

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

Payment rates for the services listed below are effective for services provided on or after the corresponding date:

<b>Service</b>	<b>Attachment</b>	<b>Effective Date</b>
Physician and Anesthesia Services	Attachment 4.19-B, Pages 4 and 5	July 1, 2018
Optometry Services	Attachment 4.19-B, Page 7	July 1, 2018
Eyeglasses Services	Attachment 4.19-B, Page 8	July 1, 2018
Home Health Services	Attachment 4.19-B, Page 10	July 1, 2018
Clinic Services	Attachment 4.19-B, Pages 12b and 34	July 1, 2018
Dental Services and Dentures	Attachment 4.19-B, Page 13	July 1, 2018
Physical Therapy and Occupational Therapy	Attachment 4.19-B, Page 14	July 1, 2018
Speech Pathology Services	Attachment 4.19-B, Page 16	July 1, 2018
Audiology Services	Attachment 4.19-B, Page 17	July 1, 2018
Transportation Services (Special Services)	Attachment 4.19-B, Page 18	July 1, 2018
Transportation Services (Ambulance)	Attachment 4.19-B, Page 18	July 1, 2018
Rehabilitative Mental Health Services	Attachment 4.19-B, Page 25	July 1, 2018
Chiropractic Services	Attachment 4.19-B, Page 30	July 1, 2018

T.N. # 18-0006

Approval Date 6-6-18

Supersedes T.N. # 17-0020

Effective Date 7-1-18

A. OUTPATIENT HOSPITAL AND OTHER SERVICES

1. Effective for service end dates on or after September 1, 2011, the payment for outpatient hospital claims will be based on Medicare's Outpatient Prospective Payment System (OPPS) payment methodology. Medicare's Outpatient Code Editor and CMS pricer will be utilized for payment amounts.

A. OPPS hospitals will be paid per applicable APC, Medicare fee schedule, or reasonable cost method (reasonable cost will be paid using the facility-specific cost-to-charge (CCR) multiplied by the line-item billed charge).

The CCR used will be the Medicare CCR calculated from the most recently filed Medicare Cost Report as available through the HCRIS database or the Medicare fiscal intermediary.

B. Services not priced using OPPS or CAH methodology will be based on the established Medicaid fee schedule and the reimbursement policies for those services may be found in Attachment 4.19-B as follows:

- Section C – Laboratory and Radiology Services
- Section D – Physicians
- Section E – Anesthesiologist/Anesthetist
- Section F – Podiatrists
- Section G – Optometrists
- Section H – Eyeglasses
- Section K – Medical Supplies and Equipment
- Section M – Dental Services and Dentures
- Section N – Physical and Occupational Therapy
- Section O – Prosthetic Devices and Braces
- Section P – Speech Pathology
- Section Q – Audiology
- Section S – Prescribed Drugs

Typically, these services are not covered by Medicare.

Except as otherwise noted in the plan, payments for these services based on state-developed fee schedule rates, are the same for both governmental and private providers. All rates are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at <http://health.utah.gov/medicaid/>.

C. Vaccines for Children (VFC) services will be paid using the Medicaid VFC rates. Non-VFC services will be paid using Medicare's pricer. The reimbursement policies for those services may be found on Page 9a of Section 1.5.

D. Revenue code 72[0-9], if not accompanied with procedure code detail, will be paid using the reasonable cost methodology.

E. Transitional Outpatient Payments (TOPs) will be calculated according to Medicare principles and paid on a semi-annual basis to in-state providers only.

2. Critical Access Hospitals (CAH) will be paid 101% of costs using the facility-specific CCR.

The CCR used will be the Medicare CCR calculated from the most recently filed Medicare Cost Report as available through the HCRIS database or the Medicare fiscal intermediary.

3. Out-of-state hospitals will be paid by hospital type (OPPS or CAH) like in-state hospitals, but will not receive any specialty payments (e.g., TOPs).

4. Billed charges shall not exceed the usual and customary charge to private pay patients.

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OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

Beginning February 3, 2004, FQHCs may elect to be paid under one of two payment methods—the Prospective Payment Method (PPS) or the Alternative Payment Method (APM). Each FQHC must elect its payment methodology preference and give notice to the Division of Health Care Financing (DHCF) on or before January 1, 2004, to be effective February 3, 2004. If an FQHC elects to change payment methods in subsequent years, an election to do so must be made no later than thirty (30) days prior to the beginning of the FQHC's fiscal year by written notice to (DHCF).

a. Prospective Payment System (PPS).

1. Payment under PPS methodology conforms to the Federal methodology as contained in section 702 of the Benefits Improvement and Protection Act of 2001. PPS is the only approved methodology for the time period January 1, 2001 thru February 2, 2004, under the State Plan in effect for that time period.

PPS rates for each FQHC are determined on the basis of their 1999 and 2000 fiscal years' reasonable costs, adjusted for any subsequent change in scope of services (See Section A.9.c). The average of the two-year costs are divided by the average number of visits (physician services as defined by the State Plan, Attachment 3.1-A, Attachment #5) for the same two-year period. The resulting prospective rate is increased on January 1 of each subsequent year by the applicable Medicare Economic Index for primary care services.

2. Regarding FQHCs which contract with Managed Care Organizations (MCOs), supplemental payments will be estimated and paid quarterly to the FQHCs for the difference between amounts paid by the MCOs and amounts the FQHCs are entitled to under the PPS. Quarterly interim payments will be made no later than thirty (30) days after the end of the quarter. Annual reconciliations will be made and settled.
3. Mental Health (MH) services require FQHCs to contract with local MH providers that are paid a capitation rate by DHCF to avoid duplicate payments. FQHC MH charges are billed to MH providers which reimburse FQHCs on the basis of the MH provider fee schedule. The difference between FQHC MH cost and MH provider payments are reimbursed by DHCF as noted in section A.9.d.
4. The PPS rate for newly qualified FQHCs in 2001 and later will be established by reference to PPS rates of other FQHCs in the same or adjacent areas with similar caseload, or by cost reporting methods.

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A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) (Continued)

(6) FQHCs located out-of-state that serve Utah Medicaid clients will be paid the reimbursement rate applicable to the state in which services are provided.

b. Alternative Payment Method (APM)–Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable Cost (RCCAC)

- (1) Beginning February 3, 2004, an alternative payment method (APM) is adopted and available for election. Under RCCAC, allowable costs are determined using applicable Medicare cost principles, as addressed in 42 CFR and CMS Publication 15-1, and allowable costs are allocated to Medicaid using the percentage of Medicaid covered billed charges to total charges for all patients. Total allowable costs are multiplied by the Medicaid charge percentage to determine the amount of allowable cost to be paid by Medicaid. Interim payments will be made on the basis of billed charges and valid claims processed and paid by Medicaid will reduce the final settlements. Third party liability (TPL) collections for Medicaid patients will also be considered as claim reimbursements in completing cost settlements.
- (2) FQHCs participating in the alternative payment method will provide DHCF with annual cost reports and other information required by DHCF within ninety (90) days from the close of their fiscal year-end to include the provider calculations of their anticipated settlement. DHCF will review submitted cost reports and provide a preliminary payment, if applicable, to FQHCs on the basis of a desk settlement. About 6 months after the FQHC's fiscal year-end, DHCF will conduct a desk review or audit of submitted cost reports and perform final settlements. This will allow for inclusion of late filed claims and adjustments processed after the submitted cost report was prepared. Claims data changes from the final settlement through one year will be added to the following year's settlement. If Medicaid over-payments to a provider occur, pay-back to the State is required. If underpayment occurs, a payment adjustment will be made to the FQHC.
- (3) The alternative payment method described herein will be compared with the reimbursements calculated using the PPS methodology described in A.9.a. The greater amount will be paid to the FQHCs.

