2022 Medicaid Statewide Provider Training

Healthcare Policy

Utah Department of Health & Human Services

Agenda

- Neurological Assessment
- COVID-19 Vaccination Counseling
- Dental Services
- Laboratory Services
- Nutritional Services
- Assistants to Surgery
- PT and OT
- Qualifying Clinical Trials
- Radiology
- Transportation
- Inpatient Hospital Claims
- Modifier 24 & 25
- Retroactive Authorizations

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.

Utah Department of
Health & Human Services
Integrated Healthcare

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).

Central Nervous System Neurological Assessment

Effective November 1, 2021, brief emotional or behavioral neurological assessments are covered by Medicaid for EPSDT-eligible members

- CPT Code 96127 - *Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument*
    - Typically used for administering, scoring, and documenting a brief behavioral or emotional screening, including assessments used for depression, anxiety, suicide risk, substance use, ADHD, and other conditions.
    - Intended for use in physical medicine settings, such as primary care, to screen for underlying mental health conditions.
- Utilization is restricted to 4 units per member, per year, with a maximum of 2 units per date of service (CMS National Correct Coding Initiative [NCCI] standard)

COVID-19 Vaccination Counseling

- Effective January 1, 2022, a COVID-19 vaccine counseling visit, in which the healthcare provider discusses the importance of childhood vaccinations against COVID-19, is covered by Medicaid and reportable for reimbursement.
    - CPT code 99401 - *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes*, and appending the CR modifier to the claim line.
- Providers should be aware that this is a carve-out service billed directly to fee for service Medicaid, instead of the member's managed care entity (e.g., Molina, Healthy U, Select Health).

COVID-19 Vaccine Counseling

Dental Services

Dental crown coverage updates, effective July 1, 2022:

- Medicaid covers porcelain dental crowns for EPSDT and Pregnant Members.
  - Services covered for permanent teeth only.
- Dental crown services for Aged, Blind/Disabled, and Targeted Adult Medicaid (TAM) members undergoing treatment for substance use disorders continue to be provided by University of Utah School of Dentistry (UUSOD) and their network.
  - The following dental crown CDT codes have been updated: D2740, D2750, D2751, D2752, D2753, D6740, and D6752

Dental Crown Coverage

Effective July 1, 2022, Medicaid covers posterior resin-based composite restorations for EPSDT, Pregnant, Aged, Blind/Disabled, and Targeted Adult Medicaid (TAM) members undergoing treatment for substance use disorders.

- The following resin-based composite restoration CDT codes have been opened for coverage:
  - D2391 - *Resin-based composite - one surface, posterior; Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure*
  - D2392 - *Resin-based composite - two surfaces, posterior two surfaces*
  - D2393 - *Resin-based composite - three surfaces, posterior three surfaces*
  - D2394 - *Resin-based composite - four or more surfaces, posterior four and + surfaces*

Posterior Resin-Based Composite Fillings

Silver Diamine Fluoride (SDF) is a liquid substance used to help prevent tooth cavities (or caries) from forming, growing, or spreading to other teeth.

Medicaid covers SDF for treatment of primary dentition for EPSDT eligible and pregnant members when:

- Used for treatment of dental caries
- May be applied once per tooth every 6 months

Medicaid does not cover SDF for caries prevention or dental hypersensitivity.

Silver Diamine Fluoride Coverage for EPSDT Eligible Members

- Denture relines and adjustments, when performed by the original denture provider within six months of a member receiving dentures, are included in the global denture payment and do not reimburse separately.
- After the global period, two relines/adjustments per arch per year are allowed.

Laboratory Services

Updates have been made to the Hospital Services and the Physician Services Manuals Laboratory Services chapters.

- Hospital Services Manual, Chapter 8 - 10
- Physician Services Manual, Chapter 8 - 11

Starting July 1, 2022, the Medicaid claims processing will be updated to require the appropriate CLIA certification number on the provider record in order to allow laboratory claims to be paid. This update is consistent with existing Medicaid policy that requires CLIA certification for correct billing.

