



Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Section I: General Information

Division of Integrated Healthcare

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Table of Contents

1	GENERAL INFORMATION	8
1-1	Utah Medicaid Provider Manual.....	8
1-1.1	Manual Maintenance.....	9
1-1.2	Statewide Provider Training	10
1-2	Overview of the Medicaid Program	10
1-3	Application for Medicaid	11
1-4	Medicaid Contact Information.....	12
1-5	Medicaid Member Guide	13
1-6	Medicaid Member Card.....	13
1-7	Fee for Service and Managed Care	14
1-8	Constituent Services.....	15
1-9	Definitions	15
2	MANAGED CARE ENTITIES	24
2-1	Member Enrollment in MCEs	25
2-2	Members Not Enrolled in MCEs	26
2-3	Member Eligibility Verification	26
2-4	Authorization for MCE Services and Claims Filing.....	26
2-5	Changing ACO or Dental MCEs	27
2-5.1	Transition of Care	27
2-6	MCE Carve-Out Services	28
2-7	Accountable Care Organizations.....	29

2-8	Prepaid Mental Health Plans	30
2-9	HOME	32
2-10	Dental Plans	32
2-11	Emergency Services for Members in an MCE	32
2-12	Appeals Related to MCEs	32
2-13	Grievances Related to MCEs	33
3	PROVIDER PARTICIPATION AND REQUIREMENTS.....	33
3-1	Provider Agreement	34
3-2	Ineligibility of Provider	36
3-3	Civil Rights Compliance and Practice Capacity	36
3-4	Medicaid as Payment in Full, Client Billing Prohibited	37
3-5	Exceptions to Prohibition on Billing Members	38
3-5.1	Non-Covered Services.....	38
3-5.2	Spenddown Payment	39
3-5.3	Broken Appointments.....	40
3-6	Referrals	40
3-6.1	Documenting the Referral/Consultation	40
3-6.2	Billing Claims Based on a Referral	41
3-6.3	Provider Ownership and Prohibition of Referrals	41
3-7	Ensure Member Receives Medically Necessary Services	42
3-8	Medical Interpretive Services.....	42
3-8.1	Member Enrolled in an MCO	43
3-8.2	Fee for Service Members	43
3-8.3	How to Obtain an Interpreter	43
4	RECORD KEEPING	44
4-1	Government Records Access and Management Act (GRAMA)	44

4-2	Record Keeping and Disclosure	44
4-3	Confidentiality of Records	45
4-4	Access to Records.....	45
4-5	Documentation Requirements	46
4-6	Signature Requirements	47
4-6.1	Dated Signature	48
4-6.2	Missing Signature.....	48
4-6.3	Illegible Signature.....	49
4-6.4	Signature Log.....	49
4-6.5	Electronic Signatures.....	49
4-7	Physician Responsibilities	50
4-8	Determining Compliance with Standards	50
5	PROVIDER SANCTIONS	51
5-1	Suspension or Termination from Medicaid	52
5-2	Employment of Sanctioned Individuals	53
5-3	Medicaid Audits and Investigations.....	53
5-4	Hearings and Administrative Review.....	55
5-4.1	Managed Care Entities Hearing and Administrative Review	55
6	MEMBER ELIGIBILITY.....	57
6-1	Verifying Medicaid Eligibility	57
6-1.1	Tools to Verify Medicaid Eligibility	57
6-2	Temporary Proof of Eligibility	58
6-3	Third Party Liability.....	58
6-4	Ancillary Providers	59
6-5	Medicaid Member Identity Protection	59

7	MEMBER RESPONSIBILITIES.....	59
7-1	Charges that are the Responsibility of the Member	59
7-1.1	Cost Sharing	60
7-2	Charges Not the Responsibility of the Member	60
8	PROGRAMS AND COVERAGE	61
8-1	Medical Necessity.....	62
8-2	Medicaid Programs.....	63
8-2.1	Medically Needy Program and Spenddown Program	63
8-2.2	Medicare Cost-Sharing Programs	64
8-2.3	Retroactive Eligibility	64
8-2.4	Utah Breast and Cervical Cancer Program (UBCCP)	64
8-2.5	Baby Your Baby (BYB)	65
8-2.6	Hospital Presumptive Eligibility Program (HPE).....	66
8-2.7	EPSDT Medical Services for Individuals Ages Birth through 20	66
8-2.8	Children's Health Insurance Program (CHIP)	67
8-2.9	Custody Medical Care Program (Children in Foster Care)	67
8-2.9.1	Children in State Custody (Foster Care)	68
8-2.10	Emergency Services Program for Non-Citizens.....	70
8-2.10.1	Medicaid Member Card and Documentation	71
8-2.10.2	Billing for Emergency Services Provided to a Non-citizen	71
8-2.11	Refugee Medicaid	73
8-3	Medicaid Restriction Program	73
8-3.1	Payment on Claims for Restricted Members:	76
8-3.2	Inmates of Public Institutions	76
8-4	Covered Services.....	77
8-4.1	Pharmacy Services	77
8-4.2	Telehealth	77
8-4.3	Other Covered Services	83
9	NON-COVERED SERVICES AND LIMITATIONS	87
9-1	Limited Abortion Services	87
9-2	Services Not Covered Regardless of Medical Necessity	88

9-3	General Non-Covered Services	88
9-3.1	Limiting Amount, Duration, or Scope of Services.....	88
9-3.2	Out-of-State Services	89
9-3.3	Experimental, Investigational, or Unproven Medical Practices	90
9-3.4	Exceptions when Medicaid will pay for Non-Covered Procedures	93
9-3.5	Quantity Limits.....	93
9-3.6	Requesting Exceptions for Non-Covered Services and Services Exceeding Limitations.....	93
10	PRIOR AUTHORIZATION.....	95
10-1	Request Prior Authorization	96
10-1.1	Denial Letter	97
10-2	Prior Authorization for EPSDT Eligible Members	98
10-3	Retroactive Authorization	99
10-3.1	Inaccurate Information	99
10-3.2	Medicaid Member Eligibility	100
10-3.3	Medical Emergency	100
10-3.4	Medical Supplies Provided in a Medical Emergency	100
10-3.5	Surgical Procedures	101
10-3.6	Anesthesia Providers	101
10-3.7	Inmates of Public Institutions.....	102
10-3.8	Members with Medicaid and Medicare (Dual Eligibility)	102
10-3.9	Exceeding Quantity Limits.....	102
10-4	Exceptions to Prior Authorization Requirements and Non-Covered Services	103
11	BILLING MEDICAID	104
11-1	Medicaid is the Payer of Last Resort	104
11-2	Unacceptable Billing Practices	104
11-3	Business Agents	105
11-3.1	Attending Provider	105
11-4	Factoring Prohibited	105
11-5	Third Party Coverage	106
11-5.1	Medicare Crossover Claims.....	106
11-5.2	Correcting Third Party Liability Information	107

11-5.3	Billing Third Parties	108
11-5.4	Billing Services for Newborns	109
11-6	Submitting Claims.....	109
11-6.1	Electronic Claims	109
11-6.2	NCPDP Pharmacy Point of Sale (POS) System	111
11-6.3	Electronic Data Interchange (EDI) Resources	112
11-6.4	Time Limit to Submit Medicaid Claims	112
11-6.5	Clean Claims and New Claims.....	114
11-6.6	Resubmit Claims with Corrected Information.....	115
11-7	Payment Denial for Members Not Eligible for Medicaid or Enrolled in an MCO	116
11-8	HIPAA Transaction and Code Set Requirements	116
11-8.1	Electronic Claim with Attachment(s)	119
11-8.2	Pharmacy Claims NCPDP Version D.0	120
11-9	Electronic Visit Verification Requirements for Home Health and Personal Care Services.....	120
11-10	Reporting and Billing Covered and Non-Covered Services for Acute Inpatient Hospital Claims	121
12	CODING.....	121
12-1	Coding Maintenance	123
12-2	Classifying Patients as New or Established.....	124
12-3	Diagnosis Must Agree with Procedure Code; Use of 'Z' Codes	124
12-4	Procedures for Children	125
12-5	Diagnosis and Procedure Incomplete or Not in Agreement	126
12-6	Procedures with Time Definitions	126
12-7	Manual Review	126
12-7.1	Manual review criteria	126
12-7.2	Request a Manual Review	127
12-7.3	Modifiers	128
12-7.4	Multiple Procedure Payment Reduction	133

12-7.5	Appealing Denial	134
13	REFERENCES	135
14	ACRONYMS	136

1 General Information

1-1 Utah Medicaid Provider Manual

The 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 Medicaid program is administered by the Utah Department of Health and Human Services, Division of Integrated Healthcare. The 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 Medicaid Program to assist enrolled providers with submitting claims for services rendered to 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 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 Medicaid Program to assist enrolled providers with submitting claims for services rendered to 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 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

Medicaid makes every attempt to ensure that the information contained in each section of the manual is current and reliable. The contents of the 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) bimonthly. The MIB is emailed to enrolled providers who subscribe to the Medicaid newsletter. To receive the newsletter, sign up on the "Medicaid Official Publications" page at the Medicaid website. For additional information on obtaining updated information,

refer to the 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 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, Medicaid Program, which generally describes the Medicaid program. This rule incorporates by reference the 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 Medicaid website for dates <https://medicaid.utah.gov>.