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A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) (Continued)

c. Scope of Service Changes

Scope of service changes must be substantiated by adequate documentation. FQHCs electing the PPS method must submit documentation with an estimate of the cost of the change in scope of service to receive an adjustment in their encounter rate. Scope changes need to be accounted for by all FQHCs because annual comparisons to APM need to be made. Actual detail cost elements need to be tracked in the general ledger accounts or otherwise to allow for verification and testing. Overstated estimated costs require pay-back. Underestimated costs will be reimbursed.

d. Managed Care Organization and Mental Health Settlements

For FQHCs servicing Medicaid clients of Managed Care Organizations (MCOs) and capitated MH organizations, the difference between FQHC costs minus MCO, MH and TPL reimbursement will be determined annually and settled. The determination of cost will be on the basis of the RCCAC as noted in Section A.9.b. Quarterly estimated payments will be made to FQHCs on the basis of the most recent prior year annual reconciliation.

10. RURAL HEALTH CLINICS (RHCs)

a. Prospective Payment System (PPS)

- (1) Payment for Rural Health Clinic services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. All Rural Health Clinics are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding year.
- (2) Payment rates will be set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that fiscal year. The clinic must supply documentation to justify scope of service adjustments.

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A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

10. RURAL HEALTH CLINICS (RHCs) (Continued)

a. Prospective Payment System (PPS) (Continued)

(3) For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar case load, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.

(4) Until a prospective payment methodology is established, the state will reimburse RHCs based on the State Plan in effect on December 31, 2000. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

b. Managed Care Organization Settlements

In the case of any RHC which contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

c. Out-of-State Providers

RHCs located out-of-state that serve Utah Medicaid clients will be paid the reimbursement rate applicable to the state in which services are provided.

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Effective Date 1-1-05

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**11. STATE TEACHING HOSPITAL SUPPLEMENTAL PAYMENTS**

The State Teaching Hospital will be paid a supplemental payment for outpatient hospital services based on a reasonable cost methodology. Reasonable cost is determined using Medicare principles by applying a cost-to-charge ratio derived from the latest filed Medicare cost report to Medicaid claims data as described in #14 below. The supplemental payment equals the difference between reasonable costs adjusted for inflation and utilization trends and claims payments made pursuant to otherwise applicable methodologies as described on Page 1 of this Attachment.

Quarterly interim payments will be made that will each be equal to one-fourth of the total projected supplemental payment. Before making the first interim supplemental payment in a state fiscal year, the total projected supplemental payment will be calculated. Using data from the federal HCRIS database, the calculation uses recently filed and available cost reports with provider fiscal year end before the beginning of the state fiscal year for which the calculation is made and as available at the time the calculation is made.

**12. NON-STATE GOVERNMENT HOSPITALS SUPPLEMENTAL PAYMENTS**

Government owned, other than state owned, hospitals shall be eligible to receive a supplemental payment for outpatient hospital services based on a reasonable cost methodology. Reasonable cost is determined using Medicare principles by applying a cost-to-charge ratio derived from the latest filed Medicare cost report to Medicaid claims data as described in #14 below. The supplemental payment equals the difference between reasonable costs adjusted for inflation and utilization trends and claims payments made pursuant to otherwise applicable methodologies as described on Page 1 of this Attachment.

Quarterly interim payments will be made that will each be equal to one-fourth of the total projected supplemental payment. Before making the first interim supplemental payment in a state fiscal year, the total projected supplemental payment will be calculated. Using data from the federal HCRIS database, the calculation uses recently filed and available cost reports with provider fiscal year end before the beginning of the state fiscal year for which the calculation is made and as available at the time the calculation is made. The payments will be distributed to each hospital based on the proportion of the hospital's UPL room that is greater than zero.

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Effective Date 7-1-13

**13. PRIVATE HOSPITALS SUPPLEMENTAL PAYMENTS**

Privately-owned in-state hospitals shall be eligible to receive a supplemental payment for outpatient hospital services based on a reasonable cost methodology. Reasonable cost is determined using Medicare principles by applying a cost-to-charge ratio derived from the latest filed Medicare cost report to Medicaid claims data as described in #14 below. The UPL room equals the difference between reasonable costs adjusted for inflation and utilization trends and claims payments made pursuant to otherwise applicable methodologies as described on Page 1 of this Attachment. The supplemental payment pool each year shall be the lesser of the total UPL room for this class or the calculated total funds amount using a non-federal share amount equal to \$3,777,777.78. The non-federal share amount will be used to generate additional matching Federal Funds. The total funds will be determined for each State Fiscal Year (SFY) by using a blended SFY FMAP rate for the SFY. The following example is for illustrative purposes only:

FFY	FMAP	Quarters	Extended
2018	0.7026	1	0.7026
2019	0.6971	3	2.0913
Total			2.7939
Quarters			4
Blended FMAP (rounded)			0.6985
Blended State Match Rate (BSMR) for SFY 2019			0.3015
Non-federal share (NFS) amount			\$3,777,777.78
Total Funds (NFS/BSMR)			\$12,529,942.89

Quarterly interim lump sum payments will be made that will each be equal to one-fourth of the total projected supplemental payment pool. Before making the first interim supplemental payment in a state fiscal year, the total projected supplemental payment will be calculated. Using data from the federal HCRIS database, the calculation uses recently filed and available cost reports with provider fiscal year end before the beginning of the state fiscal year for which the calculation is made and as available at the time the calculation is made.

The payments will be allocated to each hospital based on the proportion of the hospital's UPL room that is greater than zero with an increased proportion being given to rural hospitals. The annual payment allocation is divided into two sub-allocations. One allocation is only for rural hospitals and the other is for all hospitals. The allocations are calculated as follows:

Hospital's Annual Payment Allocation = Hospital's Base Allocation + Hospital's Rural Enhancement Allocation

Total Rural Enhancement Allocation = Supplemental Payment Pool x Historical Rural Enhancement Percent (579/544-1)

Total Base Allocation = Supplemental Payment Pool - Total Rural Enhancement Allocation

Hospital's Base Allocation Percent = (Hospital's UPL room that is greater than zero) / (Sum of all hospitals' UPL room that is greater than zero)

Hospital's Base Allocation = Total Base Allocation x Hospital's Base Allocation Percent

Only Rural Hospital's with UPL room greater than zero are included in the Rural Enhancement Allocation below:

Hospital's Rural Enhancement Allocation Percent = (Rural Hospital's Annualized Medicaid Payments) / (Sum of Annualized Medicaid Payments to All Rural Hospitals)

Hospital's Rural Enhancement Allocation = Total Rural Enhancement Allocation x Hospital's Rural Enhancement Allocation Percent

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#### 14. UPL Calculation Overview

For purposes of calculating the Medicaid outpatient hospital upper payment limits for hospitals, the state shall utilize hospital specific Medicare outpatient cost to charge ratios applied to Medicaid charges. The Medicaid upper payment limit for state hospitals and non-state government owned hospitals are independently calculated. Each Medicaid upper payment limit shall be offset by hospital Medicaid and other third party outpatient payments to determine the available spending room (i.e., the gap) applicable to each Medicaid upper payment limit. The base year utilized to determine each Medicaid upper payment limit shall be trended to the applicable spending year as follows:

- Inflation trend shall be an annual average calculated using the consumer price index available the December prior to the start of each state fiscal year for "Outpatient Hospital Services" as published by the U.S. Department of Labor, U.S. Bureau of Labor Statistics as compared to the previous December.
- Utilization trend shall be calculated using historical Utah Medicaid outpatient hospital services data. The utilization trend for State Fiscal Year 2019 shall be -4.5 percent.

Following is the data used to calculate the UPL for each state fiscal year:

Medicare Cost to Charge ratio:

- 2552-96: Costs are from Worksheet D, Part V, Columns 9, 9.01, 9.02, 9.03 line 104
- 2552-10: Costs are from Worksheet D, Part V, Columns 5, 6, and 7 line 202
- 2552-96: Charges are from Worksheet D, Part V, Columns 5, 5.01, 5.02, 5.03 line 104
- 2552-10: Charges are from Worksheet D, Part V, Columns 2, 3, 4 line 202

Note: As Medicare may amend the cost report structure from that noted above, corresponding Medicare Cost Report data will be used in place of the elements noted above.

