Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Physician Services

Division of Integrated Healthcare

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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 outlined 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.

1-1.1 Associate physician

An associate physician, as defined in Utah Code 58-67-302.8, Restricted licensing of an associate physician, may enroll as a Medicaid provider.

The associate physician may provide medically necessary primary care services, consistent with the clinician's skill, training, education, and competence, to Medicaid members. Associate physician services must be performed under the direction of a collaborating physician as defined in Utah Code 58-67-807, Collaborative practice arrangement.

2 Health plans

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

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid mental health plans, and the Managed Care Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide healthcare 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 to secure and supervise 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

8-3.1 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 responsible for getting prior authorization for all codes with a prior authorization requirement. When Medicaid issues a PA for a procedure requiring authorization, associated anesthesia codes 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. When the surgeon did not obtain prior approval, the anesthesia provider might 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 procedures in which prior authorization was requested and denied.

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

8-3.2 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 the anesthetic/analgesic care (MAC). Postoperative pain management services may begin preoperatively, intraoperatively, or postoperatively.

8-3.3 Anesthesia time reporting

Report anesthesia time in minutes.

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

8-3.4 Obstetrical anesthesia – time reporting

An anesthesiologist may attend to more than one patient concurrently under continuous regional anesthesia related to neuraxial anesthesia for planned vaginal delivery.

There is a reduction in the unit value after the first hour of anesthesia time. For example, the first hour, 5-time units are 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 PRISM System calculates the appropriate reduction in the unit value.

8-3.5 Dental services

Ambulatory surgical centers (ASC) and outpatient hospitals report dental services using CPT 41899. Anesthesia providers directly rendering services should bill CPT 00170. Refer to the Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual and the Coverage and Reimbursement Lookup tool for coverage details.

8-3.6 Procedure codes

Anesthesia procedure codes with accompanying criteria and limitations are found on the Medicaid website Coverage and Reimbursement Lookup Tool.

8-3.7 Anesthesia modifiers

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

8-3.8 Physical status modifiers

Physical status modifiers distinguish between the levels of complexity of the anesthesia service provided. Although, when reporting a claim, there are no physical status modifiers, modifier P1, which indicates a normal healthy patient, is used in the 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 by a licensed physician, a physician assistant, or a nurse practitioner, 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, the provider must submit a copy of the history and physical exam, the operative report, and the discharge summary for review.

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. Both services are covered when a provider performs an evaluation and management (E&M) service and administers a covered immunization. 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. Reimbursement to providers participating in the VFC program is limited to E&M services and immunization administration, but not the drug product. The Centers for Disease Control and Prevention (CDC) administers the VFC program.

8-5.2 IV infusions and injections, including chemotherapy administration

When a visit to the physician's office is for the administration of a medication or chemotherapy agent, only the administered drug ("J-code") for the medication and the administration code (96400-96549) are covered. The administration fee covers the skill, evaluation, and management required to administer the chemotherapy agent. Therefore, a separate E/M is not reimbursable. However, if there are significant separately identifiable services, those services must be reported using modifier 25. Reporting an E/M with modifier 25 requires the review of supportive documentation for significant separately identifiable services beyond the services covered under administration and the medication.

When administering multiple infusions, injections, or combinations, providers report the initial service code unless protocol requires two IV sites. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first service within a group of services. In that case, the provider reports the appropriate code.

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

IV-line flush between drugs is considered part of the drug administration service and not reimbursed separately.

Coverage of a heparin flush is limited to one payment after the infusion.

8-6 Telehealth services

Telehealth services are an additional method of delivering healthcare to patients. Refer to Section I: General Information, Chapter 8-4.2, Telehealth.

8-7 Diabetes prevention programs

Medicaid encourages providers to screen and refer their patients to evidence-based diabetes prevention programs (DPPs) recognized by the Centers for Disease Control

and Prevention (CDC) when they are found to be at risk for the development of type 2 diabetes.

DPP services include behavioral counseling and lifestyle-change programs which are proven effective when delivered to prediabetic patients at high risk for developing type 2 diabetes, specifically those with minimal physical activity, obesity, and genetic predisposition. Intensive behavioral counseling includes care management, lifestyle coaching, the facilitation of a peer support group, and the provision of clinically validated educational lessons based on a standardized curriculum focused on nutrition, exercise, stress, and weight management while allowing care plan oversight by a trained provider.

DPP services must be performed by trained lifestyle coaches who have completed a nationally recognized training program. Lifestyle coaches must be available to interact with the participants.

For a member to be considered eligible for coverage of these services, they must meet the following requirements:

1. Receive DPP from a CDC-recognized diabetes prevention lifestyle change program.
2. Meet all of the following requirements:
    a) 18 years of age or older
    b) Overweight – BMI of 25 or higher
    c) Not diagnosed with diabetes type 1 or 2
    d) Not currently pregnant
3. Have at least one of the following:
    a) Had a blood test result in the prediabetes range within the past year (includes any of these tests and results):
        i. Hemoglobin A1C: 5.7–6.4%.
        ii. Fasting plasma glucose: 110–125 mg/dL.
        iii. 2-hour plasma glucose (after a 75 g glucose load): 140–199 mg/dL.
    b) Previously diagnosed with gestational diabetes
    c) High-risk results on prediabetes risk test

i. A score of 5 or higher
ii. https://www.cdc.gov/prediabetes/pdf/Prediabetes-Risk-Test-Final.pdf

See Chapter 12-1, Coding for diabetes prevention programs, of this manual for reporting requirements of DPP services.

8-8 Diabetes self-management training

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

8-8.1 Requirements

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

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

Note: This program does not cover self-management training for the sole use of glucose monitoring or nutritional counseling.

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 Office of Medicaid Operations Provider Enrollment.

