2023 Medicaid Statewide Provider Training

Health Care Policy

Utah Department of Health & Human Services

Agenda

- Dental
- Durable medical equipment/supplies
- Behavioral health services
- Physician services
- Hospital services
- Transportation
- General information
- Home based services
- Electronic Visit Verification

Dental

Dental hygienists

- Beginning January 1, 2023, dental hygienists may be reimbursed for services performed independently in a public health setting
- As of July 1, 2023 dental hygienists are no longer required to work under a written agreement or general supervision of a dentist
- Covered services available to the dental hygienist provider type are limited
    - Refer to the Coverage and Reimbursement Lookup Tool for information regarding code coverage

Endodontics

Rate Increase

An increased reimbursement rate for endodontic services was applied for CDT codes D3310, D3320, D3330 and D3410, effective August 1, 2022. These new rates are applied to Fee for Service and managed care dental providers who pay equal to or greater than the new rates. The increased rates are as follows:

Code	Previous Rate	8/1/22 Rate
D3310 - Anterior Root Canal	$232.86	$330.00
D3320 - Bicuspid Root Canal	$294.94	$394.00
D3330 - Molar Root Canal	$349.28	$487.00
D3410 - Anterior Apicoectomy	$176.97	$281.00

Resin-based composite restoration

Coverage

- Effective July 1, 2022, Medicaid now covers posterior resin-based composite restorations for EPSDT and pregnant members

Durable medical equipment/supplies

Automatic blood pressure monitor

Coverage

- Medicaid covers the purchase of an automatic blood pressure monitor when medically necessary
    - Reported under HCPCS code A4670 - automatic blood pressure monitor
- The monitor must be ordered by a qualified practitioner
- In-home monitoring of blood pressure readings must be required as part of a comprehensive treatment plan
- A unit limit of one every three years applies
- Refer to the Coverage and Reimbursement Lookup Tool for more information

Nutritional services

- The Medical Supplies and Durable Medical Equipment Services manual was updated as of July 1, 2022 to reflect the current coverage of medical foods and enteral formulas, including:
    - Clarification for providers concerning coverage of medical foods and enteral formulas for members with dual eligibility for Medicaid and the Utah Women, Infants, and Children (WIC) nutrition program
        - Medicaid is the primary payor for for dual eligible members
            - Formula must meets medical necessity criteria
            - Must meet policy criteria for coverage
- Clarification provided concerning coverage of medical foods and enteral formulas for the treatment of inborn errors of metabolism

Nutritional services

- Effective September 1, 2022, prior authorization requirements were removed from enteral formula products for members enrolled in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This includes products reported under the following HCPCS codes:
    - B4149—EF blenderized foods
    - B4150—EF complete w/intact nutrient
    - B4152—EF calorie dense>/=1.5Kcal
    - B4153—EF hydrolyzed/amino acids
    - B4154—EF spec metabolic non-inherit
    - B4155—EF incomplete/modular
    - B4157—EF special metabolic inherit
    - B4158—EF ped complete intact nut
    - B4159—EF ped complete soy based
    - B4160—EF ped caloric dense>/=0.7kc
    - B4161—EF ped hydrolyzed/amino acid
    - B4162—EF ped spec metabolic inherit

Behavioral health services

Autism spectrum disorder services

Manual update

- The Autism Spectrum Disorder (ASD) Services Provider Manual was updated on January 1, 2023. Changes to the manual include:
  - The style of the manual was changed to meet the style guidelines used for Utah Medicaid provider manuals
  - Unnecessary and redundant information was removed from the manual
  - Medicaid now accepts any standardized assessment tool used to diagnose the presence of ASD according to current DSM criteria
  - The PA requirement was removed for CPT 97151 - *Behavior identification assessment*
    - There continues to be limitations on the number of units a provider may report
  - HCPCS code H0032 has been opened for reporting of indirect case supervision services
    - Direct case supervision services will continue to be reported using CPT code 97155