The hospitals in the analysis have fiscal year ends during the state fiscal year Medicaid Charges and payments - Paid hospital outpatient claims from services in a recent period and as available at the time the calculation is made.

Costs for critical access hospitals shall be calculated at 101 percent of cost with any appropriate inflation and utilization added as noted above.

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C. LABORATORY AND RADIOLOGY SERVICES

Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed the usual and customary charge to private pay patients. Payment will not exceed the Medicare fee schedule as required by Section 2303 of P. L. 98-369.

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D. PHYSICIANS (Except Anesthesiologists)

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page.

These rates are published at

<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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42 CFR

ATTACHMENT 4.19-B  
Page 4b

Deleted August 1, 2013

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T.N. # 13-027

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## D. PHYSICIANS (Except Anesthesiologists)(Continued)

## 7. ENHANCED PAYMENT RATES

**Rural Areas**

Physicians, including persons providing services under the direct supervision of a physician as allowed by state law, providing services in rural areas of the state are paid a rate differential equal to 112 percent of the physician fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake and Utah counties.

**University of Utah Medical Group**

Physicians, including persons providing services under the direct supervision of a physician as allowed by state law, and practitioners (e.g., podiatrist, optometrist, dentist, covered independent nurse practitioners) employed by University of Utah Medical Group (UUMG) will be paid at a rate commensurate with the average commercial insurance professional rate (ACR) for services. Data used to calculate the ACR will be provided by UUMG based on paid commercial insurance claims for service dates in the previous calendar year.

$$\text{ACR} = (\text{Reimbursement} + \text{Third Party Liability} + \text{Copayments}) / (\text{Total Charges})$$

The average Medicaid rate (AMR) is also calculated annually based on paid Medicaid claims for service dates in the previous calendar year.

$$\text{AMR} = (\text{Reimbursement} + \text{Third Party Liability} + \text{Copayments}) / (\text{Total Charges})$$

In order to determine the total payment to UUMG, a rate differential is calculated prior to making any payments for the period. The rate differential will be effective for payments made between September 1<sup>st</sup> of that year and August 31<sup>st</sup> of the following year.

$$\text{Rate Differential} = \text{ACR} / \text{AMR}$$

$$\text{Payment} = (\text{Rate Differential} - 1) \times \text{Medicaid Allowed Amount}$$

(The *Medicaid Allowed Amount* is the Reimbursement Amount + Third Party Liability + Copayments, during the period under review for payment.)

Anesthesiologists employed by the University of Utah Medical Group will be considered part of this enhanced payment program, regardless of the anesthesiologist exception noted in this section [Section D, Physicians (Except Anesthesiologists)].

The rate differential payment made to the UUMG will be made as a separate annual, semi-annual, quarterly, monthly or any combination thereof payment to the UUMG on behalf of the physicians and practitioners employed based on the paid claims during the period under review for payment. If new or corrected information is identified that would modify the amount of a previous payment the department may make a retroactive adjustment payment in addition to previously paid amounts.

**Evaluation and Management (E&M) Services for Psychiatric Pharmacologic Management**

To ensure continued access to specialized psychiatric pharmacologic management, when physicians and other qualified prescribers allowed under state law include the CG modifier with evaluation and management codes 99213, 99214, 99308, 99309, 99310, 99348 or 99349, then the fee in effect for psychiatric pharmacologic management, procedure code 90862, on December 31, 2012, is used to determine payment. The methodology is not applied if the evaluation and management service is billed with any add-on procedure codes allowed by Current Procedural Terminology (CPT) coding for evaluation and management services.

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D. PHYSICIANS (Except Anesthesiologists)(Continued)

9. PAIN MANAGEMENT

Physicians may bill for consultations using the appropriate evaluation and management codes. Physicians and other primary care providers may provide chronic pain management services using the appropriate evaluation and management codes. Payment for services does not include facility fees.

A psychiatrist or licensed clinical psychologist may provide the comprehensive psychiatric or psychological evaluation using the appropriate service codes. Effective October 1, 2009, physician consultations and ongoing chronic pain management services are no longer reimbursed an enhanced rate. The agency's fee schedule rate for medical services was set as of May 25, 2009, and is effective for services on or after that date.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

All rates are published at <http://health.utah.gov/medicaid/>.

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**Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- The rates reflect all Medicare site of service and locality adjustments.
- The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- The rates reflect all Medicare geographic/locality adjustments.
- The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: \_\_\_\_\_

Notes: The Medicare rates used will only be updated for each January 1 to reflect the then current Medicare rates. The state uses the Deloitte Medicare fee schedule. Additionally, Utah has only one Medicare GPCI.

**Method of Payment**

- The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19-B, Section D Physician Services, of the State Plan and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made:  monthly  quarterly

The supplemental calculation is made as follows for each qualifying provider after the end of each quarter and excludes the University of Utah Medical Group providers that are paid at the Average Commercial Rate:

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Supersedes T.N. # New Effective Date 1-1-13



1. By servicing provider, by claim line for qualifying billing codes, identify allowed units and allowed amounts through the claim system for qualifying E&M billing codes paid during the quarter.
2. By servicing provider, by claim line for qualifying billing codes, calculate the sum of the payments that would have been paid for the qualifying codes and the Medicare rate effective as of January 1 of the calendar year in which the service was incurred (Total Allowed Units x Medicare Rate).
3. By servicing provider, by claim line for qualifying billing codes, calculate the difference between step 2 and step 1 (step 2 result less step 1 result).
4. By billing provider, the sum difference calculated in step 3 will be paid after the end of each quarter.

The calculation for the 100 percent federal match will be based on the difference between the Medicare rate effective as of January 1 of the calendar year in which the service was incurred and the Medicaid rates in effect on July 1, 2009. This calculation will exclude any FFP already claimed when the base payments were made to the provider; to the extent those base payments were greater than the July 1, 2009 rate. The 2009 base rate for codes not covered in 2009 but subsequently added will be \$0.

In addition to the quarterly payments, if an audit or review reveals an overpayment or underpayment, then recoveries or additional payments will also occur.

**Primary Care Services Affected by this Payment Methodology**

- This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- This payment applies to all covered Evaluation and Management (E&M) billing codes 99201 through 99499 except the following codes for which the State did not make payment as of July 1, 2009 and will not make enhanced payments under this SPA (with the exception of coverage of Medicare Crossover claims):

99224 (1/1/11)	99340	99380	99408	99450
99225 (1/1/11)	99360	99386	99409	99455
99226 (1/1/11)	99363	99397	99412	99456
99239	99364	99401	99420	99485 (1/1/13)
99288	99374	99402	99429	99486 (1/1/13)
99315	99375	99403	99441	99487 (1/1/13)
99316	99377	99404	99442	99495 (1/1/13)
99318	99378	99406	99443	99496 (1/1/13)
99339	99379	99407	99444	

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The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009:

90460 (1/1/11)	99359 (9/1/11)	99368 (9/1/11)	99466 (9/1/11)	99489 (1/1/13)
90461 (1/1/11)	99366 (9/1/11)	99387 (1/1/14)	99467 (9/1/11)	
99358 (9/1/11)	99367 (9/1/11)	99396 (1/1/14)	99488 (1/1/13)	

**Physician Services – Vaccine Administration Related to VFC**

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

Medicare Physician Fee Schedule rate

State regional maximum administration fee set by the Vaccines for Children program

Method of Payment

The supplemental calculation is made as follows for each qualifying provider after the end of each quarter and excludes the University of Utah Medical Group providers that are paid at the Average Commercial Rate:

1. By servicing provider, by claim line for qualifying VFC billing codes, identify allowed units and allowed amounts through the claim system for qualifying VFC billing codes paid during the quarter.
2. By servicing provider, by claim line for qualifying VFC billing codes, calculate the sum of the payments that would have been paid for the qualifying codes during the covered quarter at the state regional maximum administration fee set by the VFC program (\$20.72 from the table in the final rule) (Total Allowed Units x Current Medicare Rate).
3. By servicing provider, by claim line for qualifying VFC billing codes, calculate the difference between step 2 and step 1 (step 2 result less step 1 result).
4. By billing provider, the sum difference calculated in step 3 will be paid to providers after the end of each quarter.