8-9 Nutritional counseling

Nutritional counseling is covered with a maximum of 1 hour for the initial assessment and intervention. For coverage limitations on reassessment 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. However, physicians and other qualified providers permitted to report evaluation and management services may bill with a prolonged service code to include the time for nutritional counseling.

8-10 Tobacco cessation counseling

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

8-11 Maternity services

Maternity services are available as pregnancy-related or postpartum services to the end of the 12th month after the pregnancy ends.

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.

8-11.1 Global maternity care

Global maternity care includes services typically 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 reportable as separate services.

8-11.1.1 Antepartum care

Antepartum care includes standard prenatal services. The initial visit must be included in antepartum care and is not a separately reportable service.

Antepartum care consists of:

1. The initial and subsequent history,
2. Physical examinations,
3. Recording of weight, blood pressure, fetal heart tones,
4. Routine chemical analysis,
5. Hematocrit,
6. Maternity counseling,

7. Monthly visits up to 28-week gestation, with subsequent biweekly visits to 36-week gestation, and weekly visits after that until delivery,
8. Treatment of routine complaints accompanying pregnancy.

Diabetic glucose monitoring is part of the global maternity payment. Therefore, additional billing for an office visit, diabetes self-management training, or nutritional medical counseling for diabetic glucose monitoring in pregnancy is inappropriate.

8-11.1.2 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.

8-11.1.3 Postpartum care

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, a 6-week postpartum visit, and obtaining a PAP smear. Medicaid covers postpartum services to the end of the 12th month after the pregnancy ends. Family planning services are covered separately.

8-11.1.4 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 indications are reported separately.

8-11.2 Ultrasound in pregnancy

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

An incompetent cervix must be diagnosed with a transvaginal ultrasound.

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

8-11.3 Billing for maternity care

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

8-11.4 Coding for maternity care

8-11.4.1 Gestational age

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

8-11.4.2 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.

8-11.4.3 Modifier 22

All obstetrical and delivery procedure codes submitted with modifier 22 requires documentation (e.g., operative report) for review before payment. Services for enhanced payment with modifier 22 include multiple gestations or complications during the delivery, placing the mother or fetus at risk of adverse outcomes.

8-11.5 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 Chapter 8-2.11, Emergency services program for non-citizens, of Section I: General Information provider manual.

8-11.6 Extended services for pregnant women

The services described in this section are available to pregnant women eligible for Medicaid or 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 to the end of the 12th month after the pregnancy ends.

8-11.6.1 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.

Reporting of perinatal care coordination services is limited to qualified healthcare professionals acting within the scope of their license.

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

8-11.6.2 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:

1. Prenatal and postnatal care,
2. Provide direct care,
3. Encourage regular visits for prenatal care,
4. Provide emotional support, and
5. To determine educational needs.

Reporting of prenatal and postnatal home visits are limited to qualified healthcare professionals acting within the scope of their license.

The service is reported using HCPCS H1004 Prenatal care, at-risk enhanced, follow up home visit and is limited to 6 visits during a 12-month period.

8-11.6.3 Group prenatal and postnatal education

Group prenatal and postnatal education is a classroom learning experience for improving pregnancy, labor, childbirth, parenting, and infant care. This planned educational service aims to promote informed self-care, prevent the development of conditions that may complicate pregnancy, and enhance early parenting and childcare skills.

Reporting of group prenatal and postnatal education is limited to qualified healthcare professionals acting within the scope of their license.

The service is reported using HCPCS S9446 Patient education, not otherwise classified, non-physician provider, group, per session. Group education is limited to 8 units during any 12-month period.

8-11.6.4 Nutritional assessment and counseling

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

A registered dietitian may provide nutritional assessment and counseling.

8-11.6.5 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, 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:

1. Licensed clinical social worker
2. Clinical psychologist
3. Marriage and family therapist

The service is reported using HCPCS H0046 Mental health services, not otherwise specified and is limited to 12 visits during any 12-month period.

8-11.6.6 Risk assessment

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

In addition to standard care, a care plan for high-risk members 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.

Reporting of risk assessment is limited to physicians or other qualified healthcare professionals acting within the scope of their license.

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 and is limited to 2 assessments during any 10-month period.

8-11.6.7 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.

Reporting of prenatal assessment visit (initial visit only) is limited to physicians or other qualified healthcare professionals acting within the scope of their license.

The service is reported using an appropriate CPT E/M code. Limited to 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.

8-11.6.8 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 were completed, without further care provided.

Reporting the single prenatal visit(s), other than initial visit, is limited to physicians or other qualified healthcare professionals acting within the scope of their license.

The service is reported using an appropriate CPT E/M code and is limited to 3 visits in any 10-month period. The service is limited to billing only when the member is lost to follow-up for any reason.

8-11.7 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.

8-12 Laboratory services

Medicaid coverage of laboratory services is dependent upon facilities meeting the Clinical Laboratory Improvement Amendments (CLIA) provider certification requirements. In addition, coverage is limited to laboratory tests identified by the Centers for Medicare and Medicaid Services (CMS) and includes microbiology, serology, immunohematology, cytology, histology, chemical, hematology, biophysical, or toxicology.

Clinical laboratory services are furnished primarily in three distinct settings: independent clinical laboratories, physician office laboratories, and hospital-based laboratories. The type of CLIA certification needed to perform each test is determined by the complexity of the tests provided. Laboratory tests are classified into one of four categories: waived, provider-performed microscopy (PPM) procedure, moderate, and high.

Medicaid requires that laboratory services ordered must be medically necessary and appropriate to the patient's current care and condition in order to be covered. The documentation in the medical record must support medical necessity. CLIA services

must maintain a high standard of quality and shall be provided within the limitations and exclusions specified within this chapter.

