

Section I
General Information

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1 General Information

1-1 Utah Medicaid Provider Manual

The Utah Medicaid Program pays medical bills for people who have low incomes or cannot afford the cost of health care and who are found eligible for the program. The program is based on a medical need. The Utah Medicaid program is administered by the Utah Department of Health, Division of Medicaid and Health Financing. The Utah Medicaid Provider Manual contains the coverage policy for the fee-for-service Medicaid Program. The manual consists of several distinct sections, attachments, and periodic published updates as described below.

- **Section 1** - General information applicable to all providers. It provides general information about the Utah Medicaid Program to assist enrolled providers with submitting claims for services rendered to Utah Medicaid members. Section 1 contains information common to all provider types, including eligibility, covered services, provider enrollment, and participation guidelines.
- **Section 2** - Consists of multiple sections (also called manuals) that address coverage specific to a provider or service type (e.g., dental services, home health services, physician services, hospital services, etc.).
- **Section 3, 4, etc.** - Some Section 2 manuals have subsections numbered 3, 4, etc. For example, Section 3, Anesthesia Services is a subsection of Section 2, Physician Services).
- **Attachments** - May contain information that is specific to the Section to which it is attached or an attachment is intended for general use and thus is found in General Attachments. Attachments often contain information that may change frequently. Forms are an additional type of attachment.
- **Medicaid Information Bulletin (MIB)** - The MIB is Utah Medicaid's official means for notifying providers of updates to manuals, policy changes, etc.

Note: An electronic version of the provider manual as well as other Medicaid information, is found on the Medicaid website <https://medicaid.utah.gov>.

Section 1 of the provider manual provides general information about the Utah Medicaid Program to assist enrolled providers with submitting claims for services rendered to Utah Medicaid members. Use Section 1 in conjunction with the other more specific provider manual sections, attachments and forms. Providers and their staff should familiarize themselves with these documents and refer to them to answer program and billing questions. This will reduce misunderstandings concerning the coverage of services, member eligibility, and proper billing procedures, which can result in payment delays, incorrect payments, or payment denials.

The information in the Utah Medicaid Provider Manual represents available services when medically necessary. Each Section outlines covered services as well as limitations. At times services may be more limited or may be expanded, using the utilization review process, if a proposed service is medically necessary and more cost effective than alternate services.

1-1.1 Manual Maintenance

Utah Medicaid makes every attempt to ensure that the information contained in each section of the manual is current and reliable. The contents of the Utah Medicaid Provider Manual are updated

regularly. Sections with changes are published and a report of the changes is published in the Medicaid Information Bulletin (MIB) quarterly. The MIB is emailed to enrolled providers who subscribe to the Medicaid newsletter. To receive the newsletter, sign up on the "Utah Medicaid Official Publications" page at the Medicaid website. For additional information on obtaining updated information, refer to the Utah Medicaid website, <https://medicaid.utah.gov>, or contact medicaidops@utah.gov.

Payment for services is made in accordance with the policy and fee schedule in effect at the time services are rendered. The provider rendering services is responsible to be aware of and comply with the policies and procedures in the Utah Medicaid Provider Manual, the MIBs, the Coverage and Reimbursement Lookup Tool, and applicable policies and procedures of managed care plans.

Compliance with all applicable Utah state laws, regulations, and administrative guidelines is required of all providers. In particular, providers must adhere to the Utah Administrative Code R414-1, Utah Medicaid Program, which generally describes the Medicaid program. This rule incorporates by reference the Utah Medicaid Provider Manual. Therefore, you must consider the content of the provider manuals along with applicable federal and state laws and regulations. If you have questions or need further information, refer to the Medicaid website, or contact Medicaid (Refer to this *Chapter, Medicaid Contact Information*).

1-1.2 Statewide Provider Training

Annually a statewide provider training is offered. The training covers significant changes in Medicaid and other topics of concern to the provider as well as question and answer time. Refer to the Utah Medicaid website for dates <https://medicaid.utah.gov>.

1-2 Overview of the Medicaid Program

Utah Medicaid is a public assistance program providing medical services to individuals meeting certain income, resource, and eligibility criteria. Established by Title XIX of the Social Security Act, it is administered by the State of Utah and financed jointly by state and federal funds. At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services, which provides funding to the states, establishes minimal program requirements, and provides regulatory oversight. Federal guidelines are designed to ensure the states administering Medicaid programs provide appropriate, medically necessary quality health care services for all members, while maintaining financial accountability. State funds are appropriated by the Utah Legislature. Utah's Medicaid program is administered by the Utah Department of Health, Division of Medicaid and Health Financing, which is the single state agency responsible for administering the program.

Each state establishes and administers its own Medicaid program, and determines the type, amount, duration and scope of services covered within broad federal guidelines. States must cover certain mandatory benefits, and may choose to provide other optional benefits. Federal law requires states to cover certain mandatory eligibility groups, including qualified parents, children and pregnant women with low income, as well as older adults and people with disabilities with low income.

Utah Medicaid establishes eligibility standards for Medicaid providers, determines benefits, sets payment rates, and reimburses providers. Medicaid maintains the State Plan and files amendments to the plan (state plan amendments, or SPA) with appropriate regulatory authorities.

1-3 Application for Medicaid

Although this Section does not cover in detail, policies to determine if an individual is eligible for Medicaid, the following information provides a general summary of the member application process, a description of the member guide, and how to access to Medicaid constituent services which may be useful information for providers.

Individuals seeking assistance for payment for medical services may apply on-line at <https://medicaid.utah.gov/apply-medicaid>. Medicaid applications are available in English and Spanish. Application may also be made through the Department of Workforce Services (DWS) or outreach offices in most major hospitals and many area public health clinics. Call DWS Customer Relations at (801) 526-0950 or 1(866) 435-7414, or to find a local outreach office, go to <http://jobs.utah.gov>. The DWS offices also assist individuals who are seeking other types of assistance, including food stamps, financial assistance, and childcare assistance.

Individuals needing assistance with the application process may call the above DWS Customer Relations number. For additional information on applying for Medicaid, refer to the Medicaid website, <https://medicaid.utah.gov>.

1-4 Medicaid Contact Information

Internet

The Medicaid website address is <https://medicaid.utah.gov>.

Telephone - Medicaid Information:

- Salt Lake City area.....(801) 538-6155
- Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada
(toll-free)1(800) 662-9651
- From other states.....1(801) 538-6155

Medicaid Information has a telephone menu to reduce waiting time and the number of transfers for Medicaid providers and members.

Customer service representatives are available:

- Monday, Tuesday, Wednesday, Friday.....8:00 A.M. to 5:00 P.M.
- Thursday.....11:00 A.M. to 5:00 P.M.
- Closed on all state and federal holidays.

FAX Numbers

Each Medicaid team has its own FAX line in order to provide better customer service. These FAX numbers are on the back of the AccessNow instructions in *General Attachments* of this Manual.

Mailing Address for Medicaid Claims (Claims sent by mail must be sent by U.S. Postal Service)

Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, Utah 84114-3106

Street Address

Department of Health
288 North 1460 West
Salt Lake City, Utah 84114

Note: The Department of Health (the Martha Hughes Cannon Building) is a secure building. Public access is restricted to the lobby area, cafeteria, Vital Records, and a designated conference room, all located on the first floor. Access to other areas of the building requires an employee escort. State and Federal privacy laws do not permit staff at the Martha Hughes Cannon Building's information desk, or any other reception desk in the building, to handle Medicaid claims.

1-5 Medicaid Member Guide

The information booklet, "Medicaid Member Guide," is mailed to all new members. The guide explains the Medicaid program including rights and responsibilities, selection of a health care provider, and health care services covered by Medicaid. The Medicaid Member Guide may also be obtained by calling 1(866) 608-9422 or on the Medicaid website at http://health.utah.gov/umb/forms/pdf/Medicaid_Member_Guide.pdf. The guide can be read, printed, or saved from this screen.

1-6 Medicaid Member Card

The Division of Medicaid and Health Financing (DMHF) issues a wallet-sized plastic Medicaid Member Card to members eligible for Traditional Medicaid, Non-Traditional Medicaid, Baby Your Baby, Hospital Presumptive Eligibility, or the Primary Care Network (PCN). The card is the same for each program. Possession of the card does not guarantee a member's eligibility for any of these programs. It is the provider's responsibility to use the information on the card to verify program and eligibility information.

The Medicaid Member Card has the member's name, Medicaid ID number, and date of birth. The back of the card has contact information and websites useful to both providers and members. The member must present the card with a photo identification at each service.

To view a sample Medicaid Member Card go to:

[https://medicaid.utah.gov/Documents/pdfs/Medicaidcard_FINAL_sample%20\(1\).pdf](https://medicaid.utah.gov/Documents/pdfs/Medicaidcard_FINAL_sample%20(1).pdf)

Medicaid members also receive a benefit letter in the mail. The letter has eligibility and plan information. When there are changes, Medicaid sends a new benefit letter.

A member's eligibility for Medicaid, Baby Your Baby, Hospital Presumptive Eligibility, or PCN, may change from month to month. Additionally most Medicaid members are enrolled in a managed care organization to receive their services. Before providing services to a Medicaid member, providers are

responsible for determining a member's eligibility and whether the member is enrolled in an MCO. Eligibility and plan enrollment information for each member is available to providers from these sources: Eligibility Lookup Tool, AccessNow, or ANSI 270 or ANSI 271. Refer to *Chapter 6, Member Eligibility* for additional information and links.

1-7 Fee-for-Service and Managed Care

The Medicaid Provider Manual contains information regarding Medicaid policy and procedures for fee-for-service Medicaid members. Managed Care Organizations (MCO) must provide the services outlined in the applicable Sections as well as the applicable services described in the Utah Medicaid State Plan. However, MCOs may have different prior authorization requirements and post-payment review requirements. Providers who render services to members enrolled in MCOs should contact the MCO or refer to the MCO's manual for additional information. If a Medicaid member is enrolled in an MCO, they must receive services through that MCO.

At times there are exceptions to MCO coverage. Service exceptions are called "carve-out services," which may be billed directly to Medicaid on a fee-for-service basis. Medicaid will deny fee-for-service claims submitted directly to the DMHF, unless payment for the service is not the responsibility of the MCO. In such cases the claim is considered for payment under the requirements found in this and other applicable Sections.

To determine if a member is enrolled in an MCO, or if services may be billed to DMHF on a fee-for-service basis, providers must verify member eligibility using one of the following tools: Eligibility Lookup Tool, AccessNow (touch tone telephone verification) or, ANSI 270 or ANSI 271, an online service, for providers enrolled in the Utah Health Information Network (UHIN). Refer to *Chapter 6, Member Eligibility* for links and more information or go to the Medicaid website, <https://medicaid.utah.gov/>.

Medicaid members not enrolled in an MCO and not enrolled in DMHF's Restriction Program, may receive services from any qualified provider who accepts Medicaid.

1-8 Constituent Services

For general member concerns, contact the Utah Department of Health, Division of Medicaid and Health Financing, Constituent Services representative at medicaidmemberfeedback@utah.gov or (801) 538-6417 or toll free at 1(877) 291-5583.

For concerns related to a managed care organization, contact the MCO first. If the concern is unresolved, contact a state DMHF Health Program Representative at 1(866) 608-9422.

1-9 Definitions

Following is a list of definitions relevant to the administration, policies, and procedures of the Utah Medicaid Program:

Accountable Care Organization (ACO): A physical health plan that contracts with Utah Medicaid to provide services to Medicaid clients.

Assigned Claim: A claim for which the provider accepts the Medicare assignment of payment.

Accredited Standards Committee (ASC X12): An ANSI accredited standards organization responsible for the development and maintenance of electronic data interchange (EDI) standards for many industries. The “X12” or insurance section of ASC X12 handles the EDI for the health insurance industry’s administrative transactions. Under HIPAA, X12 standards have been adopted for most of the transactions between health plans and providers.

Baby Your Baby (BYB): This program provides temporary Medicaid coverage for qualified low income pregnant women prior to establishing eligibility for ongoing Medicaid. Members apply for the program through a qualified BYB provider and qualify based on preliminary information provided on the BYB application.

Carve-out Service: Services *not* included in the Medicaid contract with an MCO (ACO, PMHP or dental plan.)

Child Health Evaluation and Care (CHEC) program: Utah's version of the federally mandated Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. All Medicaid members enrolled in Traditional Medicaid ages birth through twenty may receive CHEC services. The program is designed to bring comprehensive health care to eligible members.

Clinical Laboratory Improvement Amendments (CLIA): The federal Centers for Medicare & Medicaid Services (CMS) program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.

Code of Federal Regulations (CFR): The publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid program. Federal rules promulgated by the Centers for Medicare & Medicaid Services (CMS) place requirements upon the state Medicaid agency, Medicaid providers, and recipients.

Covered Medicaid Service: Service available to an eligible Medicaid member within the constraints of the Utah Medicaid Program and criteria for approval of service.

Current Procedural Terminology Manual (CPT): The manual published by the American Medical Association that provides a systematic listing and coding of procedures and services performed by physicians and simplifies the reporting of services to third party payers.

Diagnosis Related Group (DRG): The system established to recognize and reimburse for the resources used to treat a client with a specific diagnosis or medical need. The Federal DRG relative weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files or from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS).

Division of Medicaid and Health Financing (DMHF): The organizational division in the Utah Department of Health which administers the Medicaid program in Utah.

Early Periodic Screening Diagnosis and Treatment (EPSDT): The federal preventive health care services program for children, which is known in Utah as the Child Health Evaluation and Care (CHEC) Program. (For Medicaid members enrolled in Traditional Medicaid ages birth through twenty.)

Enrolled Provider: A licensed practitioner of the healing arts or an entity providing approved Medicaid services to patients under a provider agreement with the Department.

Explanation of Benefits (EOB): The form sent by a liable third party to a provider to explain whether a claim is paid and the amount paid or denied and the reason denied.

Explanation of Medicare Benefits (EOMB): The form received by the provider from Medicare to explain whether a claim is paid, the amount paid, or denied and the reason denied.

Federal Financial Participation (FFP): The Medicaid program is funded jointly by the federal government and the state. FFP is the specified percentage the federal government pays the state for Medicaid program expenditure.

Federal Poverty Level (FPL): The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. This level varies by household size. FPLs are used to determine financial eligibility for certain federal programs. The guidelines are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The Federal Poverty Level is available on the Internet at <http://aspe.hhs.gov/poverty/index.shtml>.

Fee-for-Service: Medicaid covered services that are billed directly to and paid for directly by Medicaid based on an established fee schedule.

Fee-for-Service Medicaid Member: A member who is not enrolled in an MCO; or is enrolled in an MCO, but the service that is needed is a carve-out service covered directly by Medicaid.

Fraud: Refer to “Medicaid Fraud.”

Healthcare Common Procedure Coding System (HCPCS): The system mandated by the Centers for Medicare & Medicaid Services (CMS) to code procedures and services. This system incorporates the CPT Manual for physicians and individually developed service codes and definitions for non-physician providers.

Hospital Presumptive Eligibility (HPE): The program provides temporary Medicaid coverage for qualified low income individuals prior to establishing eligibility for ongoing Medicaid. Members

apply for this program through a qualified hospital provider and qualify based on preliminary information provided on the application.

Intermediary: An entity which contracts with Centers for Medicare & Medicaid Services (CMS) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis and to perform other related functions.

International Classification of Diseases (ICD): The source for coding the diagnosis for which a patient is being treated.

Limited Enrollment Provider: Providers who wish only to order, refer, or prescribe and not provide any other services to Medicaid members. This type of enrollment does not allow Medicaid to reimburse the provider for services.

Managed Care Organization (MCO): For the purposes of this manual, means a health, behavioral health or dental plan that contracts with the Medicaid agency to provide services to Medicaid members and attempts to control the cost and quality of care by coordinating services. MCO is sometimes used as a generic term to mean an ACO, PMHP and/or dental plan.

Medicaid: The medical assistance program authorized under Title XIX of the Social Security Act.

Medicaid Agency: The Utah Department of Health, Division of Medicaid and Health Financing.

Medicaid Audit: A civil or administrative process of reviewing Medicaid provider records to ensure accurate billing and payment for Medicaid claims.

Medicaid Fraud: Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive unauthorized Medicaid benefit for any person or entity. Refer to Utah Code Ann. §26-20-1, et seq. Some examples of fraud include: knowingly or intentionally billing Medicaid for services that were not provided, making a materially false statement in connection with any claim for payment to the Medicaid program, accepting kickbacks or bribes for referrals or services.

Medicaid Fraud Control Unit (MFCU): The official state Medicaid fraud control unit in the Utah Office of the Attorney General, certified by the federal government, to investigate and prosecute complaints of abuse and neglect of patients, and Medicaid fraud under state laws as required by 42 CFR 1007.7 through 1007.13. The MFCU has statewide prosecutorial authority.

Medicaid Information Bulletins (MIB): An official, periodic publication of the Division of Medicaid and Health Financing to update the Utah Medicaid Provider Manual or issue information to Medicaid providers.

Office of Inspector General: This office, like the MFCU mentioned above, also addresses issues related to fraud, utilization control, audits, and investigations, but is part of the Office of Inspector General.