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T.N. # # 14-033 Approval Date 9-16-14

Supersedes T.N. # 13-002 Effective Date 4-1-14

The calculation for the 100 percent federal match will be based on the difference between the state regional maximum administrative fee, as noted above, effective for the service date and \$8.37 which is the imputed rate for code 90460. This calculation will exclude any FFP already claimed when the base payments were made to the provider; to the extent those base payments were greater than the July 1, 2009 rate. The 2009 base rate for codes not covered in 2009 but subsequently added will be \$0.

Rate using the CY 2009 conversion factor

**Documentation of Vaccine Administration Rates in Effect 7/1/09**

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: \$8.37.

A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \_\_\_\_\_.

Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: \_\_\_\_\_

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

**Effective Date of Payment**

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014. Payments will continue while timely filing applies for all services rendered during the time period noted above.

All rates are published at:

<http://health.utah.gov/medicaid/stplan/physician.htm>.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. Payments will continue while timely filing applies for all services rendered during the time period noted above.

All rates are published at:

<http://health.utah.gov/medicaid/stplan/physician.htm>.

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T.N. # # \_\_\_\_\_ 13-002

Approval Date \_\_\_\_\_ 6-17-13

Supersedes T.N. # \_\_\_\_\_ New

Effective Date \_\_\_\_\_ 1-1-13

E. ANESTHESIOLOGIST/ANESTHETIST

1. INTRODUCTION

Payment is based on the lower of billed usual and customary charges or a calculated fee.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at

<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

2. CALCULATED FEE

Payment = (Basic Value + Time Values + Modifying Factors) x Conversion Factor.

Time Values are added to the basic value at the rate of one unit for each twelve minutes or fraction thereof.

Rural Areas: Anesthesiologists/Anesthetists providing services in rural areas of the state are paid a rate differential equal to 112 percent of the physician fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake and Utah counties.

\*Physical status modifiers and similar to account for various levels of complexity.

\*\*The conversion factor is published at:

<http://health.utah.gov/medicaid/stplan/physician.htm>

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T.N. # 17-0006

Approval Date 5-15-17

Supersedes T.N. # 16-0012

Effective Date 7-1-17

E. ANESTHESIOLOGIST/ANESTHETIST (Continued)

2. CALCULATED FEE (Continued)

Obstetrical Anesthesia

Because obstetrical anesthesia is unique and an anesthesiologist may attend more than one patient concurrently under continuous regional anesthesia, there will be a reduction in the unit value after the first hour of anesthesia time. During the second hour of anesthesia, the unit value will be reduced by 50%. During the third and each succeeding hour of anesthesia, the unit value will be reduced by 75%.

Modifying Units

Modifying units may be added to the basic value where increased risk and special technical skills are involved or necessary for extremes of age (under one year or over 70 years), two modifying units may be added.

- a. When anesthesia is administered under extenuating circumstances away from the operating room suite, two modifying units may be added.
- b. Utilization of total body hypothermia, five units may be added.
- c. Utilization of controlled hypotension, five units may be added.

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T.N. # 93-002

Approval Date 5-21-93

Supersedes T.N. # 87-37

Effective Date 1-1-93

F. PODIATRISTS

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of podiatric services. The amount billed cannot exceed usual and customary charges. The agency's rates were set in accordance with the methodology described in Section D "Physicians," and are effective for services on or after the date noted in Section D.

Payments for covered podiatric services are based on the established fee schedule unless a lower amount is billed. All rates are published on the agency's website at <http://health.utah.gov/medicaid/>.

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T.N. # \_\_\_\_\_ 13-021

Approval Date \_\_\_\_\_ 3-5-14

Supersedes T.N. # \_\_\_\_\_ 87-37

Effective Date \_\_\_\_\_ 7-1-13

G. OPTOMETRISTS

Optometrists use the physicians fee schedule described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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T.N. # 17-0007

Approval Date 5-15-17

Supersedes T.N. # 16-0013

Effective Date 7-1-17

H. EYEGLASSES

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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T.N. # 17-0011

Approval Date 5-15-17

Supersedes T.N. # 16-0017

Effective Date 7-1-17



J. HOME HEALTH SERVICES

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

RURAL AREA EXCEPTIONS

Where travel distances to provide service are extensive, enhancements in the home health reimbursement rates are provided. These enhancements are available only in rural counties where one way travel distances from the provider's base of operations are in excess of 25 miles. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah counties. In instances of travel of 50 miles or more, the Home Health fee schedule is multiplied by 1.75 to calculate the payment rate for applicable service codes.

SAN JUAN and GRAND COUNTIES EXCEPTION

To assure continued access to home health services for residents of San Juan County and Grand County, enhancements in home health reimbursement rates are provided. Effective July 1, 2007, for services provided in San Juan County and Grand County, the home health fee schedule is multiplied by 4.08 and 2.95, respectively, to calculate the payment rate for applicable service codes. These enhancement factors are applied irrespective of the distances traveled to provide these services and are in lieu of the rural area exceptions provided for other rural counties. Additionally, to compensate providers for delivering home health services in more remote areas, Medicaid payment is based upon a modifier for the two following zones:

Zone 1: For Aneth and Hatch Trading Posts, and Mexican Hat and Montezuma Creek residents or eligibles, Home Health Agency (HHA) services are billed under Modifier "UA" and mean that a factor or multiplier of 7.12 is applied (multiplied) by the existing HHA fee schedule.

Zone 2: For Monument Valley residents or eligibles, HHA services are billed under Modifier "UB" and mean that a factor or multiplier of 15.02 is applied (multiplied) by the existing HHA fee schedule.

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T.N. #	<u>17-0005</u>	Approval Date	<u>5-15-17</u>
Supersedes T.N. #	<u>16-0011</u>	Effective Date	<u>7-1-17</u>

K. MEDICAL SUPPLIES AND EQUIPMENT

1. GENERAL

For items of DME that have a HCPC code (including power wheelchairs), payment will be made to the supplier based on the lowest of:

- a. Billed usual and customary charges to the general public, or
- b. The established Medicaid fee schedule, a price discounted from the Medicare allowable for the region, or the negotiated price, or
- c. The lowest qualified bidder who meets all quality of care and service delivery requirements.

2. SPECIALIZED WHEELCHAIRS

Manual wheelchairs with special configurations, which do not fit into HCPC definitions, will be priced using the following criterion:

- a. Prior Approval of all Pricing -- "Specialized manual wheelchairs" require prior approval by the Medicaid agency. Approval is required for all components used to customize the wheelchair. Components must be:
  - i. Described in writing,
  - ii. Priced using manufacturers' list, and
  - iii. Approved by the Medicaid agency.
- b. Manufacturers Published Catalog Price Less Discount -- "Specialized manual wheelchairs," not described by HCPC coding, are manually priced and are priced at the manufacturer's published catalog price less 25%.

Wheelchair components without a specific HCPC code are priced at Manufacturers' list price less 40%.

T.N. # 07-011

Approval Date 9-11-07

Supersedes T.N. # 95-18

Effective Date 8-1-07

K. MEDICAL SUPPLIES AND EQUIPMENT (Continued)

3. DURABLE MEDICAL EQUIPMENT NOT COVERED BY HCPC DEFINITIONS

This policy is intended to address isolated problems where HCPC definitions and related fees do not correlate with equipment approved by the Medicaid Agency. Providers should not look to this policy for routine pricing. The policy assures that suppliers are not paid less than the acquisition cost paid to the equipment manufacturer.

4. PRICING POLICY

This policy is limited to durable medical equipment that is not covered by specific HCPC codes, but is approved as medically necessary by the Medicaid Agency. The DME must be approved and payment will be the greater of:

- a. Manufacturers' list price less 40%.
- b. Manufacturers' invoice, including shipping, but net of all discounts, plus an add-on of 10% with a ceiling of \$100.