8-12.1 CLIA certification

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

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

The form should be completed and mailed to the address listed below:

Unified State Laboratories:

Public Health Bureau of Laboratory Improvement
4431 South 2700 West
Taylorsville, UT 84129

The CLIA regulations require all facilities performing waived and non-waived testing to file a separate application for each facility location. Each CLIA certificate represents a facility, and each facility is responsible for complying with the applicable CLIA requirements. Refer to 42 CFR §493.35(a), §493.43(a) and §493.55(a) for additional information.

8-12.2 CLIA levels of certification

CLIA has five different certificates, each indicating the level and complexity of testing that can be performed by a facility: Waived, PPM procedure, Certificate of Registration, Certificate of Compliance (COC), and Certificate of Accreditation (COA). CLIA certifications are generally effective for two years and require ongoing renewal. Each type of certification determines the level of testing a facility can perform. The categorization of tests is determined by the Food and Drug Administration (FDA).

Certificate of Waiver

Certificate of Waiver is issued to a facility that only performs waived tests.

Certificate for Provider-Performed Microscopy (PPM) Procedures

A PPM procedure certificate is issued to a facility in which a physician, midlevel practitioner, or dentist performs only specific microscopy procedures during the course of a patient's visit.

Certificate of Compliance, Accreditation, and Registration

A COC or COA is based on the agency chosen to survey the facility.
COC is issued to a facility after an inspection by a CLIA state survey agency that finds the facility in compliance with all applicable CLIA requirements.

COA is issued to a facility on the basis of the facility's accreditation by an accreditation organization approved by CMS. A non-profit accreditation organization's requirement must equal or exceed CLIA program requirements to receive CMS approval.

A Certificate of Registration (COR) is temporary and permits the facility to conduct nonwaived (moderate and/or high complexity) tests until the laboratory is inspected and found to comply with CLIA regulations. The COR is valid for no more than two years. Only facilities applying for a COC or COA will receive a COR. Under a COR, a facility is also permitted to conduct waived tests.

8-12.3 CLIA testing complexity

The FDA categorizes diagnostic laboratory tests by their complexity, from the least to the most complex:

1. Waived tests
    a) Waived tests are simple examinations and procedures that have an insignificant risk of an erroneous result.
    b) Laboratory services performed in an office are generally limited to waived tests. However, the CMS certification determines the

testing each individual provider can perform and report for reimbursement.

2. Provider-Performed Microscopy (PPM) Procedure
    a) PPM procedures are a select group of moderately complex microscopic tests that do not meet the criteria for waiver because they are not simple procedures; they require training and specific skills for test performance and they must meet certain other criteria. Controls are generally not available to monitor the complete testing process for these procedures. Therefore, only limited activities are suitable for inspection.
    b) A limited list of PPM procedure is included under this certificate type, which are categorized as moderate complexity testing. Please refer to the CMS PPM procedure document for a comprehensive list of allowed services under this level of certification.
3. Moderate complexity tests
    a) Moderate complexity tests require minimal scientific and technical knowledge.
4. High complexity tests
    a) High complexity tests are more difficult to perform or interpret than moderate and waived tests. Specialized scientific knowledge and training are required.

8-12.4 Proprietary Laboratory Analysis (PLA) codes

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

8-12.5 Urine drug testing

Urine drug testing is a covered service when medically necessary for eligible, enrolled Medicaid members. Reporting of urine drug testing services is limited to a provider or laboratory CLIA certification and enrollment with Medicaid.

Medicaid considers urine drug testing medically necessary when used in conjunction with:

1. Chronic opioid therapy (COT), or
2. As part of a substance use disorder (SUD) treatment program.

Medicaid has established drug testing limits under the American Society of Addiction Medicine (ASAM) in The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine guidelines. In addition, it supports drug test type selection (presumptive or definitive and level of substances tested) and frequency that aligns with evidence-based standards and practices.

Providers are required to utilize the most medically appropriate urine drug test based on the service meeting the definition of "medically necessary service" as outline in Utah Administrative Code R414-1-2(18) and Chapter 8-1, Medical necessity, of the Section I: General Information provider manual.

8-12.5.1 Limitation for urine drug testing

Annual quantity limits for both presumptive and definitive tests promote flexible, patient-specific testing throughout treatment. In addition, Medicaid evaluates exceptions to quantity limits on a case-by-case basis through the prior authorization process.

Urine Drug Testing Limitations					
Drug test type	CPT and HCPCS codes	Level of test	Rate	Annual quantity limit	Daily quantity limit
Pre-sumptive	80305 - results obtained by direct visual reading, such as in the case of viewing urine dipsticks, urine cups, test cards, or cartridge	Waived	$11.99	60/year	1/day
	80306 - direct visual reading of test results assisted by instrumentation	Moderate	$15.99		

	80307 - tests performed utilizing instrument chemistry analyzers, such as immunoassay, chromatography, and mass spectrometry with or without chromatography	Moderate	$51.50		

Urine Drug Testing Limitations					
Drug test type	CPT and HCPCS codes	Level of test	Rate	Annual quantity limit	Daily quantity limit
Definitive	G0480 - definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers, qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es),	Moderate	$64.51	16/year	1/day
	G0481 - 8-14 drug class(es),	Moderate	$99.25		
	G0482 - 15-21 drug class(es),	Moderate	$99.25		
	G0483 - 22 or more drug class(es),	Moderate	$99.25		

8-12.5.2 Non-covered urine drug testing

Medicaid does not cover urine drug testing when not medically necessary.

Urine drug testing is not medically necessary when:

1. ASAM guidelines are not met, or
2. For court ordered drug testing that does not meet ASAM guidelines.

8-12.6 Prior authorization

Refer to the Coverage and Reimbursement Code Lookup to determine if specific laboratory services are covered and for the rate of reimbursement, if covered. Some laboratory services will require prior authorization. Refer to Utah Medicaid Prior Authorization for additional information.

