits during any 12-month period.

### 8-10.6.6 Risk Assessment

Risk assessment is the systematic review of relevant member data to identify potential problems and determine a plan for care. Early identification of high-risk pregnancies with appropriate consultation and intervention contributes significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality.

A care plan for high risk members, in addition to standard care, includes referral to or consultation with an appropriate specialist, individualized counseling and services designed to address the risk factor(s) involved. A care plan for low risk members includes primary care services and additional services specific to the needs of the individual.

Risk Assessments may be provided by one of the following licensed Medicaid providers:

- Physician
- Certified Nurse Practitioner
- Certified Nurse-Midwife

The service is reported using HCPCS H1000 *Prenatal Care, At Risk Assessment* for a low risk assessment or HCPCS H1001 *Prenatal Care, At Risk Enhances Service; Antepartum Management* for high risk assessment. Limited to two (2) assessments during any 10-month period.

### 8-10.6.7 Prenatal Assessment Visit (Initial Visit Only)

The initial prenatal assessment visit is a single prenatal visit for a new patient with a confirmed pregnancy, providing an evaluation of the mental and physical status of the patient, an in-depth family and medical history, physical examination, development of the medical data and initiation of a plan of care.

Prenatal Assessment Visit may be provided by one of the following licensed Medicaid providers:

- Physician
- Certified Nurse Practitioner
- Certified Nurse-Midwife
The service is reported using an appropriate CPT E/M code. Limited to one (1) visit in any 10-month period, to be used only when the patient is referred immediately to a community practitioner because of identified risks or otherwise lost to follow-up because the patient does not return.

8-10.6.8 Single Prenatal Visit(s) Other than Initial Visit

A single prenatal visit other than the initial visit is a single prenatal visit for an established member who does not return to complete care for unknown reasons. The initial assessment visit was completed, a plan of care established, one or two follow-up visits completed, without further care provided.

Single Prenatal Visit may be provided by one of the following licensed Medicaid providers:

- Physician
- Certified Nurse Practitioner
- Certified Nurse-Midwife

The service is reported using an appropriate CPT E/M code. Limited to three (3) visits in any 10-month period. The service may be billed only when the member is lost to follow up for any reason.

8-10.7 Birthing Center

Birthing centers are specialty units or freestanding facilities specifically designed to provide a low-cost alternative to the traditional hospital childbirth experience for a select, low risk population of healthy maternal patients expected to have an uncomplicated pregnancy, labor, delivery and recovery. Birthing Centers must assure quality care and a safe environment and must follow all federal, state and local laws, rules and regulations. Refer to Utah Administrative Code R432-550. Birthing Centers for health and safety standards for the organization, physical plant, maintenance and operation of birthing centers.

Birthing centers are to report facility services with revenue code 0724 (Birthing Center).

Authority for Birthing Center Services is found in Section 1901 ET. Seq. and Section 1905 of the Social Security Act, and by 42 Code of Federal Regulations 440.90 [October 1, 1996 edition] which is adopted and incorporated by reference.

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.

Procedure codes with accompanying criteria and limitations are found on the Medicaid website Coverage and Reimbursement Code Lookup. 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.

**Laboratory procedures**

Laboratory services provided by a physician in his office are limited to waived tests or those laboratory tests identified by CMS for which each individual physician is CLIA certified to provide, report, and receive Medicaid payment. For a list of CLIA waived tests refer to: Tests granted waived status under CLIA.

**8-11.1 Genetic Testing**

**Definitions**

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

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

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

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

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

**Coverage**

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

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

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

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

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

The following criteria applies only if there are not specific criteria, located in Medicaid’s evidence-based criteria tool, for testing. If criteria do exist, then the criteria for medical necessity will supersede the criteria in this policy. For the specific categories of testing where criteria do not exist, the following criteria must be met:

Testing of an affected (symptomatic) individual’s germline DNA to benefit the member (excluding reproductive testing)

- **Diagnostic**
  - An association of the marker with the disorder has been established; and
  - Symptoms of the disease are present; and
  - A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, standard diagnostic studies/tests; and
  - The clinical efficacy of identifying the mutation has been established:
    - Leads to changes in clinical management of the condition that improve clinical outcomes; or
    - Eliminates the need for further clinical workup or invasive testing; or
    - Leads to discontinuation of interventions that are unnecessary and/or ineffective