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T.N. # 07-011

Approval Date 9-11-07

Supersedes T.N. # 95-018

Effective Date 8-1-07

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L. CLINIC SERVICES

Clinic services are paid differently depending on the type of services rendered. Such payments are limited to the amount paid by Medicare as specified in 42 CFR 447.321. Subject to these limitations, payments are determined as follows:

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T.N. # 12-018

Approval Date 12-12-12

Supersedes T.N. # 10-005

Effective Date 7-1-12

L. CLINIC SERVICES (Continued)

1. Dialysis Clinics -- Payment for renal dialysis is based on the established fee schedule unless a lower amount is billed. The amount billed shall not exceed usual and customary charges. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Effective for services on or after April 1, 2016, the payment for dialysis claims will be Medicare's ESRD PPS Base Rate. All rates are published on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published as follows:

<http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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T.N. # 16-0023 Approval Date 6-30-16

Supersedes T.N. # 15-0013 Effective Date 4-1-16

L. CLINIC SERVICES (Continued)

2. Surgical Centers -- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

**MULTIPLE AND BILATERAL PROCEDURES**

The primary surgical procedure with the highest payment rate is paid based on 100% of the established Medicaid fee. The second highest payment rate is paid based on 50% of the established fee schedule. Payment for the other lower payment rates is made at 25% of the established fee schedule for multiple and bilateral procedures. When CPT modifiers are used, the rate is adjusted for CPT modifiers before the percentages are applied for multiple units billed for designated procedure codes to pay at 100% of the established Medicaid fee schedule.

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T.N. # 17-0012

Approval Date 5-15-17

Supersedes T.N. # 16-0018

Effective Date 7-1-17

L. CLINIC SERVICES (Continued)

3. Alcohol and Drug Clinics

Deleted July 1, 2015

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T.N. # \_\_\_\_\_ 15-0013

Approval Date \_\_\_\_\_ 2-29-16

Supersedes T.N. # \_\_\_\_\_ 14-021

Effective Date \_\_\_\_\_ 7-1-15

Deleted July 1, 2015

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T.N. # 15-0013

Approval Date 2-29-16

Supersedes T.N. # 14-021

Effective Date 7-1-15



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M. DENTAL SERVICES AND DENTURES

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

Enhanced Payments

Urban Counties

As an incentive to improve client access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers (excluding state-funded clinics) willing to sign an agreement to see 100 or more clients during the next year will be reimbursed at the lesser of billed charges or 120 percent of the established fee schedule.

Rural Counties

As an incentive to improve client access to dental services in rural counties (all counties except Weber, Davis, Salt Lake, and Utah), dental providers in these counties including state-funded clinics will be reimbursed at the lesser of billed charges or 120 percent of the established fee schedule.

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T.N. # 17-0016 Approval Date 5-15-17

Supersedes T.N. # 16-0024 Effective Date 7-1-17

M. DENTAL SERVICES AND DENTURES (Cont.)

Supplemental Payments

These supplemental payments will be calculated each year by using State Funds equal to \$206,150. That amount will be used to generate additional matching Federal Funds. The State Funds and the matching Federal Funds combined will equal the Total Amount that will be distributed. The matching Federal Funds will be determined by the FMAP Rate for the then current period. The calculation for the matching Federal Funds = (State Funds Amount / (1 – FMAP Rate) X FMAP Rate).

Supplemental payments will be distributed annually, typically between April 1 and June 30, in accordance with the calculated distribution amounts.

The supplemental payment pool is distributed based upon the proportion each then currently enrolled pediatric dental care provider received in Medicaid paid claims from the previous April 1 through March 31 period (period of interest). The supplemental payment will be based on a provider's percentage of total Medicaid reimbursement to pediatric dental providers in the period of interest. The following example is for illustrative purposes only:

Supplemental Payment Pool:			\$100.00
<b>Pediatric Dental Provider</b>	<b>Paid Claims in Period of Interest</b>	<b>Proportion</b>	<b>Supplemental Payment</b>
A	\$1,000	66.7%	\$66.67
B	\$300	20.0%	\$20.00
C	\$200	13.3%	\$13.33
Total	\$1,500	100.0%	\$100.00

T.N. # 17-0018

Approval Date 6-1-17

Supersedes T.N. # 16-0024

Effective Date 4-1-17

N. PHYSICAL THERAPY

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

OCCUPATIONAL THERAPY

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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T.N. # 17-0013

Approval Date 5-15-17

Supersedes T.N. # 16-0019

Effective Date 7-1-17

O. PROSTHETIC DEVICES AND BRACES

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Fees are established by discounting historical charges, by professional judgment and by discounting published price lists.

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T.N. # 87-37

Approval Date 11-9-87

Supersedes T.N. # 82-25

Effective Date 7-1-87

P. SPEECH PATHOLOGY

The fees are established by using the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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T.N. # 17-0008

Approval Date 5-15-17

Supersedes T.N. # 16-0014

Effective Date 7-1-17

Q. AUDIOLOGY

The fees are established by using the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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T.N. # 17-0009

Approval Date 5-15-17

Supersedes T.N. # 16-0015

Effective Date 7-1-17

R. TRANSPORTATION

1. Ambulance – Payment will be made on an established Medicaid fee schedule. The fee schedule will include base rate, mileage rate, oxygen fee and waiting time. The fee schedule will include both ground, air and water transportation.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

2. Special Services – These include Para-Transit, Ambucar, Servicar, and other specialized/similar transportation services. Payment will be the lower of the usual and customary charge or the established fee schedule for Medicaid.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

3. Bus Service – Payment will be the rates established by contract between the provider and Medicaid. If there is no contract, payment will be the same as the fares paid by the general public.
4. NEMT Brokerage Contracted services – Payment is based on the contracted capitated rate derived from a competitive bidding process.

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T.N. #	<u>17-0015</u>	Approval Date	<u>5-15-17</u>
Supersedes T.N. #	<u>16-0021</u>	Effective Date	<u>7-1-17</u>

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S. PRESCRIBED DRUGS

Covered outpatient drugs will be reimbursed based on an established product cost plus a professional dispensing fee. The payment for individual prescriptions shall not exceed the amount billed. The amount billed must be no more than the usual and customary charge (U&C) to the private pay patient. The following methodology is used to establish Medicaid payments:

Effective for claims adjudicated on or after April 1, 2017, except as otherwise stated in this section and in addition to a reasonable professional dispensing fee as applicable, reimbursement for brand and generic covered outpatient drugs will be as follows:

The lesser of the Utah Estimated Acquisition Cost (UEAC), Federal Upper Limit, National Average Drug Acquisition Cost (NADAC), Utah Maximum Allowable Cost (UMAC), or the Ingredient Cost Submitted.

Federal Upper Limit

The federal upper limit is the maximum allowable ingredient cost reimbursement established by the Federal government (e.g., Centers for Medicare and Medicaid Services (CMS) for selected multiple-source drugs. The aggregate cost of product payment for the drugs on the federal upper limit list will not exceed the aggregate established by the Federal government.

Utah MAC

Utah MAC is the Maximum Allowable Cost reimbursement established by the State for selected drugs.

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Approval Date 7-26-18

Supersedes T.N. # 17-0002

Effective Date 7-1-18



S. PRESCRIBED DRUGS (Continued)

Utah Estimated Acquisition Cost (UEAC)

The Utah EAC is the Wholesale Acquisition Cost (WAC).

Professional Dispensing Fees

The Utah Medicaid professional dispensing fees are as follows:

1. \$9.99 for urban pharmacies located in Utah;
2. \$10.15 for rural pharmacies located in Utah;
3. \$9.99 for pharmacies located in any state other than Utah; and
4. \$716.54 for hemophilia clotting factor dispensed by the contracted pharmacy and in accordance with Attachment 4.19-B, Page 22g.

Urban pharmacies are pharmacies physically located in Weber, Davis, Utah and Salt Lake counties.