Exceptions to established limits for urine drug screening will be evaluated on a case-by-case basis through the prior authorization process. Urine drug screen prior authorization criteria can be found at Utah Medicaid Prior Authorization.

8-12.7 Billing

Providers must submit laboratory claims on a CMS-1500 form with the CLIA certification number appended. Failure to submit a CMS-1500 claim with the CLIA certification number will result in denial of the service. Facilities billing laboratory services on a UB-04 form are not required to append their CLIA certification number. In addition, laboratories must only submit laboratory codes whose level of complexity is permitted within their level of certification. Submission of a laboratory code that a facility is not certified to perform will result in the denial of the service.

Waived tests must be billed with a QW modifier. Refer to the Tests Granted Waived Status Under CLIA document for a list of CLIA waived tests.

Some laboratory codes allow for a technical and professional component. These codes are billed with a 26 (professional component) or TC (technical component) modifier, where applicable. Providers only completing the professional portion of the code must append modifier 26 to the claim line. Providers only completing the technical portion of the code must append the TC modifier to the claim line.

Providers submitting for the professional component of the laboratory service do not need to have a CLIA certification. This service is based on a provider practicing within their scope of licensure and training.

Medicaid rates for laboratory services are set using the CMS Laboratory Fee Schedule https://www.cms.gov/medicare/medicare-fee-for-service-payment/clinicallabfeesched/. Only the facility performing the service may submit the claim.

8-12.8 Indian health services

Indian health services (IHS) are excluded from CLIA regulations. IHS follow their own federal guidelines. The manual on laboratory services for IHS can be found at this link IHS Laboratory Services Manual.

8-12.9 Genetic testing

8-12.9.1 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 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 the disease and predicts the 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 the disease, e.g., testing breast cancer tissue with Oncotype Dx.

Therapeutic: To determine that a particular therapeutic intervention is potentially effective for an individual patient and determines the probability of favorable or adverse response to medications. Additionally, therapeutic testing may detect genetic variants that alter the risk of treatment, adverse events, drug metabolism, drug effectiveness, etc., (e.g., cytochrome p450 testing). Finally, the testing may detect genetic mutations that adversely affect

response to environmental exposures that are ordinarily tolerated, such as G6PD deficiency, genetic disorders of immune function, and aminoacidopathies.

8-12.9.2 Coverage

Genetic testing may require prior authorization (PA). Specific coverage on CPT or HCPCS codes is found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

Coverage of genetic testing by Medicaid is determined by using evidence-based criteria 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 acting within the scope of their practice.

1. Providers must be able to counsel clients on the particular genetic test ordered and the results of the test, as it applies to the member, in consultation with a genetic specialist as needed.
2. 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 before ordering the test.

The following criteria apply if there are no specific criteria for testing in Medicaid's evidence-based criteria tool. If criteria do exist, then the requirements for medical necessity will supersede the criteria in this policy. For the specific categories of testing where standards 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

a) An association of the marker with the disorder has been established, and
b) Symptoms of the disease are present, and
c) A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, standard diagnostic studies/tests, and
d) The clinical efficacy of identifying the mutation has been established:
    i. Leading to changes in the clinical management of the condition, which improve clinical outcomes, or
    ii. Eliminates the need for further diagnostics or other invasive testing, or
    iii. This leads to the discontinuation of interventions that are unnecessary or ineffective.

Prognostic

e) An association of the marker with the natural history of the disease has been established
    and
f) Clinical efficacy of identifying the mutation has been established:
    i. Provides incremental prognostic information above that of standardized testing, and
    ii. Reclassifies patients into clinically relevant prognostic categories for which there are different treatment strategies, and
    iii. Reclassification leads to changes in medical management that improve clinical outcomes

Therapeutic

g) Genetic testing identifies variants of a phenotype/metabolic state that relate to different pharmacokinetics, drug efficacy or adverse drug reactions, and
h) Clinical efficacy of identifying the mutation has been established and leads to:
    i. The initiation of effective treatment,

ii. The discontinuation of treatments that are ineffective or harmful, or
iii. A change in medication that is likely to improve outcomes.

8-12.9.3 Non-covered

1. Experimental or investigational (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")
2. Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2. Newborn Hearing Screening), including:
    a) Preimplantation genetic diagnosis (PGD),
    b) Prenatal genetic screening, or
    c) In the absence of signs or symptoms
3. Tests, for the member or family members, performed solely for genetic counseling, family planning, or health screening
4. Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
5. Direct-to-consumer (DTC) genetic tests
6. Tests of a member's germline DNA to benefit family member(s) rather than to benefit the member
7. Establishment of paternity
8. Genetic testing is 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 is 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.

8-12.10 Genetic testing policy for EPSDT eligible members

8-12.10.1 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 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 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 the disease and predicts the 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 the disease.

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

8-12.10.2 Coverage

Genetic testing may require prior authorization (PA). Specific coverage on CPT or HCPCS codes is 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 acting within the scope of their practice.

1. Providers must be able to counsel clients on the particular genetic test ordered and the results of the test, as it applies to the member, in consultation with a genetic specialist as needed.
2. 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 before ordering the test.

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

1. Clinical presentation fits a well-defined syndrome for which a specific or targeted gene test is available, or
2. A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, or standard diagnostic studies or tests, or

3. 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, or medical setbacks, or
4. There is a clinical syndrome with a broad number of potential diagnoses, and a specific diagnosis will determine prognosis and appropriate medical management.

8-12.10.3 Documentation requirements (see genetic testing PA request form)

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

1. Specific risk factors, the clinical scenario, or family history that supports the need for the requested test(s),
2. Clinical examination and conventional diagnostic testing have been unsuccessful in determining the member's specific diagnosis,
3. The members medically necessary medical management may not be determined without genetic testing, and
4. Testing may change the medical management of the member.