Medicaid Provider Agreement: A signed contract between a provider and the Utah Medicaid program by which the provider agrees to abide by all state and federal law related to the Medicaid Program, including providing medical and billing records for the purposes of conducting Medicaid and MFCU audits to determine fraud or abuse of the Medicaid program. The provider also agrees to abide by any subsequent amendments to the Agreement published in the Medicaid Information Bulletin. This agreement, together with the recipient's Medicaid application, authorizes the release of Medicaid records for Medicaid and MFCU auditing purposes.

Medical Necessity: A service is "medically necessary" if it is (1) reasonably calculated to prevent, diagnose, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a disability; and (2) there is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly. (R414-1-2 (18))

Medicare: The national health insurance program for aged and disabled persons under Title XVIII of the Social Security Act. Part A includes hospital and nursing home services. Part B pays professional fees, such as physicians, physical therapy, etc.

Member: The preferred term to refer to a person who is eligible for the Utah Medicaid Program. "Member" is often used interchangeably with "client," "recipient," "patient," or "enrollee" when the person is eligible for the Utah Medicaid Program.

Non-Traditional Medicaid: A medical plan based on the Traditional Medicaid Plan but additional limitations and/or restrictions are imposed, under a waiver of federal regulations, on benefits and services of Traditional Medicaid as covered by the Medicaid State Plan. Members eligible for Non-Traditional Medicaid includes: adults on Family Medicaid programs (adults with dependent children) and adult caretaker relatives on Family Medicaid. Services are based on the program type a person is eligible to receive. For services covered under NTM please refer to the Administrative Rule UT Admin Code R414-200. Non-Traditional Medicaid Health Plan Services and the Coverage and Reimbursement Code Lookup.

Overpayment: Refer to "Provider Overpayment."

Patient: An individual awaiting or receiving professional services directed by a licensed practitioner of the healing arts, also referred to as a Medicaid member or member.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the state.

Prepaid Mental Health Plan (PMHP): The Medicaid mental and substance use disorder managed care plan that covers inpatient and outpatient mental health services and outpatient substance use disorder services for PMHP-enrolled Medicaid members.

Presumptive Eligibility: Provides temporary Medicaid coverage for qualified low income individuals prior to establishing eligibility for ongoing Medicaid. Presumptive eligibility programs include the Baby Your Baby program and the Hospital Presumptive Eligibility program.

Prior Authorization (PA): Required approval obtained by a health care provider from Medicaid (the Division of Medicaid and Health Financing, Department of Health) or from an MCO, if applicable before certain services are rendered.

Primary Care Network (PCN): A medical program that serves a population not previously eligible for Medicaid. The Scope of Service is limited to basic medical service of a general nature to provide preventive and palliative care in an outpatient, office setting. Services in the office should comport with the definition of Primary Care found in Utah Administrative Code R414-1002(3).

Provider: An entity or licensed practitioner of the healing arts furnishing medical, mental health, dental or pharmacy services.

Provider Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices resulting in unnecessary Medicaid costs. Reimbursement for services that are not medically necessary, failure to meet professionally recognized standards of care, or any similar practice that results in increased costs to Medicaid are also considered abuse. Criminal intent need not be alleged nor proved to establish abuse.

Provider Agreement: Refer to “Medicaid Provider Agreement.”

Provider Overpayment: An overpayment occurs when a Medicaid provider receives more Medicaid reimbursement than the provider is entitled, regardless of which party is at fault.

Recipient: A person who is eligible for the Utah Medicaid Program and eligible to receive covered Medicaid services from an enrolled Medicaid provider also known as a member.

Reimbursement: An established amount of money paid to a provider in exchange for a specifically defined and coded service provided to a Medicaid client.

Remittance Statement: The explanation from Medicaid as to claims which have been paid, denied or are in process.

Restricted Member: A Medicaid member who is enrolled in the Restriction Program due to unnecessary overutilization of their Medicaid Benefit. Restricted members are locked-in to one Primary Care Provider who can authorize specialty providers as needed and are also locked-in to one pharmacy.

Restriction Program: Provides safeguards against inappropriate and excessive use of Medicaid services.

Services: The types of medical assistance specified in Sections 1905(a)(1) through (25) of the Social Security Act and interpreted in 42 CFR §440 [October 1, 1996, edition].

Single State Agency: The agency which administers the Medicaid program in the State of Utah is the Utah Department of Health, Division of Medicaid and Health Financing.

Third Party Liability (TPL): The responsibility of an individual, entity, or program which is or may be liable to pay all or part of the medical cost of injury, disease, or disability of a patient.

Title XIX: The Medicaid Program authorized by the Federal Social Security Act.

Traditional Medicaid: A medical plan that will pay for many medical services for eligible individuals. Individuals eligible for Traditional Medicaid include: children; pregnant women; aged, blind or disabled adults; women eligible under the cancer program. Some services are available only to children and to pregnant women under Traditional Medicaid.

Utah Department of Health: The single state agency designated to administer or supervise the administration of the Medicaid Program under Title XIX of the federal Social Security Act. All references to "the Medicaid agency" mean the Department of Health. Reference: Utah Code Annotated §26-18-2.1 (1953, as amended) and Utah Administrative Code, Rule R414-1-2.

Utah Health Information Network (UHIN): (1) a coalition of insurers, providers, the Utah Medical Association, the Utah Hospital Association, and State Government which developed an electronic data exchange to centralize transactions for providers and payers, including Medicaid. (2) The electronic data exchange, also referred to as UHIN or the UHIN network.

Year: Any 12-month period of time unless specified as a calendar year.

2 Health Plans

Many Medicaid members are required to enroll with a Managed Care Organization (MCO). An MCO that covers physical health care is called an Accountable Care Organization (ACO); one that covers behavioral health is a Prepaid Mental Health Plan (PMHP), and one that covers dental services is called a dental plan (only for those eligible for full dental coverage). Medicaid members enrolled in MCOs are entitled to the same Medicaid benefits as fee-for-service members. However, MCOs may offer more

benefits and may have different prior authorization requirements than the Medicaid scope of benefits explained in this section of the provider manual. A Medicaid member enrolled in an MCO must receive services through that plan with some exceptions called “carve-out services.”

Limited information regarding Medicaid’s involvement with various MCOs is included here. The Division of Medicaid and Health Financing (DMHF) contracts with MCOs to provide physical, behavioral health care, and dental care for most Medicaid members. DMHF pays a monthly premium for each Medicaid member enrolled in the ACO, PMHP, or dental plan. The managed care organization is responsible for the health care services specified in the contract with DMHF. Services not included in the DMHF contract with an MCO are referred to as “carve-out” services. DMHF pays providers directly for carve-out services.

Each MCO is responsible to determine which services require prior authorization and the process providers use to request authorization of services for Medicaid members enrolled in the MCO. Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCO when the services are the responsibility of the plan. Providers requesting prior authorization for MCO covered services for a member enrolled in an MCO are referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member’s enrollment in an MCO. However, it is the provider’s responsibility to verify eligibility and MCO enrollment for a member before providing services. *Therefore, if a Medicaid member is enrolled in an MCO, a fee-for-service claim will not be paid unless the claim is for a “carve-out service.”*

2-1 Accountable Care Organizations

The Division of Medicaid and Health Financing (DMHF) contracts with four accountable care organizations (ACO): HealthChoice Utah, Healthy U, Molina Healthcare, and SelectHealth Community Care . Not all ACOs are available in each county.

2-1.1 ACO Enrollment

DMHF requires all Medicaid members living in the following counties to enroll with an ACO: Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber.

When determined eligible for Medicaid, a member must select an ACO. A Health Program Representative (HPR) employed by DMHF explains the health plan choices, including mandatory ACO enrollment and the exemption policy for members whose health care needs cannot be met by an ACO. HPRs are also resources for a members and providers who may have problems related to an ACO.

Prior to delivering services, providers must verify eligibility and determine if a member is enrolled in an ACO. For tools to verify eligibility, refer to *Chapter 6, Member Eligibility*.

2-1.2 Prepaid Mental Health Plans

Under the Prepaid Mental Health Plan (PMHP), DMHF contracts with local county mental health and substance abuse authorities or their designated entities to provide inpatient and outpatient mental health services and substance use disorder services to Medicaid members.

The PMHP covers most counties of the state. Medicaid members are automatically enrolled with the PMHP contractor serving their county of residence and must receive inpatient and outpatient mental health services and outpatient substance use disorder services through that PMHP.

Prior to delivering services, providers must verify eligibility and determine if a member is enrolled in a PMHP. For tools to verify eligibility, refer to *Chapter 6, Member Eligibility*.

A list of PMHP contractors by county and telephone number is provided in the *General Attachments* section of this Manual.

Additional Options:

All Medicaid members enrolled in the PMHP also may get services directly from a federally qualified health center (FQHC). PMHP authorization is not required. FQHCs obtain reimbursement from DMHF.

In addition, American Indian and Alaska Native Medicaid members enrolled in the PMHP may get services directly from Indian health care providers, including an Indian Health Program or an Urban Indian Organization. PMHP authorization is not required. Providers obtain reimbursement from DMHF.

Exceptions to PMHP enrollment:

- Wasatch County is not covered under the PMHP. Medicaid members living in Wasatch County may receive mental health and substance use disorder services from qualified Medicaid providers.
- In Box Elder, Cache and Rich counties, outpatient substance use disorder services are not covered under the PMHP. Medicaid members living in one of these counties may receive outpatient substance use disorder services from qualified Medicaid providers. However, Medicaid members living in one of these counties must receive their mental health services through the PMHP.
- For Medicaid members in state custody (foster care), only inpatient mental health services are covered under the PMHP. Children in foster care are not enrolled in the PMHP for outpatient mental health and substance use disorder services.
- Medicaid members with adoption subsidy may disenroll from the PMHP on a case-by-case basis for outpatient mental health and substance use disorder services. Like children in foster care, they remain enrolled in the PMHP for inpatient mental health services only.
- Methadone maintenance services are not covered under the PMHP. Medicaid members may receive methadone maintenance from qualified Medicaid methadone maintenance services providers.
- Individuals with presumptive eligibility are not enrolled in the PMHP. DMHF reimburses the provider on a fee-for-service basis.

Retroactive Medicaid Eligibility

In some instances, individuals applying for Medicaid may receive Medicaid eligibility retroactively. PMHPs are responsible for inpatient and outpatient mental health services and outpatient substance use disorder services provided during up to 12 months of the member's retroactive eligibility period. Therefore, even if an individual is not yet enrolled with a PMHP, if he or she is given retroactive

Medicaid eligibility, then the provider must contact the PMHP contractor for payment of mental health or substance use disorder services provided during the retroactive period.

2-1.3 Dental Health Plans

DMHF requires all Medicaid members living in Davis, Salt Lake, Utah, and Weber counties who qualify for dental benefits to enroll with a dental plan. The Department contracts with Delta Dental and Premier Access to deliver dental services. Prior to delivering services, providers must verify eligibility and determine if a member is enrolled in a dental plan. For tools to verify eligibility refer to *Chapter 6, Member Eligibility*.

2-1.4 Emergency Services for Members in an ACO or PMHP

ACOs and PMHPs are responsible for covering certain emergency services for enrollees. Contact the ACO or PMHP for coverage information.

2-1.5 Grievances and Appeals - MCO

Members or providers with grievances concerning an MCO should first submit the grievance to the MCO. Members or providers may also contact the DMHF Constituent Services representative at medicaidmemberfeedback@utah.gov or (801) 538-6417 or toll free at 1(877) 291-5583 to discuss their concern.

When an MCO makes a decision that constitutes an action (e.g., a decision to deny a payment of a claim in whole or part, etc.) members and providers may appeal the decision with the MCO. If the MCO's appeal decision is adverse, the member or provider may request a hearing with DMHF.

2-1.6 Changing Enrollment in an ACO or Dental Plan

Once per year, between Mid-May and Mid-June, DMHF has an open enrollment period during which Medicaid members can change to a new ACO or dental plan effective July 1st of the year. Medicaid members are also allowed to change their ACO or dental plan during the first 90 days after a plan is chosen or has been assigned. A Medicaid member who wants to change their ACO or dental plan selection should contact their Health Program Representative; call 1(866) 608-9422.

3 Provider Participation and Requirements

This chapter covers topics such as provider agreement, co-payments, prohibition on billing clients, record keeping, provider sanctions, and audits.

There are general requirements which must be met for a provider to participate in the Medicaid Program. Any provider of health care services must be enrolled in the Utah Medicaid Program, shall only render services within their scope of licensure, before Medicaid will cover any services provided by the provider to Medicaid members. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable Section of this Provider Manual, and state and federal law. Section 2 of this manual, which comprises several individual manuals, contains additional requirements for each specific provider type. Medicaid can reimburse a provider who satisfies all credential requirements for each provider type, completes and signs the Utah Medicaid Provider agreement, and receives notice from the Utah Medicaid Program of acceptance.

Keep Medicaid informed of any address changes. Returned mail will result in your provider agreement being closed. Medicaid may close providers who have not billed Medicaid for one or more years without notification.

3-1 Provider Agreement

A provider enrolls as a Medicaid Provider by completing the Medicaid Provider Application and signing the Provider Agreement. A provider must execute the Agreement before they are authorized to furnish Medicaid services. When the State accepts the provider's application and the agreement is signed, the State will notify the provider by approval letter with the effective date of enrollment. Providers submitting applications for Medicaid enrollment or re-credentialing of an existing enrollment, must send in a completed application packet with all required documentation and information. If the submission is incomplete or incorrect, the provider will be notified by letter that the application was not accepted due to missing and or incorrect documentation or information and the application will be discarded. Medicaid will consider a new application if the provider submits a completed application packet that includes all required documentation and information.

The following provisions are part of every Provider Agreement, whether included verbatim or specifically incorporated by reference:

- The provider agrees to comply with all laws, rules, and regulations governing the Medicaid Program.
- The provider agrees that the submittal of any claim by or on behalf of the provider will constitute a certification (whether or not such certification is reproduced on the claim form) that:
 - The medical services for which payment is claimed were furnished in accordance with the requirements of Medicaid;
 - The medical services for which payment is claimed were actually furnished to the person identified as the patient at the time and in the manner stated;
 - The payment claimed does not exceed the provider's usual and customary charges or the maximum amount negotiated under applicable regulations of the Division of Medicaid and Health Financing; and
 - The information submitted in, with, or in support of the claim is true, accurate, and complete.

3-2 Ineligibility of Provider

The Division of Medicaid and Health Financing may refuse to grant provider privileges to anyone who has been convicted of a criminal offense relating to that person's involvement in any program established under Titles XVIII, XIX, XXI or XX of the Social Security Act, or of a crime of such nature that, in the judgment of the Department, the participation of such provider would compromise the integrity of the Medicaid Program or put the clients at risk. The Division may terminate any provider from further participation in Medicaid if the provider fails to satisfy all applicable criteria for eligibility. Specific rules, including grounds for sanctions and termination, are found in Utah Administrative Code R414-22, and is discussed in *Chapter 5, Provider Sanctions*.

3-3 Civil Rights Compliance and Practice Capacity

When providing medical assistance under programs administered by the Utah Department of Health, a provider must agree to provide services in accordance with Title VI of the Civil Rights Act as well as

other federal provisions which prohibit discrimination based upon race, color, religion, national origin, disability, age, or gender.

A Utah Medicaid provider is under no obligation to accept all Medicaid members who seek care, and may limit the number of members accepted into the provider's practice. However, the limitation may not be based on prohibited discriminatory factors such as race, color, religion, national origin, disability, age, or sex. Restrictions to individual patient care, based upon the limits placed upon provider practice by specialty, and because of medically related determinations made within the scope of practice, are generally permissible. In addition, limitations are generally permissible if applicable to both Medicaid and non-Medicaid clients. Some grounds for denying or dismissing Medicaid clients include limiting the number or percentage of Medicaid clients, missed appointments, abusive behavior, and provider lack of training or experience. Providers may wish to consult their respective state licensing rules for definitions of standards of care for any additional limitations.

A provider should set up established business guidelines that delineate the limitations on accepting Medicaid members, and abide by those guidelines. Exceptions that would allow for accepting Medicaid clients outside the established guidelines would be acceptable as long as those exceptions did not violate the prohibited actions identified in this manual.

3-4 Medicaid as Payment in Full, Client Billing Prohibited

Medicaid and MCO

A provider who accepts a member as a Medicaid, Hospital Presumptive, or Baby Your Baby patient must accept the Medicaid or state payment as reimbursement in full. A provider who accepts a member enrolled by Medicaid in an MCO must accept the payment from the plan as reimbursement in full. If a member has both Medicaid and coverage with a responsible third party, do not collect a co-payment that is usually due at the time of service. The provider may not bill the member for services covered by Medicaid, Hospital Presumptive, or Baby Your Baby or by an MCO. The payment received from Medicaid or from an MCO is intended to include any deductible, co-insurance, or co-payment owed by the Medicaid member. In addition, the administrative cost of completing and submitting Medicaid claim forms are considered part of the services provided and cannot be charged to Medicaid members.

