UTAH DEPARTMENT OF HEALTH
MEDICAID

DIVISION OF MEDICAID & HEALTH FINANCING

Provider Enrollment

New Enrollment

- Beginning July 1, 2016 all new applications are submitted online through the PRISM system
- You will need to have the NPI, SSN/FEIN, date of birth, licenses, and ownership information ready for each new application
- An application can be started by visiting our website: https://medicaid.utah.gov
- Click on the tab titled ‘Health Care Providers’
  - Click on the first link titled ‘Become a Medicaid Provider’
- A Utah ID will be required to start a new application
  - To obtain a Utah ID visit login.utah.gov

New Enrollment

- Choose the enrollment type that is appropriate for the provider
- A page will appear asking for the name of the provider, Tax ID, Provider Requested Effective Date, etc. All fields marked with an asterisk need to be completed. **Always maximize the windows that pop up.**
- Once all of the information is entered, press the 'Validate NPI' button (For enrollment types: Individual, Group, Facility/Agency/Organization, and Indian Health Services) in the lower right corner of the screen. An error may appear, as long as the NPI and Tax ID are correct press the 'Finish' button and move on with the application.

New Enrollment

- Complete all required steps
  - The “Billing Providers” step is optional
  - If your provider practices as part of a group, you will need to add the group NPI to the Billing Providers step
- Every new application will need a Provider Agreement and Provider User Access Agreement
  - The forms can be obtained here: https://medicaid.utah.gov/utah-medicaid-forms
- If the application is not submitted within 60 days of the day it was started, it will be purged from the system. At this point the process would start over again.

Re-Credentialing

- All providers are required to re-credential every 3-5 years depending on their risk level with CMS
- Utah follows CMS guidelines for re-credentialing
- Re-credentialing is done through the PRISM system
- A letter will be mailed to the “pay to” address on file when the provider is due to re-credential

Retroactive Enrollment

- Providers enrolling in Utah Medicaid will receive the date their application is correctly and completely submitted as their effective date
- A backdate can be requested for extenuating circumstances
  - An email will need to be submitted to: providerenroll@utah.gov
  - The email must include the requested begin date, provider's NPI, and a detailed justification of why the request is needed

PRISM Validation

- All providers enrolled with Medicaid prior to July 1, 2016 will be required to validate information converted from the legacy MMIS
- Online training for validations can be found here: https://medicaid.utah.gov/pe-training
  - Select ‘Validating Converted Medicaid Provider Information in PRISM Web-Based Training’

PRISM Troubleshooting

UTAH DEPARTMENT OF HEALTH MEDICAID

- **Question:** I need to update my EDI and provider information. How do I log into PRISM?
- **Answer:** A validation letter is required to log into PRISM for the first time for providers enrolled prior to PRISM go-live. You can request a validation letter by emailing providerenroll@utah.gov or calling 1-800-662-9651, option 3 and then option 4
- In order to complete the validation process, all steps that are marked as required and optional inside the Business Process Wizard, need to be clicked on and updated