Drugs Dispensed by IHS/Tribal facilities

Covered outpatient drugs dispensed by an IHS/Tribal facility to an IHS/Tribal member are reimbursed at the encounter rate in accordance with the Utah Medicaid Indian Health Services Provider Manual.

Specialty Drugs and Covered Outpatient Drugs Primarily Dispensed through the Mail

Specialty drugs and covered outpatient drugs primarily dispensed through the mail are reimbursed in the same manner as other covered outpatient drugs in accordance with the reimbursement rules of this section.

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T.N. # \_\_\_\_\_ 17-0002

Approval Date 4-12-17

Supersedes T.N. # \_\_\_\_\_ 16-0010

Effective Date 4-1-17

S. PRESCRIBED DRUGS (Continued)

Covered Outpatient Drugs Purchased Through the 340B Program

Covered entities that purchase covered outpatient drugs through the 340B program and used the 340B covered outpatient drugs to bill Utah Medicaid are required to submit the 340B acquisition cost on the claim and identify the medications as being purchased through the 340B by using the Submission Clarification Code = '20' or 'UD' modifier.

Payment for covered outpatient drugs purchased through the 340B program will be the lesser of the 340B acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

Payment for covered outpatient drugs not purchased through the 340B program are to be submitted, and reimbursed, in accordance with the reimbursement rules under this section.

340B covered entities may not utilize contract pharmacies to bill Utah Medicaid unless the covered entity, contract pharmacy, and State Medicaid agency have a written agreement in place to prevent duplicate discounts.

Federal Supply Schedule

Providers that purchase covered outpatient drugs through the Federal Supply Schedule (FSS) and use the covered outpatient drugs to bill Utah Medicaid are required to submit the FSS acquisition cost on the claim, unless the reimbursement is made through a bundled charge or all-inclusive encounter rate.

Payment for covered outpatient drugs purchased through the FSS will be the lesser of the FSS acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

Payment for covered outpatient drugs not purchased through the FSS are to be submitted, and reimbursed, in accordance with the reimbursement rules of this section.

Nominal Price

Providers that purchase covered outpatient drugs at Nominal Price and use the covered outpatient drug to bill Utah Medicaid are required to submit the acquisition cost on the claim.

Payment for covered outpatient drugs purchased at Nominal Price will be the lesser of the Nominal Price acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

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T.N. # 17-0002

Approval Date 4-12-17

Supersedes T.N. # 09-001

Effective Date 4-1-17

S. PRESCRIBED DRUGS (Continued)

Covered Outpatient Drugs not Dispensed by a Retail Community Pharmacy

Covered outpatient drugs not dispensed by a retail community pharmacy are reimbursed in the same manner as other covered outpatient drugs in accordance with the reimbursement rules of this section.

Provider Administered Drugs

Covered provider administered drugs will be reimbursed according to the Average Sale Price (ASP) Drug Pricing File, published quarterly by the Centers for Medicare and Medicaid Services (CMS), for drugs that have an ASP price set by CMS.

Covered provider administered drugs for which CMS does not publish an ASP price will be reimbursed in accordance with the Utah Medicaid fee schedule published on Medicaid's Coverage and Reimbursement Code Look-up Tool.

Hemophilia Drugs

Hemophilia drugs are reimbursed in accordance with the rules of this section and the Hemophilia Disease Management program in Attachment 4.19-B, Page 22g.

Investigational Drugs

Investigational drugs are not covered by Utah Medicaid.

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T.N. # 17-0002

Approval Date 4-12-17

Supersedes T.N. # 93-002

Effective Date 4-1-17

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LICENSED CERTIFIED REGISTERED NURSE-MIDWIFE SERVICES

Payments are based on the established fee schedule for selected HCPCS codes unless a lower amount is billed. Selected HCPCS codes are established in compliance with HIPAA requirements. The amount billed cannot exceed usual and customary charges to private-pay patients. Payment for registered nurse-midwife services includes the physician's collaboration fee for the co-management of the case.

Rate Adjustment for Rural Areas

Effective October 1, 1991, licensed certified registered nurse-midwives who provide services in rural areas of the State will be paid the lower of usual and customary charges or rate equal to 112% of the established Medicaid fee schedule. Rural areas are defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.

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T.N. # 03-013

Approval Date 2-4-04

Supersedes T.N. # 91-18

Effective Date 10-1-03

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NURSE PRACTITIONERS (NP)

Approved procedure codes may be directly billed by a licensed nurse practitioner (NP). Payment for approved services will be made at the lower of the usual and customary charge or the established physician's fee schedule. The fees are established by using the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of these services. The agency's rates were set in accordance with the methodology described in Section D "Physicians", and are effective for services on or after the date specified in Section D. Payments for covered audiology services are based on the established fee schedule unless a lower amount is billed. All rates are published on the agency's website at <http://health.utah.gov/medicaid/>.

Rate Adjustment for Rural Areas

The 12% rate differential, not to exceed usual and customary charges, will be paid for services rendered in rural Utah. Rural Utah is defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.

Billing Arrangements

When service is provided by a licensed NP employed and working under supervision in a group practice, private office, community health center, or local health department, the supervising provider shall bill for the service according to their usual and customary fee schedule.

When service is provided by a licensed NP working in a private independent practice, the licensed NP shall bill according to their usual and customary fee schedule.

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T.N. # 14-010

Approval Date 4-10-14

Supersedes T.N. # 91-18

Effective Date 4-1-14

### TARGETED CASE MANAGEMENT SERVICES

Targeted Case Management services for pregnant women are paid based on the established fee schedule for one month of service. Payment is limited by the usual and customary charges of the providers.

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T.N. # 93-002 Approval Date 5-21-93  
Supersedes T.N. # 88-05 Effective Date 1-1-93

TARGETED CASE MANAGEMENT - CHRONICALLY MENTALLY ILL

This payment plan covers targeted case management services for individuals with serious mental illness.

Targeted case management services are paid using a uniform fee schedule. Services are defined by HCPCS code and prices using a fixed fee schedule. Payments are made to providers on a fee-for-service basis for defined units of service. The service unit is a 15-minute unit. The state-developed fee schedule rate is the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2013, and is effective for services provided on or after that date. Fee schedule payments are based on the established fee schedule unless a lower amount is billed. All rates are published at <http://health.utah.gov/medicaid/>.

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Supersedes T.N. # 03-024

Effective Date 1-1-13

Deleted September 1, 2015

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T.N. # 15-0004

Approval Date 11-13-15

Supersedes T.N. # 93-002

Effective Date 9-1-15



Targeted Case Management – Substance Abuse

Payment for targeted case management services to clients with a substance abuse disorder will be made on a fee-for-service basis to qualified providers. Medicaid payments will be the lesser of (1) the billed usual and customary charges to the general public; or (2) the established fee schedule.

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T.N. # 95-014

Approval Date 12-6-95

Supersedes T.N. # New

Effective Date 10-1-95

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TARGETED CASE MANAGEMENT SERVICES FOR MEDICAID HMO ENROLLEES AND  
POTENTIAL ENROLLEES

Total reimbursement for targeted case management services for HMO enrollees is based on historical cost adjusted annually (effective July 1) based on Legislatively approved cost of living and merit increases.

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T.N. # 01-022 Approval Date 12-6-01  
Supersedes T.N. # New Effective Date 7-1-01

DISEASE MANAGEMENT - HEMOPHILIA

Disease management payments will be in accordance with the contracted rates or billed charges, whichever is less. Reimbursement for disease management is fee-for-service and includes the following:

Reimbursement per in-home monthly nursing visit is reimbursed per 15-minute units.

In-home nursing visits will be reimbursed at the lesser of \$30 per 15-minute unit or the billed charges.

Payment for disease management services, reimbursed per month and capped at 1 unit per month, under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Payment for disease management services will be reimbursed at the lesser of \$631.65 as a monthly rate or the billed charges; however, the initial month a member is serviced by the contract provider the disease management services will be reimbursed at the lesser of \$1,000 per member or the billed charges. The initial month fee is only eligible to be paid once per member. The monthly payment rate shall not be paid unless an allowable hemophilia disease management service is provided to an eligible beneficiary.

