



Medicaid Information Bulletin

January 2002



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◆ Bulletin Numbering System

The first two digits of a bulletin number are the year published. (Bulletins published for the year 2002 begin with "02".) The second two digits of the bulletin number are the order in which the bulletin was published. For example, Bulletin 02-01 is the first bulletin published in the Year 2002.

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02 - 01 Documentation and Signature Requirements for Medical Records

This bulletin clarifies the Medicaid documentation and signature requirements for medical records. The information which follows is added to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 10, RECORD KEEPING AND DISCLOSURE, as a new sub-chapter 10 - 4. The update starts on page 38 of SECTION 1. The on-line version of SECTION 1, with this latest revision, is at:

www.health.state.ut.us/medicaid/SECTION1.pdf

SECTION 1, Chapter 10 - 4, Documentation and Signature Requirements

To support its mission to provide access to quality, cost-effective health care for eligible Utahns, the Division of Health Care Financing requires providers to meet the Evaluation and Management Documentation Guidelines developed jointly by the American Medical Association and the Health Care Financing Administration, effective July 1, 1998. In addition, the Division uses InterQual criteria and criteria developed internally under the guidance of the Utilization Review Committee. Documentation and signature requirements are as follows:

A. Documentation requirements

The General Principles of Medical Record Documentation in the Evaluation and Management Documentation Guidelines are listed below:

1. The medical record should be complete and legible.
2. There is no specific format required for documenting the components of an E/M service.
3. The documentation of each patient encounter should include:
 - a. the chief complaint and/or reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
 - b. assessment, clinical impression or diagnosis;
 - c. plan for care; and
 - d. date and a verifiable, legible identity of the health care professional who provided the service.
4. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.

5. 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.
6. Appropriate health risk factors should be identified.
7. The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
8. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
9. 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.
10. Timeliness: A service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record.
11. The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

B. Signature Requirement

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 patient record must include a verifiable, legible signature and professional specialty designation following all entries.

1. Physician Responsibilities

The physician has the major responsibility for the patient's medical record and services provided. A recognizable signature, customary to the way in which the physician identifies himself, should be found throughout the record on all direct service entries, consultations or reports.

When service to the patient 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

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the physician in planning, supervising or reviewing the service.

The physician's signature must accompany every documented patient encounter if the service is being billed with the physician provider number.

2. Other Professional Services

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 patient's medical record

3. Electronic Signatures

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. Unacceptable Signature

A signature stamp affixed to an entry in the patient'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.

* * * * *end of new Chapter 10 - 4* * * * *

Background for Documentation Requirements

The Medicaid program is given responsibility through the Social Security Act Section 1902(a)(30)(A) to establish a State Plan for Medical Assistance that provides "such methods and procedures relating to the utilization of, and the payment for, care and services under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency,

economy, and quality of care" This responsibility is further codified at 42 CFR 456, Subpart B, Utilization control: All Medicaid Services. Section 456.23 notes that:

The agency must have a post payment review process that:

1. Allows State personnel to develop and review –
 - A. Recipient utilization profiles;
 - B. Provider service profiles; and
 - C. Exceptions criteria; and
2. Identifies exceptions so that the agency can correct misutilization practices of recipients and providers.

Post payment review as established by these regulations emphasizes review of professional services provided by individual providers, group practices, and by ancillary service providers.

In meeting the responsibility for this post payment review process, Health Care Financing utilizes patient/medical record review. The record review is based on use of InterQual criteria and/or criteria developed internally under the guidance of the Utilization Review Committee. In addition, the Evaluation and Management Documentation Guidelines, developed jointly by the American Medical Association and the Health Care Financing Administration, effective July 1, 1998, are also used. The emphasis of these guidelines is to provide assistance to providers and reviewers in preparing or evaluating documentation. The guidelines can be adapted for use, by all providers, for all services in all settings.

As identified in the Evaluation and Management Documentation Guidelines, documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The patient medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor health care over time.
- communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education. □

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02 - 02 Health Common Procedure Coding System - 2002 Revisions

Effective for dates of services on or after January 1, 2002, Medicaid begins accepting the 2002 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 2002 Physicians' Current Procedural Terminology (CPT) codes. You must continue to obtain prior authorization required for procedures on the 2001 list, even though new codes may be added for the same or similar procedures, or codes may be changed on the 2002 list.

The April 2002 Medicaid Information Bulletin will contain details about coding changes for services by physicians, medical suppliers and so forth. Any 2001 HCPCS codes discontinued in 2002 may be used for dates of services prior to April 1, 2002. For services on and after April 1, 2002, providers must use the 2002 HCPCS codes. If you have a question concerning billing the 2002 HCPCS codes, please contact Medicaid Information. □

02 - 03 Claim Submission Accountability

Regardless of any claims edits performed by the Medicaid agency, when submitting a claim, a provider must ensure that the clinical documentation supports the services submitted to Medicaid for reimbursement. Every provider must comply with the rules regarding records as stated in the Utah Medicaid Provider Manual, SECTION 1, Chapter 10, Record Keeping and Disclosure, and must make those records available for audit by the state or state approved organization upon request.

Whether a claim is paid or denied, the documentation must substantiate the services submitted on the claim. This is true regardless of whether any money is actually paid. A provider may be liable under various state and federal laws if appropriate documentation is not maintained.