- **Prognostic**
  - An association of the marker with the natural history of the disease has been established
    And
  - Clinical efficacy of identifying the mutation has been established:
    - Provides incremental prognostic information above that of standard testing; and
▪ Reclassifies patients into clinically relevant prognostic categories for which there are different treatment strategies; and
▪ Reclassification leads to changes in medical management that improve clinical outcomes

• **Therapeutic**
  ○ Genetic testing identifies variants of a phenotype/metabolic state that relate to different pharmacokinetics, drug efficacy or adverse drug reactions; and
  ○ Clinical efficacy of identifying the mutation has been established:
    ▪ Leads to initiation of effective medication(s) or other treatments; or
    ▪ Leads to discontinuation of medications or other treatments that are ineffective or harmful; or
    Leads to clinical meaningful change in the dosing of medications that is likely to improve outcomes

**Non-covered**

• Experimental and/or investigational
• Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2, Newborn Hearing Screening), including:
  ○ preimplantation genetic diagnosis (PGD); or
  ○ prenatal genetic screening; or
  ○ in the absence of signs and/or symptoms
• Tests, for the member or family members, performed solely for the purposes of genetic counseling, family planning, or health screening
• Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
• Direct-to-consumer (DTC) genetic tests
• Tests of a member’s germline DNA is done to benefit family member(s), rather than to benefit the member being tested
• Establishment of paternity
• Genetic testing is considered not medically necessary when performed entirely for non-medical reasons (e.g., a general interest in genetic test results)

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

**Genetic Testing Policy for EPSDT Eligible Members**

**Definitions**

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

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

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

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

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

**Coverage**

Genetic testing may require Prior Authorization (PA). Specific coverage on CPT or HCPCS codes are found in the [Utah Medicaid Coverage and Reimbursement Code Lookup](https://www.medicaid.utah.gov/). Coverage of genetic testing by Medicaid is determined by using an evidence-based criteria tool and may require review by a Medicaid Consultant.

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

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

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

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

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

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

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

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

**Whole Exome Sequencing (WES)**

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

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

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

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

**Non-Covered Testing**

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

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

- Experimental and/or investigational
- Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2, Newborn Hearing Screening), including:
  - preimplantation genetic diagnosis (PGD); or
  - prenatal genetic screening; or
  - in the absence of signs and/or symptoms
- Tests, for the member or family members, performed solely for the purposes of genetic counseling, family planning, or health screening
● Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
● Direct-to-consumer (DTC) genetic tests
● Tests of a member’s germline DNA to benefit family member(s), rather than the member being tested
● Establishment of paternity
● Genetic testing is considered not medically necessary when performed entirely for non-medical reasons (e.g., a general interest in genetic test results)

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

8-12 Hospice Services

In-home physician services are only available for individuals who have filed an election statement with a Medicare certified hospice agency and have been approved through the prior authorization process to receive the Medicaid hospice care benefit. In-home physician visits are authorized for hospice patients if the attending physician determines that direct management of the patient in the home setting is necessary to achieve the goals associated with the hospice approach to care. If a patient's hospice services are discontinued for any reason including but not limited to voluntary revocation of hospice election or loss of hospice eligibility, in-home physician visits are no longer authorized.

8-13 Medical Supplies and Durable Medical Equipment

Refer to Utah Administrative Code R414-70. Medical Supplies, Durable Medical Equipment, and Prosthetic Devices, and the Medical Supplies and Durable Medical Equipment Provider Manual.

8-14 Mental Health Services


8-14.1 Evaluations and Psychological Testing

Mental health evaluations and psychological testing performed for physical health purposes including prior to medical procedures, or for the purpose of diagnosing intellectual or developmental disabilities, or organic disorders are carved out services from the Accountable Care Organizations (ACOs) and the Prepaid Mental Health Plan (PMHP). These services must be reported through Fee-for-Service Medicaid with the UC modifier. This carve-out policy does
not apply to psychiatric consultations during a physical health inpatient hospitalization. These psychiatric consultations remain the responsibility of the ACOs. This carve-out policy does not apply to HOME enrollees.