Qualified Medicare Beneficiary

Providers who serve Qualified Medicare Beneficiary (QMB) clients must accept the Medicare payment and the Medicaid payment, if any, for co-insurance and deductible as payment in full. Providers may not bill members eligible for the Qualified Medicare Beneficiary Program for any balance remaining after the Medicare payment and the QMB co-insurance and deductible payment from Medicaid. (42 CFR §447.15)

Providers must follow policies and procedures

Providers must follow policies and procedures concerning, but not limited to: medical services covered; medical service limitations; medical services not covered; obtaining prior authorization; claim submission; reimbursement; and provider compliance, as set forth in all Sections of the Utah Medicaid Provider Manual, Medicaid Information Bulletins, and letters to providers. If a provider does not follow the policies and procedures, the provider may not seek payment from the member for services not

reimbursed by Medicaid. This includes services that may have been covered if the provider had requested and obtained prior authorization.

3-5 Exceptions to Prohibition on Billing Members

There are certain circumstances in which a provider may bill a Medicaid member. They are: non-covered services, providers serving PCN members, spenddown medical claims, Medicaid cost sharing (co-payments and co-insurance), and broken appointments. The specific policy for each item must be followed before the Medicaid member can be billed. Refer also to *Chapter 7, Member Responsibilities*. Before collecting a co-payment, confirm the service requires a co-payment and that the member has a co-payment requirement. Give the member a receipt for the co-payment collected. The member is responsible to keep co-payment receipts in case of delayed billings by providers or discrepancies. If a co-payment is not collected at the time of service, the provider may bill the client for it.

3-5.1 Non-Covered Services

A non-covered service is a service not covered by a third party, including Medicaid. Since the service is not covered, a provider may bill a Medicaid member when the following conditions are met:

- The provider has an established policy for billing all members for services not covered by a third party. (The charge cannot be billed only to Medicaid members.)
- The member is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
- The member agrees to be personally responsible for the payment.
- The agreement is made in writing between the provider and the member which details the service and the amount to be paid by the member.

Unless all conditions are met, the provider may not bill the member for the non-covered service. Further, the member's Medicaid Member Card may not be held by the provider as guarantee of payment by the member, nor may any other restrictions be placed upon the member.

3-5.2 Providers Serving Primary Care Network (PCN) Members

Providers serving Primary Care Network members may bill members for non-covered services set forth in the Primary Care Network Manual, Primary Care Network Information Bulletins, and letters to providers. A written agreement upon time of service is recommended, but not required.

3-5.3 Spenddown Payment

Some members are responsible for “spenddown” payments to qualify for medical services. The member may pay the spenddown amount to the DWS or may pay a medical bill and use this expense to offset their spenddown.

When rendering services to a member with a spenddown, the provider submits a claim to Medicaid for the full amount; do not submit a partial charge. If the member, as part of the spenddown, owes the full amount, the provider may choose not to bill Medicaid.

Medicaid bases reimbursement on the total claim, or on the standard reimbursement, whichever is less. Medicaid deducts the client's obligation from the Medicaid reimbursement. The remainder is paid to the provider. Therefore if the provider submits a partial charge (the total less the spenddown amount), the Medicaid reimbursement amount may be less than the actual amount owed to the provider. When the member's obligation to pay is equal to or more than the Medicaid reimbursement amount, the Medicaid payment is zero.

Information concerning a member's spenddown requirement, if any, is available at AccessNow, 1(800) 662-9651, and the Eligibility Lookup Tool, <https://medicaid.utah.gov/eligibility>.

3-5.4 Broken appointments

A broken appointment is not a service covered by Medicaid. Since the charge is not covered, a provider may bill a Medicaid member only when three conditions are met:

- The provider has an established policy for acceptable cancellations. For example, the member may cancel 24 hours before the appointment.
- The member has signed a statement agreeing to pay for broken appointments.
- The provider charges all members in the practice for broken appointments. The charge cannot be billed only to Medicaid members.

3-6 Referrals

The Primary Care Provider (Physician, Osteopath, or Nurse Practitioner) may make any referral in writing or verbally. However, the member's medical record must indicate that a referral or consultation was requested.

The consulting physician is responsible for sending the Primary Care Physician a letter describing the consult findings and a summary of the recommendations.

Providers who make referrals to another provider should consider that Medicaid limits medical transportation to the nearest provider or the nearest appropriate facility which can provide the needed services. Therefore, if the member must use medical transportation covered by Medicaid, the referral must be to the nearest provider or the nearest appropriate facility which can provide the needed services. This limitation includes all medical transportation, in both emergency and non-emergency situations.

3-6.1 Documenting the Referral/Consultation

Both the referring provider and the servicing/consulting physician are responsible for documenting the consultation or referral written or verbal request. When Medicaid conducts a post-payment review, all of the following information must be in the member's records to document the referral:

- The date the requesting provider contacted the servicing/consulting physician.
- Consultant physician's name and medical reason for the consultation/referral request.
- The consulting physician documents a summary of their evaluation, opinion, and recommendations in the patient's medical record. A separate written summary report is sent to the requesting physician and noted in the patient's medical record. If the consultant takes over as the servicing provider, the referring provider is notified.

3-6.2 Billing Claims Based on a Referral

Follow the CMS-1500 (08/05) instructions for entering the referring provider's number on the claim form. If it is a CHEC Well Child follow-up referral, enter TS in the modifier field.

Follow the Implementation Guides for entering the referring provider's identifier/number on the electronic claim. If the visit is a CHEC Well Child follow-up referral, enter TS in the modifier field.

3-6.3 Physician Ownership and Prohibition of Referrals

A physician or immediate family member of the physician who has a financial interest in a health service or item is prohibited from making referrals to those services when payment would be made as a result. Services or items include physical therapy services, occupational therapy services, radiology, MRI and other advanced imaging services, durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, home health services, prescription drugs, inpatient and outpatient hospital services, and free standing surgical centers, etc. The health service may not send a bill to an individual or file a claim with a third party for services provided as a result of such a referral.

A financial interest may be through ownership, or through a direct investment interest (such as holding equity or debt), or through another investment which has ownership or an investment interest in the health service. Penalties include denial of payment for the services provided, payment of civil penalties, and exclusion from participation in the Medicaid program.

3-7 Ensure Member Receives Medically Necessary Services

A Medicaid provider who accepts a Medicaid member for treatment accepts the responsibility to ensure the member receives all medically necessary services. A definition of medical necessity is provided in this manual in *Chapter 1, Definitions* and *Chapter 8, Programs and Coverage*. A provider's responsibilities include verifying program coverage; referring a member to other Medicaid providers; ensuring ancillary services are also delivered by a Medicaid provider; and ensuring the member receives all covered medically necessary services at no cost.

It is the responsibility of the provider to review Medicaid coverage policy for the procedure or service and request prior authorization (PA) or submit documentation for manual review as noted in the Coverage and Reimbursement Code Lookup tool. The ordering provider must provide the medical record documentation of medical necessity to ancillary providers such as the laboratory or radiology when requested so the ancillary provider may obtain the prior authorization or provide documentation to Medicaid for medical review of the service.

3-8 Medical Interpretive Services

Medicaid providers are required to provide foreign language interpreters for Medicaid members who have limited English proficiency. Members are entitled to an interpreter to assist in making appointments for qualified procedures and during visits. Providers must notify members that interpretive services are available at no cost. Medicaid suggests providers encourage members to use professional services rather than relying on a family member or friend, though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

3-8.1 Member Enrolled in an MCO

If medical interpretative services are needed for a service covered by an MCO, the member is responsible for contacting the plan to obtain an interpreter. The MCO is required to provide interpretive services to the MCO's enrollees consistent with Medicaid policy.

3-8.2 Fee-for-Service Members

Medicaid will cover the cost of an interpreter when three conditions are met.

- Member is eligible for a federal or state medical assistance program. Programs include Medicaid, CHIP, and services authorized on a State Medical Services Reimbursement Agreement Form (MI-706).
- Member is fee-for-service, as defined in *Chapter 1, General Information, Definitions*.
- The health care service needed is covered by the medical program for which the member is eligible. Services covered by Medicaid are listed in Section 1 and the applicable other Sections of this Manual, under Covered Services.

If the three conditions of coverage are not met, the provider may be responsible for the cost of interpretive services. The provider may not bill the member for the service except under the conditions stated in *Chapter 3, Provider Participation and Requirements*.

3-8.3 How to Obtain an Interpreter

Medicaid offers a “Guide to Medical Interpretive Services.” The guide lists member eligibility requirements, contractors, languages offered, and information required from the provider. The guide is available in General Attachments on the Medicaid website at <https://medicaid.utah.gov>.

4 Record Keeping

4-1 Government Records Access and Management Act (GRAMA)

The Utah Department of Health, Division of Medicaid and Health Financing, follows the provisions of the Government Records Access and Management Act (GRAMA) in classifying records and releasing information.

4-2 Record Keeping and Disclosure

Medicaid providers must comply with all disclosure requirements in 42 CFR §455, Subpart B, such as those concerning practice ownership and control, business transactions, and persons convicted of fraud or other crimes. A provider must also disclose fully to Utah Medicaid information about the services furnished to Medicaid members, as circumstances may warrant.

Every provider must comply with the following rules regarding records:

- Maintain for a minimum of five years all records necessary to document and disclose fully the extent of all services provided to Medicaid members and billed, charged, or reported to the State under Utah's Medicaid Program;
- Promptly disclose or furnish all information regarding any payment claimed for providing Medicaid services upon request by the State and its designees, including the Office of Inspector General (OIG) and the Medicaid Fraud Control Unit, or the Secretary of the United States Department of Health and Human Services. This includes any information or records necessary to ascertain, disclose, or substantiate all actual income received or expenses incurred in providing services. In addition, all providers must comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B as applicable, except for individual practitioners or groups of practitioners. (A copy of these requirements will be furnished upon request);

- Allow for reasonable inspection and audit of financial or member records for non-Medicaid members to the extent necessary to verify usual and customary expenses and charges.

Upon request, the State will furnish reimbursement to the provider for the cost of making copies of records in compliance with Subsection B, at a rate not to exceed 10 cents per page when there are 20 or more pages to copy.

4-3 Confidentiality of Records

Providers must safeguard members' privacy and confidentiality, as required by all applicable state and federal laws. The use and disclosure of individually identifiable information or protected health information must be consistent with HIPAA. In accordance with HIPAA, HITECH, and the Government Records Access and Management Act (GRAMA), any information gained from member records is classified as *controlled* and must be protected pursuant to the guidelines established by law in order to protect the privacy rights of the members.

Any information received from providers is classified as *private* and will be protected pursuant to the guidelines established by law in order to protect the privacy rights of providers. Records and information acquired in the administration of any part of the Social Security Act are *confidential* and may be disclosed only under the conditions prescribed in rules and regulations of the Department of Health and Human Services, or on the express authorization of the Secretary of the Department of Health and Human Services.

A Medicaid provider may disclose records or information acquired under the Medicaid Program only under conditions prescribed in the rules and regulations of HIPAA, HITECH, and GRAMA.

4-4 Access to Records

The DMHF may request records that support provider claims for payment under programs funded through the DMHF. Responses to requests must be returned within 30 days of the date of the request and must include the complete record of all services for which reimbursement is claimed and all supporting services. If there is no response within the 30 day period, or a provider cannot provide adequate records for reimbursed services, the services shall be deemed undocumented. The Department will recover all payments for undocumented services.

A provider who receives a request from Medicaid for access to or inspection of documents and records must comply with free access to the records and facility. A provider may not obstruct any audit or investigation, including the relevant questioning of employees of the provider.

Repeated refusal to provide or grant access to the records as described above will result in the termination of the Medicaid provider agreement.

4-5 Documentation Requirements

To support its mission to provide access to quality, cost-effective health care for eligible Utahans, the Division of Medicaid and Health Financing requires providers to meet the *Evaluation and Management Documentation Guidelines* developed jointly by the American Medical Association and the Centers for Medicare and Medicaid Services. Documentation requirements are as follows:

General Principles of Medical Record Documentation in the *Evaluation and Management Documentation Guidelines*:

- The medical record should be complete and legible.
- There is no specific format required for documenting the components of an E/M service. However, the provider must determine whether they are using 1995 or 1997 CMS evaluation and management guidelines in their practice. When auditing, the OIG will request this information. The documentation of each member encounter should include:
 - The chief complaint and/or reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
 - Assessment, clinical impression, or diagnosis;
 - Plan for care; and
 - Date and a verifiable, legible identity of the healthcare professional that provided the service.
- If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
- To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The member's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
- The CPT and international classification of diseases codes (ICD) reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
- An addendum to a medical record should be dated the day the information is added to the medical record, not the day the service was provided.
- Timeliness: A service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record.
- The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

4-6 Signature Requirements

In keeping with the objectives of 42 CFR §456 Subpart B (to review and evaluate utilization, service, exceptions, quality of care, and to promote accuracy and accountability), providers and the service they provide must be clearly recognized by name and specialty. Any professional providing service and entering documentation in the member record must include a verifiable, legible signature and professional specialty designation following all entries.

- The physician's signature must accompany every documented member encounter if the service is being billed with the physician provider number.
- Other professionals working in group practices, clinics or hospitals such as nurses, physical therapists, occupational therapists, dietitians, social workers, etc., providing service under a plan

of care or following orders of a physician, must provide appropriate documentation, signature and professional designation following entries in the member's medical record.

4-6.1 Acceptable Alternative Signature

- Electronic signatures, by federal law, are acceptable. Record documentation made by electronic means has the same legal weight as signatures on paper.
- When a service note is dictated and subsequently transcribed into the record over the typed name of the provider, legible initials of the provider next to the typed name are acceptable and imply review and agreement with the documentation.

4-6.2 Unacceptable Signature

A signature stamp affixed to an entry in the member's medical record is not sufficient to assure physician review and agreement that the documentation is an adequate representation of the service. Initials alone following an entry are not appropriate, unless that is the customary way a signature is provided.

4-7 Physician Responsibilities

- The physician has the major responsibility for the member's medical record and services provided. A recognizable signature, customary to the way in which the physician identifies himself or herself, should be found throughout the record on all direct service entries, consultations or reports.
- When service to the member is provided "incident to" or "under the supervision" of the physician and documented by non-physician personnel, the medical record entry must have sufficient documentation to show active participation of the physician in planning, supervising or reviewing the service.

4-8 Determining Compliance with Standards

A provider's failure to comply with medical standards, federal audit, quality assurance review, or prior authorization requirements may be determined in the course of manual claim review. Coding errors are often discussed with billers either in the course of manual review or through the pre-hearing process.

Either the Division of Medicaid and Health Financing or the provider may request a pre-hearing or peer review of the reimbursement determination. A written request by either the Division or the provider for a pre-hearing review must be made within 30 days following the date of the original notice to the provider of the determination of noncompliance. The written request from the provider must be submitted to:

Office of Administrative Hearings
Division of Medicaid and Health Financing
PO Box 143105
Salt Lake City, UT 84114-3105

Or via UPS or FedEx
Office of Administrative Hearings Division of Medicaid and Health Financing
288 North 1460 West
Salt Lake City, UT 84116-3231

In situations of violations of compliance of professionally recognized medical standards, as identified by peer review, the Division of Medicaid and Health Financing may pursue any legal sanction for recovery of overpayments.

If the provider is found at fault, and Federal Financial Participation is disallowed on reimbursements made to the provider, the provider must reimburse to the State the total amount the State paid for the services disallowed. When manual review documentation suggests attempts to circumvent prior authorization or coverage policy, a case may be referred to the OIG for review. (Refer to *Chapter 5, Provider Sanctions.*)

5 Provider Sanctions

Sanctions, which include termination or suspension from participation in the Medicaid program, may be imposed against a provider for conduct such as fraudulent billing practices, failure to keep records to substantiate services to members, failure to repay unauthorized funds, and conviction of certain criminal offenses. Prospective providers may also be excluded from the Medicaid program on certain grounds, such as fraud or current license limitation imposed by the Division of Professional and Occupational Licensing (DOPL) or another state's licensing board. Before a sanction may be imposed, a provider must be notified of the pending sanction and of his hearing rights. Utah Administrative Code R414-22, Administrative Sanction Procedures and Regulations, provides a more complete description of grounds for sanctions, and administrative sanctions that may be taken against providers.

5-1 Suspension or Termination from Medicaid

The Department may suspend or terminate from Medicaid participation any medical practitioner or other health care professional licensed under state law who is convicted of Medicaid or Medicare related crime(s) in either a federal or state court.

When a practitioner or other health care professional is convicted and sentenced in a state court of Medicaid-related crime(s), the Department notifies the Office of Inspector General. (Refer to *Chapter 5, Provider Sanctions.*)

The Department may request a waiver of suspension or termination if the sanction is expected to have a substantial negative impact on the availability of medical care in the community or area. The waiver request should contain a brief statement outlining the problem, and be submitted to the Centers for Medicare & Medicaid Services (CMS). CMS will notify the Department if and when it waives the sanction. Waivers should only occur if:

- The Secretary of the Department of Health and Human Services has designated a health manpower shortage area; and
- An insufficient number of National Health Services Corps personnel has been assigned to the needs of that area.

5-2 Employment of Sanctioned Individuals

Federal Fraud and Abuse regulations adopted by Health and Human Services, Office of Inspector General, provide for significant civil and criminal actions that may be taken against Medicaid providers who employ federally sanctioned individuals. This is true even if the sanctioned individual does not work directly in providing services to individuals under the Medicaid program.