All Medicaid disease management hemophilia services are paid pursuant to a selective contract authorized through authority in an approved 1915(b)(4) Waiver.

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T.N. # 18-0007

Approval Date 7-26-18

Supersedes T.N. # 17-0002

Effective Date 7-1-18

**PRESUMPTIVE ELIGIBILITY/EXPANDED PRENATAL SERVICES**

Payments are based on the established fee schedule for the defined services unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Reimbursement methodology is based on the established fee schedule for the defined services described in other sections of ATTACHMENT 4.19-B.

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T.N. # 13-032

Approval Date 1-15-14

Supersedes T.N. # 93-002

Effective Date 1-1-14

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PERSONAL CARE SERVICES

Medicaid payments for personal care services will be based on a fee schedule unless a lower amount is billed. Fees will be established based on the historical cost adjusted by economic trends and conditions. Providers must bill their usual and customary fees.

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T.N. # 93-002

Approval Date 5-21-93

Supersedes T.N. # 87-38

Effective Date 1-1-93

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MENTAL HEALTH DIAGNOSTIC AND REHABILITATIVE SERVICES

This payment plan covers rehabilitative mental health and substance use disorder services (hereinafter referred to as mental health services).

Rehabilitative mental health services are paid using a uniform fee schedule. Services are defined by HCPCS codes and prices using a fixed fee schedule. Payments are made to providers on a fee-for-service basis for defined units of service. The state-developed fee schedule rates are the same for both governmental and non-governmental providers.

The agency's fee schedule rates for mental health services are effective for services provided on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>. Fee schedule payments are based on the established fee schedule unless a lower amount is billed.

To ensure continued access to specialized psychiatric pharmacologic management, when physicians and other qualified prescribers allowed under state law include the CG modifier with evaluation and management code 99213, 99214, 99308, 99309, 99310, 99348 or 99349, then the fee in effect for psychiatric pharmacologic management, procedure code 90862, on December 31, 2012, is used to determine payment. The methodology is not applied if the evaluation and management service is billed with any add-on procedure codes allowed by Current Procedural Terminology (CPT) coding for evaluation and management services.

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Supersedes T.N. # 16-0020 Effective Date 7-1-17

MENTAL HEALTH DIAGNOSTIC AND REHABILITATIVE SERVICES (Continued)

Deleted April 1, 2016

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T.N. # \_\_\_\_\_ 16-0006

Approval Date 4-5-16

Supersedes T.N. # 03-019

Effective Date 4-1-16

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OTHER DIAGNOSTIC, PREVENTIVE, SCREENING, AND REHABILITATIVE SERVICES

Poison Control Center

Payment for the State Poison Control Center will be in the amount established by contract between the Division of Family Health Services and the Division of Health Care Financing. This contract will be renegotiated annually based on the estimated percentage of Medicaid eligibles in the population served by the Center.

Diabetes Self-Management Training

Payments for approved Diabetes Self-Management Training are based on the established fee schedule, unless a lower amount is billed.

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T.N. # 15-0001

Approval Date 1-29-15

Supersedes T.N. # 99-013

Effective Date 1-1-15



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PAYMENT FOR PRIVATE DUTY NURSING

Payment for private duty nursing provided to ventilator-dependent individuals will be calculated by multiplying the fixed hourly rate for each level of nursing (RN or LPN) by the number of hours authorized by the Medicaid agency. Payments will not exceed the usual and customary charges to private-pay patients.

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T.N. # 93-002

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Effective Date 1-1-93

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PAYMENT FOR HOSPICE SERVICES

Agency Only Services

For recipients who are not in a nursing home, Medicaid payments for hospice services will be made at one of the four predetermined rate categories that coincide with the categories established under Medicare. The hospice rates will be at least the Medicaid rates set by CMS. For each day that an individual is under the care of a Medicare-certified hospice agency, the hospice agency will be paid in accordance with the established Medicare fee schedule. Payment rates are based on the type and intensity of the services furnished to the individual for a given day according to one of the following levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. All of these levels of care are paid on a per diem basis other than continuous home care that is paid on an hourly basis. Additionally, the hospice payments will be adjusted according to recognized geographic areas to reflect differences in the wage index as published by the Centers for Medicare and Medicaid Services (CMS). Payments are made according to the area in which the service was provided, not according to the billing office location. Payment to the hospice agency may be considered retroactive to allow the hospice eligibility date to coincide with the Medicaid eligibility date, if the hospice service met the prior authorization criteria at the time service was delivered and if no other provider was reimbursed by Medicaid or any other payer for care related to the individual's terminal illness. The hospice agency must provide documentation to the Medicaid agency that demonstrates its service met all prior authorization criteria at the time of delivery.

Concurrent Care for Recipients Under 21 Years of Age

Concurrent treatment allowed under the State Plan for a terminal illness and other related conditions is available to recipients who are under 21 years of age and elect to receive Medicaid hospice care. For life-prolonging treatment provided to these recipients, Medicaid shall reimburse the appropriate Medicaid-enrolled medical care providers directly through the usual and customary Medicaid billing procedures.

Agency Services Delivered in Conjunction with Nursing Home Services

For a recipient in a nursing facility who elects to receive hospice service from a Medicare-certified hospice agency, Medicaid will pay the hospice agency an additional per diem (for routine home care days only) to cover the cost of room and board in the nursing facility. The room and board rate will be 95 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider (facility/provider "specific rate") if the recipient had not elected to receive hospice care. In the event a Medicare-certified facility provides hospice services and is not Medicaid-certified, the room and board rate will be 95 percent of the statewide average Medicaid reimbursement rate for nursing facilities. For a recipient who is under 21 years of age, the room and board rate will be 100 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider if the recipient had not elected to receive hospice care. With the election to receive hospice services, Medicaid payment to the nursing facility discontinues and the hospice agency pays the nursing facility the cost of room and board. In this context, room and board costs are for the performance of personal care services that include daily living assistance, social activities, administration of medication, room maintenance, supervising and assisting in the use of durable medical equipment and prescribed therapies, and other services associated with a nursing home inpatient stay.

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Supersedes T.N. # 06-008

Effective Date 3-8-13

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PAYMENT FOR HOSPICE SERVICES (Continued)

Service Intensity Add-On

Effective for dates of service on and after January 1, 2016, Medicaid hospice providers may receive a Service Intensity Add-On payment (SIA) for client's receiving routine home care by the registered nurse and the clinical social worker during the last seven days of the recipient's life.

The SIA payment is provided under the following conditions:

- 1) SIA payment is provided in addition to the routine home care rate.
- 2) To qualify for SIA payment, the SIA visit must be a minimum of 15 minutes but not more than four hours combined for both nurse and social worker per day.
- 3) SIA rates will be equal to the rates established by CMS for each geographical area of the State. The SIA payment amount is calculated by multiplying the Continuous Home Care (CHC) rate per 15 minutes by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.

Limitation for Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31 (cap period), the aggregate number of inpatient days (both for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied on an agency-wide basis and is not applied to individual patient stay services. At the end of each cap period, the Department calculates a limitation on payment of inpatient care for each hospice, to ensure that Medicaid payment is not made for days of inpatient care (including inpatient respite and general inpatient care) that exceed 20 percent of the total number of days of hospice care furnished to Medicaid recipients. The hospice agency then repays the Medicaid program a "prorated" share of total inpatient payment. This repayment will be computed as follows:  $[(\text{"Excess" Medicaid inpatient days} / \text{total paid Medicaid inpatient days}) \times (\text{payment rate per diem})]$ .

The inpatient care limitation does not apply to individuals with AIDS or to individuals who are under 21 years of age and receiving life-prolonging treatment for a terminal illness.

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Supersedes T.N. # 13-006 Effective Date 1-1-16

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MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES

Unless otherwise indicated below, payment for EPSDT services is based on the established fee schedule unless a lower amount is billed.