1-2 Overview of the Medicaid Program

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 and Human Services, Division of Integrated Healthcare, 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.

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 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, Wednesday, Thursday, Friday.....8:00 A.M. to 5:00 P.M.

Tuesday.....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 found in the *General Attachments* section of the provider manuals.

Mailing Address

Office of Medicaid Operations

PO Box 143106

Salt Lake City, Utah 84114-3106

Street Address

Department of Health and Human Services

288 North 1460 West

Salt Lake City, Utah 84114

Note: The Department of Health and Human Services (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 <https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/MemberGuide2025.pdf> The guide can be read, printed, or saved from this screen.

1-6 Medicaid Member Card

The Division of Integrated Healthcare issues a wallet-sized plastic Medicaid Member Card to members eligible for Traditional Medicaid, Baby Your Baby, or Hospital Presumptive Eligibility. 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, or Hospital Presumptive Eligibility 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, 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 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 DIH, 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 DIH on a fee for service basis, providers must verify member eligibility using one of the following tools: Eligibility Lookup Tool, 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 DIH’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 and Human Services, Division of Integrated Healthcare, 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 DIH 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 Medicaid Program:

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

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

Assistant to Surgery: A physician or other qualified healthcare professional who actively assists the physician in charge of a case in performing a surgical procedure.

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 or PMHP plan.)

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 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 or other qualified healthcare professionals and simplifies the reporting of services to third party payers.

Dental Claim (837D): electronic claims billing form ANSI ASC X12N 837D is the standardized electronic data interchange (EDI) format used for submitting dental service claims to payers.

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

Division of Integrated Healthcare (DIH): The organizational division in the Utah Department of Health and Human Services which administers the Medicaid program in Utah.

Early Periodic Screening Diagnosis and Treatment (EPSDT): The federal preventive health care services program for children, formally known 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 other qualified healthcare professionals.

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.

Institutional Claim (837I): electronic claims billing form ANSI ASC X12N 837I is the standardized electronic data interchange (EDI) format used for submitting institutional healthcare service claims to payers. It serves as the electronic equivalent and replacement for the paper billing form UB-04.

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- or behavioral health 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 or PMHP.

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

Medicaid Agency: The Utah Department of Health and Human Services, Division of Integrated Healthcare.

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 Integrated Healthcare to update the Medicaid Provider Manual or issue information to Medicaid providers.

Medicaid Provider Agreement: A signed contract between a provider and the 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 member 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 Medicaid Program. “Member” is often used interchangeably with “client,” “recipient,” “patient,” or “enrollee” when the person is eligible for the Medicaid Program.

Nurse Practitioner: A nurse practitioner (NP) is an individual who performs professional services within their scope of licensing, under [Utah Code, Title 58: Occupations and Professions, Chapter 31b: Nurse Practice Act](#).

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.

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.

Physician Assistant: A physician assistant (PA) is an individual who performs professional services within their scope of licensing, under [Utah Code, Title 58: Occupations and Professions, Chapter 70a: Utah Physician Assistant Act](#).

Prepaid Mental Health Plan (PMHP): The Medicaid mental and substance use disorder managed care plan operating under the authority of the Department’s 1915(b) waiver.

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 Integrated Healthcare, Department of Health and Human Services) or from an MCO, if applicable before certain services are rendered.

Professional Claim (837P): electronic claims billing form ANSI ASC X12N 837P is the standardized electronic data interchange (EDI) format used for submitting professional healthcare service claims to payers. It serves as the electronic equivalent and replacement for the paper billing form CMS-1500. Ambulatory Surgical Centers (ASCs) bill on the 837P form for both facility and professional services.

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.

Provider Reimbursement Information System for Medicaid (PRISM): the Utah Medicaid information exchange system for Managed Care processes, prior authorization submission, member eligibility verification, claims adjudication, claims payments, member web portal, and auditing.

Qualified Healthcare Professional (QHP): An individual who is qualified by education, training, licensure, and regulation who performs a professional medical service within their scope of practice and is enrolled with Medicaid as a provider.

Recipient: A person who is eligible for the 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 member.

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 (PCP) 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 and Human Services, Division of Integrated Healthcare.

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 and Human Services: 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 and Human Services. 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 Managed Care Entities

This section provides summary information about Medicaid managed care; types of managed care entities (MCEs); member enrollment and disenrollment; services covered and not covered by MCEs; and grievances and appeals related to MCEs.

Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid benefits through contract arrangements between the Division of Integrated Healthcare (DIH) and MCEs. DIH contracts with MCEs to provide physical health care, behavioral health care (mental health and substance use disorders), and pharmacy services for Medicaid members. DIH pays a monthly premium for each Medicaid member enrolled in the MCE. The MCEs are responsible for the services specified in their contracts with DIH.

The following types of MCEs provide services to Medicaid managed care enrollees:

- Accountable Care Organizations (ACOs) that cover physical health care and some pharmaceutical services
- Prepaid Mental Health Plans (PMHPs) that cover behavioral health services
- Healthy Outcomes Medical Excellence (HOME) that covers both physical and behavioral health services

Medicaid members enrolled in MCEs are entitled to the same Medicaid benefits as fee for service Members. However, MCEs may offer additional benefits and may have different prior authorization requirements than the Medicaid fee for service scope of benefits. A Medicaid member enrolled in an MCE must receive services through that MCE, with some exceptions called “carve-out services”. The MCE pays providers for services covered under the MCE’s contract. DIH pays providers for services that are carved out of MCE contracts.

2-1 Member Enrollment in MCEs

Specific Medicaid members are required to enroll in an ACO. If the member lives in one of the counties in which enrollment is mandatory, the member must choose an ACO.

Enrollment in a PMHP is based on the county in which the member resides. Members do not choose a PMHP but are automatically enrolled with the PMHP(s) serving their county of residence. Members must receive behavioral services through their assigned PMHPs.

HOME is a voluntary program and therefore, members may choose to enroll in HOME if they meet certain criteria.

Health Program Representatives (HPRs) employed by DIH educate members on the Medicaid Program, managed care, the ACO options, and the PMHP. In addition, the HPRs can help members choose an ACO. HPRs are resources for members and providers who may have issues related to MCEs.

2-2 Members Not Enrolled in MCEs

The following Medicaid members are not enrolled in MCEs:

- Members with presumptive eligibility
- Most Medicaid Expansion members
- Residents of the Utah State Developmental Center
- Residents of the Utah State Hospital
- Targeted Adult Medicaid (TAM) members

2-3 Member Eligibility Verification

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in an MCE. However, it is the provider's responsibility to verify a member's eligibility and service delivery model (MCE or fee for service) before providing services. Eligibility for Medicaid and enrollment in an MCE may change from month to month.

To determine if a Medicaid member is enrolled in an MCE or is a fee for service member, providers may verify member eligibility using the provider Eligibility Lookup Tool, or ANSI 270/271.

- Eligibility Lookup Tool: <https://medicaid.utah.gov/eligibility>

2-4 Authorization for MCE Services and Claims Filing

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

Each MCE has its own network of providers. Depending on the type of MCE and services that are covered, provider networks can include but are not limited to clinics, hospitals, physicians, and pharmacies. If a provider wishes to enroll with a specific MCE network, the provider must contact the MCE directly.

Claims for services covered by an MCE must be submitted to the MCE in which the member is enrolled using the methods established by the MCE.

2-5 Changing ACOs

Once per year, between mid-May and mid-June, Medicaid has an open enrollment period during which Medicaid members can change to a different ACO effective July 1st of the year. Medicaid members are also allowed to change their ACO during the first 90 days after an MCE is chosen or has been assigned. Medicaid members who want to change their ACO selection should contact an HPR toll-free at 1-866-608-9422.

Members enrolled in the Medicaid Restriction Program are not eligible to change to a different ACO, including within the ACO open enrollment period. For complete information on the Restriction Program, refer to Chapter 8-3 (Medicaid Restriction Program).

2-5.1 Transition of Care

If a member's enrollment is changed to a different MCEs or fee for service, approved prior authorizations for medical care from the previous MCE will be honored for the member until:

- A prior authorization (PA) has been evaluated for medical necessity of the service and the MCE has determined that the PA is no longer medically necessary; or
- The member is discharged from an inpatient hospital setting.

When a provider receives a PA, the provider must submit the associated claim for the authorized service to the entity that issued the PA (i.e., ACO, PMHP, HOME, or DIH).

2-6 MCE Carve-Out Services

If a Medicaid member is enrolled in an MCE, DIH will not pay a claim unless it is for a carve-out service. A carve-out service is a service that is covered by Medicaid but not covered by an MCE. Services that are carved out from an MCE differ depending upon the type of MCE.