Where criteria do not exist, the PA requester must submit publicly accessible data from peer-reviewed scientific literature or the national databases that address the clinical validity, predictive value, or medical benefits of the genetic test.

8-12.10.4 Next Generation Sequencing (NGS)

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

1. 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.
2. Surveillance for later-onset comorbidities.
3. Reducing the financial and psychological impact of diagnostic uncertainty.

4. Eliminating lower-yield testing, and additional screening(s) that may later be proven unnecessary once a diagnosis is achieved.

Next-generation sequencing (NGS) includes genetic testing options such as whole exome sequencing (WES) and whole genome sequencing (WGS) and can detect the most significant variant types, meaning genetic alterations with sufficient evidence to classify as pathogenic.

Whole Exome Sequencing (WES)

WES focuses on the genomic protein coding regions (exons). It is a cost-effective, widely used NGS method that requires fewer sequencing reagents and takes less time to perform bioinformatic analysis compared to WGS. Although the human exome represents only 1-5% of the genome, it contains approximately 85% of known disease-related variants.

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:

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

Whole Genome Sequencing (WGS)

Whole-genome sequencing (WGS), in contrast to (WES), may detect larger deletions or duplications, triple repeat expansions, and pathogenic variants in deep intronic regions; regulatory regions that are outside of the coding regions; and untranslated gene regions.

WGS is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in members aged less than one year of life and currently admitted to a Neonatal Intensive Care Unit (NICU), when all of the following criteria are met:

1. Test is ordered by one of the following provider types, who has evaluated the patient and family history, and recommends and/or orders the test:
    a) Neonatologist or neurologist in collaboration with a medical geneticist or certified genetic counselor
    b) The patient has been evaluated by a board-certified clinician with expertise in clinical genetics and counseled about the potential risks of genetic testing
    c) Pre- and post-test counseling is performed by an American Board of Medical Genetics or American Board of Genetic Counseling certified genetic counselor
2. Clinical indications:
    a) A definitive diagnosis cannot be made based on standard clinical workup
    b) The patient's phenotype does not clearly identify a specific disease or the patient has phenotypic characteristics outside of, or in addition to, what has been established for the disease
    c) A genetic etiology is the most likely explanation for the phenotype or clinical scenario, or the affected individual is faced with invasive procedures or testing as the next diagnostic step (e.g., muscle biopsy.)
    d) No other causative circumstances (e.g., environmental exposures, injury, infection) can explain the symptoms

8-12.10.5 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:

1. Experimental or investigational (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")

2. Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2. Newborn Hearing Screening), including:
   a) Preimplantation genetic diagnosis (PGD), or
   b) Prenatal genetic screening, or
   c) In the absence of signs or symptoms.
3. Tests, for the member or family members, performed solely for genetic counseling, family planning, or health screening
4. Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
5. Direct-to-consumer (DTC) genetic tests
6. Tests of a member's germline DNA to benefit family member(s) rather than to benefit the member
7. Establishment of paternity
8. Genetic testing is 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 is 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.

8-13 Hospice services

In-home physician services are only available for individuals who have filed an election statement with a Medicare-certified hospice agency and are 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 patient management 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 that case, in-home physician visits are no longer authorized.

8-14 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.

8-15 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. Behavioral Health Services, and the Behavioral Health Services Provider Manual.

8-15.1 Evaluations and psychological testing

Mental health evaluations and psychological testing performed for physical health purposes, including before medical procedures, or to diagnose intellectual or developmental disabilities or organic disorders are carved out services from the Accountable Care Organizations (ACOs) and the Prepaid Mental Health Plan (PMHP). Providers report these services 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 Behavioral Health Services Provider Manual.

8-16 Organ transplant services

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

8-17 Modifiers

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

8-18 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.

8-19 Chiropractic services

Coverage of chiropractic service is limited to spinal manipulation treatment. Chiropractors may use manual devices in performing manual manipulation of the spine. However, no additional payment is available for the 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.

8-20 Gender dysphoria treatment services

Gender dysphoria treatment is a covered service when it meets the medically necessary service criteria defined in R414-1-2(18) and when it meets the criteria below. Gender dysphoria treatment services must be of a quality that meets professionally recognized standards of health care and be substantiated by records that include evidence of such quality.

8-20.1 Psychotherapy

Members may receive psychotherapy to treat a gender dysphoria diagnosis. Members who seek pharmaceutical or surgical interventions must first undergo psychotherapy.

8-20.2 Pharmacy

Refer to the pharmacy prior authorization criteria at:
https://medicaid.utah.gov/pharmacy/prior-authorization/

8-20.3 Surgery

Members less than 18 years of age may not receive surgery to treat a gender dysphoria diagnosis regardless of medical necessity. Members 18 years of age or older may receive surgery to treat a gender dysphoria diagnosis when medically necessary and when the following criteria are met.

1. The member:
    a) Is 18 years of age or older.
    b) Has a gender dysphoria diagnosis.
    c) Has received cross-sex hormone therapy for at least 12 months except when hormone therapy is contraindicated.
    d) Has lived for at least 12 months in a gender role congruent with their gender identity.
2. There is documentation indicating clinically significant distress or impairment in social, occupational, or other important areas of functioning due to gender dysphoria.
3. The treating mental health professional has documented that the member has:
    a) Gender dysphoria,
    b) Capacity to make fully informed decisions,
    c) The ability to consent to surgery, and
    d) No history of psychiatric disorders that would interfere with the treatment or the ability to provide informed consent, or any existing psychiatric disorder is well-managed and under control.

For 8-20.3 a mental health professional means any of the following:

1. a physician who is board certified for a psychiatry specialization recognized by the American Board of Medical Specialists or the American Osteopathic Association's Bureau of Osteopathic Specialists,
2. a psychologist licensed under Chapter 61, Psychologist Licensing Act,

3. a clinical social worker licensed under Chapter 60, Part 2, Social Worker Licensing Act,
4. a marriage and family therapist licensed under Chapter 60, Part 3, Marriage and Family Therapist Licensing Act, or
5. a clinical mental health counselor licensed under Chapter 60, Part 4, Clinical Mental Health Counselor Licensing Act.