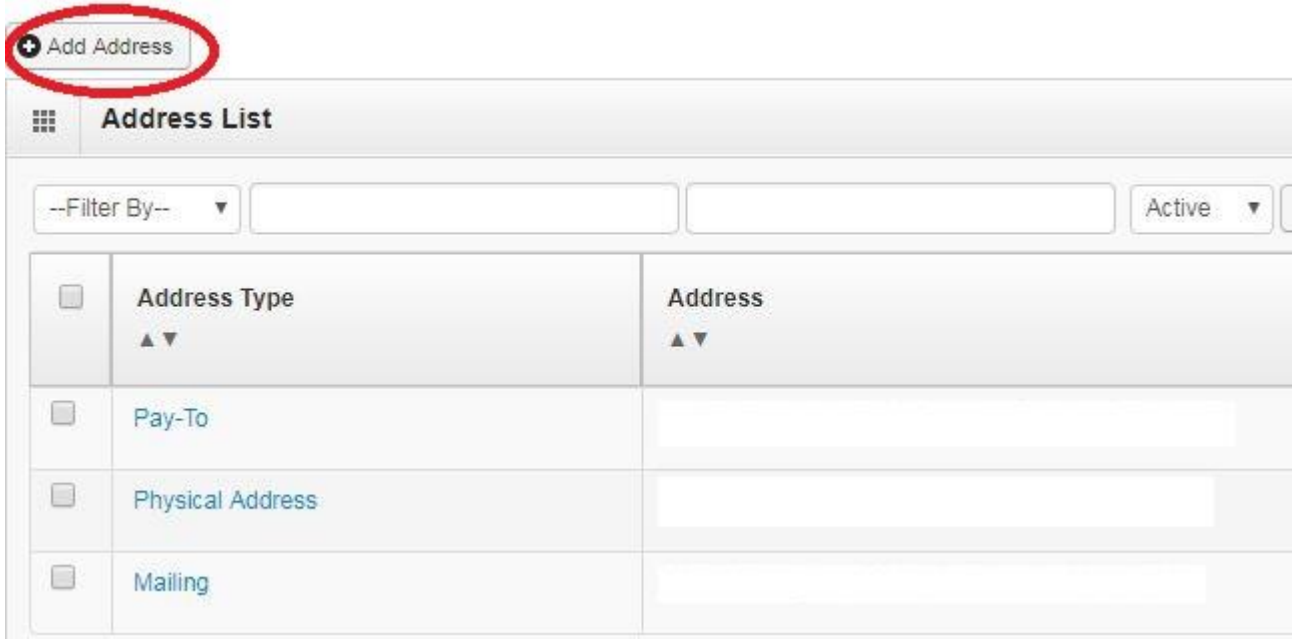
PRISM Troubleshooting

- **Question:** I am trying to validate, but I am stuck on 'Step 2: Locations'. How can I get this step to complete?
- **Answer:** Click on the 'Step 2: Locations' link. You will then click on the '00' link that says 'In Review'. If there isn't one 'In Review' simply click on the one that is available.

Location Code	Location Name	Location Type	Location Details	Start Date	End Date	Status
00		Base Location		01/03/2013	12/31/2999	Approved
00		Base Location		01/03/2013	12/31/2999	In Review

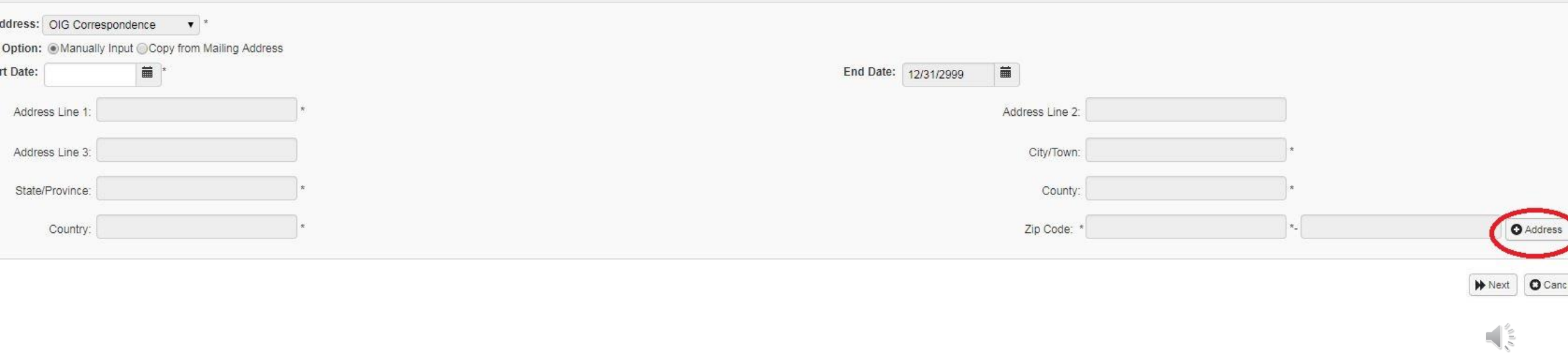
PRISM Troubleshooting

- After clicking on the '00' link you will be on the 'Location Details' page. Scroll down to the bottom of the page. There will be a heading labeled Address List. Directly above the Address List is a button that says '+ Add Address'. ***Always maximize new windows that pop up.**