For clarification of documentation requirements, contact the Program Integrity Unit through Medicaid Information: 801-538-6155 or 1-800-662-9651. □

02 - 04 Utah Medicaid Fee Schedule, DRG Payment Calculator

The Utah Medicaid Agency has a copy of two fee schedules, that is, the payment under the Utah Medicaid program, available on the Internet at www.health.state.ut.us/medicaid/st_plan/bcrp.htm. One fee schedule is the payment for CPT codes. The other is the payment formula and values used to pay anesthesia. In addition, the on-line resource has the Utah Medicaid DRG payment calculator for inpatient hospital charges.

Please note that the on-line schedule is updated only when there is a major rate change, like an annual fee increase. The last date of publication was July 1, 2001. Medicaid adjusts the fee schedule continuously, so minor changes will not appear in the on-line copy until it is republished after a major change. The schedule file shows both the current and the prior effective dates.

Instructions for Download and Use of the Fee Schedule

The fee schedule and DRG Calculator use Microsoft Excel software. Instructions for download and use are on the web site. The Fee Schedule is a zipped (compressed) file due to its large size. To see the contents, you must save and unzip it (extract the information). Then you can open the fee schedule as a Microsoft Excel file. Here are the steps:

1. Save the attached file (called UMcd0701.exe) to a local disk drive. (Steps 2 and 3 do not work if the file is saved to a network drive.)
2. Using the Windows Explorer (or other utility), double click on the saved file.
3. You will be prompted for the directory to which you want to extract the file.
4. After the file called "Utah Med.xls" has been extracted, open the file in Microsoft Excel.
5. Read the tab labeled "Instructions" for further information about how to use the file.

Division of Health Care Financing Contact

On the web site, there is a telephone number and an e-mail address for Randy K. Baker, Division of Health Care Financing, who maintains the fee schedule: 801-538-6733 or e-mail at rbaker@doh.state.ut.us. □

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02 - 05 Inpatient or Outpatient Procedures Requiring Prior Approval, Such as Bone Marrow Transplant and Neurostimulator

When prior approval is required for a procedure, the requirement must be met whether the procedure is performed on an outpatient or inpatient basis. Approval is not limited to inpatient procedures.

Bone marrow transplant: Neurostimulator

Here are two examples of how the prior approval requirement applies whether the procedure is performed on an outpatient or inpatient basis.

1. Written prior approval must be obtained prior to the implantation of a neurostimulator for partial epilepsy (345.41, 345.51) for both a hospitalized patient and a patient implanted with the device on an outpatient basis.
2. An autologous bone marrow transplant procedure provided to the patient on an outpatient basis as a series of transplants or a mini bone marrow transplant must have written prior approval following the same criteria for prior authorization as an inpatient who receives a bone marrow transplant. Outpatient bone marrow transplants include lymphocyte infusion transplants, stem cell transplantation, or any other blood component when provided as a mini bone marrow transplant.

Effective January 1, 2002, facilities providing neurostimulator implantation for partial epilepsy or mini bone marrow transplantation must ensure the physician has obtained prior authorization. Should an audit find the procedure was not approved, payments may be recovered.

Hospital Manual Updated

This information is added to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, SECTION 2, Chapter 3, LIMITATIONS, under item 14 (pages 16 - 17). Providers will find the pages attached to add their manual. A vertical line in the left margin marks where text has been added. □

02 - 06 Hospitals: Psychiatric Services and the Utah Prepaid Mental Health Plan

Under the Utah Prepaid Mental Health Plan (PMHP), Medicaid contracts with nine community mental health centers to provide all outpatient and inpatient psychiatric care to Medicaid clients. The name of the PMHP contractor responsible for the Medicaid client's mental health care is specified on the Medicaid Identification Card. Unless there are extenuating circumstances, you must request authorization for inpatient services within 24 hours of admission. If you do not have a contract with the PMHP provider responsible for the inpatient stay, the PMHP provider may choose to transfer the individual to one of its contracting hospitals.

Also, if you think an individual may qualify for Medicaid, you should contact the appropriate PMHP to obtain authorization. If the individual becomes Medicaid eligible and receives retroactive eligibility, the PMHP contractor will be responsible for the inpatient stay. By requesting authorization at the time of admission for individuals who may become Medicaid eligible, you will avoid later disputes over coverage of the stay. This information is added to SECTION 1, Chapter 4 - 2, Mental Health Services.

Hospital Manual Updated

To remind hospitals to contact the PMHP immediately when a Medicaid patient requires inpatient psychiatric care, and when a patient may potentially be eligible for Medicaid, information in this bulletin is added to three chapters in the Utah Medicaid Provider Manual for Hospital Services, SECTION 2, Hospital Services:

- Chapter 1 - 1, Clients Enrolled in a Managed Care Plan;
- Chapter 2 - 2, Emergency Department Reimbursement; and
- Chapter 3, LIMITATIONS, as a new item 20 B, Emergency Services for Clients in a Managed Care Plan.

Providers will find the pages attached to update the hospital manual. A vertical line in the left margin marks where text has been added.

Telephone Numbers for PMHPs

Hospitals will also find attached a list of telephone numbers for Prepaid Mental Health Plans to use in requesting authorization for inpatient services. These numbers are added to the list of telephone numbers for Prepaid Mental Health Plans which is in the General Attachments Section of the Utah Medicaid Provider Manual. The telephone list is now on the Internet at www.health.state.ut.us/medicaid/html/phonelist.pdf. □

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02 - 07 **Emergency Services Program for Alien/Non-citizens**

The Emergency Services Program is a health program designed to cover a limited scope of services for a specific, defined group of individuals. This bulletin clarifies who is covered by the program, billing and payment. The on-line version of SECTION 1 of the [Utah Medicaid Provider Manual](http://www.health.state.ut.us/medicaid/SECTION1.pdf), Chapter 13 - 8, Emergency Services Program for Non-Citizens, pages 51 A - 51 B, is updated to include the following information. www.health.state.ut.us/medicaid/SECTION1.pdf

This information represents current Medicaid policy, which is under review. Any changes to this policy will be addressed in future bulletins.

