SECTION 2

PHYSICIAN SERVICES MANUAL

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1 General Information

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

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

1-1 Physician Services

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

With the cooperation and advice of the Utah Medical Care Advisory Committee, the Department has established standards and regulations governing care for which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for reasonable and medically necessary services and supplies subject to the exclusions and limitations set forth in policy and Utah Administrative Code Title R414.

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

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

2 Health Plans

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

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid Mental Health Plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

3 Provider Participation and Requirements

Refer to Section I: General Information, Chapter 3, Provider Participation and Requirements.
4 Record Keeping

Refer to Section I: General Information, Chapter 4, Record Keeping.

5 Provider Sanctions

Refer to Section I: General Information, Chapter 5, Provider Sanctions.

6 Member Eligibility

Refer to Section I: General Information, Chapter 6, Member Eligibility, for information about how to verify a member’s eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member Responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements refer to Section I: General Information, Chapter 7, Member Responsibilities.

8 Programs and Coverage

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

8-1 Definitions

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

8-2 Emergency Services Program for Non-Citizens

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

8-4 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.

8-4.1 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).

8-4.2 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.

8-5 **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.

8-6 **Diabetes Self-Management Training**

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

**Requirements**

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

- Nationally recognized American Diabetes Association (ADA) certified diabetes educator [refer to http://www.diabetes.org] 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.

8-7 **Nutritional Counseling**

Nutritional counseling and an E/M are not covered for the same provider on the same date of service. Medicaid does not pay two E/M codes on the same date of service. The E/M service
may be billed with a prolonged service code to include the time for nutritional counseling with supportive documentation.

- Coverage of nutritional counseling for malnutrition or obesity is covered under code S9470 for pregnant adults (14 visits) and EPSDT eligible (unlimited)
- Benefits for coverage of initial and subsequent individual nutritional counseling CPT codes are limited to one hour each for pregnancy
- Adults who are not pregnant may receive one hour of initial and one subsequent hour of nutritional counseling for a BMI > 30 with supportive documentation
- EPSDT eligible members with malnutrition or a BMI ≥ 27 are covered with supportive documentation of medical necessity and progress

### 8-8 Tobacco Cessation Counseling

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

### 8-9 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.

#### 8-9.1 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.

8-9.2 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.

8-9.3 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.

8-9.4 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.

**8-9.5 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.

**8-9.6 Extended Services for Pregnant Women**

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

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

**8-9.6.1 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.
8-9.6.2 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.

8-9.6.3 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.

8-9.6.4 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.

### 8-9.6.5 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.

### 8-9.6.6 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.
8-9.6.7 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.

8-9.6.8 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.

8-9.7 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.

8-10 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.

8-10.1 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
8-11 Allergy Testing

Allergy skin testing is a clinical procedure that is used to evaluate an immunologic response to allergenic material. The number and type of antigens used for testing must be chosen judiciously given the patient’s presentation, history, physical findings, and clinical judgment.

In vitro testing (blood serum analysis): immediate hypersensitivity testing by measurement of allergen specific serum IgE in the blood serum, are useful when testing for inhalant allergens (pollens, molds, dust mites, animal danders), foods, insect stings, and other allergens such as drugs or latex, when direct skin testing is impossible due to extensive dermatitis, marked dermatographism, or in children younger than four years of age.

In vitro testing is covered when skin testing is not possible or would be unreliable; or in vitro testing is medically reasonable and necessary as determined by the physician. When in vitro testing is ordered, or performed, the medical record must clearly document the indication and why it is being used instead of skin testing.

In vitro testing is not covered when done in addition to a skin test for the same antigen, except in the case of suspected latex sensitivity, hymenoptera, or nut/peanut sensitivity where both the skin test and the invitro test may be performed. The number of tests done, choice of antigens, frequency of repetition and other coverages issues are the same as skin testing.

Testing must be based on a careful history/physical examination that suggests IgE medicated disease. Total Serum IgE is not appropriate in most general allergy testing. Instead, individual IgE tests are performed against a specific antigen.

The CPT code 86003 - Allergen specific IgE will require submission of medical record documentation to support medical necessity of IgE testing. Providers must provide documentation supporting the medical necessity including history of the suspected allergy, duration, severity, results of other allergy tests, any previous treatment of the disorder, and an attachment to the IgE testing that includes at least one of the following:

- Direct skin testing is impossible due to infancy, extensive dermatitis or the patient has marked dermatographism
- Patient is unable to discontinue medication (i.e. tricyclic antidepressant, prednisone, or beta blocker, antihistamine) that interferes with skin testing
- Direct skin testing is negative despite clinical indications of an allergic condition and specific IgE tests have been determined

Routine allergy re-testing does not meet the definition of medical necessity per the practice parameters and recommendations from the American College of Allergy, Asthma, and
8-12 Allergen Immunotherapy

CPT procedure code 95165 is used to report multiple dose vials of non-venom antigens. CPT code 95165 is defined as a one (1) cc aliquot from a single multidose vial. Providers should report the number of units representing the number of one (1) cc doses of antigen concentrate (extract) being prepared. The reporting unit is not any of the following: the number of antigens, the number of vials, the number of injection services that the patient is expected to receive, or the concentration of the antigen.

When reporting code 95165, providers should report the number of units representing the number of one (1) cc doses being prepared. A maximum of 10 doses per vial is allowed for reporting, even if more than ten preparations are obtained from the vial. In cases where a multidose vial is diluted, Medicaid shall not be billed for diluted preparations more than the 10 doses per vial allowed under code 95165.

No more than 20 units may be reported in a nine (9) month period. Injections are reported separately. Single injection dose allergen supervision and provision is a non-covered service.

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 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.