Listed below are carve-out services that are not covered by any of the MCEs. These services are paid by DIH:

- Apnea monitors
- Autism Spectrum Disorder services
- Chiropractic services (for EPSDT members 6-20 years old and pregnant members)
- Early Intervention Services
- Emergency and non-emergency transportation*
- Evaluations and psychological testing performed for physical health purposes, including prior to medical procedures, or for the purpose of diagnosing intellectual or developmental disabilities, or organic disorders
- Facility charges for dental services performed at a hospital or ambulatory surgical center
- Fertility preservation
- Genetic carrier screening
- Hemophilia disease management waiver services
- Home and Community-Based Waiver Services
- In vitro fertilization
- Methadone administration services
- Pharmaceutical drugs as follows:

- Antianxiety
- Anticonvulsant
- Antidepressant
- Antipsychotic
- Attention deficit hyperactivity disorder stimulant
- Hemophilia
- Substance use disorder
- Transplant immunosuppressive
- Services performed at the Utah State Hospital or the Utah State Developmental Center
- Services performed by a provider or facility enrolled as Provider Allowable Code (PAC) 068 – Tribal Health Centers

*MCEs may be responsible for transportation in some situations. Contact the MCE to determine responsibility for coverage.

2-7 Accountable Care Organizations

DIH contracts with four ACOs: Health Choice Utah, Healthy U, Molina Healthcare, and Select Health Community Care. Not all ACOs are available in every county. There are from two to four ACOs available in each county.

Medicaid requires most 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.

In addition to the Medicaid members listed in the *Members Not Enrolled in MCEs* section above, members who are admitted to a skilled nursing facility, intermediate care facility or a Long-Term Acute Care Hospital for a long-term stay (i.e., a stay intended to last more than 30 days) will be disenrolled from the ACO. Disenrollment

due to a long-term stay requires notification to DHMF. In addition, Medicaid members enrolled in Utah's Buyout Program do not have to enroll in an ACO.

Other than the excluded members above, when determined eligible for Medicaid, a member residing in one of the counties specified above must select an ACO.

ACOs cover most Medicaid-covered services with the exception of behavioral health and dental. In addition, the ACOs do not cover the carve-out services listed in the *MCE Carve-Out Services* section above.

Members enrolled in an ACO may need to be in the Restriction Program due to possible abuse or misuse of Medicaid services. A member enrolled in the Restriction Program must receive services provided by one PCP and one pharmacy, unless otherwise authorized by the PCP.

Referrals for possible enrollment in the Restriction Program may be submitted to medicaidrestriction@utah.gov or 801-538-9045 or to the ACO in which the member is enrolled. For complete information on the Restriction Program, refer to Chapter 8-3 (Medicaid Restriction Program).

2-8 Prepaid Mental Health Plans

DIH contracts with local county mental health and substance abuse authorities or their designated entities (as PMHPs) to provide inpatient hospital psychiatric services and outpatient mental health and outpatient substance use disorder services to Medicaid members.

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

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 obtain outpatient substance use disorder services from any qualified Medicaid provider and providers may bill DIH. Medicaid members living in any of these

counties are enrolled in the PMHP for mental health services, and must obtain their mental health services through the PMHP contractor serving these counties.

Wasatch County is not covered under the PMHP. Medicaid members living in Wasatch County may obtain mental health and substance use disorder services from any qualified Medicaid provider. Providers may bill DIH.

Exceptions to PMHP enrollment are:

- Medicaid members in state custody (foster care) are enrolled in the PMHP only for inpatient hospital psychiatric services. They are not enrolled in the PMHP for outpatient mental health and substance use disorder services. They may obtain these outpatient services from any qualified Medicaid provider. Providers may bill DIH.
- Medicaid members eligible for Medicaid under subsidized adoption may be disenrolled from the PMHP on a case-by-case basis for outpatient mental health and substance use disorder services. Once disenrolled, they remain enrolled in the PMHP only for inpatient hospital psychiatric services. They may obtain outpatient services from any qualified Medicaid provider. Providers may bill DIH.
- In some instances, individuals applying for Medicaid are given retroactive Medicaid eligibility. Although an individual's retroactive Medicaid eligibility may go back further than 12 months, PMHPs are financially responsible only for inpatient hospital psychiatric services, and outpatient mental health and substance use disorder services provided during the most recent 12 months of the individual's retroactive eligibility period. Providers must contact the PMHP contractor for payment of services provided during this 12-month time period.

PMHPs are responsible for inpatient hospital psychiatric services when they are performed on an inpatient basis under the direction of a physician or other qualified healthcare professional for a psychiatric condition manifesting itself with a sudden onset. At the time of the inpatient admission, the psychiatric condition should be of

such a nature as to pose a significant and immediate danger to self, others, or public safety, or which has resulted in marked psychosocial dysfunction or grave mental disability of the patient. PMHPs are also responsible for electroconvulsive therapy (ECT) and related charges.

PMHPs are not responsible for pharmacy services. In addition, the PMHPs do not cover the carve-out services listed in the *MCE Carve-Out Services* section above.

Medicaid members enrolled in the PMHP may get services directly from a federally qualified health center (FQHC). PMHP prior authorization is not required. FQHCs may bill DIH.

2-9 HOME

The Healthy Outcomes Medical Excellence program (HOME), operated by the University of Utah, is a voluntary MCE for Medicaid members who have a developmental disability and mental health or behavioral challenges.

HOME is a coordinated care program that provides services normally covered by the ACOs and the PMHPs. HOME is not responsible for pharmacy services. When Medicaid members enroll in HOME, they are disenrolled from their ACO and PMHP.

2-10 Emergency Services for Members in an MCE

All MCEs cover emergency services for members 24 hours a day, seven days a week whether or not the services are provided within the MCE's provider network.

2-11 Appeals Related to MCEs

When an MCE makes a decision that constitutes an adverse benefit determination, a member, provider, or an authorized representative, may request an appeal with the MCE. An appeal is a review by an MCE of an adverse benefit determination.

Examples of MCE adverse benefit determinations are:

- The denial or limited authorization of a requested service
- The reduction, suspension, or termination of a previously authorized service

- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner

The timeline to request an appeal with the MCE is within 60 calendar days from the date on the notice of Adverse Benefit Determination. If the MCE's appeal resolution is not wholly in favor of the member, the member or provider may request a State fair hearing with DIH no later than 120 calendar days from the date of the MCE's notice of resolution. The hearing request form can be found at <https://medicaid.utah.gov/utah-medicaid-forms>.

Members, providers, or authorized representatives must exhaust the MCE's appeals process prior to requesting a State fair hearing.

2-12 Grievances Related to MCEs

A grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Examples of grievance are:

- The quality of care or services provided by the MCE
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the member's rights regardless of whether remedial action is requested

Grievances may be filed with an MCE at any time by a member, provider, or authorized representative. A grievance should be submitted to the MCE. Aggrieved parties may also contact the DIH Constituent Services representative at medicaidmemberfeedback@utah.gov or 801-538-6417 or toll-free at 1-877- 291-5583 to discuss the grievance.

3 Provider Participation and Requirements

This chapter covers topics such as provider agreement, co-payments, prohibition on billing members, 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 Medicaid Program, will only render services within their scope of licensure, before Medicaid will cover any services provided by the provider to Medicaid members. Medicaid will only reimburse covered services performed by a QHP as indicated in the PRISM Coverage and Reimbursement Code Lookup for their specific provider enrollment type. 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 Medicaid Provider agreement, and receives notice from the 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 to follow all guidelines and edits of the following agencies or organizations:
 - Medicaid Integrated Outpatient Code Editing obtained from CMS via secure RISSNET files.
 - American Medical Association Guidelines
 - National Correct Coding Initiative
 - National Uniform Billing Code
- 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 Integrated Healthcare; and
 - The information submitted in, with, or in support of the claim is true, accurate, and complete.

- Providers are prohibited from submitting inaccurate Medicaid claims.

3-2 Ineligibility of Provider

The Division of Integrated Healthcare 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 members 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 are 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 and Human Services, 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 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 members. Some grounds for denying or dismissing Medicaid members include limiting the number or percentage of Medicaid members, 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 established business guidelines that delineate the limitations on accepting Medicaid members, and abide by those guidelines. Exceptions that would allow for accepting Medicaid members 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) members 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 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, 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 member 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 patients 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 for Financial Responsibility Form is completed which details in writing 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 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 member’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 on the Eligibility Lookup Tool at <https://medicaid.utah.gov/eligibility>.

3-5.3 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 patients in the practice for broken appointments. The charge cannot be billed only to Medicaid members.

3-6 Referrals

The PCP, which includes physician or other qualified healthcare professional 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 or other qualified healthcare professional is responsible for sending the PCP 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 provider 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 provider.
- Consultant provider's name and medical reason for the consultation/referral request.
- The consulting provider documents a summary of their evaluation, opinion, and recommendations in the member's medical record. A separate written summary report is sent to the requesting provider and noted in the member'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 professional claim (837P) "[PRISM Reference Guide Submitting Payment Information for Medicare or Other Insurance](#)" instructions for entering the referring provider's number on the electronic claim form. If it is an EPSDT 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 an EPSDT Well Child follow-up referral, enter TS in the modifier field.

Medicaid only accepts electronic claims or Direct Data Entry (DDE) through the PRISM portal.

3-6.3 Provider Ownership and Prohibition of Referrals

A provider or immediate family member of the provider 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 and Human Services, Division of Integrated Healthcare, follows the provisions of the Government Records Access and Management Act (GRAMA) in classifying records and releasing information.