Authority

The Social Security Act Section 1903(v)(1) and 42 CFR 440.255(c) provides that no payment can be made to the state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence status in the United States. People who meet all Medicaid eligibility requirements except citizenship can receive services only for an "emergency medical condition." The act defines "emergency medical condition" (including emergency labor and delivery) as "manifesting itself by sudden onset of acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

- (A) placing the patient's health in serious jeopardy,
- (B) serious impairment to bodily functions, or
- (C) serious dysfunction of any bodily organ or part."

Such care and service cannot be related to an organ transplant procedure. (Emphasis added)

Definitions

The following is the Utah Medicaid definition of "emergency" as it applies to these services:

"Emergency shall mean a medical condition for which the absence of immediate medical attention could reasonably be expected to result in death or permanent disability to the person, or in the case of a pregnant woman, to the unborn child. Emergency services shall be those rendered from the moment of onset of the emergency condition, to the time the person's condition is stabilized at an appropriate medical facility, or death results. The definition of emergency services shall include labor and delivery services, but not pre-natal or post-partum

services. Emergency services shall not include prolonged medical support, medical equipment, or prescribed drugs which are required beyond the point at which the emergency condition has been resolved. Emergency services also shall not include long term care or organ transplants."

Medical Identification Card

Individuals who qualify only for Emergency Medical Services have a special card issued by Medicaid which states "EMERGENCY SERVICES." The client is eligible only for the restricted scope of emergency service defined by the Social Security Act and Medicaid's definition of emergency as noted above. These services are covered only until the condition is stabilized. A condition is stabilized when the severity of illness and the intensity of service is such that the patient can leave the facility. Services rendered subsequent to the patient leaving the facility, such as follow-up visits, follow-up treatment or visits scheduled in the future, are not covered by this program.

Documentation

Only labor and delivery services are paid for the Emergency Services client without documentation and review. Pre-natal and post-partum services are NOT covered for a non-citizen. Physicians and certified nurse midwives may use only the non-global delivery codes specified in SECTION 2 of the [Utah Medicaid Provider Manual for Physician Services](#) and for [Certified Nurse Midwife Services](#).

All other services provided to a non-citizen, eligible only for the Emergency Services Program, require documentation and review before payment to determine that the services meet the definition and limitations of an emergency medical condition as outlined in the Social Security Act and 42 CFR 440.255(c).

Advising Client of Non-Covered Services

Because the Emergency Services Program has a very restricted scope of services, it does not have some of the same restrictions on billing the patient as is the case in Medicaid-covered services. If a provider does not receive payment because the provider failed to follow procedure to get a service covered, the provider is prohibited from pursuing payment from the patient. If, however, payment is not made because the service was not an emergency, or the service is not provided under the program, then the patient can be billed for those services.

When a service to be rendered to an Emergency Services client is not or does not appear to be emergent

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in nature, the provider would be prudent to inform the patient, prior to the service, that the service will not be covered by Medicaid, and that the patient will be financially responsible for paying the bill. However, if the service meets the Medicaid definition of "emergency," Medicaid will pay for the service.

Criteria to Identify an Emergency Service

For services to be covered under the Emergency Services program, ALL of the following criteria must be present:

1. The condition manifests itself by sudden onset.
2. The condition manifests itself by acute symptoms (including severe pain).
3. The condition requires immediate medical attention.
 - A. Immediate medical attention means provision of service within 24 hours of the onset of symptoms or within 24 hours of diagnosis (whichever is earlier).
 - B. The condition requires acute care, and is not chronic.
 - C. Coverage will only be allowed until the condition is stabilized sufficiently so that the patient can leave the acute care facility or no longer needs constant attention from a medical professional.
 - D. The condition is not related to an organ transplant procedure.

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

Steps to Seeking Payment for Services Provided to an Emergency Services Client

1. Provider submits a claim to Medicaid.
2. Medicaid pays a claim for labor and delivery for a qualified client. The MMIS payment system denies claims for all other services in an Emergency Dept. A remittance advice will be sent to the provider.
3. When the remittance advice is received stating payment was denied, FAX or mail to Medicaid a copy of the remittance advice, the medical record specific to the case in question, including reports and consultations, and any other documentation in support of the services as a medical emergency. DO NOT rebill the claim.

All information to be considered for review MUST be included in this initial submission.

FAX number for the Emergency Services Program is (801) 536-0475. Use the same mailing address as for Medicaid claims. (See box at bottom of page, or SECTION 1 of the Utah Medicaid Provider Manual,

Chapter 12, Medicaid Information.)

4. Medicaid staff will review the submitted documentation. If services meet the definitions of "emergency medical condition" and "immediate medical attention" and are approved as an emergency, the claim will be reprocessed and paid. A second remittance advice will be sent to confirm payment. If criteria are not met, a letter will be sent from the Utilization Management Unit outlining the reasons for denial. Administrative Review and Fair Hearing rights will be explained in the denial letter.
5. A provider who does not agree with Medicaid's decision can refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 15, Administrative Review/Fair Hearing.
6. Any payment made by the Medicaid Agency for a service is considered payment in full. Once that payment has been made to the provider, no additional reimbursement can be requested from the client.