8-14 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, Rehabilitative Mental Health and Substance Use Disorder Services; and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.
8-15.1 Psychiatric Evaluations for Medical Procedures

Standard, comprehensive, psychiatric evaluations, performed by a qualified mental health professional, are required as part of the prior authorization process for certain medical procedures.

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.

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

Reconstructive or restorative services are only covered when medically necessary and performed on abnormal structures of the body to improve or restore bodily function or to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention. They are generally performed to improve function or treat a medical condition.

Cosmetic procedures performed solely for the purpose of improving appearance are not covered services, including non-medically necessary procedures that are performed in the same episode as a covered procedure when there was more than one purpose for the cosmetic procedure.

Reconstructive Breast Procedures Related to Cancer

Coverage includes reconstruction of the breast on which the procedure was performed, reconstruction of the breast on which the procedure was not performed to produce a symmetrical appearance, and prostheses. Reconstructive surgeries require prior authorization and are limited to initial occurrences including multi-step procedures to achieve the final result. Repeat procedures may only be approved based on medical necessity.

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.

9-8 **Hearing Screens for Infants**

Hearing screens for infants are limited to those under the age of one (1) year. The recommendation is to have the screening completed as soon as possible after birth. Payment methodologies for this screening are limited by the type of service provider covering the child, e.g., ACOs or fee for service.

9-9 **Radiation Therapy**

A treatment plan which is basically a mirror image will be reimbursed with one unit of payment (i.e. PA and AP of a specific site, right lateral and left lateral). Payment is limited to four plans (billed as units) per one anatomical site.

When over four units are billed, the documentation of all the plans over the course of treatment must be submitted for manual review. Exact duplicates will be denied. Secondary or sub-plans for the primary plan may be considered for additional payment.

Design blocks which are mirror images (i.e. AP and PA, right lateral and left lateral) are reimbursed with one unit of payment. There must be significant differences in the block design to warrant additional payment.

Payment is limited to 3 units per one anatomical site.
9-10  Intensity Modulated Radiation Therapy

IMRT requires manual review. The following information outlines the requirements:

- **IMRT is covered for:**
  - Malignant unresectable neoplasms of the head and/or neck
  - Stage III or IV nasopharyngeal or oropharyngeal cancer

- **If one or more of the following critical structures may be spared using IMRT:**
  - Brain stem
  - Optic nerve (e.g. ethmoid sinus tumor)
  - Prevention sensorineural hearing loss-ototoxicity (e.g. parotid gland tumor, medulloblastoma)
  - Carotid artery
  - Mandible
  - Salivary glands (e.g. nasopharyngeal tumor, IMRT results in less xerostomia)
  - Parotid glands
  - Cervical spinal cord

- For the Manual Review process, the physician must state in a summary document all of the following:
  - The planned site for treatment is not a moving organ (e.g. heart, lung, intestine)
  - Provide supportive clinical evidence based literature if site is not one of critical sites listed in number 1
  - The site of the malignant neoplasm is close to a critical tissue and stereotactic 3D-radiation will not be as effective as high precision IMRT in sparing specified essential surrounding tissue
  - Document that at least one of the following applies. (Provide documentation for all that apply):
    - Important dose limited structures are adjacent to, but outside of planned treatment volume area defined by CT or MRI images
      - Include CT or MRI reports with submitted documentation
      - Images must be available upon request
    - Immediately adjacent areas have been irradiated and area must be targeted with high precision
    - Gross tumor are concave, convex, or irregular and in close proximity to critical structures
  - The prescription treatment plan (CPT code 77301) must address the specific dose need for the target site and constraints with surrounding normal tissue

9-11  Fiber Optic Endoscopic Evaluation of Swallowing (FEES)

Fiber optic endoscopic evaluation of swallowing (FEES) is an alternative to modified barium swallow evaluation for patients at risk of aspiration (codes 92610, 92612, 92613).
Patients have one of the following conditions which have shown benefit from the procedure:

- Stroke or other central nervous system disorders which affect swallowing and speech
- Patients without an obvious CNS disorder with difficulty in swallowing, a clinical history of aspiration, or a history of aspiration pneumonia
- Presence of oral motor disorders with symptoms such as drooling for food or liquids placed in the mouth or oral food retention
- Lack of coordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting the ability to close the buccal cavity, bite, chew, suck, shape or squeeze a food bolus into the upper esophagus while protecting the airway
- To visualize the larynx directly for signs of trauma or neurologic damage and assess laryngeal competence post-surgery where the laryngeal nerve was vulnerable

- The diagnosis or clinical suspicion of aspiration currently must be present for the procedure to be considered medically necessary
- Medical record documentation must support the medical necessity and describe why the FEES procedure provides more information and benefit than barium swallow evaluation studies
- The results of FEES testing will impact the clinical decisions which affect the daily dietary management of the impaired patient and impact the E/M of therapy programs

Limitations and non-coverage:

- Services are limited to physicians, incident to services cannot be reported
- The procedure is not covered for routine screening, excessive frequency, or when performed in the absence of a specific sign or symptom supporting medical necessity
- The clinical effectiveness and applicability of the addition of sensory testing to the FEES procedure have not been determined, therefore, CPT codes 92614 through 92617 are non-covered services

### 9-12 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
9-13 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
- Treatment and evaluations of subluxation or flat feet
  - Treatment of flat foot is a condition in which one or more arches in the foot have flattened out
  - Surgical or nonsurgical treatments undertaken for the purpose of correcting a subluxated structure in the foot or devices directed toward care or correction of this condition, including prescription of supportive devices are not covered
- Surgical procedures for the reversal of previous elective sterilization, both male and female
- Infertility studies
- In-vitro fertilization
- Artificial insemination
- Surrogate motherhood, including all services, tests, and related charges
- Prolonged educational and counseling services beyond and those in included within the initial E/M service

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.

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