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 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.

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 DIH may request records that support provider claims for payment under programs funded through the DIH. 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 will 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 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 Integrated Healthcare 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 provider.
- 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 or qualified healthcare professional's signature must accompany every documented member encounter if the service is being billed with the provider number.

- Other professionals working in group practices, clinics or hospitals such as nurses, physical therapists, occupational therapists, dietitians, or social workers, etc., providing service under a plan of care or following orders of a physician or other qualified healthcare professional, must provide appropriate documentation, signature and professional designation following entries in the member's medical record.

In order for a signature to be valid, the following criteria are used:

- Services that are provided/ordered must be authenticated by the author
- Signatures will be handwritten or an electronic signature.
- Signatures are legible
- Rubber Stamps for signatures are allowed in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to Medicaid, if requested, their inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that he/she has reviewed the document.
- Medical record entries completed by a scribe must be authenticated by the treating physician's or other qualified healthcare professional's signature and date.

4-6.1 Dated Signature

All signatures need to be dated; however, when requested Medicaid must be able to determine on which date the service was performed or ordered. If the entry immediately above or below is dated, Medicaid may reasonably assume the date of the entry in question.

4-6.2 Missing Signature

Providers should not add late signatures to the medical record, other than those that result from the short delay that occurs during the transcription process.

Providers should use the signature attestation process. Medicaid does not accept retrospective orders.

If a clinical diagnostic test order does not require a signature, regulations state there must be medical documentation by the treating provider (e.g., a progress note) that he/she intended the clinical diagnostic test to be performed. This must also be authenticated by the author via a handwritten or electronic signature.

4-6.3 Illegible Signature

Illegible signatures should be accompanied by a typed/printed name on the documentation. If requested by Medicaid, providers may submit a signature log or attestation to support the identity of the signer. However, Medicaid will look for some indication in other documentation to support the identity of the signer.

4-6.4 Signature Log

A signature log is a typed listing of provider names followed by a handwritten signature. A signature log may be used to establish signature legibility as needed throughout the medical record documentation. Providers should include their professional credentials/titles on the signature log; illegible signatures will be processed more quickly than those that do not have a signature log provided.

4-6.5 Electronic Signatures

Providers must have a system and software products that maintain an auditable signature record, protect against modification, and have administrative procedures that correspond to recognized standards and laws.

The individual whose name is on the electronic signature and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided.

4-6.5.1 Acceptable Electronic Signatures (Examples; Not Limited To)

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name

- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitalized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D.'

Note: 'Signed but not read' is not acceptable

4-7 Physician Responsibilities

- If 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 other qualified healthcare professional, 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 Integrated Healthcare 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 Integrated Healthcare

PO Box 143105

Salt Lake City, UT 84114-3105

Or via UPS or FedEx

Office of Administrative Hearings Division of Integrated Healthcare

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 Integrated Healthcare 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 and 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 are 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 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 adverse coverage or benefit determination taken by the Division of Integrated Healthcare (DIH) or a managed care entity (MCE). 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.

When Medicaid issues a determination on a claim for a specific item or service, the aggrieved person has 30 days to request a hearing. Adjustments to the initial claim or a claim resubmission that does not revise the initial determination, shall not extend or change the appeal rights and timing of the initial determination.

If a provider has received a claim denial for lack of prior authorization, the claim must be rebilled with the prior authorization number for the claim to adjudicate properly.

For additional information on retroactive prior authorization, see *Chapter 10-3, Retroactive authorization*.

5-4.1 Managed Care Entities Hearing and Administrative Review

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

To request a hearing, send a completed hearing request form to the Office of Administrative Hearings. The form must be faxed, emailed, or postmarked within

120 calendar days from the date the MCE sends written notice of its denial or intended action, unless a different time period is indicated on the denial document.

All hearing requests for DIH and Managed Care Entities must include the following:

- A completed hearing request form
- A denial notice
- If a medical issue is in dispute, each request must include supporting medical documentation

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 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, email, or fax.

Mail:

Via U.S. Post Office-

Division of Integrated Healthcare
Office of Administrative Hearings
Box 143105
Salt Lake City, UT 84114-3105

Via UPS or FedEx-

Division of Integrated Healthcare
Office of Administrative Hearings

195 North 1950 West
Salt Lake City, UT 84116

FAX: (801) 536-0143

EMAIL: utmedicaidhearings@utah.gov

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 PCP; 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 the 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 make 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>.

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 ensure 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 PCP 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 PCP, 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.

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 healthcare and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to 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). This policy does not apply to members participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the “Consolidated Appropriations Act, 2021.”

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 Utah Breast and Cervical Cancer Program (UBCCP)

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 in order to help low-income, uninsured, and underinsured women gain access to timely breast and cervical cancer screening, diagnostic, and treatments services.

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. Note: There is no asset test to qualify.

The Utah Breast and Cervical Cancer Program also provides education to help women learn how they can prevent cancer, understand the importance of early detection, and link them with treatment resources.

For more information, call the Utah Department of Health and Human Services, Utah Breast and Cervical Cancer Program at 1(800) 717-1811, or visit the Utah Breast & Cervical Cancer Program (UCCP) website for more information.

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 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 EPSDT Medical Services for Individuals Ages Birth through 20

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is federally mandated for enrolled Medicaid Members and is an integral part of the Medicaid program. EPSDT services are available to all members enrolled in Traditional Medicaid ages birth through twenty.

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

8-2.8 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](#).

8-2.9 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.

Services requiring prior authorization must be 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 prior authorization is obtained before billing. Services must be billed within 365 days of the date of service or six months of the date prior authorization was issued, whichever is later. To bill claims, follow the same instructions as for billing Medicaid claims. 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.

8-2.9.1 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 PCP 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 and Human Services 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.

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 (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.

Children in Foster Care Not Eligible for Medicaid

When a foster child is not 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 through prior authorization and give it to the foster parent. FHC is a program within the Department of Health and Human Services which contracts with the Division of Community and Family Health Services, to provide nursing case manager services.

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 EPSDT exam within 30 days of removal.
- A mental health assessment within 30 days of removal.
- A dental exam within 60 days of removal.

8-2.10 Emergency Services Program for Non-Citizens

Emergency services for non-citizens are designed to cover a limited scope of services as outlined in 42 CFR 440.255(c). Individuals meeting all Medicaid eligibility requirements except citizenship may receive coverage for a qualifying emergency service as defined in Utah Administrative Code R414-1-2(11) and meeting service coverage criteria outlined in Utah Administrative Code R414-518.

When determining eligibility and coverage related to outpatient hemodialysis, see the “[Provider Instructions for EOP Dialysis Coverage](#).”

8-2.10.1 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.

8-2.10.2 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:

- Submit a claim to Medicaid.
- If payment denial is received - ***Do not rebill the claim.***
- Follow these instructions, rather than rebilling the claim.
 - Upload medical record documentation into PRISM’s Document Management Portal, this may include:

- The transaction control number for accurate claim matching.
- Reports and consultations (e.g., admissions history and physical, physician notes, operative reports, progress notes, and/or discharge summary).
- Other documentation in support of the services as a medical emergency.
- Retroactive prior authorizations.
- Any required consent forms.

A Document Submission Form will be generated by PRISM when all required fields within the Document Management Portal are completed.

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.

8-2.10.3 Review Process

In accordance with [Utah Administrative Code R414-1-14](#), Medicaid staff will review submitted documentation for medical necessity.

If criteria are not met, a letter of denial is sent from the Office of Medicaid Operations outlining the reason(s). The letter will include an explanation of the administrative review process and fair hearing rights.

A provider or member may request an administrative hearing to dispute a denial decision. Please refer to Chapter 5 for further details on the hearings and administrative review process.

Additional billing guidance for End-Stage Renal Disease (ESRD) can be found in the [Hospital Services](#) provider manual.

8-2.11 Refugee Medicaid

Refugees entering the United States that are not Medicaid eligible may be eligible for Refugee Medical Assistance (RMA) for a period of up to four months starting on the date they enter into the country. Individuals who became eligible for RMA before May 5, 2025, may continue to receive up to 12 months of RMA coverage. After RMA ends, individuals may be screened for other medical programs.

In accordance with [45 CFR 400.105](#), refugees that qualify for Medicaid enrollment are able to receive coverage for services as outlined in the [State Plan, Section 3.1\(a\)\(6\)\(ii\)](#). Furthermore, refugee children may receive additional preventative services upon their enrollment into the Medicaid program. To verify specific services, please use the coverage criteria established in the [Coverage and Reimbursement Code Lookup](#).

Medicaid offers [interpretative services](#) for those who do not speak or read English.

8-3 Medicaid Restriction Program

The Medicaid Restriction Program safeguards against inappropriate and excessive use of Medicaid services. If a Medicaid member utilizes pharmacy services, emergency department or provider services at a frequency or amount that is not medically necessary, that individual may be referred to and enrolled in the Restriction Program. Members enrolled in the Restriction Program are assigned to one PCP to oversee the member's healthcare and one Primary Pharmacy.