Nutritional Services

Clarification for reporting Medical Foods and Enteral formulas for the treatment of inborn errors of metabolism

- The Coverage and Reimbursement Lookup notes have been updated
- Use the following codes to report Medical Foods/Enteral Formulas:
  - B4157 - Used for non-EPSDT members for oral/enteral administration
  - B4162 - Used for EPSDT members for enteral administration
  - S9435 - Used for EPSDT members for oral administration

Medicaid serves as the primary payor for medically necessary medical foods for members with eligibility for both Medicaid and the Utah Women, Infants, and Children Supplemental (WIC) Nutrition Program when:

- The member is one year of age or older;
- Medicaid coverage criteria are met; and
- The requested medical food is found on the Pricing, Data Analysis and Coding (PDAC) and is reportable by a HCPCS code.

Providers should submit requests for medical foods to Medicaid first when the provisions listed above apply. Medical Food requests that do not meet the listed requirements or are non-covered services should be submitted to WIC for coverage.

Medical Foods for Women, Infants, and Children (WIC) Eligible Medicaid Members

Non-Covered Services:

- Oral nutritional supplements for adults are not a Medicaid benefit except for members with inborn errors of metabolism.
- Enteral Formula is not covered for members under one year of age, as most enteral products are breast milk substitutes, with the exception of inborn errors of metabolism.

Assistants to Surgery

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)

Physical and Occupational Therapy

Physical Therapy (PT) and Occupational Therapy (OT) are covered benefits for eligible Utah Medicaid members.

PT and OT for Traditional Medicaid members:

- PT and OT services are limited to twenty (20) therapy sessions, per member, per calendar year, when criteria are met
  - Prior authorization is required for more than 20 sessions per calendar year for both PT and OT

PT and OT services for Non-Traditional Medicaid members:

- PT and OT are limited to sixteen (16) total aggregate PT and/or OT sessions, per member, per calendar year, when criteria are met
  - Prior authorization is required for more than 16 aggregate sessions per calendar year

Reporting PT and OT services:

- PT services- report modifier GT
- OT services- report modifier GO

Physical Therapy and Occupation Therapy Coverage for Tradition and Non-Traditional Members

Qualifying Clinical Trials

An update to Section 1905(a) of the Social Security Act (the Act), titled the Consolidated Appropriations Act, 2021, was approved by congress and outlines the mandated coverage of routine member costs associated with participation in certain qualifying clinical trials. Due to this mandate the following have been updated:

- The Utah Medicaid State Plan effective date 1/1/2022
- Utah Administrative Rule, R414-71 Early and Periodic Screening, Diagnostic and Treatment Program (currently undergoing the update process)
- The following Utah Medicaid Provider Manuals:
  - EPSDT Services, Hospital Services, Physician Services, and Section I: General Information manuals

Qualifying Clinical Trials

Radiation Treatment Delivery and Management

- The policy surrounding the reporting of radiation treatment delivery and management codes was updated to reflect that of the National Correct Coding Initiative as found in the CPT coding book published by the American Medical Association (AMA).
- Specific coding of these services is published in the CPT code book and is now included in the Physician Services Provider Manual, Chapter 9-10 *Radiation Treatment and Management*.

More changes include:

- CPT code 77387 is used to report professional services and must have a modifier 26 appended to the claim in order to be reimbursed
    - Do not report this code on claims with CPT codes 77432 and 77435 as the professional component is included in these codes
    - Do not report this code on claims with CPT codes 77371, 77372, 77373, 77385 and 77386 as the technical component is included in these codes
- CPT codes 77427, 77431, 77432 and 77435 are used to report professional services and must have a modifier 26 appended to the claim in order to be reimbursed

Radiation Treatment Delivery and Management (Con't)

Transportation Services

UTA Transit Card

Starting July 1, 2022, the Utah Transit Authority (UTA) is replacing their paper UTA punch passes with a UTA Transit Card. As such, the paper punch passes will no longer be accepted by UTA staff starting in July.

- **Issuance**
  - Medicaid will be issuing UTA Transit Cards to all qualifying members who currently have a UTA paper punch pass and to those who request one up until June 24th, 2022. Members who need a UTA Transit Card after this date will be able to request one on MyBenefits (https://mybenefits.utah.gov) or by calling a Health Program Representative (HPR) at 1-844-238-3091.

- **Who Qualifies for a UTA Transit Card?**
  - Traditional Medicaid members who live within the service areas of UTA and who do not have access to a working, personal vehicle.
  - Children age 5 and younger do not need a UTA Transit Card to use UTA services. Parents or legal guardians of children, age 5 and younger, will need a UTA Transit Card in order to ride with their children. Parents or legal guardians of Medicaid eligible children under the age of 17 can request a UTA Transit Card. This will be limited to two parents/guardians per household.
  - Members who require assistance during transportation for medical reasons (physical or mental) may be authorized to have an attendant.