Providers need to be aware that it is their responsibility to verify that the individual is not on a federal sanctions list. Thus, it is essential that providers regularly check (i.e., monthly) the federal sanctions list, which is at <https://exclusions.oig.hhs.gov/>. If a provider employs an individual who is on the federal sanctions list, and that person provides services which are directly or indirectly reimbursed by a federally funded program, the employer may be subject to legal action which could include civil penalties, criminal prosecution and exclusion from program participation.

It is essential that providers regularly check the federal sanctions list which can be found at the website listed above. It would be advisable for all providers to check current and potential employees against the list on the federal database to ensure that no sanctioned individuals are working for their organization.

5-3 Medicaid Audits and Investigations

Federal regulations require the implementation of a statewide surveillance and utilization control program that safeguards against excessive Medicaid payments, and unnecessary or inappropriate utilization of care and services.

The Utah Office of Inspector General (UOIG) for Medicaid Services, and the Medicaid Fraud Control Unit, Office of Attorney General, address issues related to fraud, utilization control, audits, and investigations. These programs work to ensure Utah's Medicaid program is in compliance with applicable state and federal law. These offices may receive complaints and referrals from Medicaid recipients, the public, providers, or federal and state agencies. Medicaid fraud is a crime which may result in criminal charges and possibly conviction, incarceration, fines, penalties and also exclusion from the Medicaid and Medicare programs. What constitutes fraud is defined by statute under the False Claims Act found at Utah Code Ann. 26-20-1, et. seq. (Refer to, <http://le.utah.gov/xcode/Title26/Chapter20/26-20.html>). Some examples of fraud include, but are not limited to, the knowing or intentional act of billing Medicaid for services that were not rendered, including billing for items or materials that were not delivered. Fraud also includes the making of a materially false statement or representation in connection with any claim for payment to the Medicaid program. Providers are also prohibited from accepting illegal kickbacks or bribes for referrals or services, and are also prohibited from billing for services that are medically unnecessary or charging for those services at a rate higher than those charged by the provider to the general public. It is important that you familiarize yourself with the False Claims Act, or contact the Utah Office of Inspector General for Medicaid Services or the Utah Medicaid Fraud Control Unit if you have questions or concerns.

Contact Information for Complaints and Reporting Fraud, Waste and Abuse

Director, Medicaid Fraud Control Unit
Office of the Attorney General
Medicaid Fraud Control Unit
5272 South College Drive, Suite 300
Murray, Utah 84123
(801) 281-1259

Utah Office of Inspector General for Medicaid Services
288 North 1460 West
PO Box 143103
Salt Lake City, Utah 84114
(801) 538-6087, 1(855) 403-7283
<https://oig.utah.gov/>

5-4 Hearings and Administrative Review

A provider or member may request an administrative hearing to dispute an action taken by the Division of Medicaid and Health Financing (DMHF) or an MCO. Actions taken that may be appealed include, but are not limited to:

- Denial of a prior authorization request.
- Denial of a claim, as indicated by an explanation of benefits or other remittance document issued by Medicaid.
- Denial by manual review.

With respect to denials issued by an MCO, providers or members must complete the MCO's appeal process prior to requesting a hearing with DMHF.

To request a hearing, send a completed hearing request form to the Office of Administrative Hearings. The form must be faxed or postmarked within 30 calendar days from the date DMHF or the MCO sends written notice of its denial or intended action, unless a different time period is indicated on the denial document. Failure to submit a timely request for a hearing constitutes a waiver of the due process right to a hearing. The agency is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change. Utah Administrative Code R410-14 et seq. sets forth the administrative hearing procedures for Medicaid hearings.

A *Request for Hearing/Agency Action* form (Hearing Request) is available on the Utah Medicaid website at: <https://medicaid.utah.gov/utah-medicaid-forms>, Hearing Request, or a copy may be requested from the Office of Administrative Hearings by calling (801) 538-6576.

Submit the form by mail or fax.

Mail:

Division of Medicaid and Health Financing
Office of Administrative Hearings
Box 143105
Salt Lake City, UT 84114-3105

FAX: (801) 536-0143

6 Member Eligibility

6-1 Verifying Medicaid Eligibility

A Medicaid member is required to present the Medicaid Member Card before each service, and every provider must verify each member's eligibility each time before rendering services. Presentation of the

Medicaid Member Card does not guarantee a member continues eligible for Medicaid. Verify the member's eligibility, and determine whether the member is enrolled in an MCO, Emergency Only Program, or the Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance. Eligibility and health plan enrollment may change from month to month. Retain documentation of the verified eligibility for billing purposes.

Verify member eligibility using AccessNow, Eligibility Lookup Tool, and ANSI 270 and ANSI 271. Brief descriptions of each are below; for detailed information, call Medicaid Information, or go to the Medicaid website at <https://medicaid.utah.gov/medicaid-online>.

Note: Medicaid staff makes every effort to provide complete and accurate information on all inquiries. However, federal regulations do not allow a claim payment even if the information given to a provider by Medicaid staff was incorrect.

6-1.1 Tools to Verify Medicaid Eligibility

These tools may be used to verify member eligibility:

Eligibility Lookup Tool

The eligibility lookup tool allows providers to electronically view a member's Medicaid eligibility and plan enrollment information. To use this tool a provider must register with the State of Utah Master Directory (UMD), available at <https://medicaid.utah.gov/eligibility>.

AccessNow

Is a touch-tone telephone eligibility line and is a free information system for Medicaid providers. AccessNow allows the provider to access information directly. AccessNow is available Monday through Saturday from 6:00 a.m. to midnight, and Sunday from noon to midnight. There is no limit to the number of inquiries a provider may make. Call Medicaid Information ((801) 538-6155) and follow the menu instructions to reach AccessNow (*Chapter 1, General Information*).

ANSI 270 and ANSI 271

These two HIPAA compliant transactions offer member eligibility and claim status for providers who are members of the Utah health Information Network (UHIN).

6-1.2 Documentation of Medicaid Coverage for Medicaid Members

Medicaid members who need confirmation of coverage may call Medicaid Information (Refer to *Chapter 1, General information*) or access the member Benefit Lookup Tool at <https://medicaid.utah.gov>.

6-2 Temporary Proof of Eligibility

The Interim Verification of Eligibility (Form 695) is a temporary proof of eligibility. Form 695 is issued when a member needs proof of eligibility and does not yet have a Medicaid Member Card. When a temporary proof of eligibility expires, Medicaid will no longer pay claims, unless the member has since been issued a ten digit Medicaid identification number.

6-3 Third Party Liability

Information on third party coverage should be verified. Note that some members of a family may have third party coverage, while others may have no coverage or different coverage.

If third party liability (TPL) information is incorrect, advise the member to call the TPL unit in the Office of Recovery Services at the Department of Human Services at (801) 536-8798. Providers may also call the TPL unit about incorrect information. TPL information is corrected by the Office of Recovery Services:

In the Salt Lake area, call.....(801) 741-7437

Medicaid policy states the provider must pursue payment from all other liable parties such as insurance coverage. Refer to *Chapter 11, Billing Medicaid*, for information on billing the TPL.

6-4 Ancillary Providers

Providers who accept a member covered by Medicaid are asked to ensure that any ancillary services provided to the member are delivered by a participating Medicaid provider. This includes lab, x-ray, and anesthesiology services. Give all ancillary providers a copy of the member's Medicaid Member Card or, at minimum, the Medicaid identification number. In addition, when the service requires prior authorization (PA) and a PA number is obtained from Medicaid; give the PA number to any other provider rendering service to the member. This will assist other providers who may be required to submit the prior authorization number when billing Medicaid.

6-5 Medicaid Member Identity Protection

A provider should ask for the member's Medicaid Member Card and a picture ID prior to each service to assure the individual presenting the card is the same person on the Medicaid Member Card. Medicaid is a benefit only to eligible persons. Possession of a Medicaid Member Card does not ensure the person presenting the card is eligible for Medicaid.

7 Member Responsibilities

Members are responsible for providing complete and accurate information to establish eligibility, providing information about all other health insurance, paying co-payment amounts at the time of service, and cooperating with the primary care provider to receive medical services.

7-1 Charges that are the Responsibility of the Member

A Medicaid member is responsible for certain charges, including:

- Charges incurred during a time of ineligibility
- Charges for non-covered services, including services received in excess of Medicaid benefit limitations, if the member has chosen to receive and agreed to pay for those non-covered services.
- Charges for services which the member has chosen to receive and agreed in writing to pay as a private pay member.
- Spend down liability.
- Cost sharing amounts such as premiums, deductibles, co-insurance, or co-payments imposed by the Medicaid program.

7-1.1 Cost sharing

The Medicaid program may require certain members to pay for services or benefits, referred to as cost sharing. Cost sharing amounts may include such items as premiums, deductibles, co-insurance, or co-payments.

Refer to Utah State Plan Attachments 4.18-A through H, for additional cost sharing information.

7-2 Charges Not the Responsibility of the Member

Except for the cost sharing responsibilities discussed above, members are not responsible for the following charges:

- A claim or portion of a claim that is denied for lack of medical necessity. (For exceptions refer to *Chapter 3, Provider Participation and Requirements, Exceptions to Prohibition on Billing Members.*)
- Charges in excess of Medicaid maximum allowable rate.
- A claim or portion of a claim denied due to provider error.
- A service for which the provider did not seek prior authorization or did not follow up on a request for additional documentation.
- A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.
- The difference between the Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.
- Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service by a responsible third party. Members are not responsible for deductibles, co-payments, or co-insurance amounts if such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid amount is zero.
- The member is not responsible for private insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the member as a Medicaid member. Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.
- Laboratory, radiology, outpatient mental health, and substance use disorder (SUD) services.

8 Programs and Coverage

This chapter covers services available under the Utah State Medicaid Plan. Services are reimbursed either directly by Medicaid or by a Managed Care Organization (MCO) with which Medicaid contracts to provide the covered services. When the Medicaid member has a primary care provider, this provider must provide an appropriate referral for medical services received from any other provider (Refer to *Chapter 3, Provider Participation and Requirements.*)

Covered services are limited by federal guidelines as set forth under Title XIX of the federal Social Security Act, Title 42 of the Code of Federal Regulations (CFR), and the Utah Administrative Code, Rule R414-1-5, Services Available.

Utah Medicaid pays for medically necessary, covered health services, as well as certain services, available by special waiver, provided to eligible members by Medicaid providers. The fact that a

provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Certain services are covered only for specific categories of eligible members. All covered services, both traditional and special services, must be medically necessary, may be limited in scope (i.e., specific number of units of services), and may be subject to prior authorization. Refer to the applicable Section 2 provider manual for specific provider policy and billing instructions and to the *Coverage and Reimbursement Code Lookup Tool* for covered services [<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>].

Medicaid may exceed the limitations on covered services under certain circumstances. Some services may be provided if Medicaid staff determine, through the utilization review process, the proposed services are medically appropriate and more cost effective than alternative services.

8-1 Medical Necessity

A provider must only furnish or prescribe medical services to the member that are medically necessary. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a disability, and there is no other equally effective course of treatment available or suitable for the member requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the Medicaid upon request. Medicaid reserves the right to make the final determination of medical necessity.

Services or procedures considered experimental or investigational are not considered medically necessary and thus are not covered by Medicaid. (Refer to *Chapter 9, Non-Covered Services and Limitations, Experimental, Investigational, or Unproven Medical Practices*)

8-2 Medicaid Programs

To qualify for a Medicaid program, an individual must fit into a specific category and within that category, meet certain citizenship and income criteria (some programs also have a resource or asset test). Some categories and programs provide a full range of medical benefits, while others may offer limited benefits or may require cost sharing by a member. If an individual has income over the limit ("excess income"), he may be asked to spend the excess on medical care or "spenddown" to the Medicaid income level to qualify for the Medicaid Medically Needy Program. Refer to the Medicaid website <https://medicaid.utah.gov/> for program details.

The categories of Medicaid:

- Age 65 or older
- Legally disabled or blind (for example, an SSI recipient)
- Pregnant
- Children from birth through 20 years
- Parent or caretaker relative of a child under age 19
- Woman with breast cancer or cervical cancer

8-2.1 Medically Needy Program and Spenddown Program

An individual who is below the asset limit and has monthly income which exceeds the monthly income standard, but less than the amount needed to pay his or her medical bills, may be considered for the Medicaid Medically Needy Program. The program, also known as the “spend down” program, requires the individual to “spend down” his income to the Medicaid income level. The individual may choose to either pay the “excess” monthly income to the state (by sending a payment to DWS), or to pay a portion of his monthly medical bills directly to the medical provider. Pursuant to federal law, Medicaid cannot accept spenddown payments when the source is from a Medicaid provider’s own funds, or if a Medicaid provider has loaned the money to the individual.

8-2.2 Medicare Cost-Sharing Programs

There are three Medicare cost-sharing programs for people with Part A Medicare: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary program (SLMB), and Qualified Individual program (QI). While these are not Medicaid programs, they help cover some of the member’s costs for Medicare services. For further information refer to <https://medicaid.utah.gov/>, Medicare Cost-Sharing Programs.

8-2.3 Retroactive Eligibility

The eligibility worker may approve Medicaid coverage for a beneficiary for the three months prior to application date. This is called the retroactive period. Coverage can begin as early as the first day of the third prior month. For example: The application date is April 15, this coverage may begin January 1.

8-2.4 Breast and Cervical Cancer Program (BCCP)

The Breast and Cervical Cancer Prevention and Treatment Act allows states to provide full Medicaid benefits to qualified individuals in need of treatment for breast and cervical cancers, including precancerous conditions and early stage cancer. The Utah Cancer Control Program (UCCP) refers the individuals for Medicaid coverage.

To qualify the individual must meet all of the following requirements:

- Diagnosis after April 1, 2001, by a Utah health care provider, of breast or cervical cancer which requires treatment, including precancerous conditions.
- Under the age of 65.
- Does not have insurance to cover the needed treatment.
- U.S. citizen or qualified non-citizen.
- Income at or below 250% of the Federal Poverty Level (The FPL is available on the Internet at <http://aspe.hhs.gov/poverty/index.shtml>.) Note: There is no asset test to qualify.

For more information, call the Utah Department of Health, Utah Cancer Control Program: (801) 538-6157 or 1(800) 717-1811. Please have the member’s complete name and telephone number(s).

8-2.5 Baby Your Baby (BYB)

The Baby Your Baby presumptive eligibility program covers outpatient, pregnancy-related, Medicaid covered services for eligible pregnant women prior to establishing eligibility for ongoing Medicaid. Pregnant women apply for this program through a qualified health provider, usually a community health

center or public health department. Inpatient hospital services, and labor and delivery are not covered benefits during the Baby Your Baby presumptive eligibility period.

Members eligible for the Baby Your Baby program are given a 'Presumptive Eligibility Receipt' to show they are approved for coverage. A Medicaid Member Card is mailed to the member within a few days of eligibility determination. The member card is used to verify the member's eligibility. Do not collect a co-payment from a member eligible for the Baby Your Baby Program; a co-payment is not assessed by Medicaid. For more information about application, eligibility, and covered or non-covered services under this program, call the Baby Your Baby Hotline, 1(800) 826-9662.

Note: A newborn infant is not covered when the mother is eligible only for the Baby Your Baby Program. A Medicaid application must be submitted on behalf of the child if assistance is needed in paying the child's medical bills.

8-2.6 Hospital Presumptive Eligibility Program (HPE)

The Hospital Presumptive Eligibility Program (HPE) provides temporary fee-for-service Medicaid coverage for qualified low income individuals prior to establishing eligibility for ongoing Medicaid. Members apply for this program through a qualified hospital provider.

There are different subprograms under HPE: Child Medicaid 0-5 or Child Medicaid 6-18, Parent/Caretaker Relative, Pregnant Woman, and Former Foster Care Individuals. HPE has the same coverage benefits as Medicaid, and the same prior authorization requirements apply, when provided by any Utah Medicaid provider, with one exception. The Pregnant Woman subprogram under HPE covers only outpatient, pregnancy-related, Medicaid covered services like BYB. Under the Pregnant Woman subprogram, inpatient hospital services, and labor and delivery are not covered benefits during the presumptive eligibility period. In addition, the Pregnant Woman subprogram does not cover charges for services for a newborn infant. (Refer to "Baby Your Baby")

Similar to BYB presumptive eligibility program, members eligible for the Hospital Presumptive Eligibility Program are given a 'Presumptive Eligibility Receipt' to show they are approved for coverage. A Medicaid Member Card is mailed to the member within a few days of eligibility determination.

8-2.7 Primary Care Network

The Primary Care Network (PCN) serves individuals ages 19 to 64 with incomes under 95% of the federal poverty level who are not otherwise eligible for Medicaid. PCN coverage is limited to basic medical services of a general nature to provide preventive and palliative care in an outpatient office setting. The following types of services are covered with limitations: limited outpatient hospital services, physician services, general preventive services and health education, family planning services, laboratory and radiology services, pharmacy, prescriptions, dental services, vision services, medical supplies and equipment, emergency transportation services. For more information, refer to the Primary Care Network, Utah Medicaid Provider Manual, available through the Medicaid agency or at the Medicaid website, <https://medicaid.utah.gov>.

8-2.8 CHEC Medical Services for Individuals Ages Birth through 20

The Child Health Evaluation and Care (CHEC) program is Utah's version of the federally mandated Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. CHEC is for enrolled Medicaid

Members and is an integral part of the Medicaid program. CHEC services are available to all members enrolled in Traditional Medicaid ages birth through twenty. (Individuals aged 19 through 20 enrolled in Non-Traditional Medicaid do not qualify for CHEC services.)