Members are identified for the Restriction Program through on-going surveillance of member profiles to detect excessive use of services and by referral from providers, pharmacies, law enforcement, citizens etc. Medicaid members enrolled in an ACO and fee for service members can be enrolled in the Restriction Program. Restricted ACO members are managed by the ACO's Restriction Program, while restricted fee for service members are managed by the Department of Health and Human Services (DHHS) Medicaid Restriction Program.

If it is suspected that a Medicaid member is over-utilizing, abusing or fraudulently using Medicaid services, referrals for possible enrollment in the Restriction Program may be submitted to medicaidrestriction@utah.gov or 801-538-9045 or to the specific ACO Restriction Program in which the member is enrolled, as applicable.

Medicaid members, referred to a Restriction Program or identified by Medicaid surveillance, will be subject to a utilization review for meeting or exceeding the following Restriction criteria during their most recent 12 months of Medicaid eligibility:

- Accessing ≥ 4 non-affiliated providers
- Accessing ≥ 4 pharmacies for abuse potential prescriptions
- Having ≥ 6 prescriptions for abuse potential medications in a two-month period
- Having ≥ 3 providers prescribing abuse potential medications in a two-month period
- Having ≥ 5 non-emergent ED visits
- Concurrent prescriptions for scheduled medications from different prescribers
- Cash payments for Medicaid covered services

Member's diagnoses, extenuating circumstance and limited access to care (as sometimes seen in rural geographic locations or homelessness) will be taken into consideration during each utilization review. Subsequent to such considerations, members who meet or exceed Restriction Program criteria will be enrolled in the Restriction Program for a minimum of 12 months of Medicaid eligibility.

Restricted members are encouraged to use Urgent Care services when their assigned PCP is not available for immediate medical needs and the need is not emergent. In order for prescriptions written by Urgent Care Providers to be paid, the Urgent Care prescriber's name and NPI must be added to the member's case by

contacting the ACO or DHHS Medicaid Restriction Program, as applicable. As per federally mandated “*Emergency Medical Treatment and Labor Act (EMTALA)*”, access to emergent medical services are available to restricted members.

Members selected for enrollment in the Restriction Program are notified of the reasons for the enrollment, counseled in the appropriate use of health care services, and offered assistance in selecting a single PCP and a single pharmacy. Prior to assigning a PCP to a restricted member’s case, the PCP must approve of the assignment and agree to manage the restricted member’s healthcare needs.

Assigned PCPs must provide referrals for restricted members in need of specialty or secondary healthcare services. In addition, PCPs must notify the ACO or DHHS Medicaid Restriction Program of the addition of the approved specialty or secondary providers to the member’s restriction case. To submit approval for the additional providers/prescribers to a restricted member’s case, the PCP or PCP’s designee must contact the DHHS Medicaid Restriction Program at 801-538-9045 or medicaidrestriction@utah.gov for FFS members or by contacting the specific ACO Restriction Program in which the member is enrolled, as applicable.

In making provider and pharmacy assignments, DHHS and the ACOs ensure that the member has reasonable access to healthcare, taking into account geographic location, reasonable travel time to pharmacy services, and adequate quality of necessary healthcare.

Temporary pharmacies may be approved for use by restricted members for good cause such as filling prescriptions for compounded medications; the primary pharmacy is temporarily out of a prescribed medication, hospital discharge medications filled by a hospital pharmacy etc. To request approval for additional temporary pharmacies to be added to the restricted member’s case, members, pharmacies and providers may contact the DHHS Restriction Program at 801-538-9045 or the specific ACO Restriction Program in which the member is enrolled, as applicable.

8-3.1 Payment on Claims for Restricted Members:

Claims will not be paid unless services rendered to restricted members are submitted by the assigned PCP or submitted by other specialty or secondary providers to whom the PCP has provided a referral. Claims submitted for services rendered by specialty or secondary providers to restricted members must note the name and NPI of the referring PCP on the submitted claim in order to be eligible for payment. Claims submitted for specialty services for restricted members with modifiers 23, 25, 30, 47, 55, 56, 62, 75, 66 and 80 are only eligible for payment with a referral from the assigned PCP. Hospital inpatient claims are not subject to the Restriction Program.

Prior to providing services to Medicaid members, all providers are strongly advised to use the available resource of the online Eligibility Lookup Tool in order to identify member's enrollment in the Restriction Program. These tools will list any approved providers and pharmacies on the restricted member's case. Providers and pharmacies not listed on a restricted member's case are not approved for payment by the ACO or DHHS Medicaid Restriction Program.

8-3.2 Inmates of Public Institutions

Utah's 1115 Demonstration Waiver allows for the reimbursement of limited services for adult and juvenile inmates in a state prison, county jail, or juvenile justice facility for up to 90 days prior to the individual's release date. Adult and juvenile inmates, including former foster care youth up to age 26, housed in a jail or prison setting who meet criteria can receive Medicaid eligibility up to 90 days prior to their release from the facility. In accordance with the 1115 Demonstration Waiver, inmates are eligible to receive case management services, physical and behavioral health clinical services, laboratory and radiology services, durable medical equipment upon release, medications and medication administration, and Medication Assisted Treatment (MAT) services for up to 90 days before they are released.

When services are provided outside of the 90-day coverage period or are not considered to be part of the covered 1115 Demonstration Waiver, the facility is

responsible for the expenses incurred. If the member becomes inpatient in a hospital outside of the eligible pre-release timeframe, the inmate may qualify for Medicaid for the inpatient stay if they meet 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 Medicaid Provider Manual for Pharmacy Services at: <https://medicaid.utah.gov>.

8-4.2 Telehealth

Definitions

Telehealth means the use of electronic information and telecommunications technologies that support distant healthcare to provide ease of access to health assessments, diagnostics, intervention, consultations, supervision, and education.

Telemedicine see Telehealth.

Teledentistry is the use of information technology and telecommunications for dental care, consultation, and education.

Telepsychiatric Consultation is a consultation between a physician or other qualified healthcare professional and a board-certified psychiatrist that utilizes:

- the health records of the member, provided from the member or the referring provider
- a written, evidence-based member 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 (hub site) – is where the provider delivering the service is located at the time the service is provided via telecommunications system.

Originating site (spoke site) – is the location of the Medicaid member at the time the service is being furnished via telecommunications.

Synchronous care is a live two-way interaction via telecommunication technology between a member at an originating site and a provider at a distant site that includes audio-visual (videoconference) or audio-only (telephone) communication.

Remote Patient Monitoring (RPM) is the deployment and use of technology to capture biometric information that is automatically shared with a remote provider. The transmission of patient data and clinical information to the provider may occur either through in-home devices or information entered and transmitted electronically by the patient.

8-4.2.1 Services

Telehealth services seek to improve an individual's health by permitting two-way communication between members and their providers and may be performed for a variety of medically necessary services. This communication often requires the use of interactive telecommunications equipment that can include both audio and video components but may also be conducted via audio-only. Audio-only telehealth is not allowed if it is solely for the sake of provider convenience. The utilization of telehealth services is dependent upon the member and their situation. As such, providers must determine the clinical appropriateness and medical necessity of the services being delivered through clinical-based decision making. Some examples of when telehealth may be appropriate are:

- Diagnostic review and discussion of results
- Evaluation and management services
- Management of chronic conditions
- Medication management

- Mental health, behavioral health, and substance use disorder services
- Telepsychiatric consultation
- Teledentistry
- Treatment counselling
- Wellness checks

There are no geographic restrictions surrounding the use of telehealth services. Medicaid covers telehealth services when performed via synchronous care.

Telecommunication technologies that support synchronous care include:

- Live video two-way, face-to-face interaction between the member and the provider using audio-visual communication, including E-visits through an online patient portal.
- Audio only visits by means of telephone or other forms of communication without video.

As outlined by the Centers for Medicare and Medicaid Services (CMS), audio-only synchronous care or care that does not clinically require visual inspection, is covered for a limited number of services. Medicaid limits these services to:

- Behavioral health, including substance use disorders (SUD)
- Diabetes self-management
- Speech and hearing
- Nutritional counselling
- Tobacco cessation
- Education for chronic kidney disease
- Advanced care planning
- Medication therapy management

Providers are responsible for determining the applicable CPT and HCPCS codes associated with each of the above-listed services and ensure the codes are covered. Reporting requirements for services provided via telehealth are the same as those provided for services performed in-person.

Medicaid does not cover telehealth services when performed by means of asynchronous communication. Examples of asynchronous communication include:

- Email communication
- Text messaging
- Other forms of messaging with follow-up instructions or confirmations
- Mobile Health (mHealth)
 - Fitness tracker
 - Phone applications that record a patient's exercise
 - Automatic reminders such as when to take medicine.
 - Storing information or educational materials such as discharge instructions
- Remote patient monitoring (RPM)
 - Blood pressure monitors
 - Pacemakers
 - Glucose meters
 - Oximeters
 - Wireless scales
 - Heart rate monitors
- Store-and-forward imaging
- Transmission of lab or other diagnostic/screening results

Telepsychiatry

When psychiatrists consult with a physician or other qualified healthcare professional regarding a member's possible need for telepsychiatry, they must report the following CPT codes to receive payment for services:

- 99446 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- 99447 11-20 minutes of medical consultative discussion and review
- 99448 21-30 minutes of medical consultative discussion and review
- 99449 31 minutes or more of medical consultative discussion and review

The treating physician or other qualified healthcare professional, consulting with the psychiatrist, reports CPT code 99358- *Prolonged evaluation and management service before and/or after direct patient care*.

