



# Medicaid Information Bulletin

October 2005



Web address: <http://health.utah.gov/medicaid>

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**This bulletin is available in editions for people with disabilities.**

**Call Medicaid Information:**

**538-6155**

**or toll free 1-800-662-9651**

**On-Line (Internet) Address for Medicaid:**

<http://health.utah.gov/medicaid>

Please make sure that any Medicaid bookmarks that you have are the new Medicaid Internet address shown above. The old web site is not being kept up to date. The old Medicaid Internet address was printed in many Medicaid documents. The address will be corrected when the document is updated.

**World Wide Web:** <http://health.utah.gov/medicaid>  
**Medicaid Information**

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

(Formerly <http://www.health.state.ut.us/medicaid>)

**Requesting a Medicaid publication?**

**Send a Publication Request Form.**

- by FAX: 1-801-536-0476
- by mail to: Division Of Health Care Financing  
Box 143106, Salt Lake City UT 84114-3106

**05 - 109 National Provider Identifier**

Reminder--Health care providers are required by law to apply for a National Provider Identifier (NPI). To apply online, visit: <https://nppes.cms.hhs.gov>, or call 1-800-465-3203 to request a paper application. Visit <http://www.cms.hhs.gov/hipaa/hipaa2> for the latest information regarding the NPI, including a transcript from CMS' recent National Provider Identifier Roundtable conference call.

The NPI will not be mandated as the sole identifier to be used in standard transactions with most health plans until May 2007 (May 2008 for small health plans). While the NPI must be used on standard transactions with health plans no later than May 23, 2007, health care providers should not begin using the NPI in standard transactions on or before the compliance dates. Medicaid will notify providers when to begin using NPIs in standard transactions to Medicaid.

When you receive your NPI number, please fax or mail the information to Medicaid Provider Enrollment, include your name and Medicaid Provider ID number.

Medicaid will keep you informed of our progress with implementing the NPI.

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**05 - 110 Utah Medicaid Provider Manuals On-line**

All Utah Medicaid Provider Manuals are now on-line. When a manual is updated, the new version will be added immediately. Outdated manuals will be available in an Archive section. To access the on-line manuals, go to the Utah Medicaid home page, <http://health.utah.gov/medicaid/>. There are two links on the page to the list of manuals. One is on the left, under the Provider navigation button. The other link is on the right, under the list of Information for Health Care Providers.

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**05 - 111 Electronic Funds Transfer (EFT)**

Medicaid is anticipating that Electronic Funds Transfer (EFT) will be available for enrolled Medicaid providers in November 2005. The EFT form is on the Medicaid web site, at <http://health.utah.gov/medicaid/> under Enroll as a Utah Medicaid Provider. Medicaid will accept receipt of completed EFT forms at this time. If you have any questions, please contact Provider Enrollment at (801) 538-6155 or toll free (800) 662-9651, press option 3 then 4.

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**05 - 112 Electronic Billing Required for Institutional Claims and Medicaid/Medicare Crossover Claims**

Currently, all Medicaid institutional claims must be billed electronically to electronic mail box HT000004-001. Effective October 1, 2005, Medicaid/Medicare Crossover claims billed on a UB-92 claim form must be billed electronically to electronic mail box HT000004-005. All paper claims received on or after October 1, 2005 will be returned.

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**05 - 113 Coordination of Benefits**

Reporting Third Party Liability (TPL) instructions for paper claims and electronic claims have been updated on the Medicaid WEB site at <http://health.utah.gov/medicaid/>.

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**05 - 114 Physician Services: Code 44210; Modifiers 25 and 29; Anesthesia; Claim Editing Software Update****Covered CPT code**

44210—Laparoscopic colectomy, total. This code is removed from the Medical and Surgical Procedures “CPT Code List” and added to the list “Codes NOT Authorized for an Assistant Surgeon.”

**Policy Reminder**

Review of medical record documentation for modifier 25 (April 2005) and modifier 59 (July 2005) will be required for processing of these claims. An adjustment to the editing program has been made so that these codes will no longer be paid prior to approval of supportive documentation.

**Anesthesia Provider Clarification**

Medicare uses the AS modifier to indicate when a physician assistant or nurse practitioner serves as the assistant surgeon. The AS modifier is not covered under Medicaid. It has always been Utah Medicaid policy that the modifier 80—assistant surgeon is payable strictly to a qualified surgeon.

Physician Assistants and Nurse Practitioners cannot be reimbursed as the assistant surgeon through the physician’s provider number as an incident to service.

**Coming Soon - Editing Software Update**

The Department will be bringing a new version of the claim editor on line in January. The current program has approximately 44% of CCI edits included. The new version has the ability to install all CCI edits. Because some CCI edits do not consider children’s issues, a code review will be completed to determine which of the CCI edits in the new version are appropriate for Medicaid.

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**05 - 115 Physician Services: Codes Not Covered for Assistant Surgeon**

Codes considered for assistant surgeon coverage are based on the most current list published by the American College of Surgeons. Codes in the range 7000-9999 therefore do not require an assistant surgeon and will no longer be individually listed. Code 44210 is added to the list.