Orthodontic Services

A fixed fee is paid for attaching the approved orthodontic appliance. In addition, a fixed fee is paid every three months for maintenance service. The maximum number of payments for maintenance is eight quarterly payments. Total payments for the appliance and for the maintenance service are limited to usual and customary charges.

Diagnostic, Preventive, Screening, and Rehabilitative Services

**Early Intervention Services** -- Providers of early intervention services will be paid on a fixed monthly rate. The rate is based on historical cost for FY 1996 inflated forward annually using the UCPI-U all services index published by the U.S. Department of Labor. Payment is intended to cover all early intervention services outlined in the child's Individual Family service Plan (IFSP). Providers may bill for the monthly rate when at least one face-to-face contact is made, but may only bill once in each month when services are given.

**Skills Development Service** -- Payment is based on the average cost per day for services received. Historical costs are used to establish interim payments. Actual costs are used to determine final payment. Except for the first period of covered services, the cost settlement will be for a twelve-month period. Allowable costs are defined by HCFA Pub. 15-1. Direct costs are defined as the total compensation, including benefits, of the staff who provide "hands-on" care. Total compensation for the direct staff at the school is divided between "academic educational" and "functional skills development and maintenance." Other costs are allocated using direct costs for "academic educational" and "functional skills." Total days are divided into the accumulated "functional skills" costs, including indirect cost allocations, to arrive at an average cost per day.

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T.N. # 98-009

Approval Date 10-20-98

Supersedes T.N. # 93-017

Effective Date 7-1-98

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PAYMENT FOR TARGETED CASE MANAGEMENT SERVICES FOR EPSDT ELIGIBLES

Payment for targeted case management services for EPSDT eligibles is made on a fee-for-service basis. A separate prospective rate is established for each type of targeted case management provider identified below. In accordance with Federal Office of Management and Budget Circular No. A-87 requirements, payments made to governmental service providers shall not exceed the costs of providing such services.

Independent Professional: Rates are established on the basis of the historical cost of the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U. S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider without RMS Capability: Rates are established on the basis of the historical cost for the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U. S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider with RMS Capability: Rates are based on an enrolled agency's average allowable cost to provide a monthly unit of targeted case management services to an eligible recipient. Rates will be authorized for a period of 12 months. Except for the initial period, an agency's rate will be calculated as follows:

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T.N. #	<u>00-005</u>	Approval Date	<u>6-28-00</u>
Supersedes T.N. #	<u>94-017</u>	Effective Date	<u>1-1-00</u>

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PAYMENT FOR TARGETED CASE MANAGEMENT SERVICES FOR EPSDT ELIGIBLES (Cont.)

Compute: the Agency's actual total cost for the most recently completed 12 month period for which actual cost data exist, including (1) the salaries and benefits of case managers, their direct supervisory and support staff, and their indirect administrative staff, and (2) other operating costs including travel, supplies, telephone, and occupancy cost, and indirect administrative costs in accordance with Circular A-87. To determine the agency's "allowable costs", subtract from its total costs all personnel, operating, occupancy, and indirect administrative costs that are both unrelated to the delivery of Medicaid's scope of targeted case management services and are not allocated by the RMS.

Multiplied by: the percentage of time spent by agency personnel performing Medicaid allowable targeted case management services and related indirect activities on behalf of clients, ages birth through 20 years (regardless of the client's Medicaid eligibility) during the 12 month period. This percentage is derived from random moment time studies (RMS).

Multiplied by: the percentage of the agency's clients (regardless of Medicaid eligibility) who received a Medicaid allowable targeted case management service during the period.

Equals: total allowable costs incurred by the agency to provide and support Medicaid's scope of targeted case management services.

Divided by: 12 months.

Equals: the agency's average allowable monthly cost to provide and support Medicaid's scope of targeted case management services on behalf of individuals in the target group.

Divided by: the average monthly number of agency's clients in the target group (ages birth through 20 years regardless of Medicaid eligibility) who received a covered case management service during the period.

Equals: the agency's monthly allowable cost per targeted case management recipient in the target group. This cost equals the monthly fee for service amount that the agency will be authorized to claim for each EPSDT eligible recipient in the target group who received one or more covered targeted case management services that month. Documentation of case management services delivered will be retained in the service worker case files.

When determining an agency's initial rate, the Medicaid agency will apply the same calculations described above, but may use less than 12 months of data in calculating the rate. This initial rate may be in effect for less than a 12 month period.

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Effective Date 1-1-00

Deleted July 1, 2013

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Approval Date 8-7-13

Supersedes T.N. # 94-027

Effective Date 7-1-13

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Deleted August 1, 2017

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T.N. # 17-0021

Approval Date 7-27-17

Supersedes T.N. # 11-001

Effective Date 8-1-17



PAYMENT FOR CHIROPRACTIC SERVICES

Payments for covered chiropractic services use the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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T.N. # 17-0010

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Effective Date 7-1-17

REIMBURSEMENT FOR INDIAN HEALTH SERVICE  
AND TRIBAL 638 HEALTH FACILITIES

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PAYMENT FOR SERVICES

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Health Care Financing Administration (HCFA) and the IHS and which are published in the Federal Register or Federal Register Notices.

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T.N. #	<u>00-007</u>	Approval Date	<u>6-15-00</u>
Supersedes T.N. #	<u>New</u>	Effective Date	<u>1-1-00</u>

REIMBURSEMENT FOR OUT-OF-STATE PROVIDERS

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PAYMENT FOR SERVICES

Except as otherwise specified in this Attachment, 4.19-B, out-of-state providers are reimbursed using the reimbursement methodology in effect for those services; however, as needed, the state will negotiate rates directly with out-of-state providers in order to secure access to care for clients needing specialized services through an out-of-state provider. Prior authorization must be obtained from the Division of Medicaid and Health Financing to qualify for this special payment provision.

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T.N. # 11-008 Approval Date 11-22-11  
Supersedes T.N. # New Effective Date 9-1-11

Provider-Preventable Conditions (Continued)

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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section 4.19 (B) of this State plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

For claims with dates of service on or after July 1, 2012, Utah Medicaid will not reimburse providers for any of the OPPCs indicated above. Payment will be denied for OPPCs in any health care setting identified in Attachment 4.19-B.

In compliance with 42 CFR §447.26(c):

1. No reduction in payment for a provider-preventable condition will be imposed on a provider when the condition defined as a PPC existed prior to the initiation of treatment for that patient by that provider.
2. The reductions in provider payment may be limited to the extent that the following apply:
  - a. The identified provider-preventable condition would otherwise result in an increase in payment.
  - b. The State can isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable condition.
3. The State provides assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursement according to the methodology above.

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T.N. # 11-009 Approval Date 8-1-12

Supersedes T.N. # New Effective Date 7-1-12

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FREESTANDING BIRTH CENTER SERVICES

Licensed Birthing Centers -- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

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Approval Date 2-4-16

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Effective Date 1-1-16

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: \_\_\_\_\_

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment specified in the chart on page 2 of this supplement. Codes appearing in the chart have the meanings defined below:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters **SP**.

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in items 1 and 2 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters **MR**.
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items 1 and 2 of this attachment, for those groups and payments listed below and designated with the letters **NR**.
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in items 1 and 2 of this attachment (see 3. above).

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Supersedes T.N. # \_\_\_\_\_ 10-016

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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Medicaid payment for Medicare crossover claims will be limited to the patient's liability. Further, Medicaid payment for specified Medicare crossover claims will be the lower of:

- (1) the allowed Medicaid payment rate less the amounts paid by Medicare and other payors; or
- (2) the Medicare co-insurance and deductibles.

In the event Medicaid does not have a price for codes included on a crossover claim, the Medicaid price will be 80 percent of the Medicare price.

Following is specific information relating to certain providers:

Anesthesiologists - In order to convert to Medicaid units, the Medicare units will be multiplied by 1.25 and rounded-up to the nearest integer.

Nursing Facilities - Excluding "room and board" revenue codes from this requirement: If crossover claims do not include HCPCS codes on each claim line, then Medicaid's price is 80% of the total Medicare allowed amount for that claim.

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