02 - 08 Vision Services Manual: Code Corrections

There are three code corrections in the Utah Medicaid Provider Manual for Vision Services, Chapter 7, PROCEDURE CODES, subheading Protheses (page 17).

- Code Y2624 is corrected to V2624. The description is correct.
- Codes V2628, Fabrication and fitting of ocular conformer, and V2629, Prosthetic, eye, other type were discontinued April 1, 2000. These are removed.

Page 17 will be reissued the next time the manual is updated. If you would like the corrected SECTION 2 immediately, contact Medicaid Information or use the Publication Request Form.

02 - 09 Infant Hearing Screening Code

Medicaid supports the nationally recommended strategy to have all infants receive a hearing screen. Use code V5008 for a hearing screening (otoacoustic test) for infants under one year of age. It is not appropriate to bill Y5005 and 92585 for children under the age of one year.

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02 - 10 Postoperative Pain Management and Palliative Therapy

Effective for services provided on or after July 1, 2001, postoperative pain management and selective palliative therapy provided by anesthesiologists are covered Medicaid services. Pain management must be related to the immediate postoperative period or a catastrophic or terminal illness where palliative therapy is indicated. The Primary Care Physician or surgeon must request or order pain services to be provided by an anesthesiologist. Prior authorization is not required. A claim for epidural placement or patient controlled analgesia (PCA) will be reviewed before payment.

The criteria for coverage replaces the old policy in the Utah Medicaid Provider Manual for Physician Services, SECTION 3, ANESTHESIA SERVICES, Chapter 9 - 1, Pain Management (pages 11 - 12). The updated chapter, Postoperative Pain Management and Palliative Therapy, includes billing codes and instructions. In SECTION 2, PHYSICIAN SERVICES, a reference to postoperative pain management is added to Chapter 2, Covered Services, item #33, Anesthesia (page 16). The words "pain management" are removed from Chapter 5, PHYSICIAN SERVICES, Non-covered Services, item o (2), including the footnote on that page (page 26). Pain clinics continue to be non-covered.

Providers of physician services will find attached pages to update SECTIONS 2 and 3 of the manual. A vertical line in the left margin marks where text has changed. An asterisk in the left margin marks where text was deleted. Other providers who are interested in this policy may view the updated manual on the Medicaid web site at: www.health.state.ut.us/medicaid/phystoc.pdf. If you do not have Internet access, contact Medicaid Information for a copy of the revised physician manual, or use the Publication Request Form.

The remainder of this bulletin provides background on the policy change regarding pain management services.

Pain is a complex phenomenon involving physical, psychosocial, and behavioral factors, demonstrated in response to a stimulus of illness, trauma, or surgical interventions. Pain relief involves a therapeutic course of action designed to modify pain or perceptions of pain. For most individuals, pain is relieved by self-directed therapies or short term, professional assistance. For others, it lingers and touches the quality of life, and more intensive supervised service is necessary.

Improved techniques and technology have established pain management as a specialty service provided by anesthesiologists which promotes improved recovery and lessens suffering through the use of continuous epidural analgesia or patient controlled analgesia (PCA).

□

02 - 11 Pharmacists: Federal Upper Limits

The federal Health Care Financing Administration (HCFA), through the Federal Upper Limit Bureau, provides to the State Medicaid agency a biannual list which contains the mandated generic, multi-source level of reimbursement for the identified drugs. Revisions are generally made January 1 and July 1 each year.

First Data Bank, under contract to Utah Medicaid, maintains these pricing regulations on the Utah Master Reference File. Generic substitution may only be made with products with an A rating identified in the Approved Drug Products (orange) Book published by the U. S. Department of Health and Human Services. The Federal Upper Limit information is available through the Medicaid Point of Sale system and on the Internet at the following address:

www.hcfa.gov/medicaid/drug10.htm

A paper copy of the FUL list may be obtained by contacting Medicaid Information. If you have a question, contact either:

Raedell Ashley	(801) 538-6495
Duane Parke	538-6452

To call toll-free, call Medicaid Information. Ask for Raedell Ashley at extension 86495 or Duane Parke at extension 86452. □

02 - 12 Influenza Vaccine

Influenza vaccine provided by pharmacists must be billed as .5 milliliter as a single immunization. Reimbursement will be made for each .5 ml.

Physicians, use CPT code 90659 for the vaccine. Use 90782 for the administration fee.

Codes 90669 or Y9095, Prevnar, are no longer open. Prevnar is covered through the Vaccines For Children (VFC) program. □

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02 - 13 Venipuncture (G0001); Blood Glucose by Reagent Strip (82948)

The finger stick related procedure, CPT 82948--blood glucose by reagent strip, is not a venipuncture procedure. Therefore, code G0001 for venipuncture will not be paid with this procedure. However, if other blood specimens are ordered which require venipuncture, G0001 payment will be allowed.

This information is added to SECTION 2 of the Utah Medicaid Provider Manual for Physician Services, SECTION 2, Chapter 3, LIMITATIONS, under item F (page 18). A vertical line in the left margin marks where text has been added. The on-line copy of the Physician Services Manual is at:
www.health.state.ut.us/medicaid/physician.pdf. □

02 - 14 Medical Supplies: Insulin Pump, Non-needle Cannula

Code A4230, Infusion set, external insulin pump, non needle cannula non-metal cannula, has been added to the Medical Supplies List under the heading "Pumps" on page 17, Category 2: Insulin pumps. This item is for a diabetic patient who is allergic to the metal needle which remains inserted into the body. This cannula is non-metal. Only seven per month are reimbursable at \$9.80 each.

