2022 Medicaid Statewide Provider Training

Claims & Billing

Agenda

Please note this training is for the current system and billing procedures and policies. PRISM trainings will be provided later this year.

Please submit your questions in the chat and we will address them in the Q&A at the end of the presentation

- ❖ EDI
- ❖ Coordination of Benefits
- ❖ Corrected Claims
- ❖ Fee Schedule
- ❖ Billing Modifiers
- ❖ Modifier 24 & 25
- ❖ Denials
- ❖ Hospital Claims
- ❖ Medical Documentation
- ❖ Appeals
- ❖ What's New
- ❖ Q&A

State Agency Consolidation

Utah DHHS Plan:
https://sites.google.com/utah.gov/hhsplan/home

The Executive Office of the Governor and legislature supported the passage of H.B. 365 State Agency Realignment during the 2021 general legislative session.

The statute directs the consolidation of the state's two primary social service agencies: the Utah Department of Health (UDOH) and Department of Human Services (DHS), creating the Utah Department of Health and Human Services by July 1, 2022.

A small piece of Medicaid eligibility components will move from the Department of Health to the Department of Workforce Services (DWS). These functions include Medicaid Eligibility Quality Control (MEQC) and eligibility adjudications.

Division of Integrated Care

The Utah Department of Health and Human Services (DHHS) is designated by the Centers for Medicare and Medicaid Services (CMS) as the “Single State Agency” to administer and supervise the administration of the State’s Medicaid program.

The Division of Integrated Healthcare (DIH), within the DHHS, is responsible for implementing, organizing, and maintaining the Medicaid program and the Children’s Health Insurance Program (CHIP).

OMO
Office of Medicaid Operations

OMO - Office of Medicaid Operations

- Comprised of multiple teams overseeing multiple programs, including:
  - Customer Service
  - EDI
  - Document Control
  - Emergency Services Program for Non-Citizens and Manual Review
  - Special Projects
  - Provider Enrollment
- Functions
  - Ensure timely and accurate claims processing
  - Addresses questions and assists providers and members
  - Responsible for receiving, researching and associating documentation to claims for policy review and hearing requests and adjudicating claims per the results of those reviews

EDI

Electronic Data Interchange (EDI)

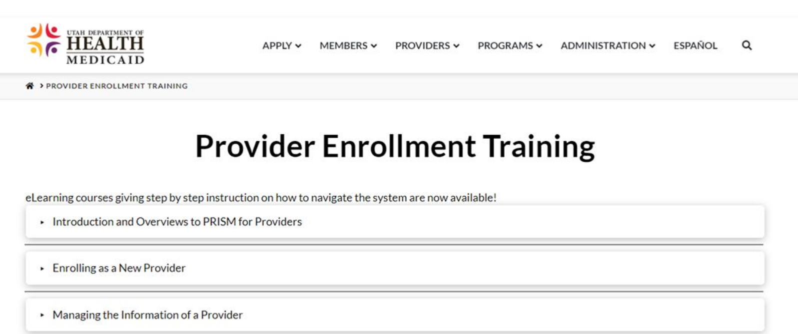
- Provider enrolls Trading Partner Number (TPN) by completing the EDI enrollment through PRISM
    - Provider selects the clearing house they use
        - UHIN - Utah Health Information Network is most widely used
    - Provider selects which EDI transaction(s) they are enrolling for

Electronic Data Interchange (EDI)

- Medicaid Trading Partner Numbers
  - HT000004-001 – Fee for Service
  - HT000004-005 – Crossovers
  - HT000004-801 - Atypical Providers

Electronic Data Interchange (EDI)

- For eLearning training materials on how to enroll as a Medicaid provider visit:
  - https://medicaid.utah.gov/pe-training/



Electronic Data Interchange (EDI)

UTAH SPECIFIC TRANSACTION INSTRUCTIONS(Companion Guides)

HIPAA transaction and code set requirements are outlined in the National Electronic Data Interchange Transaction Set Implementation Guides. Companion guides have been created outlining supplemental requirements specific to Utah Medicaid, as permitted within the structure of the HIPAA transaction sets. The guides will be updated as implementation of each transaction occurs. The most current version will be available on the website. All providers who submit claims electronically to Utah Medicaid must adhere to the HIPAA Implementation Guide, the Utah Specific Transaction Instructions (Companion Guide), and policy contained in the provider manuals.