This program provides comprehensive and preventive health care services and ensures that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. Screening services to detect physical and mental conditions are covered at established intervals, including a physical exam, appropriate immunizations, laboratory tests, and health education. In addition, dental, vision and hearing services are available. All medically necessary diagnostic and treatment services within the federal definition of Medicaid is covered, regardless of whether or not such services are otherwise covered for individuals over age 20.

In certain cases, if Medicaid staff determine that the proposed services are both medically necessary and more cost effective than alternative services, then the agency may exceed established limitations on coverage.

There are three major components to CHEC: Preventive Health Care, Outreach and Education, and Expanded Services. Refer to Section 2, CHEC Services Provider Manual for details at <https://medicaid.utah.gov/utah-medicaid-official-publications>.

8-2.9 Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program (CHIP) is not a Medicaid program but it is a state health insurance plan for children who do not have other insurance. It provides well-child exams, immunizations, doctor visits, hospital, emergency care, prescriptions, hearing and eye exams, mental health services and dental care. Preventative services (well-child visits, immunizations, and dental cleanings) do not require a co-pay. For more information, call 1(877) 543-7669 or visit the CHIP website.

8-2.10 Custody Medical Care Program (Children in Foster Care)

The Custody Medical Care Program pays medical bills for a child placed in the custody of the State and has not yet been determined eligible for Medicaid or is not eligible for Medicaid. The program may pay for services not covered by Medicaid and for services from a provider who may not be a current Medicaid provider.

Medical services are authorized on State Medical Services Reimbursement Agreement Form (MI-706), by the assigned case manager in the Division of Child and Family Services. The case manager gives the foster parent this form, and it must be presented at the time of the medical visit.

Only services identified on the MI-706 form are payable. Every service must be individually authorized before payment is made. Services provided without authorization will not be paid by the Division of Child and Family Services nor by Medicaid. Emergency services may be authorized after the fact, if the service is within the scope of service of the program, and Form MI-706 is obtained before billing. Services must be billed within 365 days of the date of service or six months of the date Form MI-706 was issued, whichever is later. To bill claims, follow the same instructions as for billing Medicaid claims with one exception: every claim requires a prior approval number. (The prior approval number is the MI-706 number.) Medicaid processes the claim, and the payment method and amount is the same as that for the Medicaid Program, even though the child is not eligible for Medicaid.

I. Children in State Custody (Foster Care)

Medical services for most children placed in state custody are covered by either Medicaid or the Custody Medical Care Program. The State pays medical bills only when the child is eligible for either of these programs. The State does not automatically pay medical bills for children in foster care. Before providing services, determine the child's health care coverage. Using the available tools found in *Chapter 6, Member Eligibility*, determine if the child is eligible for Medicaid and assigned to a Primary Care Provider or ACO.

This information is intended to assist providers in determining and providing health coverage for a child in state custody. Provide services to these children within the time frames outlined in Time Frame for Services below. The Division of Child and Family Services contracts with the Department of Health to provide health care case management for children in foster care. Contact the Fostering Healthy Children Program with questions about serving children in state custody.

a. Children in Foster Care Eligible for Medicaid

Before providing services to children in foster care, check for Medicaid eligibility. Services will not be reimbursed when the child is not eligible for Medicaid, nor when the child is covered by a health plan or Prepaid Mental Health Plan and the provider is not affiliated with the plan. To check eligibility and provider assignment, use the Eligibility Lookup Tool online at <https://medicaid.utah.gov/eligibility-lookup-tool> or call AccessNow, (801) 538-6155 or 1(800) 662-9651.

Many of the children placed in state custody are already eligible for Medicaid and enrolled in an MCO. As with any other enrollee, these children are covered only for services received from providers affiliated with the MCO(s) identified. The provider receives payment from the child's MCO. If a child is taken to a provider who is not affiliated with the child's plan, referred to as "out of plan," services may not be reimbursed by the plan or by Medicaid.

The child may be enrolled in a Prepaid Mental Health Plan (PMHP) for inpatient psychiatric services only. (Foster care children may obtain outpatient mental health services from any participating Medicaid provider.) The caseworkers in the Division of Child and Family Services are responsible for coordinating any needed outpatient or inpatient mental health services.

For new enrollees, the Division of Child and Family Services (DCFS) chooses an ACO which contracts with the provider(s) the child has seen in the past. Foster parents are trained to use providers affiliated with the health plan and PMHP plans in which the child is enrolled.

When the child is eligible on the date of service and not assigned to a health plan or a PMHP, services may be billed directly to Medicaid as fee-for-service. Some children in state custody come from outside the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties) for medical treatment and are thus not enrolled in a health plan.

b. Children in Foster Care Not Eligible for Medicaid

When a foster child is not eligible or not yet eligible for Medicaid, the child may qualify for the Custody Medical Care Program (see above Children in Foster Care Eligible for Medicaid). A nurse from the

Fostering Healthy Children Program (FHC) may authorize medical services on State Medical Services Reimbursement Agreement Form (MI-706), and give it to the foster parent. (FHC is a program within the Department of Health which contracts with the Division of Community and Family Health Services, to provide nurse case manager services). This form must be presented at the time of the visit. Services provided without this authorization will not be paid by DCFS or Medicaid.

II. Time Frame for Services (Foster Care)

Children removed from their homes must receive certain services within the specific time frames listed below. Providers are encouraged to do everything possible to provide service to the child placed in state custody within the following time frames.

Children must receive

- An initial physical exam within five days of removal.
- A complete CHEC exam within 30 days of removal.
- A mental health assessment within 30 days of removal.
- A dental exam within 60 days of removal.

8-2.11 Emergency Services Program for Non-Citizens

The Social Security Act, Section 1903(v)(1), and implementing federal regulations, 42 CFR §440.255(c), provide that no payment can be made to the state for medical assistance furnished to a non-citizen who is not lawfully admitted for permanent residence status in the United States. Full Medicaid coverage is only available to United States Citizens and legal residents. Emergency services for non-citizens are designed to cover a limited scope of services for non-citizens. People meeting all Medicaid eligibility requirements except citizenship may receive services only for an "emergency medical condition." The act defines "emergency medical condition" as "manifesting itself by sudden onset of acute symptoms of sufficient severity (including severe pain) such as that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part"

Emergency services shall be those rendered from the moment of onset of the emergency condition, to the time the person's condition is stabilized. Emergency services shall not include prolonged medical support, medical equipment, or prescribed drugs required beyond the point at which the emergency condition has been resolved.

1. Criteria to Identify an Emergency Service

For emergency services for non-citizens to be covered, ALL of the following criteria must be present:

- The final diagnosed condition for the episode of care manifests itself by sudden onset.
- The final diagnosed condition for the episode of care, including emergency labor and delivery, manifests itself by acute symptoms (including severe pain).

- The final diagnosed condition for the episode of care reasonably requires immediate medical attention.
 - Immediate medical attention means provisions of service within 24 hours of the onset of symptoms or within 24 hours of diagnosis.
 - The final diagnosed condition for the episode of care requires acute care, and is not chronic; does not require any chemotherapy or follow up care.
 - Coverage will only be allowed until the final diagnosed condition for the episode of care is stabilized. A condition is stabilized when the severity of illness and the intensity of service are such that the member can leave the acute care facility, no longer needs constant attention from a medical professional, advance to acute care for supportive care, or begins requiring long-term care.
 - The final diagnosed condition for the episode of care cannot be related to an organ transplant procedure.
 - The final diagnosed condition for the episode of care could reasonably be expected to result in:
 - Placing the patient's health in serious jeopardy;
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part.

Services provided during the prenatal or post-partum period are not covered unless the specific criteria listed above are met.

2. Medicaid Member Card and Documentation

Individuals who qualify for these services are issued a Medicaid Member Card. Services require documentation and review before payment to determine the services meet the definition and limitations stated above.

3. Billing for Emergency Services Provided to a Non-citizen

Any payment made by the Medicaid Agency for a service is considered payment in full. Once the payment is made to the provider for covered services, no additional reimbursement can be requested from the member. Because the emergency services program for non-citizens has a very restricted scope of services, it does not have some of the same restrictions on billing the member as is the case in other Medicaid covered services. If a provider does not receive payment from Medicaid because the provider failed to follow procedure to get a service covered, the provider is prohibited from pursuing payment from the member. However, if payment is not made because the service was not an emergency, or the service is not covered under the program, then the member can be billed for those services.

If a service is a covered service and meets the Medicaid definition of "emergency," Medicaid will pay for the service (subject to correct coding). However, if a non-citizen eligible for emergency services only presents at the ER with symptoms that do not appear to be emergent in nature, the provider would be prudent to inform the member, prior to the service, that the service might not be covered by Medicaid, and in that case the member will be financially responsible for paying the bill.

Billing for services provided to an emergency services only program member

1. Submit a claim to Medicaid
2. If payment denial is received - ***Do not rebill the claim.***
Follow these instructions, rather than rebilling the claim.
3. Fax or mail -
 - *A Document Submission Form* (from website) with all required fields completed.
Include the transaction control number for accurate claim matching.

- Medical records specific to the case, these may include:
 - Reports and consultations (e.g. admissions history and physical, physician notes, operative report, progress notes, and/or discharge summary)
 - Other documentation in support of the services as a medical emergency
 - Retroactive prior authorizations
 - Any required consent forms

FAX to:

Emergency Services Program for Non-Citizens

(801) 536-0475

(This number is also on the *Documentation Submission Form*)

The Medicaid billing address is in *Chapter 1, General Information*.

All information to be considered for review **MUST** be included in the initial submission. A second submission will not be considered for payment, unless additional records are requested.

Review process

All claims are held in queue for 60 days from the date of service prior to undergoing manual review, this allows for receipt of all related documentation and to help assure representation of the full episode of care.

1. Medicaid staff review submitted documentation.
 - If services meet the definitions of an “emergency medical condition” and “immediate medical attention” and are approved as an emergency, the claim is paid.
 - If insufficient documentation is received, the review cannot be completed; correspondence is sent to the provider, requesting additional documentation.
2. Notification of denial.
 - If criteria are not met, a letter of denial is sent from the Bureau of Medicaid Operations outlining the reasons.
Administrative Review and Fair Hearing rights are explained in the denial letter.
 - A provider who does not agree with Medicaid’s decision should refer to *Chapter 5, Hearings/Administrative Review*.

8-3 Medicaid Restriction Program

The Medicaid Restriction Program allows providers such as physicians and pharmacists to provide quality care while assuring that Medicaid does not facilitate drug abuse or overutilization of Medicaid services. If a Medicaid member has utilized pharmacy services or emergency department services at a frequency or amount that is not medically necessary, that individual may be referred to and enrolled in the Medicaid Restriction Program.

Members are identified in the Restriction Program through on-going reviews of member profiles to identify excessive use of services; verbal and written reports of inappropriate use of services from one or more health providers; and referral from Medicaid staff, law enforcement, or other state agencies. Members selected for enrollment in the Restriction Program are notified of the reasons, counseled in the appropriate use of health care services, and assisted in selecting an ACO, a single primary care provider and a single pharmacy. Medicaid will ensure that the member has reasonable access, taking into account geographic location and reasonable travel time, to pharmacy services of adequate quality. Before imposing restrictions, Medicaid will mail a notice to the member, which includes information about the Restriction Program and his or her right to request a hearing.

Providers who have identified Medicaid members who may be eligible for the Restriction Program may make a referral to the Medicaid member's ACO or may contact the Restriction Program at (801)538-9045 or 1(800) 662-9651 #900.

Providers may use the available resources found in *Chapter 6, Member Eligibility* to determine if a member has a restriction.

8-3.1 Payment on Claims for Restricted Members

Restricted members must receive all health care services through their assigned primary care provider (PCP). Restricted members must receive all pharmacy services through their assigned pharmacy. Unless an exception is met, providers or pharmacies that provide services to a Medicaid member enrolled in the Restriction program and who are not the assigned PCP or assigned pharmacy will not receive payment for the services rendered to a restricted member.

Providers or pharmacies not assigned to a restricted member may be eligible for payment in some exceptions. For example, temporary or secondary pharmacies may be assigned as approved by the member's Restriction Program Case Manager for specific reasons such as the member has a change of address or the restricted pharmacy does not carry a specific medication. Payment may also be made for services rendered by the allowed providers and by providers to whom the member has been appropriately referred. To facilitate an assigned PCPs ability to coordinate prescribed medications, Urgent Care and Emergency Department providers need to be approved by the PCP when a prescription is written for a restricted member. Generally, payment is made for Restricted Members who obtain emergency services and urgent care service.

Restricted members enrolled with an ACO are managed by the ACO. Members not enrolled in an ACO are managed by the Division of Medicaid and Health Financing Restriction Program Case Managers. Providers or pharmacies with questions regarding the Restriction Program should contact the Restriction Program Case Manager in the client's ACO or the Division of Medicaid and Health Financing, as applicable.

8-3.2 Inmates of Public Institutions

Medicaid members who are inmates of a public institution (including jail) are not entitled to ongoing Medicaid services. The facility is responsible for all medical expenses incurred during the member's stay, unless the member becomes an inpatient in a hospital. An inmate may qualify for Medicaid for the inpatient stay days. An inmate must meet eligibility criteria for a Medicaid program.

8-4 Covered Services

8-4.1 Pharmacy Services

For information related to the coverage and payment of outpatient drugs, including medications obtained through the 340B program, which are dispensed or administered to Medicaid recipients, refer to the Utah Medicaid Provider Manual for Pharmacy Services at: <https://medicaid.utah.gov>.

8-4.2 Telemedicine

Definitions

Telemedicine is two-way, real-time interactive communication between the member and the physician or authorized provider at the distant site. This electronic communication uses interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Telepsychiatric Consultation is a consultation between a physician and a board certified psychiatrist that utilizes:

- the health records of the patient, provided from the patient or the referring physician
- a written, evidence-based patient questionnaire

Authorized Provider means a provider in compliance with requirements as specified in this manual, refer to Chapter 3, *Provider Participation and Requirements*.

Distant site is the location of the provider when delivering the service via the telecommunications system.

Originating site is the location of the Medicaid member at the time the service is furnished via a telecommunications system.

Covered Services

Covered services may be delivered by means of telemedicine, as clinically appropriate. Services include, but are not limited to, consultation services, evaluation and management services, mental health services, and substance use disorder services.

Telepsychiatric consultations are covered.

Limitations

- Telemedicine encounters must comply with HIPAA privacy and security measures and the Health Information Technology for Economic and Clinical Health Act, Pub. L. No.111-5, 123 Stat. 226, 467, as amended to ensure that all patient communications and records, including recordings of telemedicine encounters, are secure and remain confidential. The provider is responsible to ensure for determining if the encounter is HIPAA compliant. Security measures for transmission may include password protection, encryption, and other reliable authentication techniques. Compliance with the Utah Health Information Network (UHIN) Standards for Telehealth must be maintained. These standards provide a uniform standard of billing for claims and encounters delivered via telehealth.
- The provider at the originating site receives no additional reimbursement for the use of telemedicine.

Modifier

GT - This modifier is required to indicate the service was provided through telemedicine.

GQ - This modifier is not a covered service. It is used for transmission of data.

8-4.3 Other Covered Services

The following is a high level list of covered services. More detailed information is described in State Plan Attachments 3.1-A and B and corresponding sections of this manual

1. Hospital Services:
 - Inpatient hospital services with the exception of those services provided in an institution for mental disease.
 - Outpatient hospital services
 - Outpatient surgical centers
 - Free-standing birth centers
2. Services for members age 65 or older in institutions for mental diseases:
 - Inpatient hospital services
 - Skilled nursing services
 - Intermediate care facility services
 - Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined, in accordance with Section 1902(a)(31)(A) of the Social Security Act, to be in need of such care, including those furnished in a public institution or a distinct part thereof for the intellectually disabled or persons with related conditions.
3. Rural health clinic and federally qualified health clinic services.
4. Laboratory and x-ray services.
5. Family planning services and supplies.
Family planning services and supplies are covered by Medicaid on a fee-for-service basis for an ACO plan member only if that member receives services from a Medicaid provider outside of her plan.
6. Physician's services whether furnished in the office, the member's home, a hospital, a skilled nursing facility or elsewhere.
7. Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals.
8. Podiatry services.
9. Optometry services.
10. Psychology services.
11. Chiropractic services
12. Home health services including intermittent or part-time nursing services provided by a home health agency, home health aide services, and medical supplies, equipment, and appliances.
13. Private duty nursing services.
14. Clinic services.
15. Dental services.
16. Physical therapy, occupational therapy, and related services.
17. Services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist.
18. Drugs, dentures, prosthetic devices, and eyeglasses prescribed by a qualified practitioner.
19. Medical supplies and durable medical equipment.