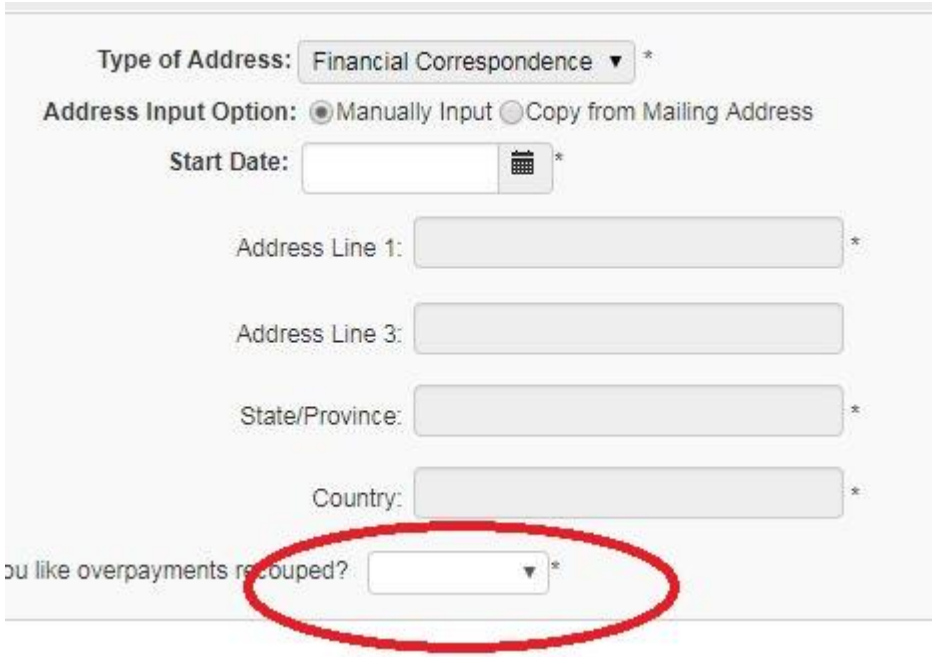
PRISM Troubleshooting

- After clicking on the ‘Add Address’ button, a new window will open asking for an OIG Correspondence. If this address is the same as the mailing address, click the ‘Copy from Mailing Address’ radio button. If you need to manually input the address, click on the ‘+ Address’ button at the end of the zip code.



PRISM Troubleshooting

- Once the address is entered and validated, press the ‘Next’ button.
- It will now ask you for a Financial Correspondence address. Fill this out and select how you would like overpayments recouped at the bottom. Press the ‘OK’ button. You will now be able to move on to Step 3.