- 837D Health Care Claim: Dental
- 837I Health Care Claim: Institutional
- 837P Health Care Claim: Professional
- 835 Health Care Claim Payment/Advice
- 270/271 – Health Care Eligibility Benefit Inquiry & Response
- 276/277 – Health Care Claim Status Request & Response
- 837 – Encounter Records (Professional, Institutional, Dental)

Visit: https://medicaid.utah.gov/hipaa/providers/#companion-guides

Coordination of Benefits

Coordination of Benefits

COORDINATION OF BENEFITS INSTRUCTIONS FOR ELECTRONIC CLAIMS

- Before submitting a claim to Medicaid, a provider must submit and secure payment from all other liable parties such as Medicare Part A and B
    - For more information, refer to the Medicaid General Information Section 1, Chapter 11
- Claims denied from Medicare as non-covered services should be submitted to Medicaid Fee for Service, not to the crossover mailbox
- If the primary payer made line level payments on the claim, please report line level data in addition to the claim level data to Medicaid

Coordination of Benefits

- Medicaid is the payer of last resort
- Reimbursement for crossover claims or other TPL will be limited to the Medicaid Fee Schedule for all types of service, including FQHC and Indian Health Services
  - HT000004-001 Medicaid Fee For Service electronic mailbox
  - HT000004-005 Utah Medicaid Crossovers (NOT when Medicare denies as non-covered) electronic mailbox
    - Corresponding EOB for Zero Pay from Medicare go to fax (801) 323-1584, not to ORS
    - Corresponding EOB for Zero Pay for other than Medicare goes to ORS fax (801) 536-8513

Corrected Claims

Criteria Resources

- Providers should submit their own corrections to claims less than three years old by submitting either a replacement or void claim
- The data elements needed to identify a replacement or void claim are:
  - Claim Frequency Code (7 For Replacement, 8 For Void)
    - Electronic: X12 Element 2300 CLM05-3
    - Paper: UB04 - Form Locator 4, Position
    - CMS1500 - Box 22 (Code)
  - Transaction Control Number (TCN) of original claim to be replaced/voided
    - Electronic: X12 Element 2300 REF02
    - Paper: UB04 - Form Locator 37 A-C
    - CMS1500 - Box 22 (Original transaction control number)