Autism spectrum disorder services

Manual update continued…

Direct and indirect supervision services require the use of a modifier that indicates the credentials of the clinician performing supervision responsibilities

- Restrictions placed on services that may be performed by qualified clinicians have been changed to correspond with the licensing requirements detailed in applicable practice act rule
- Parent training reported using CPT 97156 may be performed with or without the child present
- Providers may request alternative service hour combinations
    - That equal less than 30 hours/week for ABA services performed by a behavior technician
    - That equal less than 29 hours every six month authorization period for behavior therapist services
- Progress data for ongoing ABA services previously reported in graphical format or utilizing specific assessment tools is no longer required
- Supervision and parent training may be performed by a behavior therapist via telehealth regardless of geographic location

Autism spectrum disorder services

Applied behavior analysis services for adults

- Effective July 1, 2023, applied behavior analysis (ABA) services will be a covered benefit for all eligible members with a diagnosis of autism spectrum disorder (ASD), regardless of age
    - The Autism Spectrum Disorder Services Provider Manual has been updated to remove references to these services being limited to EPSDT eligible members only

Behavioral health groups

As of November 2022, if the patient-to-provider ratio exceeds the limit established in the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual then the group may not be reported for any of the Medicaid members attending the group.

See the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual for more details.

Physician services

Gender dysphoria treatment services

- In accordance with SB 16, the Physician Services Provider Manual has been updated to address treating members with gender dysphoria
  - Chapter 8-20, *Gender Dysphoria Treatment* has been added
  - This new section includes the psychotherapy, pharmacy, and surgery policies for treating members with a gender dysphoria diagnosis

Radiation treatment delivery and management

Beginning January 1, 2022, Medicaid updated coverage of the radiation treatment delivery and management policy to align with CMS guidance. For complete criteria and requirements, see the Physician Services Provider Manual, Chapter 9-10, *Radiation Treatment and Management* and the Coverage and Reimbursement Lookup Tool.

Chapter 9-10, *Radiation Treatment and Management* explains:

- Treatment planning
- Simulation
- Simple or complex device and port reporting
- Treatment delivery, and
- Additional reporting guidance

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

- Reporting of CPT codes 77385 or 77386 is appropriate when reporting guidance and tracking performed in an outpatient hospital setting
- Reporting HCPCS codes G6015 and G6016 is appropriate when reporting guidance and tracking performed in a freestanding non-outpatient hospital facility setting

Diabetes Prevention Program (DPP)

- Effective July 1, 2022, Medicaid covers nationally recognized diabetes prevention services
- The Physician Services Provider Manual is updated to reflect the coverage of DPP services
- In order to participate in DPP, billing providers must:
    - Ensure they are actively enrolled with Utah Medicaid
        - Providers must obtain an NPI number in order to enroll and report services
    - Must be qualified to provide a CDC-recognized Diabetes Prevention Lifestyle Change Program
        - CDC preliminary and full recognition are encouraged but not required to enroll as a DPP 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
- Members must meet the eligibility requirements found in the Physician Services Provider Manual, Chapter 8-7, *Diabetes Prevention Program*
- DPP is reported with CPT codes 0403T and 0488T

Diabetes Prevention Program (DPP)

Coding Guidance

- **0403T** - Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum
    - 0403T is reported by a DPP organization delivering a standardized DPP curriculum in a group setting
    - Report CPT code 0403T once per day (this code cannot be reported in the same 30-day time period as CPT code 0488T)
    - Do not report with CPT codes 0488T, 98960, 98961, or 98962
- **0488T** - Preventive behavior change, online/electronic structured intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum
    - 0488T is reported by a DPP 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

Proprietary Laboratory Analysis Codes

On July 1, 2022, new chapters were added to the Physician Services Provider Manual, Chapter 8-12.4, *Proprietary Laboratory Analysis Codes* and the Hospital Services Provider Manual, Chapter 8-10.1, *Proprietary Laboratory Analysis Codes* to include information related to billing of these services.