Teledentistry

Teledentistry services are covered for eligible members statewide.

Providers must report one of the following CPT codes to receive reimbursement for services:

- **D0140** –*Limited oral evaluation - problem focused; An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.*

- **D0170** - *Re-evaluation - limited, problem focused (established patient; not post-operative visit); Assessing the status of a previously existing condition. For example: - a traumatic injury where no treatment was rendered but patient needs follow-up monitoring; - evaluation for undiagnosed continuing pain; - soft tissue lesion requiring follow-up evaluation.*
- **D0171** – *Re-evaluation - post-operative office visit.*

The dentist, to receive reimbursement, must report CPT code D9995- teledentistry - synchronous; real-time encounter; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service to denote that services were rendered via teledentistry. Rates for approved teledentistry are the same as rates for in-person dental services.

8-4.2.2 Billing

Refer to the following when billing for services provided through telehealth:

Distant providers:

- Professional Claims (837P)- Provider must indicate that the service(s) was provided via telehealth by indicating Place of Service (POS) 02 – Telehealth Provided Other than in Patient’s Home, or POS 10 – Telehealth Provided in Patient’s Home on the claim form with the service’s usual billing codes.
- Institutional Claims (837I)- Providers must indicate that the service(s) was provided via telehealth by appending the GT modifier to the institutional claim form with the service’s usual billing codes.
 - GT - Via interactive audio and video telecommunication systems
- Services provided via telehealth have the same service thresholds, authorization requirements, and reimbursement rates as services delivered face-to-face.

8-4.2.3 Limitations

Telehealth 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 member communications and records, including recordings of telehealth encounters, are secure and remain confidential. The provider is responsible for ensuring 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.

Services not otherwise covered by Medicaid are not covered when delivered via telehealth.

The provider, if the member is in a facility (i.e., the originating site), receives no additional reimbursement for the use of telehealth services.

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 or other qualified healthcare professional'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 (for EPSDT members 6-20 years old and pregnant members).
 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. Physical therapy, occupational therapy, and related services.
16. Services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist.
17. Drugs, prosthetic devices, and eyeglasses prescribed by a qualified practitioner.
18. Medical supplies and durable medical equipment.
19. Other diagnostic, screening, preventive, substance abuse, and rehabilitative services, such as other than those provided elsewhere in the State Plan.
20. Nurse-midwife services and free-standing birth centers.
21. Hospice care in accordance with Section 1905(o) of the Social Security Act.
22. 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.
23. 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

24. 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

Extended services to pregnant women including pregnancy-related and postpartum services to the end of the 12th month after the pregnancy ends, including additional services for any other medical conditions that may complicate pregnancy with increases of service.

26. Skilled nursing facility services, other than services in an institution for mental diseases, for members over 20 years of age.
27. Child Health Program - Medical Services for Medicaid members enrolled in Traditional Medicaid ages birth through twenty. (Refer to *Chapter 8, Programs and Coverage*).
28. 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

29. Medical interpretive services for members with limited English proficiency or disabilities.
30. 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 physician overseeing the pregnant woman's care, abortion is necessary because the life of the mother would be endangered if the fetus were carried to term; 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 services is allowed only when:

- Prior authorization is obtained,
- A properly executed and completed Medicaid Abortion Acknowledgement and Certification Form is submitted, and

- A properly executed and completed Medicaid Prohibition of Payment for Certain Abortion Services Provider Certification form is on file with the Office 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
- Experimental or investigational, unproven procedures, services or medications (See Note below)
- Laser eye surgery used to correct refractive errors
- Fees for missed appointments

Note: Experimental, investigational, or unproven services do not include qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the “Consolidated Appropriations Act, 2021”.

9-3 General Non-Covered Services

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

The Division of Integrated Healthcare 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 (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the “Consolidated Appropriations Act, 2021”)
- Information available from the Centers for Medicare and Medicaid Services, Department of Health and Human Services. Information and recommendations from physician consultants employed by the Utah Department of Health and Human Services, Division of Integrated Healthcare. 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 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 member 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 Medicaid benefit and if the provider becomes a Medicaid provider.

9-3.2.1 Non-Resident Provider Telehealth Reporting for In-State Members

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

- The provider meets the licensing requirements of the Department of Professional Licensing (DOPL) as outlined in [Utah Annotated Code 58-1-302.1](#)
- The provider is enrolled as a Medicaid provider as explained in [Chapter 3 Provider Participation and Requirements](#)
- Follow the policies outlined in [Chapter 8-4.2 Telehealth](#).

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. (See Note below)

- **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. (See Note below)
- **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 EPSDT 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.

Note: Experimental, investigational, or unproven services do not include qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the “Consolidated Appropriations Act, 2021.”)

9-3.3.1 Qualifying Clinical Trials

A “Qualifying Clinical Trial” is a clinical trial (in any clinical phase of development) that is conducted in relation to the prevention, detection, or treatment of any serious life-threatening disease or condition and is described in any of the following as defined in the [Consolidated Appropriations Act, 2021](#) as follows:

1. The study or investigation approved, conducted, or supported (which may include funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health
 - The Centers for Disease Control and Prevention
 - The Agency for Healthcare Research and Quality
 - The Centers for Medicare and Medicaid Services
 - A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
 - Any of the following if the conditions described below are met:
 - The Department of Veterans Affairs
 - The Department of Defense

- The Department of Energy
 - Conditions, with respect to a clinical trial approved or funded by an entity described above, are that the clinical trial has been reviewed and approved through a system of peer review that are:
 - Comparable to the system of peer review of studies and investigation used by the National Institutes of Health; and
 - Assured unbiased reviews of the highest scientific standards by qualified individuals with no interest in the outcome of the reviews
2. The clinical trial is conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act.
 3. The clinical trial is a drug trial that is exempt from being required to have an exemption described in 2.
 4. Providers and the principal investigator (entity conducting the qualifying clinical trial) must validate the appropriateness of the trial by using the National Clinical Trial Number found at <https://clinicaltrials.gov/>. The National Clinical Trial Number must be placed on the [Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form](#).
 5. This form is found on the Medicaid.gov website page Medicaid SPA Processing Tools for States under the “Benefits and Coverage SPA Tools” section. Coverage determinations are not restricted to the location of the trial. Not all services that are a part of the clinical trial may require prior authorization. However, when they do, providers must include the completed [Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form](#) along with submitted PRISM prior authorization request.
 6. Please review the Qualifying Clinical Trials and Medicaid FAQ for more information regarding qualifying clinical trials.

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 ESDT program. EPSDT 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, unless otherwise prohibited by the Medicaid State Plan.

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.

9-3.6 Requesting Exceptions for Non-Covered Services and Services Exceeding Limitations

Necessary health care, diagnostic services, treatment, or other measures to correct or ameliorate defects, physical or mental illness or conditions are available based on medical necessity. Prior authorization is required before providing these services. Exceptions are considered through the prior authorization and/or

utilization review process, which is accessed by submitting a request for prior authorization.

Prior authorization requests must be submitted through PRISM and include all applicable information listed below:

- Current comprehensive evaluation of the members' condition, completed by the appropriate qualified healthcare professional, that includes all applicable medical documentation to establish the medical necessity of the requested item or service.
- Letter from the physician or other QHP describing the member specific medical necessity for the product/service, including the diagnosis, pertinent medical history, and any previous or current medical interventions utilized in treatment.
- Documentation when utilizing unlisted code to report services including the following:
 - Documentation supporting the use of an unlisted code.
 - A letter citing methodologies employed.
 - Comparison 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.
 - Documentation showing 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).
- The provider's acquisition cost or usual and customary charges for the item(s) or service. The acquisition cost, or purchase price, is the amount paid by the provider for an asset or product, either through purchasing the product

directly from a manufacturer or the cost incurred by the provider to manufacture the product, Acquisition cost is not the manufacturer's suggested retail price (MSRP). Submissions that include only MSRP information for items will be returned, without processing, for the needed acquisition cost.

- Photocopy of any durable medical equipment item(s) requested, if applicable.
- All documentation submitted must be in alignment with HIPAA guidelines and only be related to the requested services or items. Excessive documentation will not be reviewed for medical necessity and will be returned to the requestor for correction.

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

For additional information on EPSDT services, refer to the [Early and Periodic Screening, Diagnostic, and Treatment \(EPSDT\) Services](#) provider manual.

10 Prior Authorization

The information in this chapter pertains to prior authorization (PA) requests for 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 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 an electronic prior authorization request through the [PRISM portal](#). The request must be submitted with all required documentation.

When a prior authorization request is submitted without the required documentation, it will be returned to the provider without processing. A returned request is not a denial and does not accrue hearing rights. Medicaid will send an Additional Documentation Request to the provider which will clearly specify the documentation required to review for medical necessity.

If a request is returned for lack of documentation, the provider must take the following steps:

1. Upload all additional required documentation to the existing request in PRISM.
2. If any changes to the request are needed (e.g., code changes), a Modification Request Form must be uploaded along with the additional documentation.