Fee Schedule

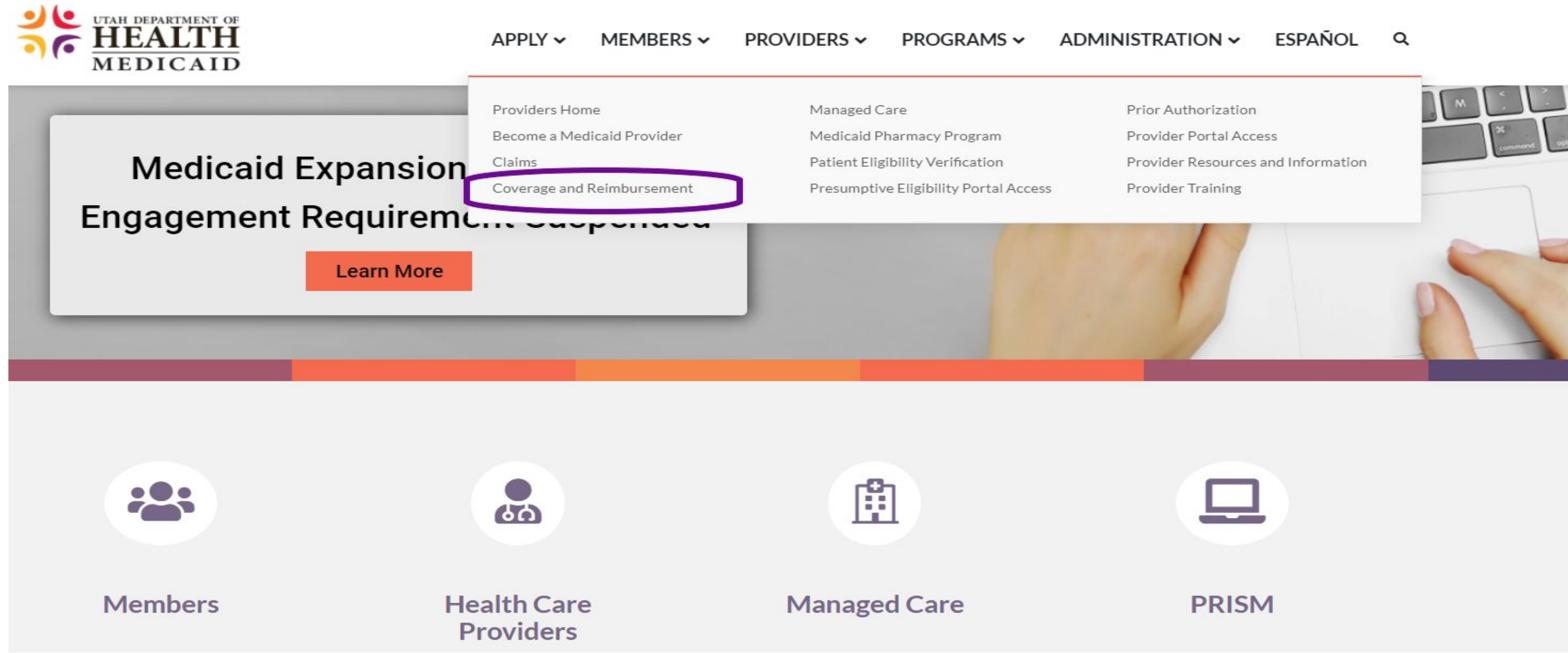
Coverage & Reimbursement Look-Up Tool

Specific coverage policy for 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

- Providers may also download various fee schedules by:
  - Plan Type
  - Provider Type
  - Provider Pricing File
  - HCPCS/NDC Crosswalk
  - Revenue Code by Plan Type

Coverage & Reimbursement Look-Up Tool



https://medicaid.utah.gov

Coverage & Reimbursement Look-Up Tool

APPLY MEMBERS PROVIDERS PROGRAMS ADMINISTRATION ESPAÑOL

› COVERAGE AND REIMBURSEMENT

Coverage and Reimbursement

Coverage and Reimbursement Look-up Tool

Coverage and Reimbursement Policy Resources

Criteria

Medicaid Health Information Technology (HIT) Incentive Payment Program

https://medicaid.utah.gov

Coverage & Reimbursement Look-Up Tool

Bureau of Healthcare Policy and Authorization

Coverage and Reimbursement Code Lookup

IMPORTANT NOTICE

Utah Medicaid is committed to ensuring our members continue to receive products and services with no interruptions or delays due to the novel coronavirus (COVID-19) outbreak. In response, Utah Medicaid is temporarily modifying certain policy conditions to allow for increased quantity limits for those medical supplies that are refilled on a monthly basis. This action is not intended to allow for unnecessary stockpiling of medical supplies but rather to help those vulnerable populations that have been directed to limit contact with other persons as part of the CDC guidance for "social distancing" or when required to be quarantined due to an active infection. Furthermore, PA requirements have been removed from CPAP, BiPAP, and sip and puff equipment in order to increase the ease of access to these items when determined to be medically necessary by a physician as outlined in the Utah Administrative Code R414-10-2(3).

The information provided by this lookup tool does not guarantee reimbursement, but is intended to provide coverage and reimbursement information for selected procedure codes as of the "Updated On" date specified in the search results. For additional information regarding specific billing requirements and coverage or rates not managed in this Lookup tool, please consult the Medicaid Provider Manuals or contact us.