20. Other diagnostic, screening, preventive, substance abuse, and rehabilitative services, such as other than those provided elsewhere in the State Plan.
21. Nurse-midwife services and free-standing birth centers.
22. Hospice care in accordance with Section 1905(o) of the Social Security Act.
23. Case management services in accordance with Section 1905(a)(19) or Section 1915(g) of the Social Security Act, as to the group or groups.
24. Enhanced services for pregnant women in addition to services for uncomplicated maternity cases and Certified Nurse Midwife services. Enhanced services may include:
 - Medical or remedial care or services provided by licensed practitioners, other than physician's services, within the scope of practice as defined by state law
 - Medical transportation
 - Skilled nursing facility services for members through age 20
 - Emergency hospital services
 - Personal care services in the member's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse
25. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider in accordance with Section 1920 of the Social Security Act.
26. Extended services to pregnant women including pregnancy-related and postpartum services for 60 days after the pregnancy ends (or to the end of the month the 60th day falls on), including additional services for any other medical conditions that may complicate pregnancy with increases of service.
27. Skilled nursing facility services, other than services in an institution for mental diseases, for members over 20 years of age.
28. Child Health Program - Medical Services for Medicaid members enrolled in Traditional Medicaid ages birth through twenty. (Refer to *Chapter 8, Programs and Coverage*).
29. Other medical care and other types of remedial care recognized under State law, specified by the Secretary of the United States Department of Health and Human Services, pursuant to 42 CFR §440.60 and 170, including:
 - Medical or remedial care or services, provided by licensed practitioners, other than physician's services, within the scope of practice as defined by state law
 - Medical transportation
 - Skilled nursing facility services for members through age 20
 - Emergency hospital services
 - Personal care services in the member's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse
30. Medical interpretive services for members with limited English proficiency or disabilities.
31. Third party insurance premiums, including the Medicare Part A and/or Part B payments. Payments for Medicare members are covered under the Buy-in Program. Other third party health care premium(s) may be covered under the Buy-Out Program if continued third party coverage for the eligible recipient is determined to be cost-effective.

9 Non-Covered Services and Limitations

9-1 Limited Abortion Services

Medicaid reimbursement for abortion services is limited to procedures consistent with the Hyde Amendment restrictions. The Hyde amendment allows for the use of federal funds for abortion procedures to terminate a pregnancy under two conditions:

- In the professional judgment of the pregnant woman's attending physician, the abortion is necessary to save the pregnant woman's life and all requirements of 42 CFR 441, Subpart E have been satisfied; or
- The pregnancy is the result of rape or incest reported to law enforcement agencies, unless the woman was unable to report the crime for physical reasons or fear of retaliation.

In addition to the above conditions, Medicaid reimbursement for abortion service is allowed only when:

- Prior authorization is obtained,
- A properly executed and completed Utah Medicaid Abortion Acknowledgement and Certification Form is submitted, and
- A properly executed and completed Utah Medicaid Prohibition of Payment for Certain Abortion Services Provider Certification form is on file with the Bureau of Medicaid Operations.

When circumstances occur that lead to a natural pregnancy loss or inevitable abortion, Medicaid will not reimburse any procedures or misoprostol when fetal heart tones are present. Ultrasound must confirm no fetal heart activity before procedures or misoprostol are initiated or administered.

9-2 Services Not Covered Regardless of Medical Necessity

The following services are not covered by Medicaid regardless of medical necessity. The list is not all inclusive, additional non-covered services are described in the Physician Services Section of this manual and other corresponding sections.

Examples:

- Complementary Alternative Medicine (CAM) (e.g. Acupuncture, biofeedback)
- Cosmetic surgery
- Drugs for weight gain or loss, hair growth, fertility, or those considered experimental, investigational or unproven
- Experimental or investigational, or unproven procedures or services
- Laser eye surgery used to correct refractive errors
- Fees for missed appointments

9-3 General Non-Covered Services

9-3.1 Limiting Amount, Duration, or Scope of Services

The Division of Medicaid and Health Financing has the authority to limit the amount, duration, or scope of services or to exclude a service or procedure from coverage by Medicaid. Policy recommendations are based on medical necessity, appropriateness, and utilization control concerns [42 CFR §440.230]. Recommendations consider the following:

- Existing policy for non-covered cosmetic, experimental, or unproven medical practices

- Information available from the Centers for Medicare & Medicaid Services, Department of Health and Human Services. Information and recommendations from physician consultants employed by the Utah Department of Health, Division of Medicaid and Health Financing. Consultation with appropriate groups or individuals from various professional organizations
- Legal counsel
- Consultation with policy staff of the local Medicare carrier
- Consultation with policy staff of Medicaid programs in other states (selected)

9-3.2 Out-of-State Services

Medically necessary, scheduled, medical services are furnished out-of-state to Utah Medicaid members in accordance with 42 CFR §431.52. Medical necessity is indicated when the same services or the closest Medicaid providers are not available within the state, or a higher level of expertise is available in another state, or there is no other equally effective course of treatment available or suitable for the patient requesting the service, that is more conservative or substantially less costly. The out-of-state provider must be enrolled or will be enrolled with Utah's Medicaid program on or before the date of service.

Emergency medical services are reimbursed if the services are a covered Utah Medicaid benefit and if the provider becomes a Utah Medicaid provider.

9-3.3 Experimental, Investigational, or Unproven Medical Practices

Medicaid does not reimburse providers for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products, or devices that are considered experimental, investigational, or unproven.

- **Experimental, investigational, or unproven medical practice:** Any procedure, medication product, or service that is not proven to be medically efficacious for a given procedure; or performed for or in support of purposes of research, experimentation, or testing of new processes or products; or both.
- **Medically efficacious:** A medical practice that has been proven to be as effective or superior to conventional therapies, and is widely utilized as a standard medical practice for specific conditions; and has been approved as a covered Medicaid service by division staff and physician consultants on the basis of medical necessity.
Some procedures may have research supporting efficacy, but do not yet have a HCPCS code available for billing. Coverage determination recommendation is made through Utilization Review or CHEC committees on a case by case basis when there is evidence-based efficacy research and documentation of member medical necessity. If coverage is recommended, the case then goes through the administrative approval process before the provider is notified of the final decision.

9-3.4 Exceptions when Medicaid will pay for Non-Covered Procedures

Generally, Medicaid does not reimburse non-covered procedures. However, exceptions are considered through the utilization review process in the circumstances listed below:

- The member is eligible for services under the CHEC program. CHEC may pay for services which are medically necessary but not typically covered by Medicaid.
- Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery.

- Reconstructive procedures to correct serious functional impairments (for example, inability to swallow).
- When performing the procedure is more cost effective for the Medicaid Program than other alternatives.

9-3.5 Quantity Limits

Some services, medical supplies, and durable medical equipment have established quantity limits. Specific quantity limits are indicated on the Coverage and Reimbursement Code Lookup tool. A prior authorization request must be submitted when requesting more than the allowed amount.

The prior authorization request must include proper documentation of medical necessity, specifically why the quantity limit needs to be exceeded, how much is being requested, and over what period of time.

10 Prior Authorization

The information in this chapter pertains to prior authorization (PA) requests for Utah Medicaid fee-for-service authorizations only. If the prior authorization request is for a member covered under a Managed Care Organization (MCO), and the service being requested is not a carve-out service, contact the MCO for instructions on requesting prior authorization. Contact information for Managed Care Organizations is found on the Utah Medicaid website at <https://medicaid.utah.gov/prior-authorization>, *Contact Us*; scroll to the applicable MCO.

When prior authorization is required for a health care service, the provider must obtain approval from Medicaid before service is rendered to unless the program specific Section of the provider manual states that there are exceptions to obtaining authorization prior to service delivery. Medicaid can pay for services only if all conditions of coverage have been met, including but not limited to, the requirement for prior authorization. Failure to obtain prior authorization may result in a denial of payment. Providers are responsible for determining whether prior authorization is required.

There are exceptions to the requirement for written prior authorization for specific provider types and services; these are noted in the related sections of this manual.

Code specific criteria and instructions are in the Coverage and Reimbursement Lookup Tool at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

10-1 Request Prior Authorization

To obtain prior authorization, the provider must complete a current copy of the appropriate prior authorization request form and submit it, with all required documentation, to the Prior Authorization Unit at the Division of Medicaid and Health Financing. The appropriate forms are found at <https://medicaid.utah.gov/prior-authorization>, *General PA Forms or Pharmacy Criteria Forms*.

When a prior authorization request is submitted without complete documentation, the request is returned without processing. Medicaid returns the request and indicates what additional documentation is required before the request can be reviewed to determine medical necessity. A returned request is not a denial and has not accrued hearing rights. When a prior authorization request is returned for lack of

documentation, the provider is required to resubmit the entire request including the additional documentation. Upon receipt of the resubmitted request, Medicaid staff reviews the PA request to determine if the service is covered by Medicaid and if the service is medically necessary. The date in which a complete request, with all necessary supporting documentation, is received will be the date posted for the PA request.

When a prior authorization request is denied, Medicaid sends a written notice of decision to the member, and a copy to the provider. Either or both may appeal the denial.

10-1.1 Denial Letter

If Medicaid denies authorization, the letter of denial is sent and includes this information:

- The action Medicaid intends to take
- The reasons for the action
- Statement of the laws and criteria supporting the action
- The right to a hearing
- The process to request a hearing
- The right to be represented by an attorney or other person
- The circumstances, if any, under which the service is continued pending the outcome of the hearing

Copies of applicable policies, laws, and criteria supporting the decision are included with the letter. A *Hearing Request Form* with instructions for requesting a hearing is also attached. The denial letter does not include a request for new or additional information.

When a request for a hearing is submitted, Medicaid follows the policy and procedure under Utah Administrative Code, Section R410-14.

10-1.2 Prior Authorization Submission Methods

FAX Requests:

FAX the PA request to the appropriate number listed on the applicable prior authorization request form. The prior authorization request forms are found at <https://medicaid.utah.gov/prior-authorization>, General PA Forms or Pharmacy Criteria Forms.

Mail PA requests to:

Medicaid Prior Authorization Unit
P. O. Box 143111
Salt Lake City, UT 84114-3111

Telephone Submission:

When policy permits, submit a request by calling:

(801) 538-6155 or
1(800) 662-9651

Select option 3, option 3 and then select the appropriate program.

Medicaid PA unit hours are:

M, T, W, F, 8:00 a.m. to 5:00 p.m.

Thursday 11:00 a.m. to 5:00 p.m.

10-2 Prior Authorization for CHEC Eligible Members

Coverage may be available for CHEC eligible members when a service is not covered by Medicaid for an adult. For complete information concerning prior authorization for CHEC eligible members, refer to the applicable Section 2 of *the Utah Medicaid Provider Manual: CHEC Services and Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals*.

Prior authorization requests for CHEC services must be in writing and include all applicable information listed below:

- Estimated cost for the service or item.
- Photocopy of any durable medical equipment item(s) requested.
- Current comprehensive evaluation of the child's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested.
- Letter from the physician describing medical necessity and including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be patient specific, indicate the reasons the physician is recommending the service or equipment, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

All providers involved in the diagnosis, evaluation or treatment of the patient, should communicate directly and work together as a team to evaluate the most appropriate services for the child.

10-3 Retroactive Authorization

Retroactive authorization is an authorization requested after a service has been provided. Retroactive authorization is considered in the circumstances listed below. To seek retroactive authorization, the provider must complete the appropriate prior authorization request form and include documentation describing the reason the service was provided before authorization was issued. The medical documentation submitted must comply with Medicaid coverage authorization requirements for consideration of retroactive coverage.

Refer to the program specific Section of *the Utah Medicaid Provider Manual*, for documentation guidelines.

10-3.1 Circumstances Eligible for Retroactive Authorization

1. Retroactive Medicaid Member Eligibility

Retroactive authorization must be requested within 90 days of Medicaid eligibility determination for services provided prior to the date of determination or services shall be denied. Services that are provided after Medicaid eligibility has been determined must be requested prior to services being provided or services shall be denied. Medicaid eligibility verification is the responsibility of each provider.

- Complete the appropriate request for prior authorization form according to instructions and provide justification for the request for retroactive authorization.
- The procedure must be covered by Medicaid and documentation must meet Medicaid coverage requirements for prior authorization.
- Include documentation from the medical record to support the medical necessity of the service.

2. Medical Emergency

Retroactive authorization must be requested within 90 days of the medical emergency or shall be denied.

Services that require prior authorization may be performed in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment. To qualify, the service must have been provided in a documented medical emergency. Emergent requests must still meet the current Medicaid criteria.

It is the responsibility of the provider to submit all documentation required to complete a review, including documentation from the medical record to support the emergent nature of the service.

3. Medical Supplies Provided in a Medical Emergency

Retroactive authorization must be requested within 90 days of medical emergency or shall be denied.

Certain medical supplies and equipment that require prior authorization may be provided in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment.

It is the responsibility of the medical supplier to substantiate the emergency and provide the necessary documentation to support a prepayment review.

Providers must obtain prior authorization for all other services, supplies, and equipment, even if the member's circumstances appear to qualify as an emergency.

Examples of medical supplies that may meet this condition: hospital bed, oxygen and related equipment. Refer to *Medical Supplies Provider Manual, Section 2*, for details.

4. Surgical Exceptions

Retroactive authorization must be requested within 90 days of surgical procedure or shall be denied.

If the planned procedure did not require prior authorization or if prior authorization was obtained for the planned procedure and during surgery it was determined that a different procedure that normally required prior authorization was needed, then retroactive authorization may be requested if the provider can demonstrate through written documentation:

- The need for the additional procedure was unexpected and was discovered during the surgery;
- The provider could not have anticipated the need for the procedure prior to the surgery; and
- There was no indication the procedure was anticipated among the differential diagnoses prior to performing the surgery.

Surgical exception requests are reviewed using the current Medicaid criteria.

5. Exceptions for Anesthesia Providers

Retroactive authorization must be requested within 90 days of procedure requiring anesthesia or shall be denied.

For cases in which a surgical procedure requires prior authorization, the associated anesthesia codes are typically prior authorized as a component of the surgical procedure prior authorization.

For cases in which a surgical procedure does not require prior authorization, but the associated anesthesia codes do, or when a surgeon failed to obtain prior authorization, retroactive authorization may be considered when all required documentation is submitted and upon confirmation that the surgery was not:

- Previously denied by Medicaid
- Cosmetic, investigational, or experimental
- A non-covered service
- A service prohibited without state or federal required consent forms.

10-4 Exceptions to Prior Authorization Requirements and Non-Covered Services

Medicaid delay in prior authorization

When a delay in prior authorization rests with Medicaid, the date of the complete submission for prior authorization is considered. However, the submitted documentation must meet the criteria for approval.

Non-covered services

Generally, Medicaid does not provide reimbursement for non-covered services. However, exceptions may be considered through the prior authorization/utilization review process in the circumstances listed below and when there is no code that is a covered Medicaid benefit that accurately describes the service to be provided:

- The member is CHEC eligible. The CHEC program may pay for services which are medically necessary but not typically covered by Medicaid.
- Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery.
- Reconstructive procedures to correct serious functional impairments (for example, inability to swallow).
- When providing a service which is more cost effective for the Medicaid program than other alternatives.

11 Billing Medicaid

This chapter covers topics such as billing procedures, third party claims, coding, and manual review.

The provider may bill Medicaid only for services which were medically indicated and necessary for the member and either personally rendered or rendered incident to his professional service by an employee under immediate personal supervision, except as otherwise expressly permitted by Medicaid regulations. The billed charge may

not exceed the usual and customary rate billed to the general public, such as individual member accounts or third party payer accounts.

11-1 Medicaid is the Payer of Last Resort

As required by law, Medicaid is the payer of last resort, meaning that other third parties must be billed before Medicaid can be billed for the service. Medicaid members may have third party coverage of health expenses, such as Medicare, employment-related insurance, private health insurance, long-term care insurance, court judgments, automobile insurance, and so forth. Again, all other resources must be exhausted before Medicaid can consider payment.

11-2 Unacceptable Billing Practices

The use of any device or strategy that may have the effect of increasing the total amount claimed or paid for any service beyond the maximum allowable amount payable for such service is not allowed. Following are examples of unacceptable billing practices.

- Duplicate billing or billing for services not provided.
- Submitting claims for services or procedures that are components of a global procedure.
- Submitting claims under an individual practitioner's provider number for services performed by the practitioner as an employee of or on behalf of a group practice or clinic when the service has been billed under the group or clinic number.
- Use of more intensive procedure code than the medical record indicates or supports.
- Separate charges for freight, postage, delivery, installation, set-up, instruction, fitting, adjustment, measurement, facility visits, or transportation since these services are considered to be all-inclusive in a provider's charge unless otherwise specified, e.g. shipping cost for hearing aid repair.

11-3 Business Agents

A billing or business agent is a person or an entity that submits a claim for a provider and receives Medicaid payments on behalf of a provider. Payments may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of a provider, if the agent's compensation for this service meets three conditions: (1) is related to the cost of processing the claim; (2) is not related on a percentage or other basis to the amount that is billed or collected; and (3) is not dependent upon the collection of payment.

11-4 Factoring Prohibited

As a reminder to all providers, federal regulations prohibit the use of a factor to obtain payment from Medicaid for any service furnished to a Medicaid member. The regulations define a factor as an individual or an organization, such as a collection agency or service bureau, which advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a business representative. Payment for any service furnished to a Medicaid member by a provider may not be made to or through a factor, either directly or by power of attorney. (Services provided under the PCN and Emergency Only programs are exceptions to this factoring prohibition.)