Upon receiving the additionally requested documentation, Medicaid staff will review it to determine medical necessity and coverage. The date a complete

submission, with all necessary supporting documentation, is received will be the date posted on the prior authorization request.

To ensure prior authorization requests are processed in a timely manner, each request will only be allowed two additional documentation submissions. If documentation is still incomplete after the third submission, the prior authorization request will be denied.

When a prior authorization request is denied, Medicaid will send a written Notice of Denial to both the member and the provider. This notice will include information regarding appeal rights and a hearing request form. Both the member and the provider retain the right to appeal the denial, as outlined in Chapter 5-4, *Hearing and Administrative Review*.

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.

10-2 Prior Authorization for EPSDT Eligible Members

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

Providers must complete and submit prior authorization requests in PRISM for EPSDT services 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 or other qualified healthcare professional 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 member specific, indicate the reasons the provider 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 member, should communicate directly and work together as a team to evaluate the most appropriate services for the child.

10-3 Retroactive Authorization

When providers have delivered a service requiring prior authorization without having obtained prior authorization, Medicaid allows requests for retroactive approval only under the limited circumstances outlined in this chapter. If the criteria are not met, Medicaid will not consider retroactive authorization and the claim will be denied.

In addition to the criteria outlined throughout Chapter 10-3.1 *Retroactive Medicaid Member Eligibility*, services provided must meet all Medicaid criteria for coverage and providers must:

- Complete the appropriate prior authorization request in PRISM,
- Provide documentation supporting the medical necessity of the services; and
- Include documentation describing why the provider delivered the service(s) without authorization

A provider must request retroactive authorization within 180 days following delivery of services or Medicaid will deny coverage of the services.

Providers should request authorization, whenever possible, prior to the service being rendered.

Refer to the program-specific Medicaid provider manuals for documentation and criteria requirements of the requested service.

10-3.1 Inaccurate Information

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

Providers must submit supporting documentation of inaccurate information in writing via email, fax, letter, or through documentation upload to PRISM if related to an active authorization request. The documentation must include corroborating

information such as the customer service representative's name with the date and time of the phone call or screenshots from the website with a timestamp, etc.

10-3.2 Medicaid Member Eligibility

There are circumstances in which an individual's eligibility and enrollment with Medicaid have yet to be determined. Upon verification of Medicaid eligibility, a provider may request retroactive approval of services that require prior authorization. Refer to Chapter 8-2.3 *Retroactive Eligibility* of this manual for additional information. Medicaid eligibility verification, including retroactive eligibility, is the provider's responsibility.

Once member eligibility has been determined, a provider may submit a retroactive authorization request for services rendered during the retroactive period.

10-3.3 Medical Emergency

Services performed during a medical emergency, that require prior authorization, are eligible for retroactive authorization including medical supplies and durable medical equipment.

Documentation must support emergent and medical necessity criteria as well as any other Medicaid coverage criteria.

10-3.4 Medical Supplies Provided in a Medical Emergency

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.

10-3.5 Surgical Procedures

If, during a surgical procedure, a physician or other qualified healthcare professional determines that an additional or different procedure is medically necessary, and if the service meets all Medicaid criteria for coverage but requires prior authorization, the service is eligible for retroactive authorization. The provider must provide documentation supporting the change in the planned procedure.

10-3.6 Anesthesia Providers

When a surgical procedure requires prior authorization, the associated anesthesia codes are typically prior authorized as a component of the procedure.

When a surgical procedure does not require prior authorization, but the associated anesthesia code does, the anesthesia code, in this instance, does not require prior authorization.

When a surgical procedure requires prior authorization and the surgeon fails to obtain prior authorization, retroactive authorization may be approved when all required documentation is submitted and upon confirmation that the surgery was not:

- Previously denied by Medicaid
- Cosmetic, investigational, or experimental (excluding members participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the “Consolidated Appropriations Act, 2021”)
- A non-covered service (for more information see General Information: Section I, Chapter 12-7.5 *Appealing Denial*)
- A service prohibited without state or federally required consent forms

10-3.7 Inmates of Public Institutions

Inmates are not eligible for Medicaid while incarcerated, unless they are eligible for the 90-day coverage through the 1115 Demonstration Waiver detailed in Chapter 8-3.2 of this manual. If the inmate was eligible for Medicaid prior to incarceration, the Eligibility Lookup Tool will indicate their eligibility status.

Before rendering services that require a PA, a request must be submitted. Medicaid authorizes requests retroactively when services are deemed medically necessary and documentation meets Medicaid policy requirements.

Providers must include the following as part of their retroactive prior authorization request:

- Complete the appropriate PA request in PRISM.
- Include inmate status on the PA request.
- Include medical documentation that establishes the medical necessity of the requested services.

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

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

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

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

10-3.9 Exceeding Quantity Limits

Providers may request retroactive authorization when quantity limits are inadvertently exceeded. For example, a provider unknowingly exceeds quantity limits for a previously performed service by a different provider. The new provider

should make every reasonable effort, such as contacting customer service, to determine if quantity limits have been met.

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

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

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 EPSDT eligible. The EPSDT 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.

Medicaid only accepts electronic claims or Direct Data Entry (DDE) through the PRISM portal.

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. The 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, or facility visits. These services are considered part of the providers' or facilities' rates unless otherwise specified in policy.

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.

11-3.1 Attending Provider

When reporting for facility services, the attending provider is a physician or other qualified healthcare professional who has the overall responsibility for the member's medical care.

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 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 *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 are 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

Electronic Claims Only

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:

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 must 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 new claim showing the correct amount received from the TPL.

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

For additional guidance on TPL and/or Coordination of Benefits, please visit the following website resource pages: <https://medicaid.utah.gov/utah-medicaid-official-publications/> and <https://medicaid.utah.gov/hipaa/providers/#companion-guides>.

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

Medicaid only accepts electronic claims or Direct Data Entry (DDE) through the PRISM portal. Medicaid promotes the use of electronic transactions through an Electronic Data Interchange (EDI). This system enables the electronic exchange of health-related information, including claims, eligibility inquiries, and prior authorization requests.

To submit electronic claims to Medicaid, providers must be enrolled in the PRISM system and complete steps 8, 9, and 13 of the Provider Enrollment Business Process Wizard. For enrollment guidance, see [Become a Medicaid Provider](#).

For questions about Utah-specific electronic billing requirements based on HIPAA 5010 rules (45 CFR Part 162), providers and their billing agents or clearinghouses can consult the PRISM Companion Guides and the PRISM FAQs and Guides.

Medicaid can accept HIPAA compliant transactions through:

- UHIN (Utah Healthcare Information Network):
 - An Internet-based system that can be used as an interface between clearinghouse and billing agent systems and is a receiving point for Medicaid healthcare transactions. Is used for both fee for service (FFS) and Managed Healthcare encounter transactions.
 - Transactions are processed by UHIN in a timely manner and uploaded to PRISM for processing.
 - If providers use a software exchange system other than UHIN, they must ensure that this clearinghouse and billing agent system is enrolled and compatible with UHIN and conforms with all currently mandated American National Standards Institute (ANSI) standards (CFR 45 Part 160).
 - For more information on UHIN, visit the UHIN website or contact them at 877-693-3071.
- Electronic Batch submission via direct upload to the PRISM portal:
 - Medicaid offers providers a direct HIPAA transaction upload through the PRISM portal for the following transaction types:
 - 837 (Professional, Institutional, Dental),
 - 270 (Eligibility),

- 276 (Claim Status), and
 - 278 (Prior Authorization).
- Providers must be enrolled in the PRISM system to submit electronic claims to Medicaid.
- Further information on this process can be found on the Electronic Batch Updated Functionality form.
- Direct Data Entry (DDE) via the PRISM portal:
 - Medicaid offers providers a Direct Data Entry (DDE) system via the PRISM portal.
 - Providers must be enrolled in the PRISM system to submit electronic claims to Medicaid.
 - Providers must complete and submit the Health Care Provider Access Agreement form and must be approved to use the Claim Submitter profile in order to use the DDE system.
 - Further information on this process can be found on the [PRISM provider training website](#), by accessing eLearnings – Claims and Encounters.

The Medicaid EDI team is available to help providers, clearinghouses, and billing agents with electronic transactions. For assistance with questions call 801-538-6155 (option 3, 5), or email HCF_OSD@utah.gov.

11-6.2 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.

11-6.3 Electronic Data Interchange (EDI) Resources

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 PRISM. Accredited Standards Committee (ASC X12) Implementation Guides are available from the [Washington Publishing Company](#).

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>.

Medicaid EDI Help Desk

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

Email correspondence to:

HCF_OSD@utah.gov for production issues.

EDItestinggroup@utah.gov for testing prior to production submissions.

11-6.4 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 electronic documentation with a copy of the Medicaid remittance within 30 days of the claim denial and a Timely Filing Document Submission Form. The Timely Filing

Document Submission Form can be found at <https://medicaid.utah.gov/utah-medicaid-forms>.

Documents may be sent via fax or through the Document Management Portal found in PRISM.

Providers must include:

- Copy of the remittance advice showing the claim processed within 30 days of the date of denial.
- Completed Timely Filing Document Submission Form.
- Any other supporting documentation.