This fee schedule does not apply to hospital outpatient services paid under the Outpatient Prospective Payment System (OPPS), Indian Health Services (IHS), School Based Skills Development (SBSD), nor does it apply to Utah's 1915(c) HCBS waivers. Medicaid covered claims adjudicated through OPPS will be paid according to the applicable Medicare fee schedule, IHS providers are generally paid using the All-Inclusive Rate (please refer to the Indian Health provider manual for more specifics) and 1915(c) HCBS waiver providers should refer to the appropriate waiver-specific fee schedule.

https://medicaid.utah.gov

Billing Modifiers

Modifiers for Waiver Programs

- U2 – Medically Complex Children’s Waiver
- U3 - Aging Waiver
- U4 - Physical Disabilities Waiver
- U5 - Acquired Brain Injury Waiver
- U6 - Community Supports Waiver
- U7 - Technology Dependant Waiver
- U8 - New Choices Waiver
- U9 - Limited Supports Waiver

Modifier Used In A Claim

*All modifiers are subject to manual review

- Modifier 22 - Unusual procedural services (Manual Review required)
- Modifier 24 - Unrelated E&M service during a post-op period (Manual Review required)
- Modifier 25 - Significant, separately identifiable E&M
- Modifier 26 - Append only for the professional component of a service
- Modifier TC - Append only for the technical component of a service
- Modifier 27 - Multiple outpatient hospital E&M encounters on the same day (Not recognized by Medicaid)
- Modifier 50 - Bilateral procedures (Not recognized by Medicaid - use instead Modifier LT/RT)
- Modifier 51 - Multiple procedures
- Modifier 52 - Reduced service - paid at 50% of established fee schedule
- Modifier 53 - Discontinued procedure - paid at 50% of established fee schedule
- Modifier 54 - Surgical care only - paid at 70% of established fee schedule
- Modifier 55 - Post-operative management only - paid at 20% of established fee schedule
- Modifier 56 - Pre-operative management only - paid at 10% of established fee schedule

More detailed information can be found in the Utah Medicaid Provider Manual: Section 1 Chapter 12-7.3

Modifier Used In A Claim

*All modifiers are subject to manual review

- Modifier AS - NEW - PA or NP assistant at surgery - paid at 20% of established fee schedule
- Modifier 81 - Minimal assistant at surgery - Medicaid does not reimburse services reported with modifier 81
- Modifier 82 - Minimal surgical assistance is needed but qualified resident not available - Medicaid does not reimburse services reported with modifier 82
- Modifier 91 - Separate services for a distinct medical purpose (manual review required)

More detailed information can be found in the Utah Medicaid Provider Manual: Section 1 Chapter 12-7.3

Modifier 24 & 25

Claims submitted with modifier 24 require the submission of documentation substantiating correct reporting of an Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period and qualifies for manual review. The provider may need to indicate that an E/M service was furnished during the postoperative period of an unrelated procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

Additionally, modifier 24 is appropriately applied when it is used for anesthesia pain management service reporting. Documentation must include when the epidural or block injection is given relative to the general anesthesia.

Reporting Modifier 24

Claims submitted with modifier 25 require the submission of documentation substantiating correct reporting of a Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician or Other Qualified HealthCare Professional on the Same Day of the Procedure or Other Service and qualifies for manual review.

Medicaid considers an E/M as a significantly separately identifiable service when the provider may need to indicate that on the day of service, the member's condition required an E/M above and beyond the other services provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the service was provided and therefore does not require a different diagnosis when reporting.

Reporting Modifier 25

Claim Denials

Claim Denial Codes

Claim Denial Codes List

https://medicaid.utah.gov/Documents/pdfs/ClaimDenialCodes.pdf

Hospital Claims

- The Hospital Services Manual Chapter, 13-2 *Inpatient Hospital Three-Day Admission Policy* has been updated.
- If an admitting hospital furnishes services in an outpatient setting up to three days before an inpatient admission, Medicaid will incorporate the outpatient services into the DRG determination for the inpatient reimbursement. Medicaid defines this as the Three-Day Admission policy.
- *For example, if a member is admitted to an inpatient hospital on a Wednesday, services performed on the previous Sunday, Monday, or Tuesday would be considered part of the inpatient services.*
- The Three-Day Admission policy only applies to acute inpatient hospital admissions.
- Preadmission services furnished within the admission window that are determined not clinically related to an inpatient admission are not subject to the Three-Day Admission DRG payment policy.