In accordance with the American Medical Association (AMA) coding guidelines:

- PLA codes for proprietary laboratory services must be reported, when available, in place of corresponding CPT codes
- Do not report PLA codes with corresponding CPT codes
- If the PLA code is not available to be used by the billing laboratory, the CPT code should be billed

Peripheral Nerve Stimulators

- Two previously closed peripheral nerve stimulator CPT codes, 64555 and 64566, were opened for coverage on February 1, 2023
- The prior authorization requirement for peripheral nerve stimulator CPT codes 64553, 64561, 64568, 64569, 64575, 64580, 64581, 64582, 64583, 64585, 64590, and 64595 was removed as of February 1, 2023

Hospital services

Requirements for inpatient rehabilitation facility claims

On July 1, 2023, the Hospital Services Provider Manual was updated to include information regarding prior authorization and reporting of services for inpatient rehabilitation facilities.

Due to the advent of the PRISM claims processing system, the following requirements are no longer necessary for claims to process correctly:

- Prior authorization (PA)
- Reporting revenue code 0128

Transportation

UTA contract

- The UTA contract was renewed on July 1, 2022 and will run thru June 30, 2027
- Most of the contract will remain the same for UTA, with the exception of the move from punch cards, to electronic tap cards
- If you want additional information, please consult the link found in the Non-Emergency Medical Transportation webpage

Renewed non-emergency medical transportation contract with Modivcare

- Medicaid's contract with Modivcare was renewed on January 29, 2023 and runs through January 28, 2028
- Much of the contract was kept the same with one notable exception, medically necessary health care appointments now includes pharmaceutical trips
- To access non-emergency medical transportation resources through Modivcare, please reference the Medical Transportation Provider Manual, Chapter 1-4, *Modivcare*

Out-of-state transportation

- Out-of-state transportation includes transportation (air, ground, or water) from Utah to another state, or from another state back to Utah
- Coverage of out-of-state transportation requires meeting all the criteria found in the Medical Transportation Provider Manual, Chapter 12, *Out-of-State Transportation*
- Additionally, the Out-of-State Transportation Prior Authorization Request Form describes in detail the documentation requirements for the approval of an out-of-state transportation request

Out-of-state transportation

Coverage Criteria and associated documentation for an out-of-state transportation request.

- A letter of medical necessity from the referring provider that includes:
  - The service requiring transportation is a Medicaid covered service;
  - The service is medically necessary, the out-of-state provider and/or facility is/are the nearest that can perform the service; or
  - It is the general practice for Medicaid members in a particular locality to use the medical resources in another state.
- Medical records supporting the letter of medical necessity
- Letter of acceptance from the facility that will be accepting the member
- Letter of acceptance from the physician who will be treating the member (including contact information)
- Treatment proposal (this can be included in the physician acceptance letter)

Transportation modifiers

- To align with National Correct Coding Initiative, Utah Medicaid updated policy to remove two-digit, numeric modifiers used for non-emergent medical transportation
- Instead, Medicaid will adopt the same two letter, alphabetic modifiers that had been only previously used for emergency transportation
- A table describing these alphabetic modifiers can be found in the Medical Transportation Provider Manual, Chapter 10, *Non-Emergency Transportation Procedure Code Modifiers*, and on the next slide

Transportation modifiers table

Code	Location
D	Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related
H	Hospital
I	Site of transfer (e.g., airport, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled nursing facility
P	Physician’s office
R	Residence
S	Scene of an accident or acute event
X	(Destination code only) intermediate stop at a physician’s office on the way to a hospital

General information

Refugee Medicaid

- The Section I: General Information Provider Manual has been updated to add Chapter 8-2.12, *Refugee Medicaid*
- This new section clarifies the services available to refugees and the timeline associated with the availability of those services