Medical Supplies List Updated

Code A4230 is added to page 17. The page will be reissued when the Medical Supplies List is next updated. Physicians who want an updated list should contact Medicaid Information or use the Publication Request Form. □

Utah Medicaid Provider Manuals on the Internet: Physician, CHEC, Lab, Pharmacy, Mental Health

Five provider manuals are available on the Internet. Go to the Medicaid Provider Guide web site at <http://www.health.state.ut.us/medicaid/html/provider.html> and choose the link to SECTION 2. The SECTION 2 list of provider manuals has links to manuals on the Internet. We suggest that, when you find the manual you want, you set a "bookmark". For example, set a bookmark for the Physician Services Manual at www.health.state.ut.us/medicaid/phystoc.pdf.

02 - 15 Podiatry Codes: Simple Wound Repair

The following CPT codes are now covered for podiatrists.

- 12001 - 12004, Simple Wound Repair
- 28505 Open treatment of fracture of great toe, phalanx, phalanges, w/wo fixation
- 28510 Closed treatment of fracture, phalanx or phalanges other than great toe, without manipulation.
- 28515 . . . with manipulation

Podiatrists will find pages attached to update SECTION 2 of the Utah Medicaid Provider Manual for Podiatric Services. The codes newly added to the manual are in bold print on pages 13 and 17. □

02 - 16 Psychologists: Billing in 15-minute increments; Fee Schedule Updated

For dates of service on or after January 1, 2002, all psychology services **must be billed** in 15-minute increments. For example, for one hour of individual therapy, four units would be billed. Also, the additional evaluation hour procedure codes are discontinued for dates of service on or after January 1, 2002 (Y3210, Y3215, Y3208, Y3209). Complete mental health evaluations need to be billed under the evaluation procedure code.

Effective January 1, 2002, the Medicaid fee schedule for psychologists has been updated. For Internet access to the fee schedule and new rates, refer to Bulletin 02 - 04, Utah Medicaid Fee Schedule . . . on page 4.

Coercive Intervention, Subsidized Adoptions

There are two other policy changes to the Utah Medicaid Provider Manual for Psychology Services:

- Clarification of the limitation on coercive intervention techniques (holding, rage, rage reduction, attachment, or rebirthing therapies). Refer to Bulletin 02 - 18, Coercive Intervention Techniques Not Covered, on page 10.
- Another exception to enrollment in the Prepaid Mental Health Plan. Refer to Bulletin 02 - 17, Children in Subsidized Adoptions, on page 10.

Providers will find attached SECTION 2 to update their manuals. On pages dated January 2002, a vertical line in the left margin marks where text changed. An asterisk (*) in the margin marks where text was removed. □

World Wide Web: www.health.state.ut.us/medicaid

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02 - 17 Children in Subsidized Adoptions: Outpatient Mental Health Services

Senate Bill 97, the Subsidized Adoption Exemption Bill passed by the 2001 Utah State Legislature, has been implemented jointly by the Division of Health Care Financing (DHCF) and the Division of Child and Family Services (DCFS). Based on this bill, children in subsidized adoptions may, on a case-by-case basis, receive outpatient mental health services outside the Prepaid Mental Health Plan (PMHP). However, a subsidized adoptive child may only receive mental health services outside the PMHP if parents request and receive a formal exemption from the DHCF. The child will remain enrolled in the PMHP for inpatient psychiatric care.

If an exemption is granted, the child's Medicaid card will say:

INPT PSYCH: (Name of PMHP provider)
OUTPT PSYCH: ANY PROVIDER

In some instances, the child's Medicaid card may have already been printed for the month and, therefore, will not yet contain this information. If you are unsure whether the child is exempt, contact RueDell Sudweeks, DHCF, at (801) 538-6636.

Billing Procedures

Providers who serve these children must follow the billing procedures outlined below:

Physicians: Bill the CPT-4 codes fee-for-service for any mental health services provided.

Psychologists: Bill the Y codes fee for-service assigned to the psychology program. Prior authorization protocols still apply.

Providers who contract with DCFS to provide mental health services for foster children: Bill Medicaid directly, using the Y codes assigned to DCFS. There is no change in the billing process when providing services to foster children. Providers who contract with DCFS have an additional provider number. You must use the new number to bill for services provided to subsidized adoptive children exempt from the PMHP. If you don't know your new provider number, or if you need help with billing Y codes, contact RueDell Sudweeks at (801) 538-6636.

Provider Manuals Updated

The exemption for subsidized adoptive children is added SECTION 1 of the Utah Medicaid Provider

Manual, Chapter 4 - 2, Mental Health Services, and to SECTION 2 for:

- Physicians, Chapter 1 - 1, Clients Enrolled in a Managed Care Plan (page 2)
- Psychologists, Chapter 1 - 1, Clients Enrolled in a Managed Care Plan (page 2)

Providers who contract with DCFS can review the exemption for subsidized adoptive children in SECTION 2 of their manual, Chapter 1 - 6, Billing Arrangements. □

02 - 18 Coercive Intervention Techniques Not Covered (holding, rage, rage reduction, attachment, or rebirthing therapies)

Medicaid does not cover the use of "coercive techniques" where the therapist or others under the direction of the therapist use restraint other than for the protection of the child, noxious stimulation, and/or interference with body functions, such as vision and breathing. These services may not be billed to Medicaid. Coercive interventions are sometimes also referred to as "holding therapy," "rage therapy," "rage reduction therapy," "attachment therapy" or "rebirthing therapy."