Inpatient Hospital Three-Day Admission Policy

- Due to the limitations of Utah's current Medicaid claims processing system, there are instances when an entire claim will deny as a result of a single denied line. For example, a claim is denied when a single line is a non-covered service. This can occur when a claim is submitted for a service requiring prior authorization, but the hospital or other provider did not obtain prior authorization.

- To allow payment for covered services, when non-covered services have also been delivered, Medicaid requires acute inpatient hospitals to submit claims that include covered services and exclude non-covered services that would otherwise result in denial of the entire claim. In addition, when a claim is submitted that excludes non-covered services, providers must not include any ICD-10-PCS, CPT, HCPCS, or revenue codes related to the non-covered services.

- Additionally, if admission to an acute inpatient hospital is primarily to receive services not covered by Medicaid, all services performed for that episode of care are non-covered and will not be reimbursed. This policy applies regardless of whether or not Medicaid would have covered some of the services performed.

- When reporting claims related to inpatient hospital intensive physical rehabilitation services, providers must use revenue code 0128 - Room & Board-Semiprivate (Two-Beds)-Rehabilitation on the first line of the UB-04 claims submission form to identify the inpatient hospital intensive physical rehabilitation claim.
- Additionally, providers must make sure that the prior authorization number permitting services is on the claim. Failure to have revenue code 0128 or the prior authorization number will result in a denial of coverage.

Inpatient Rehabilitation Facility Claims Submissions

Medical Note Guidelines

Record Keeping

- The Utah Department of Health and Human Services, Division of Integrated Healthcare, follows the provisions of the Government Records Access and Management Act (GRAMA) in classifying records and releasing information
- Medicaid providers must comply with all disclosure requirement in 42 CFR 455, Subpart B, such as those concerning practice ownership and control, business transactions, and persons convicted of fraud or other crimes
- Every provider must comply with the following rules regarding records noted in Section I: General Information, Chapter 4, on the Utah Medicaid website https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf

Record Keeping

Providers are required to maintain accurate clinical records and are subject to audits in which findings could result in the recoupment of payment from the provider. It is the provider’s responsibility to maintain accurate clinical records including:

- Keep progress notes applicable to the date of service
- Maintain and update each individual's plan of care
- Document specific tasks performed on date of service
- Document services billed, number of units billed should support units documented
- Keep record of physician's order
- Submit record keeping documentation as requested by the department or under the direction of an audit

Refer to Section I: General Information, Chapter 4, on the Utah Medicaid website https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf

Medical Note Guidelines

When submitting documentation for Manual Review, Emergency Services Program for Non-Citizens, Sterilization Consent Forms, Timely Filing, Provider Preventable Conditions, etc.:

- Submit ONLY the minimum necessary documentation for review of the requested claim/episode of care
- Current forms for review requests MUST be used or they will be returned to you
    - See following slides for guidance on where to find forms

Appeals

Appeals vs. Reviews

Appeals:

- Grievances
- Fair Hearing Requests
- Appeals of Adverse Benefit Determinations

Reviews:

- Documentation requests for manual review of claims
  - Manual Review of CPT codes, modifiers, edits
  - Emergency Services Program for Non-Citizens

Grievances, Appeals & Hearings

States are required to have a fair hearing system that complies with the provisions of 42 CFR 431, Subpart E. The Department's administrative hearing procedures are described in Utah Administrative Code R410-14.

A provider can request a hearing to challenge an action. An **Action** is defined as:

- a denial, termination, suspension, or reduction of medical assistance for a recipient
- a reduction, denial or revocation of reimbursement for services for a provider
- a denial or termination of eligibility for participation as a provider
- a determination by skilled nursing facilities and nursing facilities to transfer or discharge residents
- an adverse determination, meaning a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does not require specialized services
- an adverse benefit determination made by an MCE (see next slide)

The purpose of the fair hearing will be to determine whether the Action taken was in accordance with Medicaid policy. Requests for a hearing, other than those challenging an adverse benefit determination made by an MCE, must be filed within **30 calendar days** of the date the Department sent the provider notice of its intended action. Request for Hearing forms can be found on the Department's website.

