

**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](mailto: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.

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

## 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 provided through a:

- Nationally recognized American Diabetes Association (ADA) certified diabetes educator [refer to <http://www.diabetes.org>] or
- An educator certified by the American Association of Diabetes Educators (AADE) [refer to <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 60<sup>th</sup> 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

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

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

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. One unit is one class at least one hour in length.

### **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.

The service is reported using HCPCS S9470 *Nutritional Counseling, Dietitian Visit*. Limited to fourteen (14) units during any 12-month period. One unit equals one-half hour.

### **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.

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**

Genetic testing requires a mandatory review by a Utah Medicaid physician for prior authorization. To help establish medical necessity, the documentation listed below must be submitted with all requests for genetic testing, in addition to any other pertinent supporting documentation:

- Any previous biochemical and metabolic disease testing
- Diagnosis of non-syndromic Development Delay/Intellectual Disability or Autism Spectrum Disorder
- Malformations
- Documentation describing how chromosomal microarray analysis (CMA) testing results will specifically impact clinical management of the patient
- Documentation verifying attendance of genetic counseling by the patient's parent(s) or legal guardian(s) with a Utah Licensed Genetic Counselor

## **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**

Refer to [Section I: General Information, Chapter 2-1.2, Prepaid Mental Health Plans, Utah Administrative Code R414-10. Physician Services, Utah Administrative Code R414-36. Rehabilitative Mental Health and Substance Use Disorder Services](#); and the [Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual](#).

#### **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 service 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**

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.

All related facility claims associated with provider claims, resulting from an early elective delivery, will be identified and payment recouped in its entirety through a retrospective review process.

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.

## 9-10 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

## 9-11 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.

## 9-12 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 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

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

<b>For information regarding:</b>	
Administrative Rules	<ul style="list-style-type: none"> <li>• <a href="#">Utah Administrative Code Table of Contents</a></li> <li>• <a href="#">Diabetes Self-Management Training. R414-90.</a></li> <li>• <a href="#">Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49.</a></li> <li>• <a href="#">Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A.</a></li> <li>• <a href="#">Payment for Limited Abortion Services. R414-1B.</a></li> <li>• <a href="#">Physician Services. R414-10.</a></li> <li>• <a href="#">Transplant Services Standards. R414-10A.</a></li> <li>• <a href="#">Podiatric Services. R414-11.</a></li> </ul>
Emergency Services Program for Non-Citizens	<ul style="list-style-type: none"> <li>• <a href="#">Section I: General Information</a></li> <li>• <a href="#">42 CFR 440.255</a></li> </ul>
General information including: <ul style="list-style-type: none"> <li>• Billing</li> <li>• Fee for Service and Managed Care</li> <li>• Member Eligibility</li> <li>• Prior Authorization</li> <li>• Provider Participation</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Section I: General Information</a></li> <li>• <a href="#">Claims</a></li> <li>• <a href="#">Managed Care: Accountable Care Organizations</a></li> <li>• <a href="#">Utah Medicaid Prior Authorization</a></li> </ul> <p><i>Administrative Rules</i></p> <ul style="list-style-type: none"> <li>• <a href="#">Eligibility Requirements. R414-302.</a></li> <li>• <a href="#">Medicaid General Provisions. R414-301.</a></li> <li>• <a href="#">Program Benefits and Date of Eligibility. R414-306.</a></li> <li>• <a href="#">Utah Medicaid Program. R414-1.</a></li> </ul>
Information including: <ul style="list-style-type: none"> <li>• Anesthesia Fee Resources</li> <li>• Coverage and Reimbursement Resources</li> <li>• National Correct Coding Initiative</li> <li>• Procedure codes with accompanying criteria and limitations*</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Bureau of Coverage and Reimbursement Policy</a></li> <li>• <a href="#">Coverage and Reimbursement Code Lookup</a></li> <li>• <a href="#">The National Correct Coding Initiative in Medicaid</a></li> </ul>
Information including policy and rule updates: <ul style="list-style-type: none"> <li>• Medicaid Information Bulletins (Issued Quarterly in January, April, July, and October)</li> <li>• Medicaid Provider Manuals</li> <li>• Utah State Bulletin (Issued on the 1<sup>st</sup> and 15<sup>th</sup> of each month)</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Utah Medicaid Official Publications</a></li> <li>• <a href="#">Utah State Bulletin</a></li> </ul>
Laboratory Services	<ul style="list-style-type: none"> <li>• <a href="#">Social Security Act §1833 - Payment of Benefits</a></li> <li>• <a href="#">PART 493—LABORATORY REQUIREMENTS</a></li> </ul>