This expanded definition is added to the following Utah Medicaid Provider Manuals under SECTION 2, Chapter 2, Scope of Service: Mental Health Centers, Psychology, Substance Abuse Treatment, and Diagnostic and Rehabilitative Mental Health Services by DHS Contractors. Providers will find attached replacement pages for January 2002 to update SECTION 2 to update of their provider manuals. The date a page was updated is at the top of the page. A vertical line is placed in the margin next to the text which was changed on that date. □

02 - 19 Northeastern Counseling Center: Prepaid Mental Health Plan for Clients in Daggett, Duchesne, and Uintah Counties

Effective January 1, 2002, Northeastern Counseling Center will contract with Medicaid to provide all mental health services to Medicaid clients in Daggett, Duchesne, and Uintah counties as part of a Prepaid Mental Health Plan (PMHP).

World Wide Web: www.health.state.ut.us/medicaid

Medicaid Information

- Salt Lake City area, call 538-6155.
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All inpatient and outpatient mental health services are provided by the PMHP. The PMHP provides the following outpatient services: diagnostic assessments, psychiatric evaluations and medication management, mental health therapy (individual, family, and group), individual and group behavior management, psychological testing, individual and group skills development services, and case management.

All inpatient psychiatric hospitalizations must be authorized by the PMHP. Prior authorization must be obtained within 24 hours of admission. If you think an individual may qualify for Medicaid, you should contact Northeastern Counseling Center to obtain authorization.

Any psychiatrist or psychologist, who is not a part of Northeastern Counseling Center and who is currently treating a Medicaid client, should begin the process of transferring the client to Northeastern Counseling Center. Northeastern Counseling Center will reimburse the psychiatrist or psychologist for up to three months after January 1, 2002, until the transfer occurs. Providers must contact Northeastern Counseling Center to coordinate the transfer.

Foster care children are enrolled in the PMHP, but only for inpatient psychiatric care. A child in foster care may receive outpatient mental health services from any Medicaid mental health provider including community mental health centers, psychiatrists, psychologists, or other mental health providers under contract with the Department of Human Services.

A foster care child's card will say:

INPT PSYCH: NORTHEASTERN
COUNSELING CENTER
OUTPT PSYCH: ANY PROVIDER

For more information, call Northeastern Counseling Center Vernal office at (435) 789-6300 or the Roosevelt office at (435) 722-2855.

GENERAL ATTACHMENTS Updated

The telephone number list for Prepaid Mental Health Plans has been updated to include Northeastern Counseling Center and current phone numbers for other PMHPs. This list is in the GENERAL ATTACHMENTS Section of the Utah Medicaid Provider Manual and also available on the Medicaid web site for providers:

www.health.state.ut.us/medicaid/html/provider.html

On the web site, look under the heading "Utah Medicaid Provider Manual" for the General Attachments Section. The link will take you to a list of documents in that Section, including the PHMP and HMO telephone number list. □

02 - 20 Mental Health Centers, Substance Abuse Treatment Providers: Increase in Fee Schedule for Outpatient Services

Effective January 1, 2002, rates increase for outpatient mental health services and substance abuse treatment providers. The fee schedule is now uniform for rural and urban mental health centers. See provider-specific information below. For access to the fee schedule and new rates, refer to Bulletin 02 - 04, Utah Medicaid Fee Schedule, on page 4.

Rural Mental Health Centers

Because of the rate increase, the Y codes implemented July 1, 2001, for rural mental health centers are discontinued for dates of service on or after January 1, 2002. Rural mental health centers must use the Y codes specific to rural centers in order to be reimbursed under the new fee schedule for services provided from July 1 through December 31, 2001. For services provided before July 1, 2001, or on or after January 1, 2002, use the original set of Y codes.

Rural PMHP Contractors: Exception to Using New Procedure Codes – Encounter Data

Rural mental health Prepaid Mental Health Plan (PMHP) contractors should not use the new Y codes when reporting encounter data services provided to PMHP clients between July 1 and December 31, 2001. Because no payment is involved, rural PMHP contractors should report services provided during this time period using the current Y codes. By doing so, procedure codes used in all PMHP contractors' encounter data will be consistent.

Substance Abuse Treatment Providers

Because of the rate increase, the Y codes implemented September 1, 2001, for substance abuse treatment providers are discontinued for dates of service on or after January 1, 2002. Providers must use the discontinued Y codes in order to be reimbursed under the new fee schedule for services provided from September 1 through December 31, 2001. For services provided before September 1, 2001, or on or after January 1, 2002, use the original set of Y codes in the Utah Medicaid Provider Manual for Substance Abuse Treatment Services and for Targeted Case Management for Substance Abuse.

World Wide Web: www.health.state.ut.us/medicaid

Medicaid Information

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Manuals Updated

Manuals updated include Utah Medicaid Provider Manual for Mental Health Centers, for Substance Abuse Treatment, Targeted Case Management for Substance Abuse, and Targeted Case Management for Chronically Mentally Ill. Rural procedure codes are removed from Mental Health Centers manual, SECTION 2, Chapter 2. A reminder of when to use the original or time-specific codes is added to Procedure Codes in each manual. Providers will find attached the pages to update their manuals. On pages dated January 2002, a vertical line in the left margin marks where text has been changed or added.