Grievances, Appeals & Hearings

MCEs are required by federal regulations to have a Grievance and Appeals System.

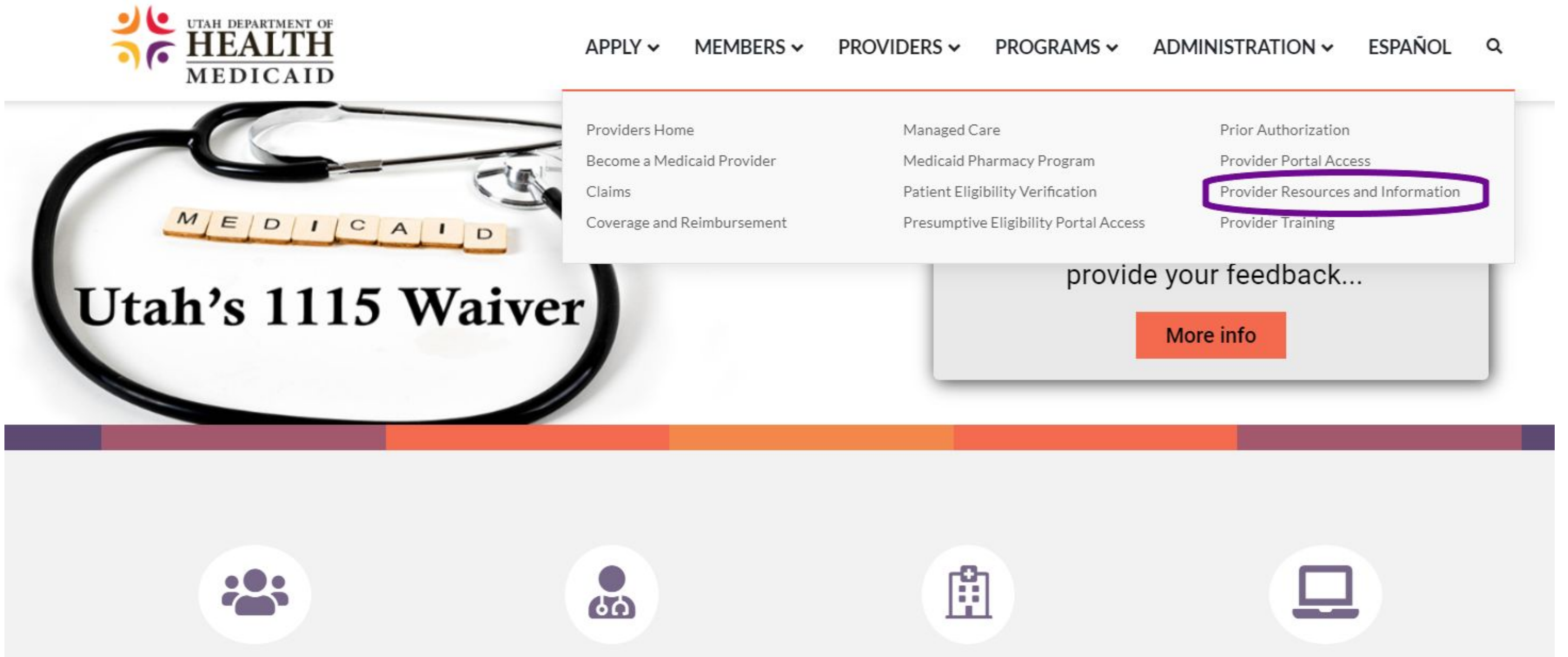
Appeals of Adverse Benefit Determinations: An appeal is a review by an MCE of an adverse benefit determination (ABD). ABDs include, but are not limited to MCE's denying payment in whole or part, denying or limiting authorization of a requested service, etc.

- If an MCE makes an ABD, the MCE must send notice of the ABD explaining how to request an appeal of the ABD. An appeal request must be filed with the MCE within 60 calendar days from the date on the notice of the ABD.
- If the MCE's appeal decision is adverse, a State fair hearing with the Medicaid agency may be requested. A hearing must be requested within 120 calendar days from the date of the MCE's notice of ABD resolution.