Language removal

- The Section I: General Information Provider Manual has been updated to remove language regarding the coverage of weight gain and hair growth medications
- The language was removed from Chapter 9-2, *Services Not Covered Regardless of Medical Necessity*
- More information can be found in Utah Administrative Rule R414-60-5, Medicaid Policy for Pharmacy Program, *Limitations*

Qualifying clinical trials

In December 2021, the Centers for Medicare and Medicaid Services (CMS) issue a letter to all state Medicaid directors, outlining a new Medicaid state plan requirement to assure coverage of routine patient costs associated with participation in qualifying clinical trials. This was due to the creation of Section 210 of the Consolidated Appropriations Act, 2021 which amended Section 1905(a) of the Social Security Act. To meet this requirement, the Utah Medicaid State Plan was updated, as well as certain Medicaid provider manuals and Utah Administrative Rule.

On July 1, 2022, the Section I: General Information Provider Manual, Chapter 9-3.3.1, *Qualifying Clinical Trials* was created to outline the parameters of the Consolidated Appropriations Act, 2021.

CMS created the Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form and Utah Medicaid follows the requirements outlined therein.

A Qualifying Clinical Trials and Medicaid FAQ is on the Utah Medicaid website under the Provider Resources and Information tab for member and provider guidance.

LOA days for members residing in a SNF, ICD/IID, or USDC

PRISM programming regarding Leave of Absence (LOA) days for Medicaid members who are residents in a Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or the Utah State Development Center (USDC) has been updated as follows:

- The allowable days to receive payment for therapeutic or rehabilitative LOA days will continue to be limited to 12 days per calendar year for each member in any SNF
    - Payment for additional LOA days may be authorized through the prior authorization process
- The allowable days to receive payment for therapeutic or rehabilitative LOA days will be changed to 100 days per calendar year for each member in an ICF/IID
    - Payment for additional LOA days may be authorized through the prior authorization process
- The allowable days to receive payment for therapeutic or rehabilitative LOA days will be changed to 25 LOA days per calendar year for each member in the USDC
    - Payment for additional LOA days may be authorized through the prior authorization process

LOA days for members residing in a SNF, ICD/IID, or USDC

When submitting a claim for LOA days providers must bill for the allowable LOA days (not to exceed 12 for SNF, 100 for ICF/IID, 25 for USDC) by using Occurrence span code 74. These allowable days will be calculated by using the residents Medicaid ID number and the provider ID number.

When billing for the additional, prior authorized, LOA days for members residing in a SNF, ICF/IID, or USDC, providers must append the following to the claim:

- Occurrence span code 74
- Revenue code 0183
- HCPCS code A9270
- The prior authorization number

LOA days for members residing in a SNF, ICD/IID, or USDC

- When the allowable LOA days for any SNF, ICF/IID, or USDC are exhausted, more LOA days for therapeutic or rehabilitative purposes may be requested through the prior authorization (PA) process
- To request additional LOA days, providers must contact their Resident Assessment nurse by calling the main Medicaid hotline at (801) 538-6155 or 800-662-9651 then choose option 3, option 3 again, then choose the correct nurse from those mentioned

Home-based services

Private duty nursing

Effective July 1, 2023, private duty nursing (PDN) maximum daily hours have been increased to maximum allowable covered hours per day from 15 to 18 hours and the acute care coverage has been increased from 2-3 days to up to 14 days in the Home Health Services Provider Manual and PDN Acuity Grid forms.

- Increase in both ‘acute care’ and ‘continuous care’ PDN services
- ‘Acute care’ PDN coverage will allow for up to 24-hour care for up to 14 days
- ‘Continuous care’ PDN will allow for up to 18 hours per date of service

Medicaid is currently assessing the current acuity grid scoring system to make changes to policies considering the need of members receiving these services.