Mental Health Centers Manual on the Internet

You can find it the Mental Health Centers Manual at: www.health.state.ut.us/medicaid/mentalhealth.pdf. Or go to the Medicaid Provider Guide web site www.health.state.ut.us/medicaid/html/provider.html and choose the link to SECTION 2. The SECTION 2 list of provider manuals has links to manuals on the Internet. Set a bookmark when you find the manual you want. □

02 - 21 Occupational Therapy Assistant

Policy on use of an assistant for occupational therapy has been added to SECTION 2 of two Utah Medicaid Provider Manuals: Occupational Therapy Services and Physical Therapy and Occupational Therapy Services in Rehabilitation Centers, Chapter 2, Covered Services. All occupational therapy services must be performed by an occupational therapist or, beginning January 1, 2002, by an occupational therapist assistant according to the provision of Utah State Code and additionally under the immediate supervision of an occupational therapist. "Immediate supervision" means the supervising occupational therapist is:

1. present in the area where the person supervised is performing services; and
2. immediately available to assist the person being supervised in the services being performed.

The patient record must be signed by the occupational therapist following the treatment rendered by an occupational therapy assistant to certify the treatment was performed under his or her supervision. Services provided by an occupational therapy assistant must be billed under the occupational therapist's Medicaid provider number.

The information on the use of an assistant is now the same in three manuals: Physical Therapy, Occupational

Therapy, and P.T./O.T. in Rehabilitation Centers. The information is in SECTION 2, Chapter 1, General Policy, and Chapter 1 - 3, Definitions, of each of these manuals. For information on manual updates, see Bulletin 02 - 22, Evaluation for Occupational Therapy or Physical Therapy. □

02 - 22 Evaluation for Occupational Therapy or Physical Therapy

For occupational or physical therapy, an evaluation is limited to one evaluation per treatment course for a specific condition or diagnosis. Written prior authorization is required beyond this limit. This change was effective October 1, 2001, as announced in Bulletin 01 - 111, Physical Therapy: Use of an Assistant; Wound Debridement, published October 2001.

Manuals Updated

Therapists will find pages attached to update SECTION 2 of their Utah Medicaid Provider Manuals, as well as SECTION 2 of the Utah Medicaid Provider Manual for Physical Therapy and Occupational Therapy Services in a Rehabilitation Center. On pages dated January 2002, a vertical line in the left margin marks where text has been added on the page. An asterisk (*) in the margin marks where text was removed. □

02 - 23 Client Information and Education

Articles sent to Medicaid clients in the quarterly newsletter "Clientell" are published on the Internet. Copies may be printed and freely distributed for nonprofit, educational purposes. An index of articles is at: www.health.state.ut.us/medicaid/html/clientell_index.htm

Below is a list of "Clientell" articles sent in November 2001 to Medicaid clients.

- ✿ Co-pays for Office Visits and Pharmacy
- ✿ People with Disabilities at Work
- ✿ Medicaid Website
- ✿ Adoption Services
- ✿ Transportation Update
- ✿ Flu Season

We welcome suggestions for articles from providers and other interested parties. The new editor of the "Clientell" is Mary Lou Beckwith, Division of Health Care Financing. Call 538-6242, or toll-free 1-877-291-5583. E-mail: mbeckwit@doh.state.ut.us. □

World Wide Web: www.health.state.ut.us/medicaid

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02 - 24 Medicaid Co-Insurance for Hospital Inpatient Services

Effective February 1, 2002, many adult Medicaid clients will be required to make a \$220.00 co-insurance payment for inpatient hospital services. Both HMO and fee-for-service clients can have a payment. The client's Medicaid Identification Card will state when co-insurance is required. The hospital is responsible to collect the payment at the time of service or bill the client. The amount of the client's co-insurance will automatically be deducted from the claim reimbursement.

Co-insurance Message on Medicaid Card, by Client

The Medicaid Card will say "COPAY/CO-INS" by the individual client's name if he or she has a co-pay. The message will say what type of co-pay to collect. Below is an example of how a name and the co-pay message may appear:

NAME
Smith, John Q
Copay/co-ins for: non-emergency use of the ER, outpat hosp & physician svcs, pharmacy, inpat hosp

The co-pay message may vary by client and by type of service. If there is no message by a client's name, the client does not owe any type of co-pay. A family may contain an adult with a co-pay and children who are exempt. So you must verify whether the individual patient has a co-pay for the type of service.

The co-pay requirement is in the list of items to be verified on the Medicaid Identification Card. [Utah Medicaid Provider Manual, SECTION 1, GENERAL INFORMATION, Chapter 5 - 1, page 18.]

Co-insurance Amount for Inpatient Hospital Services

Co-insurance for inpatient hospital services is \$220.00. Before you collect payment, be sure the client has a co-pay and that the service requires a co-pay. Please give the client a receipt for the amount collected.

As a reminder, non-emergency use of an Emergency Department has a \$6.00 co-pay.

If you do not collect a payment owed at the time of service, you may bill the client for the amount that should have been paid. Refer to the Utah Medicaid Provider Manual, SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Co-payments.

No Co-insurance for Exempt Services

Some services are exempt from co-pay. It does not matter whether the client has a co-pay or not. These

exempt services are described in SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 2 - 1, Co-payment Requirement. For example, emergency services in a Hospital Emergency Department have no co-pay.

Clients Exempt from Co-insurance

If there is not a payment message by a client's name on the Medicaid Card, the client does not owe any type of co-pay. Children, pregnant women, and certain other Medicaid clients are exempt. [Utah Medicaid Provider Manual, SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3.]

Pregnant Women Exempt from Co-insurance

Do not require a payment for services to a pregnant woman, even if there is message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt for future Medicaid cards.