Grievances: A grievance is an expression of dissatisfaction about any matter other than an ABD. Grievances may include, but are not limited to the quality of care or services provided by the MCE, rudeness of MCE providers or employees, failure to respect Medicaid member's rights, etc.

- Grievances may be filed with the MCE at any time. MCEs must address the grievance within 90 calendar days from the date the MCE receives the grievance.

Medicaid Forms



https://medicaid.utah.gov/

Medicaid Forms

Provider Resources and Information

Manuals

Medicaid Information Bulletins (MIBs)

Contact Information for Providers

Utah Administrative Rule R414-23 – Provider Enrollment

https://medicaid.utah.gov/forms-providers/

Medicaid Forms

Forms for Providers

The forms are updated on a quarterly basis when necessary. They have been alphabetized for your convenience. If you have questions, call Medicaid Information at (801) 538-6155 or 1-800-662-9651.

Provider Form Directory

For examples on properly filling out paper claim forms, click here.

https://medicaid.utah.gov/forms-providers/

Medicaid Forms

Utah Medicaid Forms

The forms below are updated on a quarterly basis when necessary. They have been alphabetized for your convenience. If you have questions, contact the webmaster or call Medicaid Information at (801) 538-6155 or 1-800-662-9651.

If you are a Medicaid member, you can access literature, forms, and other publications at the Utah Medical Benefits website; click here.

Adobe Acrobat Reader DC

If you have comments or questions, need hard copies or archived official Medicaid materials, please email MedicaidOps@utah.gov.

Directory Contents

Filename	Type	Size (bytes)	Date Modified
10A-preadmission.pdf	10A-PREADMISSION.PDF File	53,261	May 21 2021 10:07 AM
2021-04-05 Utah Medicaid Initial Wheelchair Evaluation Form.pdf	2021-04-05 UTAH MEDICAID INITIAL WHEELCHAIR EVALUATION FORM.PDF File	1,444,972	May 21 2021 10:07 AM

https://medicaid.utah.gov/utah-medicaid-forms/

Managed Care

Managed Care

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid and CHIP managed care provides for the delivery of health benefits and additional services through contracted arrangements between the Department and Managed Care Entities (MCE).

Medicaid Managed Care Programs:

- ACO - Accountable Care Organizations (physical health)
- UMIC - Utah Medicaid Integrated Care (physical health and behavioral health)
  - Only in five counties: Weber, Davis, Salt Lake, Utah, and Washington counties
- HOME - Healthy Outcomes, Medical Excellence (physical health and behavioral health)
- Dental
- PMHP - Prepaid Mental Health Plans (behavioral health)

CHIP Managed Care Programs:

- MCO - Managed Care Organizations (physical health and behavioral health)
- Dental

For more information and latest managed care information, please visit https://medicaid.utah.gov/managed-care/

Managed Care Entity Contact Information

Managed Care Plan Name	Plan Type	Phone	Website
Health Choice	ACO/UMIC	1-877-358-8797	www.healthchoiceutah.com
Healthy U	ACO/UMIC	1-833-981-0212	www.uhealthplan.utah.edu/medicaid
Molina Healthcare of Utah	ACO/UMIC/CHIP	1-888-483-0760	www.molinahealthcare.com
SelectHealth Community Care	ACO/UMIC/CHIP	1-800-442-3234	www.selecthealth.org/plans/medicaid
HOME Program	HOME	1-800-824-2073	healthcare.utah.edu/uni/programs/home/
MCNA Dental	Dental	1-844-904-6262	www.MCNAUT.net
Premier Access Dental	Dental/CHIP Dental	1-877-541-5415	www.premierlife.com/utmedicaid