	<ul style="list-style-type: none"> <li>• <a href="#">Clinical Labs Center</a></li> <li>• <a href="#">Clinical Laboratory Improvement Amendments (CLIA) and Medicare Laboratory Services</a></li> <li>• <a href="#">CMS Clinical Laboratory Improvement Amendments (CLIA)</a></li> <li>• <a href="#">State Operations Manual</a></li> <li>• <a href="#">How to Obtain a CLIA Certificate</a></li> <li>• <a href="#">FDA Clinical Laboratory Improvement Amendments (CLIA)</a></li> <li>• <a href="#">CDC Clinical Laboratory Improvement Amendments (CLIA)</a></li> <li>• <a href="#">Utah Public Health Laboratory Clinical Laboratory Certification (CLIA)</a></li> <li>• <a href="#">Medicare Claims Processing Manual Chapter 16 - Laboratory Services</a></li> <li>• <a href="#">Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report</a></li> <li>• <a href="#">State Laboratories</a></li> </ul>
Medicaid forms including: <ul style="list-style-type: none"> <li>• Abortion Acknowledgement</li> <li>• Hearing Request</li> <li>• Hospice Prior Authorization Form</li> <li>• Hysterectomy Acknowledgement</li> <li>• PA Request</li> <li>• Sterilization Consent</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Utah Medicaid Forms</a></li> </ul>
Medical Supplies and DME	<ul style="list-style-type: none"> <li>• <a href="#">Medical Supplies And Durable Medical Equipment Provider Manual</a></li> <li>• <a href="#">Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.</a></li> </ul>
Modifiers	<ul style="list-style-type: none"> <li>• <a href="#">Section I: General Information</a></li> </ul>
Non-Traditional Medicaid Health Plan Services	<ul style="list-style-type: none"> <li>• <a href="#">Non-Traditional Medicaid (NTM) Provider Manual</a></li> <li>• <a href="#">Non-Traditional Medicaid Health Plan Services. R414-200.</a></li> </ul>
Patient (Member) Eligibility Lookup Tool	<ul style="list-style-type: none"> <li>• <a href="#">Eligibility Lookup Tool</a></li> </ul>
Pharmacy	<ul style="list-style-type: none"> <li>• <a href="#">Drug Criteria Limits</a></li> <li>• <a href="#">Generic Prescriptions List</a></li> <li>• <a href="#">ICD-10 Reference Chart Pharmacy</a></li> <li>• <a href="#">Medicaid Pharmacy Program</a></li> <li>• <a href="#">OTC Drug List</a></li> <li>• <a href="#">Pharmacy Provider Manual</a></li> <li>• <a href="#">Medicaid Policy for Pharmacy Program. R414-60.</a></li> </ul>
Primary Care Network Plan Services	<ul style="list-style-type: none"> <li>• <a href="#">Primary Care Network (PCN) Provider Manual</a></li> <li>• <a href="#">Medicaid Primary Care Network Services. R414-100.</a></li> </ul>
Prior Authorization	<ul style="list-style-type: none"> <li>• <a href="#">Prior Authorization Form</a></li> <li>• <a href="#">Utah Medicaid Prior Authorization</a></li> </ul>

Provider Portal Access	<ul style="list-style-type: none"> <li>• <a href="#">Provider Portal Access</a></li> </ul>
Provider Training	<ul style="list-style-type: none"> <li>• <a href="#">Utah Medicaid Provider Training</a></li> </ul>
Other	<ul style="list-style-type: none"> <li>• <a href="#">Baby Your Baby</a></li> <li>• <a href="#">CDC Vaccines for Children Program</a></li> <li>• <a href="#">Dental, Oral Maxillofacial, And Orthodontia Provider Manual</a></li> <li>• <a href="#">Hospice Provider Manual</a></li> <li>• <a href="#">Medicaid.gov</a></li> <li>• <a href="#">Podiatric Services Provider Manual</a></li> <li>• <a href="#">Rehabilitative Mental Health And Substance Use Disorder Services Provider Manual</a></li> <li>• <a href="#">RHC-FQHC Provider Manual</a></li> <li>• <a href="#">Vision Care Services Provider Manual</a></li> <li>• <a href="#">Women, Infants and Children (WIC)</a></li> </ul>
References including: <ul style="list-style-type: none"> <li>• Social Security Act</li> <li>• Code of Federal Regulations</li> <li>• Utah Code</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">42 CFR 440.50</a></li> <li>• <a href="#">Social Security Act 1905(a)</a></li> <li>• <a href="#">Social Security Act 1861 (r)</a></li> <li>• <a href="#">Utah Annotated Code Title 58</a></li> </ul>
Tobacco Cessation Resources	<ul style="list-style-type: none"> <li>• Utah Tobacco Quit Line (1-800-QUIT-NOW)</li> <li>• <a href="#">Way to Quit</a></li> </ul>