Score	Maximum allowable covered hours per day
21-35	up to 12 hours per day
36-45	up to 14 hours per day
46-51	up to 16 hours per day
56+	up to 18 hours per day

Out-of-state provider telehealth services

A non-resident provider may report telehealth services given to an in-state Medicaid member when the following conditions are met:

- The provider meets the licensing requirements of the Department of Professional Licensing (DOPL) as outlined in Utah Annotated Code 58-1-302.1
- The provider is enrolled as a Utah Medicaid provider

For more information see the Section I: General Information Provider Manual, Chapter 8-4.2, *Telehealth*

Telehealth

Medicaid telehealth policy has been updated to reflect the following:

- Enhanced definitions for telehealth services
- Best practices for implementation of telehealth services
- Coding and reporting standards
- Clearer definitions of synchronous and asynchronous services
- Clinical appropriateness for audio-visual and audio-only telehealth

Hospice services update

Hospice updates included restructuring the Hospice Care Services Provider Manual as much as possible for provider ease, removing redundancies from the rule and the CFR, and adding the following, high level, sections from the rule to the manual:

- The requirement that individuals in hospice care for more than 18 consecutive months require a utilization review present in R414-14A-5, *Service Coverage* was removed from rule and added to the manual under Chapter 10, *Prior Authorization*
- Transferred R414-14A-6, *Hospice Election* to the manual for operational purposes
- Transferred R414-14A-8, *Revocation and Re-election of Hospice Services* to the manual for operational purposes
- Transferred R414-14A-11, *Notice of Hospice Care in Nursing Facility, ICF/ID, or Freestanding Clinic* to the manual for operational purposes
- Transferred R414-14A-12, *Notice of Independent Attending Physician* to the manual for operational purposes
- Transferred R414-14A-20, *Notification and Prior Authorization Grace Periods* to the manual for operational purposes
- Transferred R414-14A-23, *Payment for Hospice Care Categories* to the manual for operational purposes
- Transferred R414-14A-24, *Payment for Physician Services* to the manual for operational purposes
- Transferred R414-14A-28, *Medicaid Health Plans and Hospice* to the manual for operational purposes
- Transferred R414-14A-30, *Medicaid 1915c HCBS Waivers and Hospice* to the manual for operational purposes

Hospice services update

Additionally, hospice updates included the few prominent policy points identified below:

- The definition of “consecutive months” was removed from Chapter 8-1, *Definitions*
- The “cap period” end date was updated to align with the parameters outlined in the Code of Federal Regulations (CFR) 42 CFR 418
- Hospice providers are now required to report the location of where services are rendered to ensure appropriate reimbursement
- Removed Chapter 8-2.1, *Managed Care Entities (MCE)*, Chapter 13-1, *Hospice Care Rates*, and Chapter 13-2, *Date of Discharge* due to duplicative information found in the CFR
- Removed the “independent physician review” section of Chapter 10, *Prior Authorization*

Electronic Visit Verification

What is Electronic Visit Verification (EVV)?

- EVV is a system that includes multiple point-of-care verification technologies, such as telephonic, mobile, and web-based verification inputs
- The system electronically verifies the occurrence of home or community based service visits, identifying the precise time that service provision begins and ends to ensure accurate claims disbursement
- All personal care services (PCS) and home health services (HHS) are required to capture and submit an Electronic Visit Verification record
- Providers may choose the EVV system that best meets their needs as long as the system meets federal and state requirements

EVV record submission FAQs

Question: Which providers need to capture and submit EVV records?

Answer: All providers that provide personal care services or home health services. A list of applicable service codes can be found in the EVV Provider Training.

Question: When do I submit EVV records?

Answer: EVV Records should be submitted within three months of submitting the claim for payment.

Question: How do I submit EVV records?

Answer: EVV records can be submitted via API or CSV. Refer to medicaid.utah.gov/evv for detailed instructions on how to structure the submitted files.

Question: What if I don't submit EVV records?

Answer: Each provider will be audited annually. Financial penalties are assessed for non-compliance.

Contact the EVV team by email at: dmhf_evv@utah.gov

Contact us

For additional questions, please email:
dmhfmedicalpolicy@utah.gov