PMHP Contact Information and Area

County	Inpatient & Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
Box Elder, Cache, Rich	Bear River Mental Health 1-800-620-9949; 435-752-0750	Fee-for-Service Network (any Medicaid provider), including Bear River Health Department: 435-792-6500
Beaver, Garfield, Kane, Iron, Washington	Southwest Behavioral Health Center 1-800-574-6763; 435-634-5600 (hospital prior authorization: 435-705-1388)	Southwest Behavioral Health Center 1-800-574-6763; 435-634-5600
Carbon, Emery, Grand	Four Corners Community Behavioral Health 1-866-216-0017; 435-637-7200 (hospital prior authorization: 435-637-2358 & after hours: 435-637-0893)	Four Corners Community Behavioral Health 1-866-216-0017; 435-637-7200
Daggett, Duchesne, Uintah, San Juan	Northeastern Counseling Center 1-844-824-6776 435-789-6300 – Vernal 435-725-6300 – Roosevelt San Juan Counseling – San Juan County 1-888-833-2992; 435-678-2992	Northeastern Counseling Center 1-844-824-6776 435-789-6300 – Vernal 435-725-6300 – Roosevelt San Juan Counseling – San Juan County 1-888-833-2992; 435-678-2992
Davis	Davis Behavioral Health 1-844-305-4782; 801-773-7060	Davis Behavioral Health 1-844-305-4782; 801-773-7060
Piute, Juab, Wayne, Millard, Sanpete, Sevier	Central Utah Counseling Center 1-800-523-7412; 435-283-8400; 1-877-469-2822	Central Utah Counseling Center 1-800-523-7412; 435-283-8400; 1-877-469-2822
Salt Lake	Salt Lake County Division of Behavioral Health Services/Optum Salt Lake County: 385-468-4707; Optum: 1-877- 370-8953	Salt Lake County Division of Behavioral Health Services/Optum Salt Lake County: 385-468-4707; Optum: 1-877- 370-8953
Summit	Healthy U Behavioral 1-833-981-0212; 801-213-4104	Healthy U Behavioral 1-833-981-0212; 801-213-4104
Tooele	Optum Tooele County 1-800-640-5349	Optum Tooele County 1-800-640-5349
Utah	Wasatch Behavioral Health 1-866-366-7987; 801-373-4760 (prior approvals: 801-494-0880)	Wasatch Behavioral Health 1-844-773-7128; 385-268-5000
Wasatch	Fee-for-Service Network (any Medicaid provider), including Wasatch County Family Clinic/Wasatch Behavioral Health - 435-654-3003	Fee-for-Service Network (any Medicaid provider), including Wasatch County Family Clinic/Wasatch Behavioral Health, 435-654-3003
Weber, Morgan	Weber Human Services 1-844-625-3700; 801-625-3700; (after-hours hospital prior authorization: 801-513-9641)	Weber Human Services 1-844-625-3700; 801-625-3700

What's New in Claims/Billing?

- Physician's Assistants
  - During the 2021 Legislative Session, the Utah Legislature passed Senate Bill 27 (SB 27) that modifies the physician assistant (PA) scope of practice. The bill's establishment helped identify that Medicaid policy does not cover PAs or nurse practitioners (NP) as assistants to surgery, which is within their scope of practice.
  - To meet a PAs scope of practice, Medicaid has updated policies to include the following:
    - Open coverage to allow PAs and NPs (non-physician practitioners) to report services as assistants to surgery by modifying Utah Administrative Code R414-10. Physician Services
    - Open coverage to allow PAs and NPs (non-physician practitioners) to report services as assistants to surgery by modifying provider manuals
    - Open the AS modifier (assistant to surgery for non-physician)
- PRISM
  - Many updates will be coming in the upcoming months, make sure to read the MIB's to ensure you don't miss out on important information
  - eLearnings and provider training resources

FAQ’s

Frequently Asked Questions:

- How to get the remits for my claims?
  - Electronic EDI - You must go through your clearinghouse
  - Paper Remits - Refer to the Remittance Advice Request Form on the website
- Where do I find the resource for how to bill on a HCFA 1500 and a UB-04?
  - https://medicaid.utah.gov/hipaa/providers/#companion-guides
- How do we determine if a Member is enrolled in an MCE?
  - https://elt.medicaid.utah.gov/EligibilityLookupTool/

Contact Us

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801-538-6155

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