11-5 Third Party Coverage

11-5.1 Medicare Crossover Claims

Medicaid Members who have Medicare: Accepting Members with Dual Coverage

When a Medicaid member also has Medicare, a provider may either accept the member as having dual coverage *or* not accept either type of coverage. Federal Medicaid regulations do not permit a provider to reject Medicaid and accept only Medicare. For example, when a member has Medicare, a provider cannot bill the member for services that would have been provided under Medicaid, and accept only Medicare payment. A provider can only refuse Medicaid and insist the member must be "private pay" *if* there is no Medicare coverage. Of course, the Medicaid agency urges that providers accept the patient as a Medicaid member, then follow the procedures outlined in the applicable Sections of the *Utah Medicaid Provider Manual* for billing TPL.

Medicare/Medicaid Crossover Claims

To ensure prompt processing, the Medicaid provider's NPI must be on the claim. The deadline for filing a Crossover claim is 365 days from date of service or six months after Medicare disposition. Medicaid may then consider payment of a Medicare deductible and co-insurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid.

If the provider accepts assignment for Medicare Part A or Part B, the Crossover claim is sent to Medicaid Crossovers automatically from the intermediary. If the provider does not accept assignment, a claim is not sent automatically, and the provider must submit the claim directly to Medicaid Crossovers.

Payment is reported on the Crossover section of the Medicaid Remittance Statement. The Medicare and Medicaid payment is considered payment in full.

Submit claims directly to Medicaid Crossovers. Instructions are online at <https://medicaid.utah.gov/> under Coordination of Benefits.

Non-Covered Medicare Services

Bill claims for non-covered Medicare services, such as non-durable medical supplies, drugs, and Intermediate Care Facility (ICF) nursing home care provided to Medicare/Medicaid eligible members directly to Medicaid.

Submission of Crossover Claims

Paper Claims

Submit to:
Medicaid Crossovers
P.O. Box 143106
Salt Lake City, Utah 84114-3106

Electronic Claims

It is necessary to submit an Explanation of Medicare Benefits (EOMB) for \$0 payment or denials. Complete the other payer payment information, including payer paid amount, member liability, and reason codes.

Submit to:

Utah Medicaid Crossovers	HT000004-005
Fee-for-Service	HT000004-001
Atypical	HT000004-801

11-5.2 Correcting Third Party Liability Information

If third party liability (TPL) information appears to be incorrect (for example, the TPL denies a claim as "patient not eligible"), the provider should advise the member to call the TPL unit in the Office of Recovery Services (ORS) at the Department of Human Services. Providers may also call ORS to advise them of correct third party liability information.

11-5.3 Billing Third Parties

If a member has both Medicaid and coverage with a responsible third party, do not collect a co-payment that is usually due at the time of service. The provider should include the primary insurance co-payment as part of the submitted charges to Medicaid. A provider must seek and secure payment from all other liable third parties such as insurance coverage, a health plan and Medicare Part A and B. The Medicaid payment is made after all other liable third parties have made payment or sent a denial.

Bill the responsible third party, then Medicaid, as follows:

1. Submit the claim to the third party or parties.
2. If the third party pays the claim, submit a claim to Medicaid and show the TPL payment according to instructions. Medicaid bases any subsequent reimbursement on the Medicaid fee schedule.
3. Medicaid will make an additional payment to a provider for services rendered if the payment received from the insurance company is less than the Medicaid reimbursement amount or

Medicaid will not make an additional payment if the amount received from the insurance company is equal to or greater than the Medicaid reimbursement amount. In this case, the TPL payment is considered payment in full. A provider will not bill the member for any difference between the amount charged and the TPL payment received.

If a provider receives a third party payment and does not bill Medicaid for the balance because he or she anticipates the Medicaid payment to be zero, the TPL payment is considered payment in full, and the provider may not bill the member.

An exception is inpatient hospital claims with third party insurance. Refer to, *Hospital Services of Provider Manual, Section 2*.

If the third party denies the claim for any reason (non-covered benefit, patient not eligible, etc.) submit a claim to Medicaid. The claim may be filed electronically, include written documentation on the TPL response. Documentation sent separately goes to ORS. If the third party pays less than

reported on the Medicaid claim, submit a replacement claim showing the correct amount received from the TPL.

When a Medicaid claim is suspended for third party liability information, you can expedite the processing of the claim by faxing the complete Explanation of Benefits (EOB) directly to the Health Claims team at ORS. Include the second page which usually has the definitions of coded reasons for not paying the claim.

For claims other than Medicare or TPL use FAX number (801) 536-8513.

11-5.4 Billing Services for Newborns

Bill all services for newborns with the baby's own (unique) Medicaid member number. You may obtain the baby's Medicaid number by calling Medicaid Information. Refer to Chapter 1, Member Information.

If the baby does not have a unique Medicaid member number, the mother must notify her eligibility worker immediately. The worker determines the child's eligibility, and a unique Medicaid member number is assigned to the child.

Note: A newborn infant is not covered when his or her mother is eligible only for the Baby Your Baby Program. In this case, the mother must apply for Medicaid on behalf of the child if she needs assistance in paying the child's medical bills.

11-6 Submitting Claims

11-6.1 Electronic Claims

Utah Medicaid promotes the use of electronic transactions. Electronic Data Interchange (EDI) is the exchange of health-related information, including claims, electronically. The Medicaid EDI team is available to provide direction, answer questions, and assist providers or billing agents with the submission of electronic transactions. In order to submit claims electronically, providers must complete an EDI application form, which can be found on the Medicaid website at <https://medicaid.utah.gov/>.

Medicaid utilizes the Utah Health Information Network (UHIN), an internet-based system that can be used to interface between a medical billing system and UHINet (UHIN's internal portal). It can also be used to directly type in claims, eligibility inquiries, exchange administrative messages (claims, remits, claim attachments). UHIN is the receiving point for Medicaid health care transactions, and transactions sent to Medicaid via UHIN are immediately placed in the MMIS for processing during the next claim cycle. For more information, visit the UHIN website at <https://UHIN.org> or contact UHIN at (801) 466-7705.

If providers use software other than UHIN, it must be compatible with UHIN and conform to ANSI standards. Your software vendor can advise you as to the systems which use the ANSI standards in compliance with HIPAA and UHIN requirements.

11-6.2 Paper Claims

As defined in the Rule R590-164, Medicaid accepts the following paper claims:

- NCPDP Universal Pharmacy Claim
- Professional claims: HCFA 1500 02-12 Claim Form
- Institutional claims: UB04 Claim Form
- Dental claims: ADA 2012 Claim Form

Medicaid does not provide instructions for the use of each box on the paper claim forms.

The Utah Insurance Commissioner maintains standards to clearly describe the use of each box (for print images) and its crosswalk to the HIPAA transactions. The Utah standards to describe the use of each box on the Professional Claim CMS-1500 (08/05), the ADA Dental Claim (2006) and the Institutional Claim UB-04 claim forms are available from the [UHIN](#) or the [insurance commissioner](#).

NCPDP maintains instructions for the pharmacy claim form at <http://www.ncdp.org/Products/Universal-Claim-Forms>

11-6.3 NCPDP Pharmacy Point of Sale (POS) System

The Point of Sale (POS) system accepts standardized claims for pharmacy services to be submitted through an electronic data exchange. For information about acceptable software for submitting inquiries, transmitting claims, and electronic procedures and messages, refer to [Pharmacy Services Provider Manual](#), *Chapter 6 Billing*. As electronic data interchange features become available, Medicaid will notify providers in the Medicaid Information Bulletin.

11-6.4 Electronic Data Interchange (EDI) Resources

Utah Medicaid follows the HIPAA mandated TCS standards as set forth by DHHS and CMS. Electronic Data Interchange (EDI) is the most efficient method of submitting and receiving large amounts of information within the Utah Medicaid Management Information System (MMIS). Accredited Standards Committee (ASC X12) Implementation Guides are available from the [Washington Publishing Company](#).

Utah Medicaid-specific Companion Guides to the X12 Implementation Guides and National Council of Prescription Drug Programs (NCPDP) payer sheets are available on the Medicaid website at <https://medicaid.utah.gov>.

Utah Medicaid EDI Help Desk

Telephone 1(800) 662-9651 or (801) 538-6155, option 3, option 5

Mail written correspondence to:

Bureau of Medicaid Operations

PO Box 143106

Salt Lake City, UT 84114-3106

11-6.5 Time Limit to Submit Medicaid Claims

Federal regulations require that a claim must be submitted to Medicaid within 365 days from the date of service. The date of service, or “from” date on the claim, begins the count for the 365 days to determine timely filing. For institutional claims that include a span of service dates (i.e., a “from” and “end” date

on the claim), the “end” date begins the count for the 365 days to determine timely filing. Any adjustments or corrections must also be received within the 365-day time period.

Requesting Review of Claim That Exceeds Billing Deadline

It is to the provider's advantage to submit claims and follow-up on unpaid balances within the billing deadline. Claims received by Medicaid after the billing deadline will be denied. Providers may request to correct a claim outside of the timely filing deadline; however, no additional funds will be reimbursed. Any exception to the 365-day limit is stated below.

Untimely Claims - When Payment Can Be Made

If Medicaid denied a claim for exceeding the billing deadline, the provider may request a review for payment. The situations listed below may be considered for review, provided specific, appropriate documentation is submitted.

- Provider is under investigation for fraud or abuse.
- Court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.
- Situations involving a provider who conforms with Medicaid requirements by billing a third party payer first, resulting in non-payment after the 365 day billing deadline, have been allowed as an exception to the filing deadline in hearing decision numbers 13-078-02 and 13-239-03. In accordance with 42 CFR §447.45(d)(4)(iv) and the above paragraph, if a provider files a claim beyond the 365 day limit in such a situation, it is a “same situation” as to prior agency hearing decisions and may be processed.
- Situations involving agency error in processing a timely clean claim resulting in the provider having to again file the claims beyond the one-year deadline have been allowed as an exception to the filing deadline in hearing decision numbers 13-212-08 and 13-212-22. In accordance with 42 CFR §447.45(d)(4)(iv) and paragraph 2 above, if a provider files a claim in such a situation, it is a “same situation” as to prior agency hearing decisions and may be processed.

Requesting Review for Payment

If the provider has documentation to demonstrate one of the above situations, send the documentation with a copy of the Medicaid remittance and a Document Submission Form, to:

Bureau of Medicaid Operations
Attn: Timely Filing Review
PO Box 143106
Salt Lake City, Utah 84114-3106

When the documentation is received, the request is reviewed. If Medicaid finds that criterion for one of the timely filing exceptions is met, Medicaid will waive the time limit and initiate processing of the claim.

11-6.6 Clean Claims and New Claims

The definitions of the terms “clean claim” and “new claim” affect which claims and adjustments Medicaid may consider for payment when more than 365 days have passed since the date of service.

Clean claim - Federal regulations define a clean claim as a claim that Medicaid can process without obtaining additional information from the provider of the service or from a third party, including a claim with errors originating in a State’s claim system. A claim that denies for omitted or incorrect date or for missing attachment is not a clean claim. A claim filed more than 365 days after the date of service is not a clean claim.

New claim - A new claim is a claim that is unique, differing from all other claims in at least one material fact. It is important to note that identical claims received by Medicaid on different days differ in the material fact of their receipt date and are both new claims unless defined otherwise.

11-6.7 Resubmit Claims with Corrected Information

If a claim is denied for incorrect information, correct the claim and resubmit it, rather than calling Medicaid Information. Until the claim is billed correctly, it cannot be processed.

Claim Corrections through Re-Submission

Occasionally a claim is paid incorrectly (e.g., a line denied), if this occurs a replacement claim must be filed. Refer to the EOB for denial or payment information. The following data elements are required to identify the claim as a replacement or void of an original claim:

Claim Frequency Code

Acceptable values: 6 or 7 for replacement, 8 for void
Electronic: X12 element 2300 CLM05-3
Paper: UB-04 - Form Locator 4, position 3
CMS 1500 (08/05) - Box 22 (Code)

Dental - Process not available on paper.

Original Reference Number

Transaction Control Number (TCN) of original claim to be replaced or voided
Electronic: X12 element 2300 REF02
Paper: UB-04 - Form Locator 37 A-C (same line as Medicaid in 50A-C)
CMS 1500 (08/05) - Box 22 (Original Ref. No.)

Dental - Process not available on paper.

Replacement claims void the original claim and process the replacement claim. Consult with your programmer to verify the required data elements are available in your software. Claims submitted without a valid original reference number (TCN) will be rejected.

The NPI must be the same on both the replacement/void and the original claim. If providers are different, send a void for the original claim and resubmit an original claim for the correct provider.

11-7 Payment Denial for Members Not Eligible for Medicaid or Enrolled in an MCO

Medicaid is a benefit only to eligible persons. Medicaid will not pay for services rendered to an individual who is not eligible for Medicaid benefits on the date the service is rendered. Medicaid will not make fee-for-service payments when a member is enrolled in an MCO unless the service is carved out. It is the provider's responsibility to verify the individual's eligibility for Medicaid for the date the service is rendered. It is also the provider's responsibility to verify if the individual is enrolled in an MCO. Claims for ineligible individuals or claims that are the responsibility of a MCO will not be paid even when information was given in error by Medicaid staff. Staff make every effort to provide complete and accurate information on all inquiries.

11-8 HIPAA Transaction and Code Set Requirements

With established national standard for electronic claims and other transactions, healthcare providers are able to use consistent procedures and codes when submitting transactions to a health plan anywhere in the United States¹.

Standards for nine electronic transactions and code sets are used in claims transactions. These include:

- Claims or Encounter Information
 - Eligibility Inquiry and Response
 - Payment and Remittance Advice
 - Referral Certification and Authorization (Prior Authorization)
 - Claim Status Inquiry and Response
 - Enrollment/Dis-enrollment in Plan
 - Premium Payments
-
- Professional Claims (837 Professional)
837 Professional Transaction
The ASC X12N 837 Professional transaction is the electronic equivalent for the CMS-1500 (08/05) paper claim form.
 - Institutional Claims (837 Institutional)
837 Institutional Transaction
The ASC X12N 837 Institutional transaction is the electronic equivalent of the UB-04 paper claim form.
 - Dental Claims (837 Dental)
837 Dental Transaction
The ASC X12 837 Dental transaction is the electronic equivalent of the ADA 2006 paper claim form.
 - Eligibility Inquiry/Response (270/271 Transactions)
270 Eligibility Inquiry Transaction (Batch)

¹ Accredited Standards Committee (ASC X12) – An ANSI accredited standards organization responsible for the development and maintenance of electronic data interchange (EDI) standards for many industries. The “X12” or insurance section of ASC X12 handles the EDI for the health insurance industry's administrative transactions. Under HIPAA, X12 standards have been adopted for most of the transactions between health plans and providers.

ASC X12N 270 Eligibility Inquiry Transaction set is used to transmit health care eligibility benefit inquiries from health care providers, clearinghouses and other health care adjudication processors.

- 271 Eligibility Inquiry Transaction
The ASC X12N 271 Eligibility Response Transaction set is used to respond to health care eligibility benefit inquiries as the appropriate mechanism.
- Claim Inquiry/Response (276/277 Transactions)
276 Claim Inquiry Transaction (Batch)
The 276 Transaction Set is used to transmit health care claim status request/response inquiries from health care providers, clearinghouses and other health care claims adjudication processors. The 276 Transaction Set can be used to make an inquiry about a claim or claims for specific Medicaid members.
- 277 Claim Inquiry Response Transaction (Batch)
The 277 Transaction Set is used to transmit health care claim status inquiry responses to any health care provider, clearinghouse or other health care claims adjudication processors that has submitted a 276 to the Utah MMIS.
- Enrollment (834 Transactions)
834 Enrollment Transaction
The 834 Transaction Set is used to transmit health care enrollment into an Accountable Care Organization (ACO). Medicaid uses this transaction to notify the ACOs that a Medicaid recipient has been enrolled in the ACO. The transaction provides the plan with the recipient's demographics and some health data.
- Remittance Advice (RA) (835 Transactions)
835 Remittance Advice
The 835 Transaction Set will only be used to send an Explanation of Benefits (EOB) RA. For Utah Medicaid, payment is separate from the EOB RA and will therefore not be affected by changes to how the provider receives payment. The 835 transaction will be available to the providers and contracted clearinghouses requesting electronic remittance advice (ERA). Providers may choose to receive ERA or paper RA, or both.
- Premium Payment (820 Transactions)
820 Premium Payment Transaction
The 820 Transaction Set is used to transmit premium payment data to the ACO.
- Prior Authorization (278 Transactions)
278 Referral Certification and Authorization. Health Care Service Review Transaction
The 278 Transaction Set is used to transmit requests for prior authorization of services.

11-8.1 Electronic Claim/Prior Authorization with Attachment(s)

Medicaid allows claims or prior authorization request submitters to continue billing their claims or PA requests electronically even if a paper attachment needs to be sent with the claim or PA request. If documentation is required to support the claim, the claim may deny; however, once documentation is received the claim will be reprocessed.

To ensure proper handling of attachments, ensure the attachment contains the following information:

- *Document Submission Form*
- A provider assigned attachment control number (ACN) unique to this attachment. Each attachment associated with the claim must display a unique number.
- The attachment control number (ACN) (This can be the transaction control number (TCN) of the accepted claim as reported in the 277FE when sending to Medicaid) in the PWK segment in the electronic claim must be identical to the ACN or TCN on paper. Write number reported in 2300 PWK06 (Identification Code) or TCN of accepted claim as reported in the 277FE on documentation before sending to Medicaid.
- All ACNs must be unique.
- The provider and recipient numbers on the claim must match the provider and recipient numbers on the attachment.
- The ACN/TCN number on attachment must be clear and legible.