Co-insurance Maximum Per Client, Per Calendar Year

The maximum co-insurance for inpatient hospital services is \$220 per individual, per calendar year. Once a client has met the maximum, as determined by Medicaid billing information, the client will not owe another co-insurance for the remainder of that calendar year. When the maximum is met, the co-pay message on the Medicaid Card for inpatient hospital services will not appear by that client's name. The client may continue to have a co-pay for other types of services, such as pharmacy, physician, podiatry, and outpatient hospital services.

Clients Notified of Co-insurance

Medicaid will send a letter to clients to explain the hospital co-insurance. February will be the first month with the message on the Medicaid Card for inpatient hospital services. The client letters, in English and Spanish, are on-line at www.health.state.ut.us/medicaid/coinsurance.pdf. We will urge clients to keep receipts for payments in case of delayed billings or discrepancies.

Provider Manuals Updated

SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, has information on the Medicaid co-pay. View the current on-line version of SECTION 1, pages 24 - 24A, at: www.health.state.ut.us/medicaid/SECTION1.pdf.

Information on hospital co-insurance is in SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 2 - 1. Hospital providers will find attached the pages to update this manual. □

World Wide Web: www.health.state.ut.us/medicaid

Medicaid Information

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02 - 25 Prescriptions Limited to Seven a Month

Effective January 1, 2002, Medicaid limits coverage of prescriptions to a maximum of seven prescriptions a month for most adult clients, including nursing home patients. The limit includes scripts for over-the-counter medications. Medicaid exempts certain clients and certain drug classes from the prescription limit. Medicaid urges providers to please work with clients so their critical health care needs are met. More information on the prescription limit follows.

Children and Pregnant Women Exempt from Seven-Prescription Limit

Children under age 21 and pregnant women are exempt from the prescription limit. There is no limit on the number of prescriptions that may be filled for children under age 21 and pregnant women. Generally, a pregnant woman will not have a co-pay message by her name on the Medicaid Identification Card. If there is a co-pay message by the woman's name, encourage her to report the pregnancy to her Medicaid eligibility worker. The worker can change her co-pay status to exempt. Reference: Utah Medicaid Provider Manual, SECTION 1, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

Scripts Exempt from the Limit of Seven

Certain therapeutic classes of drugs are not included in the seven-prescription limit. The drug types listed in the box at the top right are not subject to the limit.

Exception to Prohibition on Billing Clients

If the number of prescriptions subject to the limit of seven a month will exceed the limit, and the client is not exempt from the Medicaid limit, the client may choose to pay for the additional prescription(s). The additional prescriptions would be non-covered Medicaid services. For information on the circumstances in which a client may be billed for non-covered services, refer to the Utah Medicaid Provider Manual, SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services. View the on-line version of SECTION 1, pages 24 - 24A, at www.health.state.ut.us/medicaid/SECTION1.pdf.

Clients Notified of Prescription Limit

Medicaid sent a letter to clients to explain the new policy on the limit of seven prescriptions a month. The client letters, in English and Spanish, are on-line at www.health.state.ut.us/medicaid/rxlimit.pdf. The letter

Drug Classes Exempt from the Seven-prescription Limit

A4A - hypotensives - vasodilator
 A4B - hypotensives - sympatholytic
 A4C - hypotensives - ganglionic blockers
 A4D - hypotensives, ACE blocking type
 A4E - hypotensives, veratrum alkaloids
 A4F - hypotensives, angiotensin receptor antagonist
 A4Y - hypotensives, miscellaneous
 A9A - calcium channel blocking agents
 C4G - insulins
 C4K - hypoglycemics, insulin-release stimulant type
 C4L - hypoglycemics, biguanide type (non-sulfonylureas)
 C4M - hypoglycemics, alpha-glucosidase inhib. Type (N-S)
 M0E - antihemophilic factor VIII
 M0F - antihemophilic factor IX
 M4E - lipotropics (cholesterol lowering agents)
 R1M - loop diuretics
 V1A - alkylating agents
 V1B - antimetabolites
 V1C - vinca alkaloids
 V1D - antibiotic antineoplastics
 V1E - steroid antineoplastics
 V1F - antineoplastics, miscellaneous
 W5B - HIV - specific
 W5C - HIV - specific, protease inhibitors

advises clients to talk to their doctors about which medications are needed. The February issue of the newsletter "Clientell" will have more information on Medicaid changes. For information on the "Clientell", see bulletin 02-23, Client Information and Education. Clients who have questions may call Medicaid Information. The toll-free telephone number is printed on the bottom of each Medicaid card.

Manuals Updated

The limit on prescriptions to seven a month has been added to two Utah Medicaid Provider Manuals:

- Physician Services, SECTION 2, Chapter 2, Covered Services, item 18, Coverage of drugs and biologicals.
- Pharmacy Services, SECTION 2, Chapter 2, Coverage of Services. A new Chapter 2 - 1, Prescriptions Limited to Seven a Month, is added. Subsequent chapters are renumbered 2 - 2 through 2 - 5.

Physicians will find the updated page included with the other policy manual updates. Pharmacists can review the addition to their manual on page 9 A of the on-line copy of the pharmacy manual:

www.health.state.ut.us/medicaid/pharmacy.pdf.

The DRUG CRITERIA and LIMITS List, an attachment to the physician and pharmacy manuals, is updated to add the list of drugs not included in the seven-prescription limit to page 29. Finally, as manuals for other prescribers, such as dentists and ophthalmologists, are updated, a statement on the seven-prescription limit will be added. □

World Wide Web: www.health.state.ut.us/medicaid

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