When the documentation is received, the request is reviewed. If Medicaid finds that the criterion for one of the timely filing exceptions in 42CFR 447.45 (d)(4)(iv) is met, Medicaid will waive the time limit and initiate processing of the claim.

11-6.5 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.

11-6.6 Resubmit Claims with Corrected Information

If a claim is denied for incorrect information, correct the claim and resubmit it, rather than calling Medicaid. 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: 1 (original submission), 7 (for replacement claim), 8 (to void a claim)

Electronic: X12 element 2300 CLM05-3

Paper: Not accepted

Original Reference Number

Transaction Control Number (TCN) of original claim to be replaced or voided

Electronic: X12 element 2300 REF02

Paper: Not accepted

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. The number of lines on the original claim must back the replacement/void claim. Claims submitted without matching lines to the original claim (TCN) will be rejected.

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 an 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 can use consistent procedures and codes when submitting transactions to a health plan anywhere in the United States.

Standards for the 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 (837P)

837 Professional Transaction

The ASC X12N 837 Professional transaction is the electronic version.

- Institutional Claims (837I)

837 Institutional Transaction

The ASC X12N 837 Institutional transaction is the electronic version.

- Dental Claims (837D)

837 Dental Transaction

The ASC X12 837 Dental transaction is the electronic version.

- Eligibility Inquiry/Response (270/271 Transactions)

270 Eligibility Inquiry Transaction (Batch)

The 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.

- 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 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).

- 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 with Attachment(s)

Medicaid allows submitters to continue billing their claims electronically even if a paper attachment needs to be sent with the claim. 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 is submitted through the PRISM Document Management Portal and 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 277CA 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 277CA 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.
- Further information on use of the PRISM document management portal can be found in the Document Management Portal Quick Reference Guide for Providers.

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.

11-9 Electronic Visit Verification Requirements for Home Health and Personal Care Services

In accordance with Utah Administrative Code R414-522 and section 12006 of the 21st Century CURES Act, providers of Home Health and Personal Care Services (including similar services offered through the Home and Community-Based Waiver programs) must comply with Electronic Visit Verification (EVV) requirements.

Home Health and Personal Care Services providers may select the system of their choosing, provided it captures the following data elements and is compliant with the standards set in the Health Insurance Portability Accountability Act. EVV systems must collect the minimum information:

- 1) type of service performed;
- 2) individual receiving the service;
- 3) date of the service;
- 4) location of service delivery;
- 5) individual providing the service;
- 6) time the service begins and ends; and
- 7) the date of creation of the electronic record.

Additional information, including technical specifications for file creation/submission can be found at <https://medicaid.utah.gov/evv>.

11-10 Reporting and Billing Covered and Non-Covered Services for Acute Inpatient Hospital Claims

Correct coding guidelines encourage the reporting of all delivered services. Therefore, providers should report covered and non-covered services when billing acute inpatient hospital claims. However, there are instances where the Medicaid claims processing system will deny an entire claim for a single denied line. Generally, this occurs for services that require prior authorization, but the hospital did not obtain one.

When an entire claim denies for a non-covered line item(s), Medicaid requires that acute inpatient hospitals report covered services and omit non-covered services that would otherwise deny the claim. Additionally, providers must omit the reporting of any other ICD-10-PCS, CPT, HCPCS, or revenue codes related to the non-covered services.

For example, a member is admitted for labor and delivery and elects to have a sterilization procedure performed but does not have prior authorization for the sterilization. In this instance, the sterilization, and the associated services, are non-covered. The facility must omit the non-covered services from the claim.

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

12 Coding

All 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

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)

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)

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 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 other qualified healthcare professional 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 other qualified healthcare professional of the same specialty who belongs to the same group practice, within the past three years.

- In the instance where a physician or other qualified healthcare professional is on call for or covering for another provider, the patient's encounter will be classified as it would have been by the provider 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 or other qualified healthcare professional is on call for or covering for another provider, classify the patient's encounter as it would have been by the provider who is not available. Medicaid considers any provider in the same clinic, group practice or other facility to be "of the same specialty" unless the member has specifically been referred to another provider 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.

When behavioral health services are rendered and a formal diagnosis has not yet been established, providers are permitted to use Z codes related to social determinants of health (Z55–Z60), other psychosocial and environmental circumstances (Z62–Z65), and counseling services and problems related to lifestyle (Z69–Z73). Once a definitive clinical diagnosis is established, the appropriate

primary diagnosis code must be used. Furthermore, the documentation must explicitly demonstrate the medical necessity for the specific procedure code billed.

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 physical and behavioral health, or maternal health, 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

- 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 ensure 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>

- 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 on the [PRISM Coverage and Reimbursement Code Lookup Tool](#) as “requiring manual review” or the 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 into the Document Management Portal in PRISM:

- 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, or is not applicable, 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 Modifiers

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

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

Modifier 25 - Claims submitted with modifier 25 require the submission of documentation substantiating correct reporting of a *Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*

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

Coverage of diagnostic or therapeutic procedures includes taking vital signs, asking the member how they feel, and obtaining written consent. Therefore, it is not appropriate to report a different E/M code for these services per the National Correct Coding Initiative (NCCI) unless the criteria mentioned above are met. When these criteria are met, a provider may report the E/M by adding modifier 25 to the appropriate level of E/M service.

Modifiers 26 and TC: Certain diagnostic and procedural services are comprised of two components: a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently or by different providers, or they may be furnished together as a global service. When services have separately billable PC and TC components, the payment for the global service equals the sum of the payment for the TC and PC.

- **Professional (Modifier 26)** - Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
- **Technical (Modifier TC)** - Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by providers; however, portable x-ray suppliers only

bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

If the same provider is performing both the technical and professional component of a service, the global service (i.e. the procedure code without the TC or 26 Modifier) should be reported.

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) Bilateral surgeries are procedures performed on both sides of the body during the same operative session. Do not append to procedures when the code description specifically states it is a unilateral or bilateral procedure.

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 modifiers 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 AS: (PA or NP assistant at surgery) Modifier AS for PA or NP assistants to surgery is limited to 20% of the established fee schedule.

Modifier 81: (Minimal assistant at surgery) Medicaid does not reimburse for services reported with Modifier 81.

Modifier 82: (Minimal surgical assistance is needed, but the qualified resident was not available) Medicaid does not reimburse for services reported with Modifier 82.

Modifier 91: Submit documentation supporting the claim that separate services were provided for a distinct medical purpose.

12-7.4 Multiple Procedure Payment Reduction

Each CPT, HCPCS, and PCS code has a designated rate and are weighted based on Relative Value Units (RVUs). These values are established based on the concept that the services reported are standalone procedures. In some instances, providers will perform multi-staged procedures that are separate but related to one another. In these instances, the expense of performing the associated procedures is reduced as they do not require a different surgical session, incisions, anesthesia, etc. This is known as Multiple Procedure Payment Reduction (MPPR). Multiple procedures performed during the same service session by the same provider are reported using modifier 51. Even if a modifier is not used, MPPR can be applied for services performed on the same date.

The MPPR applies to procedures when:

- Two or more procedure codes are subject to reductions (i.e., two or more codes on the Multiple Procedure Reduction Codes list)
 - If two codes are reported, but only one is subject to reduction, no reduction will be taken on either procedure
- A single code subject to the MPPR is submitted with multiple units
 - *For example, CPT code 11300 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less) is submitted with three units, then MPPR would apply to the second and third units*

The MPPR will be applied using the pricing method outlined below:

- **100%** of the allowable amount for the primary/major procedure
- **50%** of the allowable amount for the secondary procedure
- **25%** of the allowable amount for all subsequent procedures

Multiple Procedure Payment Reduction (MPPR) for Assistant Surgeon Services

Multiple procedures performed by an assistant surgeon or a nurse practitioner/physician assistant are subject to the MPPR concept defined above when performed by the same provider on the same service date. There are instances when a surgical procedure requires and allows for reporting an assistant surgeon. In these circumstances, the assistant surgeon reimbursement will be 20% of the allowable amount for each procedure.

Refer to Chapter 12-7.3, *Modifier used in a Claim*, of Section I: General Information provider manual for additional details related to reporting assistants to surgery.

Multiple Procedure Payment Reduction (MPPR) for Co-Surgeon/Team Surgeon Services

Multiple procedures performed by a co-surgeon are subject to the MPPR when performed by the same physician or other qualified health care professional on the same date of service. Co-surgeon and team surgeon services are considered separately and independently of any other co-surgeon or team surgeon services.

12-7.5 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.

Please see Chapter 5-4, *Hearings and Administrative Review*, for additional information on appealing a denial.

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
ALOS	Average length of stay
ANSI	American National Standards Institute
ASC X12	Accredited Standards Committee (see definitions)
CDEN	Child Health Insurance Program Dental Claims
CFR	Code of Federal Regulations
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

DIH	Division of Integrated Healthcare
DHS	Department of Human Services
DHHS	Department of Health and Human Services
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
NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
OBRM	Omnibus Budget Reconciliation Act
ORS	Office of Recovery Services
ORSIS	Office of Recovery Services Information System
PA	Prior Authorization
PERM	Payment Error Rate Measurement
PMHP	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