11-8.2 Pharmacy Claims NCPDP Version D.0

All interactive electronic pharmacy claims should be submitted using the NCPDP version D.0 standard. All pharmacy claims submitted electronically in batch must be in NCPDP version 1.1 standard.

12 Coding

All Utah Medicaid claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims. Procedure codes are dependent on the type of service and claim type. Medicaid recognizes guidelines in current editions of established coding manuals or other standard literature. However, those guidelines are adopted only as far as they are consistent with application to Utah Medicaid policy. The established coding guidance materials consist of the following:

1. Healthcare Common Procedure Coding System (HCPCS)
 - a. Physicians' Current Procedural Terminology (CPT) Manual
 - b. Healthcare Common Procedure Coding System, HCPCS Level II
 - c. Healthcare Common Procedure Coding System, HCPCS Level III
2. International Classification of Diseases (ICD), Clinical Modification (CM), and Procedural Coding System (PCS)
3. Revenue Codes (Uniform Billing Codes-UB-04)

1. Healthcare Common Procedure Coding System (HCPCS)

- a. The HCPCS System incorporates the American Medical Association, Current Procedural Terminology (CPT) Manual as Level I of the system. CPT represents the major portion of the HCPCS system. CPT uses 5 digit numeric codes and a uniform language to accurately classify medical, surgical, and diagnostic services for effective communication among health care providers, health care facilities, and third party payers. Although the CPT Manual is primarily for physician use, other providers may be authorized by Medicaid policy to use the codes and descriptors if other HCPCS codes are not available or appropriate.
- b. HCPCS Level II codes are alphanumeric codes which are uniform in description throughout the United States. The codes begin with a letter followed by four numbers. The descriptions cover

equipment, supplies, materials, injections and other items used in health care services. Although the codes and descriptors are uniform, processing and reimbursement of HCPCS Level II codes is not necessarily uniform throughout all states.

- c. HCPCS Level III codes and descriptors are developed for Medicare carriers for use at the local (carrier) level. These are 5-position alpha-numeric codes in the W, X, Y or Z series represented in the Level I or II codes. Level III codes and their descriptions are available from the local part B carrier.

2. International Classification of Diseases (ICD)

The International Classification of Diseases (ICD): Clinical Modification is a statistical classification system that arranges diseases and injuries into groups according to established criteria.

3. Revenue Codes (Uniform Billing Codes UB-04)

Uniform billing guidelines are a standard data set and format used by the health care community to transmit charge and claim information on hospital services to third party payers. The guidelines are developed on a national basis by the National Uniform Billing Committee. The Billing Manual is maintained and updates provided locally by the Utah Hospital and Health Systems Association. The approved codes in the Medicaid section of the UB-04 Manual are established consistent with Medicaid policy, reviewed and maintained by Medicaid staff periodically.

12-1 Coding Maintenance

Industry updates to CPT, HCPCS, and ICD-10-CM codes are published toward the end of each year. Medicaid staff review each new edition of the coding manuals. The purpose of the review is to identify new services, eliminated services or procedures, and altered descriptions of service. Where additions, deletions, and/or changes have occurred, research is initiated with subsequent development of appropriate policy recommendations and rulemaking to establish service coverage and/or limitations consistent with Medicaid policy. Notice of any change is given in the Medicaid Information Bulletin (MIB). All codes will be discontinued or added based on the date of implementation set by the standard setting organization.

Note: Coding information, clarification or review is not available through the Medicaid Information Hotline. In other words, Medicaid staff may not advise providers which codes to use.

12-2 Classifying Patients as New or Established

Providers must observe CPT and Medicaid guidelines on classifying a patient either as *new* or as *established*. Under CPT guidelines, a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

- In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

- No distinction is made between new and established patients in the emergency department. E&M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department. Medicaid considers the term “emergency department” only to be a designated emergency unit of a licensed hospital.

When a physician is on call for or covering for another physician, classify the patient’s encounter as it would have been by the physician who is not available. Medicaid considers any physician in the same clinic, group practice or other facility to be “of the same specialty” unless the member has specifically been referred to another physician of a different specialty for issues related to that specialty.

12-3 Diagnosis Must Agree with Procedure Code; Use of ‘Z’ Codes

When an ICD-10-CM 'Z' code is used, an additional diagnosis code must also be added to the claim form. As always, the diagnosis and procedure codes must agree.

Examples:

- Personal history of malignant breast neoplasm, Z875.3, should be accompanied by other ICD-10-CM code(s) indicating the differential diagnoses that led to a decision for CT scans of the brain and spine. The ICD-10 codes should reflect symptoms and/or the differential diagnosis that led to the decision for extensive imaging, laboratory tests, and/or a procedure.
- When using 'Z' codes in the range of Z40-Z53 (follow-up examination after surgery) include the diagnosis code related to the original surgery, injury, or fracture.

Supplying the correct diagnosis and procedure codes for payment is the responsibility of the provider. The differential diagnosis must support the medical necessity of the procedure for reimbursement. Often, more than one diagnosis is required to explain and support a service. When the diagnosis does not support the procedure, a diagnosis to procedure discrepancy will be reported on the remittance advice. Providers should then resubmit a claim with additional or other appropriate diagnoses.

12-4 Procedures for Children

When the majority of procedures are related to a routine health visit and/or childhood immunizations, Z codes related to routine child health examinations, such as Z00.121, Z00.129, Z76.1, Z76.2, will be accepted alone for payment. However, when the child also has a medical condition that requires additional procedures (such as x-rays, laboratory examinations, etc.), include on the claim the ICD-10-CM code which describes the differential diagnoses for the medical condition. The ICD-10-CM codes assist in explaining the diagnostic test.

12-5 Diagnosis and Procedure Incomplete or Not in Agreement

Claims submitted with a diagnosis which does not agree with the completed procedure will be denied. For example: A claim for CT of the abdomen which is submitted with diagnoses of headache and myalgia will not be paid. Also, with the exception of child health, maternal health, or refugee exams, claims submitted with only a Z code will not be paid; all claims require a code which describes the diagnoses for the medical condition.

Medicaid must have an accurate record of the diagnosis and procedures on submitted claims to evaluate programs and payment trends. Claim payment to providers is delayed when inaccurate diagnoses are submitted. Direct questions to Medicaid Operations (Refer to *Chapter 1, General Information*).

12-6 Procedures with Time Definitions

Many procedure codes contain time frames built into the definition. For billing services that fall between the time frames, Medicaid's policy is to round to the nearest full unit or appropriate procedure code. No partial units may be reported.

12-7 Manual Review

The manual review of claims is reserved for specific types of claims. A provider may not request a manual review of a claim unless the denial meets the criteria found in this chapter. Upon receipt of a properly submitted request, medical staff trained in reviewing these claims manages each case.

12-7.1 Manual review criteria

- Remittance advice statement exception code contains an error message stating documentation required
- All unlisted procedure codes. These typically end with "99"
- Denial for "No Prior Authorization" may actually require manual review (e.g. Diagnosis code) (These codes can only be flagged in the system by indicating prior authorization is required.)
- Radiology planning requires manual review of documentation when more than 4 units are requested. IMRT planning requires manual review of documentation to insure the treatment site is a covered service and the documented purpose is to protect a critical structure. Refer to the Coverage and Reimbursement Lookup Tool for additional codes requiring manual review.
[\[http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php\]](http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php)
- Certain modifier use. Refer to this *Chapter, Modifier used in a Claim*.

12-7.2 Request a Manual Review

To request manual review of a claim complete the following steps.

1. Review the claim to determine it meets criteria for manual review. If any one of the following is true go to step 2.
 - Remittance advice states the claim is missing documentation, lacks information required for adjudication or information received does not meet the procedure(s) or date of service for the claim under review.
 - The code is listed in the reference file as "2" (requires manual review) or the Coverage and Reimbursement Code Lookup special note indicates documentation is required.
 - The code has a modifier which requires review (Refer to this *Chapter, Modifier used in a Claim*)
2. Submit the following documentation to the applicable FAX number on the *Documentation Submission Form*:
 - *Documentation Submission Form*
 - Supporting documentation, consisting of medical records giving evidence and support the claim/code under review. Documentation may need to include similar procedures completed on the same date of service (e.g. multiple chest films)

Note: Documentation that is illegible, not applicable, or sent to an incorrect FAX number will not be returned or verified and the case will not be reviewed.

When the request is complete the claim is reviewed and the provider is notified of the results.

12-7.3 Modifier used in a Claim

All Modifiers are subject to manual review. For information on the manual review process see chapter 12-7 Manual Review.

- **Modifier 22:** (Unusual procedural services) Modifier 22 is suspended for manual review. If approved, it will be paid at an additional 10% of the established fee schedule. Exception: multiple gestation births.
- **Modifier 24:** Can be used for anesthesia pain management services and qualifies for manual review. Submit documentation showing when the epidural or block injection is given relative to the general anesthesia.
- **Modifier 25** - Use when the provider performs a comprehensive preventative medical evaluation in addition to an immunization administration or a procedure such as inhalation therapy to allow payment of the evaluation and management service.
- **Modifier 26 and TC:** Certain procedures and services have both a professional and a technical component. In procedures having a recognized technical/professional split the following coding guidelines should be followed.
 - Append modifier 26 only for the professional (physician) component of a billed service.
 - Append modifier TC when only the technical component is being billed. In the event that the provider owns the radiology overhead and also reads the exam, then submit one line for the professional component with modifier 26 and a second line for the technical component unmodified to ensure reimbursement for the global service
- **Modifier 27:** (Multiple Outpatient Hospital Evaluation and Management Encounters on the Same Day) Medicaid will not recognize Modifier 27. Modifier 27 is only appended to facility based services performed in the hospital outpatient setting. Medicaid does not reimburse for services attached to Modifier 27.
- **Modifier 50:** (Bilateral Procedures) Medicaid will not recognize modifier 50.
- **Modifier 51:** (Multiple Procedures) When more than one procedure is performed during an operative session the surgeries are subject to the multiple surgery rules and are ranked in descending order by the Medicaid fee schedule allowed amount.
- **Modifier 52:** (Reduced Service) Modifier 52 is paid at 50% of the established fee schedule.
- **Modifier 53:** (Discontinued Procedure) Modifier 53 is paid at 50% of the established fee schedule.

- **Modifier 54:** (Surgical Care Only) Modifier 54 is paid at 70% of the established fee schedule.
- **Modifier 55:** (Post-Operative Management Only) Modifier 55 is paid at 20% of the established fee schedule.
- **Modifier 56:** (Pre-Operative Management Only) Modifier 56 is paid at 10% of the established fee schedule.
- **Modifier 57:** (Decision for surgery) Medicaid will *not* recognize modifier 57. Decision for surgery performed for the purposes of hospital accreditation requirements that indicate every patient must have an initial hospital history and physical, is not a covered service and is integral to the surgical global fee.
- **Modifier 59* and subsets:** Are reviewed when the CPT code posts an incidental or mutually exclusive edit to the primary procedure. Submit documentation showing that the procedure is not a component of another procedure, but is a distinct, independent procedure. Mutually exclusive edits occur when two or more procedures that are usually not performed during the same member encounter on the same date of service. The less clinically intense procedure(s) is denied. Incidental edits occur when relatively minor procedures are performed at the same time as complex primary procedures, and are considered clinically integral to the performance of the primary procedure. Modifier 59 and the subset modifiers are the modifiers of last resort and should not be used when a more descriptive modifier is available. The subset modifiers are more selective versions of the 59 modifier so it would be incorrect to include both modifiers on the same line.
 - XE Separate encounter: A service that is distinct because it occurred during a separate encounter
 - XP Separate practitioner: A service that is distinct because it was performed by a different practitioner
 - XS Separate structure: A service that is distinct because it was performed on a separate organ/structure
 - XU Unusual non-overlapping service: The use of a service that is distinct because it does not overlap usual components of the main service.
 - The provider may submit medical records supporting the distinct or independent identifiable nature of the service. Modifier 59 or a subset modifier, are considered for manual review only after editing program denial.
- **Modifier 62:** (Two surgeons of a different specialty are required to perform a specific procedure) Modifier 62 is suspended for manual review and requires each co-surgeon to submit a separate operative report clearly describing the separate portions of the procedure that each surgeon completed. Modifier 62 is paid at 62.5% of the established fee schedule

- **Modifier 66:** (Surgical Team) Modifier 66 is suspended for manual review and is priced by Medicaid physician consultants.
- **Modifier 73:** (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure prior to the administration of anesthesia) Modifier 73 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.
- **Modifier 74:** (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure after the administration of anesthesia) Modifier 74 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.
- **Modifier 76 or 77:** When an edit posts that the claim is an exact duplicate of a paid claim, the claim is only manually reviewed when submitted with a 77 or 76 on the denied line. Submit documentation supporting the rationale for a repeated procedure or service by the same or another provider.
- **Modifier 80:** (Assistant at Surgery) Modifier 80 for assistant surgeon is limited to 20% of the established fee schedule.
- **Modifier 81:** (Minimal assistant at surgery) Medicaid does not reimburse for services attached to Modifier 81.
- **Modifier 91:** Submit documentation supporting the claim that separate services were provided for a distinct medical purpose.

12-7.4 Appealing Denial

In cases where the service has been denied after manual review, the remittance advice indicates manually reviewed and denied. At this point the provider may consider submitting a request for a hearing. All hearing requests require a *Request for Hearing/Agency Action* form and supporting documentation in addition to that sent for the manual review.

A hearing request to appeal the denial of an unlisted CPT code also requires the following.

- Documentation supporting the use of an unlisted code
- A letter citing methodologies employed
- Suggested CPT code(s) that is/are most similar in work and malpractice value (for pricing)
- Clinical publications supporting the methodology under review for safety, outcomes, and cost containment

- Document a strong case for why this method is the best strategy for the member (medical records, operative report, patient history, physical examination report, pathology report, discharge summary)

13 References

Current Procedural Terminology, American Medical Association, current edition

Health Care Procedure Coding System, HCPCS

Hearing decision numbers 13-078-02 and 13-239-03

State Plan Amendment

Attachment 3.1-A, Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy

Attachment 3.1-B, Amount, Duration, and Scope of Services Provided Medically Needy Group(s)

Social Security Act Titles XVIII, XIX, XXI, or XX

Social Security Act Sections 1902(a)(31)(A), 1903(v)(1), 1905(a)(19), 1905(o), 1915(g)

Title VI of the Civil Rights Act

Utah Administrative Code

R410-14

R414-1-2, 5, 14

R414-22

R590-164

Utah Code Annotated

§26-20-1, et seq, Utah False Claims Act

§26-18-2.1 (1953, as amended) Medical Assistance Act, Medical Assistance Programs, Division-Creation

§26-23-2-(1) UCA, (1953)

§63G-2

42 CFR

§431.52

§440 [October 1, 1996, edition]

§440.60, 170, 230, 255(c)

§455

§447.15, 45(d)(4)(iv)

§§1007.7 through 1007.13, State Medicaid Fraud Control Units

14 Acronyms

Following is a list of acronyms commonly used in the administration, policies, or procedures of Utah's Medicaid Program.

ACO	Accountable Care Organization
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ALOS	Average length of stay
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ANSI	American National Standards Institute
ASC X12	Accredited Standards Committee (see definitions)
CDEN	Child Health Insurance Program Dental Claims
CFR	Code of Federal Regulations
CHEC	Child Health Evaluation and Care
CHIP	Children’s Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DCFS	Division of Child and Family Services
DMHF	Division of Medicaid and Health Financing
DHS	Department of Human Services
DOH	Department of Health
DRA	Deficit Reduction Act
DRG	Diagnosis Related Group
DUR	Drug Utilization Review
DWS	Department of Workforce Services
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early Periodic Screening Diagnosis and Treatment
EREP	Electronic Resource and Eligibility Product
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FR	Federal Register
GRAMA	Government Records Access and Management Act
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Health and Human Services (Federal)
HIPAA	Health Insurance Portability and Accountability Act
HPR	Health Program Representative
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
ICF	Intermediate Care Facility
IPA	Independent Practice Association
LTAC	Long Term Acute Care Hospital
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MFU	Medicaid Fraud Unit, now the MFCU

MMCS	Medicaid Managed Care System
MMIS	Medicaid Management Information System
NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NTM	Non-Traditional Medicaid
OBRM	Omnibus Budget Reconciliation Act
ORS	Office of Recovery Services
ORSIS	Office of Recovery Services Information System
PA	Prior Authorization
PCN	Primary Care Network
PCP	Primary Care Physician
PERM	Payment Error Rate Measurement
PMIP	Prepaid Mental Health Plan
POS	Point of Sale
PPO	Preferred Provider Organization
PRO	Peer Review Organization
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TPL	Third Party Liability
UHA	Utah Hospital Association
UHCA	Utah Health Care Association
UHIN	Utah Health Information Network
UMA	Utah Medical Association
UPP	Utah's Premium Partnership
WIC	Special Supplemental Food Program for Women, Infants, and Children

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