Also, the carve-out policy does not apply to mental health evaluations and psychological testing for the primary purpose of diagnosing or treating mental health or substance use disorders. For more information on coverage of these services for mental health and substance use disorders refer to the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

8-15 Organ Transplant Services

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

8-16 Modifiers

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

8-17 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.

8-18 Chiropractic Services

Coverage of chiropractic services is specifically limited to spinal manipulation treatment. Manual devices may be used by chiropractors in performing manual manipulation of the spine, however, no additional payment is available for use of the device, nor does Medicaid recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

For coverage and reimbursement information for specific procedure codes, please see the Coverage and Reimbursement Code Lookup.

9 Non-Covered Services and Limitations

Certain services have been identified by agency staff and medical review 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 Utah Administrative Code R414-10. Physician 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 which 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 the purpose of 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. Consent for Sterilization Form

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

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

9-5 **Medication Administration**

Medication administration procedures are not eligible for coverage when reported with an E/M service on the same date.
9-6 Cognitive Services

Cognitive services by a provider are limited to one service per member per day. These services are defined in the CPT Manual as office visits, hospital visits except for those following a global surgical procedure, therapy visits, and other types of nonsurgical services. When a second office visit for the same problem or a hospital admission occurs on the same date as another service, the physician must combine the services as one service and select a procedure code that most appropriately indicates the overall care given.

9-7 Early Elective Delivery

Medicaid does not cover early elective deliveries, prior to 39 weeks and 0 days, and does not consider this service to be medically necessary.

Medically necessary delivery, prior to 39 weeks and 0 days, requires documentation of the medical indication that justifies the early delivery. The provider is responsible for maintaining this documentation in the member’s medical record, which is subject to post payment review.

Global delivery claims that have been denied as an early elective delivery may be refiled as antepartum and/or postpartum care services for separate reimbursement consideration.

9-8 Home Telemetry

Outpatient long-term cardiac (Holter) monitoring codes 93224, 93225, 93226, and 93227 will require prior authorization if more than 3 units of any code are reported in one year. Prior authorization will use the following criteria:

- Outpatient long-term cardiac (Holter) monitoring must be ordered by a neurologist
- Member must have had a stroke or TIA with no identifiable cause
- Member should have already had 24-hour monitoring done previously (either with outpatient long-term cardiac monitoring or as inpatient with telemetry)
- Member should not be currently anti-coagulated on Warfarin for any other reason
- Member should not have a known contraindication for Warfarin
- Outpatient long-term cardiac monitoring may only be authorized for the 30-day test
- Data from the test must be reviewed and interpreted by a cardiologist

9-9 Consultation Services

Consultation Services are reimbursed only to a physician. Under “incident-to” service in Utah Medicaid an Advanced Practice Registered Nurse (APRN) may complete the history and examination to assist the physician consultant. The APRN must personally document in the medical record their portion of the work-up. The physician is responsible for the summary of findings and developing the plan of care.
9-10 Specific Non-Covered Services

Medicaid does not cover the services specified below; services not on this list are subject to general exclusions:

- Acupuncture
- Prolotherapy
- Panniculectomy and body sculpturing procedures
- Chemical peeling or dermabrasion of the face
- Revision of minor scars not related to major trauma
- Removal of tattoos
- Hair transplant
- Electrolysis
- 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
- Prolonged educational and counseling services beyond and those in included within the initial E/M service
- Pre-pregnancy genetic counseling
- Routine preventive medicine services, including physicals, are not covered for adults

10 Prior Authorization

For Medicaid medical or surgical services requiring prior authorization, the physician must obtain approval from Medicaid before service is rendered to the patient. For information regarding prior authorization, see Section I: General Information, Chapter 10, Prior Authorization. Additional resources and information can 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 provider may request authorization after service is rendered. These limitations are described in Section I: General Information, Chapter 10-3 Retroactive Authorization.

11 Billing Medicaid

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for more information about billing instructions.
12 Coding

Refer to the Section I 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. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee-for-service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).
Resource Table

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