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**05 - 116 Physician Services: Post-operative Days**

At provider request, a list of post-operative days under Medicaid has been added to the Physician Manual.

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**05 - 117 Physician Services: Hyperbaric Oxygen Therapy**

Prior approval under criterion 21 is given to hospital-based facilities which are fully accredited through the Undersea and Hyperbaric Medical Society (UHMS).

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**05 - 118 Emergency Department: Diagnosis Codes Added to ER Only Code List**

Diagnosis codes added to ER Only Code List are:

276.51 Dehydration  
276.52 Hypovolemia  
466.19 Acute bronchitis due to other infectious organism  
599.60-599.69 Urinary obstruction  
799.01 Asphyxia

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**05 - 119 DRG Number Changed for Treatment of Drug and Alcohol Abuse/Dependence**

Medicaid does not normally publish the DRG list because we follow Medicare Updates. The DRG number was recently changed for Treatment of Drug and Alcohol Abuse/Dependence to DRG 523. Medicaid has always limited the stay under the DRG to three days, which reasonably covers required medical treatment for detoxification. If the patient requires continued treatment for mental health issues, the patient needs to be assigned a DRG for the mental health treatment.

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**05 - 120 Medicare Part D and Medicaid Prescription Drug Coverage Changes**

Beginning January 1, 2006, Medicaid recipients with dual coverage of both Medicaid and Medicare will no longer receive a drug benefit through Medicaid. They will receive the majority of their drugs through the new Medicare Part D. They will be automatically enrolled in Part D by CMS and will receive the low income subsidy. Medicaid will continue, as in the recent past, to cover certain over-the-counter drugs, certain cough and cold preparations, barbiturates, and benzodiazepine drugs. These can be billed through the Medicaid point of sale system using the same limitations and criteria as in the past.

Prescription Drug Plans (PDP) will be established that will provide prescription drug benefits to Medicare clients in Utah. Plans will vary as to coverage. These Dual Eligible (DE) individuals will need to select the plan that best suits their needs. Because Medicare Part D will operate under a drug formulary, the dual eligibles clients may need help to select the pharmacy drug plan (PDP) which will best cover their prescription drug needs and they may need help to transition to alternate drugs which are covered under their PDP. These dual eligible clients have more flexibility and can change their PDP at any time, which is different for regular Medicare clients, who are only able to change the PDP once per year at the time of enrollment.

Your aid in helping those who have dual coverage to select the best PDP for their drug needs and modifying their drug regimen where necessary to obtain the correct drugs is essential and appreciated.

Dual eligibles will have small copays (\$1-\$3), but no deductible, no premium, and no coverage gaps with their new Part D pharmacy coverage. They will receive a letter in October of 2005 from Medicare which will inform them of the PDP to which they have been assigned. In mid-November, they will receive an official notice from Medicaid telling them of the of the changes in their Medicaid pharmacy coverage which begins on January 1, 2006. □

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**05 - 121 Vision Services: Codes S0620 and S0621; Other Manual Corrections**

Codes S0620, Routine ophthalmologic exam including refraction; new patient, pays \$39.29, and S0621, Routine ophthalmologic exam including refraction; established patient, pays \$35.50, are now open for opticians and ophthalmologists. This change allows the vision exam and refraction to be billed under a single code. This will allow for more accurate and correct billing.

**Correction:** The July 2005 manual pages for the Vision Program contained an error which limits the coverage to children only. The corrected manual page should replace the July version. Beginning July 1, 2005, adults with Traditional Medicaid had eyeglasses restored as a benefit. Adults and children with Traditional Medicaid coverage now have the same vision coverage. □

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**05 - 122 Dental Services: Code 21215; Other Manual Corrections**

The last Medicaid Dental Provider Manual contained errors concerning the age for most dental services. The corrected pages should replace those sent in July. The Medicaid Oral Surgeon Provider Manual is corrected to reflect the proper ages for services for those with Traditional Medicaid coverage. The coverage for adults with Traditional Medicaid is essentially the same as for children in both the dental and oral surgeon programs.

Code 21215, Graft, bone, mandible has been opened for oral surgeons. This is not opened to general dentists. □

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**05 - 123 Medical Supplies: Code Corrections and Clarifications**

Clarification: Providers should bill using B9998 for gastronomy buttons and tubing. Please specify the brand name used and price. Only 4 buttons per year and 4 tubing or extension sets per year are allowed.

Liquid Oxygen is provided using codes E0439RR, stationary liquid oxygen system, rental which includes container, contents, use of reservoir, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing. One unit or 10 pounds of liquid oxygen are included as part of the monthly rental. S8121, Oxygen contents, liquid, 1 unit equals 1 pound has now been opened to be used with rental liquid oxygen systems for additional oxygen beyond the initial 10 lbs. This code requires prior authorization.

Code E0445, Oximeter, will change from an RR rental modifier to an LL capped rental monitor and the rentals will be capped after 12 rental periods.