8-21 Wellness visits services

Wellness visits are covered for a maximum of one visit annually for members over the age of 21. For coverage and reimbursement information for specific codes, please see the Coverage and Reimbursement Code Lookup.

8-22 Genetic carrier screening and in vitro fertilization (IVF) services

Genetic carrier screening and in vitro fertilization (IVF) services are available for certain Medicaid eligible individuals that meet the requirements listed below. This benefit is intended to reduce the likelihood that Medicaid beneficiaries who have a serious inherited disorder, or who carry a genetic trait associated with a serious inherited disorder, pass the disorder on to their children.

Eligibility: Genetic screening and IVF services are a covered benefit for eligible members who meet the following criteria:

1. Ages 18 through 35
2. Has been diagnosed, by a physician, as having a genetic trait associated with one of the following conditions:
    a) Cystic fibrosis;
    b) Spinal muscular atrophy;
    c) Morquio syndrome;
    d) Myotonic dystrophy; or
    e) Sickle cell anemia
3. Intends to reproduce with a partner who has been diagnosed by a physician as having a genetic trait associated with the same qualified condition as the individual, or
4. One partner has been diagnosed by a physician as having myotonic dystrophy and intends to reproduce.

Genetic screening and IVF services require prior authorization. Supporting documentation of the criteria listed above is required to be submitted with each prior authorization request.

Covered Services

Carrier Screening: Carrier screening analysis for a known familial mutation may be considered medically necessary for qualifying conditions when:

1. The member and/or the member's reproductive partner is considering pregnancy, and
    a) The member has a close relative with a known pathogenetic or likely pathogenetic variant associated with a disorder; or
    b) The member's reproductive partner is a carrier for a genetic disorder; or
    c) The member or the member's reproductive partner are members of a population known to have a carrier rate of 1% or higher for a genetic condition; or
    d) The member or the member's reproductive partner has a first or second degree relative who is affected with a genetic disorder, including parents, siblings, children, grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings.
2. Qualified conditions for carrier screening include:
    a) Cystic fibrosis;
    b) Spinal muscular atrophy;
    c) Morquio syndrome; or
    d) Sickle cell anemia
3. Carrier screening analysis for a known familial mutation is considered investigational for all other indications.
4. Carrier screening services are a covered benefit for enrolled eligible Medicaid members only and do not extend to ineligible reproductive partners.

IVF Services

IVF services may include the following:

1. Stimulation of ovulation
2. Monitoring of ovulation stimulation
3. Oocyte retrieval
4. Laboratory studies, including pre-implantation genetic diagnosis testing for genetic disorders
5. Genetic counseling
6. Embryo assessment and transfer
7. Luteal phase support
8. Thawing of cryopreserved embryos

All services which are provided as part of an IVF procedure are covered under the global reimbursement rate for the IVF procedure. This can include, but is not limited to:

1. Ovarian stimulation
    a) Excludes ovarian stimulation medications which are reported separately
2. Egg retrieval
3. Insemination
4. Fertilization
5. Embryo culture
6. Labs, including pre-implantation genetic diagnosis testing
7. Genetic counseling
8. Pathology
9. Surgical procedures
10. Radiology(ultrasound)
11. Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization

Current American Society for Reproductive Medicine (ASRM) and Society for Assisted Reproductive Technology (SART) guidelines regarding limits to the number of embryos transferred must be followed.

Limitations

1. Qualified Medicaid members may receive three (3) cycles of IVF per lifetime.

2. Genetic screening services are limited to one (1) per lifetime.
3. Reimbursement for genetic counseling services is limited to physicians and physician assistants with the training and qualifications to offer genetic counseling services.

For additional code specific policy information providers may refer to the Coverage and Reimbursement Code Lookup.

8-23 Fertility preservation

Fertility preservation services are covered for members undergoing gonadotoxic cancer treatments or other medically necessary treatment that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment. Qualifying members must meet the following criteria:

1. The member is post-pubertal through 40 years of age.
2. Diagnosis by a qualified healthcare professional (QHP) of a condition requiring treatment which, in the QHP's professional judgment, may pose a substantial risk of sterility or lead to iatrogenic infertility (infertility caused by treatment).
3. The member's current state of health is sufficient to undergo fertility preservation procedures.
4. The member has received infertility counseling as well as psychotherapy, when medically indicated.
5. Collection and storage of embryos, eggs or sperm is consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine (ASRM) or the American Society of Clinical Oncology (ASCO).

Coverage

Collection and storage of embryos, reproductive tissues, eggs, and sperm must use collection and storage processes that are consistent with established medical practices or professional guidelines published by the ASRM or the ASCO.

Coverage includes the following fertility preservation services:

1. Mature oocyte cryopreservation

2. Ovarian tissue cryopreservation
3. Ejaculated/surgically extracted sperm cryopreservation
4. Embryo cryopreservation

Limitations

1. Reimbursement for cryopreservation storage is covered as a single payment and includes up to a five-year storage increment.
    a) Post cryopreservation procedures for use of eggs, sperm, or embryos are not covered.
    b) Additional five-year storage increments may only be requested for member's that retain Medicaid eligibility.

Non-covered services

1. Cryopreservation of embryos or eggs or sperm for fertility preservation purposes other than chemotherapy or other treatments that may render an individual infertile.
2. Cryopreservation of embryos or eggs or sperm for reciprocal IVF.
3. Sperm storage/banking for males requesting this service for convenience or "back-up" for a fresh specimen.

For additional code specific policy information providers may refer to the Coverage and Reimbursement Code Lookup.