- **Cedar City Transportation Services (CATS)** provide Non-Emergency Medical Transportation (NEMT) for traditional Medicaid members residing in the Cedar City area
  - These services include fixed bus routes and Dial-A-Ride
  - Dial-A-Ride is available for those members who are unable to use the CATS fixed bus routes. It is a door-to-door transportation service that provides wheelchair-accessible vans to take the elderly and disabled from one destination to another, within city limits. If a member is needing to gain access to Dial-A-Ride, they must fill out an application found on the CATS website: www.cedarcity.org.
  - To schedule a ride with Dial-A-Ride members should call:
    - Weekdays 7am-6pm (M-F): 435-865-4510
    - Saturday, 10am-5:15pm: 435-592-9117
- Members will need to provide their current Medicaid member ID to utilize CATS

Cedar City Transportation Services (CATS)

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

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

Retroactive Authorization

Section I: General Information Provider Manual. Chapter 10-3 *Retroactive Authorization* has been updated and revised to provide clarity, including renaming of section headings for consistency.

10-3.1 Inaccurate Information

If a provider demonstrates that a Medicaid representative or Medicaid's website gave inaccurate information about the need for prior authorization, a retroactive authorization may be requested.

Providers must submit supporting documentation of inaccurate information in writing via email, fax, or letter. The documentation must include corroborating information such as the customer service representative's name with the date and time of the phone call or screenshots from the website with a timestamp, etc.

The Office of the Inspector General (OIG) completed an audit and found that claims containing procedures that require a prior authorization (PA) for inmates of public institutions, i.e. jail, were being forced to pay without a PA in place, per an existing Medicaid policy. This internal process resulted in an OIG recoupment of funds due to no PA obtained for procedures that require a PA. This prompted an investigation and resulted in the need for this addition of policy surrounding retroactive PA for inmate claims.

As a result of the investigation the following policy changes were made:

- Circumstance 7. Exceptions for Inmates of Public Institutions was added to Chapter 10-3 *Circumstances Eligible for Retroactive Authorization* to allow for retroactive PA for inmates of public institutions for procedures that require PA
- Updated time limits from 90 to 180 days for all of the circumstances in Chapter 10-3 *Retroactive Authorization* for consistency

Inmates of Public Institutions

10-3.7 Inmates of Public Institutions

Inmates are not eligible for Medicaid while incarcerated. However, the Eligibility Lookup Tool will indicate that the individual is eligible for Medicaid if they were eligible before incarceration. The prior authorization (PA) reviewer will verify admission to an inpatient hospital setting and that they are an inmate before issuing a PA.

Before rendering services that require a PA, acquisition of a PA is not necessary for inmates. Medicaid authorizes requests retroactively when services are deemed medically necessary and documentation meets Medicaid policy requirements.

10-3.8 Members with Medicaid and Medicare (Dual Eligibility)

Due to considerable variances in Medicare and Medicaid coverage policies, retroactive authorization for durable medical equipment, medical supplies, prosthetics, or orthotics may qualify for retroactive authorization of services.

Medicaid does not make exceptions for retroactive authorization for Medicare Supplement Plans. For additional information regarding dual eligibility, refer to *Chapter 11-5.1 Medicare Crossover Claims* of this manual.

Note: Medicare Crossover claims only apply to Medicare Part A and Part B. No exceptions will be made for Medicare Supplement Plan Coverage

10-3.9 Exceeding Quantity Limits

Providers may request retroactive authorization when quantity limits are inadvertently exceeded. For example, a provider unknowingly exceeds quantity limits for a previously performed service by a different provider. The new provider should make every reasonable effort, for example, by contacting customer service to determine if quantity limits have been met.

Each provider is responsible for checking quantity limits and requesting prior authorization once quantity limits are met. Quantity limits count to the member and are not unique to the provider. Additionally, if more than one request is received for the same item or service, the authorization for the first complete request will be the one approved.

Note: This exception does not apply to pharmacy claims. For information regarding pharmacy claims, refer to the Pharmacy Services provider manual.

Contact Us

For additional questions, please email:
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