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**05 - 124 Speech and Language: Communication Boards, Picture Boards and PECS Boards Not Covered**  
(Don Hawley August 11 )

The use of communication boards, picture boards and PECS boards are not covered by Medicaid. Treatment for non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board, such as a PECS, or picture board are not covered.

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**05 - 125 PT or OT Maintenance Not Covered**

Therapy for PT or OT maintenance is not covered, except children under the age of 20 years are limited to one therapy visit per month to allow those children who need ROM and other maintenance therapies to have them reviewed monthly by the therapist. Those who suffer from regression could have a new plan of care prescribed with stated goals and receive prior authorization for a new plan of care.

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**05 - 126 Pharmacy Services: New Cumulative Limits**

The Drug Utilization Board has established cumulative limits for 4 classes of drugs and one single agent. They are as follows:

1. Muscle relaxants- carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol, orphenadrine, orphenadrine compounds, brand names or generics, have each had a cumulative limit of 30 tablets in 30 days established by the DUR Board. No restrictions will be established for dantrolene, baclofen and tizanidine, which are used primarily for spinal cord injury cases.
2. Butalbital, butalbital/APAP and ASA combinations- cumulative limit of 30 tablets/capsules in any combination in 30 days. This cumulative limit may be changed in the future.
3. Short acting Opiate Analgesics- a cumulative limit of 180tabs/caps in any combination in 30 days has been established.
5. Erectile dysfunction drugs- The Department of Health Administration has determined that a prior authorization limiting the recipient to 5 doses in any combination per month will be established. Recipients on a convicted sex offenders listing will not be provided medication. New drugs for this use or in this category will be subject to the same limitations.
4. Spiriva capsules - a cumulative limit of 30 doses in 30 days has been established. Spiriva is used only for Chronic Obstructive Pulmonary Disease.

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**05 - 127 Palladone; Zelnorm; Vesicare and Sanctura; Ventavis; Schedule II Controlled Substance Analgesic Medications****Palladone- withdrawn from the market**

Palladone (Hydromorphone SA capsules) by Purdue, has been removed from the marketplace by the manufacturer according to an FDA recommendation.

**Zelnorm- change in prior authorization criteria**

Zelnorm prior authorization criteria have been amended. Previous information remains in place with changes. Originally, prior authorization was for 6 months. Now, a 30 day holiday which documents failure with other methods will be required before a 2nd authorization will be available. No further allowances will be allowed after 1 year. For irritable bowel syndrome (IBS), no trials with stimulant laxatives are required.

**Vesicare and Sanctura**

At the July DUR Board meeting the Board placed Vesicare and Sanctura under the prior authorization restrictions currently in place for the anti-cholinergic over-active bladder drugs. Doctors will need to obtain a prior authorization via a written request and documented therapy failures. Specific criteria may be obtained by calling the Prior Authorization desk at 538-6155.

**Ventavis- PA policy**

The DUR Board has recommended that Ventavis, a new drug for the treatment of pulmonary arterial hypertension be placed on prior authorization. Criteria required for its approval are: 1) covered for labeled indications only, 2) not for simultaneous use with Flolan, Tracleer, or Remodulin.

**Schedule II controlled substance analgesic medications**

Prior authorizations for brand name elements of this drug class require physician evaluated, charted documentation of an allergic skin eruption or reaction. "Client said", or "client reports" of "doesn't work", or "causes nausea", or "treatment failure" are not acceptable for authorization from generic to name brand in this category. □

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**05 - 128 Attention: Mental Health Centers, Substance Abuse Treatment Providers and Targeted Case Management Providers for the Homeless****Mental Health Centers**

In the Utah Medicaid Provider Manual for Targeted Case Management for the Chronically Mentally Ill, Chapter 1-4, Qualified Targeted Case Management Providers, licensed practical nurses are now included in qualified provider group #1 along with other licensed professionals, and may supervise non-licensed individuals providing targeted case management services.

In Chapter 1-5, Targeted Case Management Training Curriculum, the training requirements have been updated to reflect the Division of Substance Abuse and Mental Health's current training protocol.

**Substance Abuse Treatment Providers**

In the Utah Medicaid Provider Manual for Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse, Chapter 4-5, licensed practical nurses are now included in qualified provider group #1 along with other licensed professionals, and may supervise non-licensed individuals providing targeted case management services.

In addition, the name of this section of the provider manual has been made consistent on all pages. (See new page headers with the name: *Targeted Case Management for Substance Abuse*.)

**Targeted Case Management for the Homeless Providers**

In the Utah Medicaid Provider Manual for Targeted Case Management for the Homeless, Chapter 1-4, Qualified Targeted Case Management Providers, licensed practical nurses are now included in qualified provider group #1 along with other licensed professionals, and may supervise non-licensed individuals providing targeted case management services.

Providers will find attached the updated page(s) with this clarification. A vertical line in the margin is next to the text that has been changed. Contact Merrila Erickson at 538-6501 or [merickson@utah.gov](mailto:merickson@utah.gov) if you have any questions. □