9 Non-covered services and limitations

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

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

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

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

9-3.2 Sterilizations incident to surgical procedures

1. Prior authorization requirements must be met.
2. For hysterectomy procedures, a properly executed Utah Medicaid Hysterectomy Acknowledgement Form must be submitted for all hysterectomy procedures.
3. Refer to the Coverage and Reimbursement Code Lookup for specific codes which require the hysterectomy consent form.

9-4 Reconstructive and cosmetic services

For additional information, refer to Utah Administration Code R414-1-29.

As defined in Utah Administrative Code R414-1-2 (18), medical necessity 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 before 39 weeks and 0 days and does not consider this service medically necessary.

Prior to 39 weeks and 0 days, medically necessary delivery requires documentation of the medical indication that justifies the early delivery. The provider maintains 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:

1. A cardiologist must order outpatient, long-term cardiac (Holter) monitoring
2. Member must have had a stroke or TIA with no identifiable cause

3. Member should have already had 24-hour monitoring done previously (either with outpatient, long-term cardiac monitoring, or as inpatient with telemetry)
4. Member should not be currently anti-coagulated on Warfarin for any other reason
5. Member should not have a known contraindication for Warfarin
6. Outpatient, long-term cardiac monitoring may only be authorized for the 30-day test
7. 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) or physician assistant (PA) may complete the history and examination to assist the physician consultant. The APRN or PA 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 Radiation treatment and management

The Centers for Medicare and Medicaid Services (CMS) has provided distinct coding and reporting guidance for delivery and management of radiation treatment.

Treatment planning

Treatment planning is reportable once per course of therapy. This is a professional service only and the physician is responsible for all the technical aspects of the treatment planning process.

Simulation

Following treatment planning, simulation is used to direct the treatment beams to the specific volume of interest. However, the inclusion of treatment devices in the simulation process typically increases the complexity.

Simulation without the inclusion of devices or with any pre-made devices (e.g., blocks, immobilization) is considered simple. The addition of custom immobilization

devices or tangential ports is an indicator of complex level of simulation. No more than one simulation should be reported on any given day.

Simple or complex device and port reporting

Providers should report devices at the beginning of the treatment course and then may report again later in the course of treatment when additional or new devices are required. Coverage for one set of treatment devices may be allowed per separate port when radiation therapy is started. However, a pair of mirror imaged opposing ports, ports that direct parallel beams such as anterior-posterior or left lateral-right lateral pairs are considered one port for reporting purposes, regardless of the complexity of the devices used to create the ports.

A pair of devices for opposing ports, constructed from drawings made by a physician on a single film, is considered for physician professional reporting purposes to be one port. Therefore, each device constructed may be reported separately by the facility. Nevertheless, the physician must be directly involved in the design, selection, and placement of the devices.

When the member has a combination of a wedge compensator and a bolus covering the same treatment port, report as a single complex treatment device rather than as a separate charge for each of the additional items of lower complexity. If beam modification devices of two distinct levels of complexity are utilized for the same treatment port, only report the highest complexity. Restraining devices and beam modification devices may be reported separately for the same port, but only report one restraining device for each volume of interest treated.

Treatment delivery

Radiation treatment delivery codes are reported once per treatment session. These codes recognize the technical component only. Treatment management codes contain only the professional component. When more than one treatment is performed on the same date of service, each treatment should be reported on a separate claim line.

Radiation treatment delivery codes are reported using a date range if the treatments are performed on consecutive days and the energy and level of service are the same; the total number is indicated in the 'units' field on the claim. If the dates of service are not consecutive or the energy or level of service is not the same, each date of service must be reported on a separate claim line.

Basic radiation dosimetry is a separate and distinct service from intensity-modulated radiation treatment (IMRT) planning. It is appropriate to report a treatment device CPT code for each complex IMRT field (i.e., gantry/table angle for step and shoot and sliding windows). It is not reported for each segment within the field.

Image Guided Radiation Therapy (IGRT) is used in conjunction with IMRT in members whose tumors are located near or within critical structures or in tissue with inherent setup variation. Although an IGRT is a different service, it may be used and documented along with IMRT treatment delivery.

Additional Reporting Guidance

To aid in the reporting of radiation therapies, please see the Radiation Management and Treatment Table. This table will assist providers in reporting the delivery and management of radiation treatments.

Note: Reporting of CPT codes 77385 or 77386 is appropriate when reporting guidance and tracking performed in an outpatient hospital setting. For freestanding non-out-patient hospital facility claims, report guidance and tracking using HCPCS codes G6015 and G6016.

Category	Code	Descriptions	IGRT (77387)-TC Bundled into Code?	IGRT (77387)-PC Bundled into Code?	Code Type (technical/ professional)
Radiation Treatment Management	77427	Radiation treatment management, 5 treatment	N	N	Professional
	77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	N	N	Professional
	77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	N	Y	Professional
	77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	N	Y	Professional
Stereotactic Radiosurgery Treatment Delivery	77371	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Y	N	Technical
	77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Y	N	Technical
Stereotactic Body Radiation Therapy Treatment Delivery	77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Y	N	Technical
Radiation Treatment Delivery	77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	N	N	Technical
	77402	Radiation treatment delivery, => 1 MeV; simple	N	N	Technical
	77407	Radiation treatment delivery, => 1 MeV; intermediate	N	N	Technical
	77412	Radiation treatment delivery, => 1 MeV; complex	N	N	Technical

Category	Code	Descriptions	IGRT (77387)-TC Bundled into Code?	IGRT (77387)-PC Bundled into Code?	Code Type (technical/ professional)
Intensity Modulated Radiation Treatment Delivery	77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Y	N	Technical
	77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	Y	N	Technical
Neutron Beam Treatment Delivery	77423	High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	N	N	Technical
Proton Treatment Delivery	77520	Proton treatment delivery; simple, without compensation	N	N	Technical
	77522	Proton treatment delivery; simple, with compensation	N	N	Technical
	77523	Proton treatment delivery; intermediate	N	N	Technical
	77525	Proton treatment delivery; complex	N	N	Technical

9-11 Specific non-covered services

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

1. Acupuncture
2. Prolotherapy
3. Panniculectomy and body sculpturing procedures
4. Chemical peeling or dermabrasion of the face
5. Revision of minor scars not related to major trauma
6. Removal of tattoos
7. Hair transplant
8. Electrolysis
9. Surgical procedures for the reversal of previous elective sterilization, both male and female
10. Infertility studies
11. In-vitro fertilization
12. Artificial insemination
13. Surrogate motherhood, including all services, tests, and related charges
14. Prolonged educational and counseling services beyond and those in included within the initial E/M service
15. Pre-pregnancy genetic counseling

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 general information about billing instructions.

11-1 Billing for assistants to surgery

The AS modifier, indicating the assistant surgeon is a physician assistant or nurse practitioner, is covered by Medicaid, while Modifier 80 Assistant surgeon is reportable strictly to a qualified surgeon. Physicians, physician assistants, and nurse practitioners may be reimbursed as assistants to surgery through their own provider number as an incident to service.

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.).

12-1 Coding related to diabetes prevention programs

Providers must report DPP services using the appropriate coding guidelines outlined by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). In addition, when submitting claims for

DPP, providers must ensure that coverage criteria are met and that the services rendered are medically necessary.

DPP is reported with CPT codes 0403T and 0488T. Guidance for reporting these codes is outlined below. Do not report either of these codes for members diagnosed with diabetes type 1 or diabetes type 2.

0403T - Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day

0403T is reported by a CDC-recognized organization delivering a standardized DPP curriculum in a group setting. The lifestyle coach conducts a face-to-face, intensive behavior change therapy session lasting at least 60 minutes.

Report CPT code 0403T once per day. This code cannot be reported in the same 30-day time period as CPT code 0488T.

0488T - Preventive behavior change, online/electronic structured intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days.

0488T is reported by a CDC-recognized organization or provider delivering a standardized DPP curriculum online or electronically. This code is reported per 30 days of intense therapy. In-person components of the program are included when performed.

Do not report 0488T with CPT code 0403T in the same 30-day period of time covered under 0488T.

13 Resource table

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

For information regarding:	
Administrative Rules	• Utah Administrative Code Table of Contents • Diabetes Self-Management Training. R414-90. • Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49. • Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A. • Payment for Limited Abortion Services. R414-1B. • Physician Services. R414-10. • Transplant Services Standards. R414-10A. • Podiatric Services. R414-11.
Emergency services program for non-citizens	• Section I: General Information • 42 CFR 440.255
General information including: • Billing • fee for service and managed care • Member eligibility • Prior authorization • Provider participation	• Section I: General Information • Claims • Managed Care: Accountable Care Organizations • Utah Medicaid Prior Authorization Administrative Rules • Eligibility Requirements. R414-302. • Medicaid General Provisions. R414-301. • Program Benefits and Date of Eligibility. R414-306.

	• Utah Medicaid Program. R414-1.
Information including: • Anesthesia fee resources • Coverage and reimbursement resources • National correct coding initiative • Procedure codes with accompanying criteria and limitations	• Office of Coverage and Reimbursement Policy • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: • Medicaid Information Bulletins (Issued bimonthly) • Medicaid Provider Manuals • Utah State Bulletin (Issued on the 1st and 15th of each month)	• Utah Medicaid Official Publications • Utah State Bulletin
Laboratory services	• Social Security Act §1833 - Payment of Benefits • PART 493—LABORATORY REQUIREMENTS • Clinical Labs Center • Clinical Laboratory Improvement Amendments (CLIA) and Medicare Laboratory Services • CMS Clinical Laboratory Improvement Amendments (CLIA) • State Operations Manual • How to Obtain a CLIA Certificate

	• FDA Clinical Laboratory Improvement Amendments (CLIA) • CDC Clinical Laboratory Improvement Amendments (CLIA) • Utah Public Health Laboratory Clinical Laboratory Certification (CLIA) • Medicare Claims Processing Manual Chapter 16 - Laboratory Services • Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report • State Laboratories
Medicaid forms including: • Abortion Acknowledgement • Hearing Request • Hospice Prior Authorization Form • Hysterectomy Acknowledgement • PA Request • Sterilization Consent	• Utah Medicaid Forms
Medical supplies and DME	• Medical Supplies and Durable Medical Equipment Provider Manual • Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	• Section I: General Information
Patient (Member) Eligibility Lookup Tool	• Eligibility Lookup Tool
Pharmacy	• Drug Criteria Limits • Generic Prescriptions List

	• ICD-10 Reference Chart Pharmacy • Medicaid Pharmacy Program • OTC Drug List • Pharmacy Provider Manual • Medicaid Policy for Pharmacy Program. R414-60.
Prior authorization	• Prior Authorization Form • Utah Medicaid Prior Authorization
Provider portal access	• Provider Portal Access
Provider training	• Utah Medicaid Provider Training
Other	• Baby Your Baby • CDC Vaccines for Children Program • Dental, Oral Maxillofacial, and Orthodontia Provider Manual • Hospice Provider Manual • Medicaid.gov • Podiatric Services Provider Manual • Behavioral Health Services Provider Manual • RHC-FQHC Provider Manual • Vision Care Services Provider Manual • Women, Infants, and Children (WIC)
References including: • Social Security Act • Code of Federal Regulations • Utah Code	• 42 CFR 440.50 • Social Security Act 1905(a) • Social Security Act 1861 (r) • Utah Annotated Code Title 58
Tobacco cessation resources	• Utah Tobacco Quit Line (1-800-QUIT-NOW) • Way to Quit