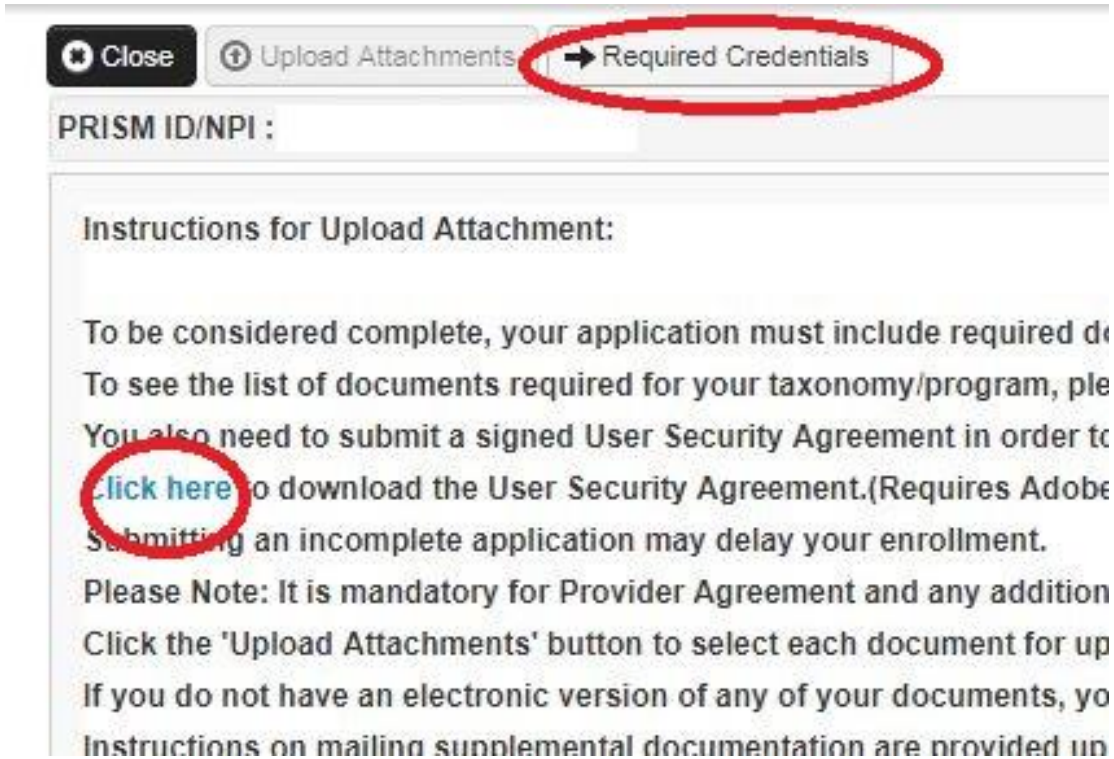


PRISM Troubleshooting

- **Question:** I can't get the view/Upload Attachments to complete. What am I missing?
- **Answer:** All new validations require a Provider Agreement and Provider User Access Agreement. You can find a list of the required uploads inside the step.
  - Click on the 'View/Upload Attachments' step
  - Under the instructions for Upload Attachment there is a link to the Provider User Access Agreement four lines down

PRISM Troubleshooting

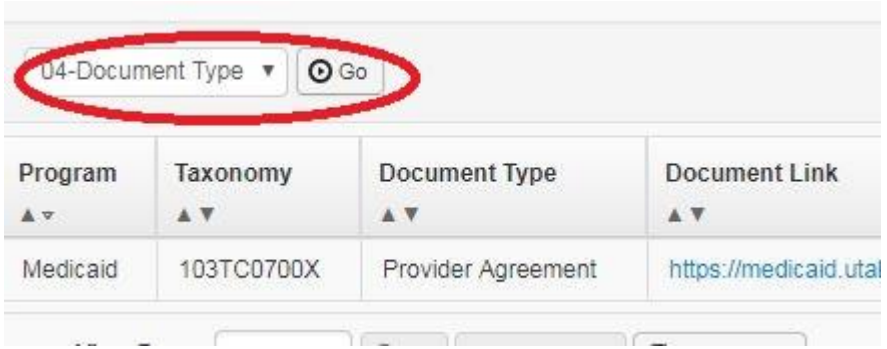
- At the top of the page there is a ‘Required Credential’ button. Click the button to see what is required.



PRISM Troubleshooting

- The licenses required for upload will be under ‘01 – License’

- Click on ‘01-License’, select ‘04- Document Type’, and press ‘Go’.



PRISM Troubleshooting

- From this page you will be able to print the Provider Agreement and review what other documents need to be uploaded
- Close out the window and click on the ‘Upload Attachments’ button to upload all of the required licenses and documents
- In order to complete the validation or the new enrollment, complete the final step which is ‘Submit Modification for Review’ or ‘Submit Enrollment Application for Review’

Questions and answers

UTAH DEPARTMENT OF HEALTH
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DIVISION OF MEDICAID & HEALTH FINANCING

Medicaid 101

Billing a Managed Care Organization

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- Medicaid uses two different payment models to reimburse for services delivered to Medicaid eligible members: managed care and fee for service
- Medicaid eligible members may have fee for service or a managed care plan, depending on the county they live in
- A Managed Care Organization (MCO) includes Accountable Care Organizations (ACO) and Prepaid Mental Health Plans (PMHP)
- Providers are responsible for verifying Medicaid eligibility and determining if a member is enrolled with an MCO before rendering services
- Medicaid eligibility can be verified using Access Now, Eligibility Lookup Tool, or ANSI 270/271
- A provider who accepts Medicaid agrees to accept the MCO payment as payment in full. This includes any deductible, co-insurance, or co-payment owed by the Medicaid member. A member may not be billed for services unless specific requirements are met.

Billing an Accountable Care Organization

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If a Medicaid member received a physical health service and has an ACO, send the claim to the ACO. An ACO contracts with Medicaid to pay for physical health services provided to Medicaid members

- Currently 85% of Medicaid members receive their physical health benefit from an ACO
- Utah Medicaid's ACOs are: Health Choice Utah, Healthy U, Molina, and Select Health
- Enrollment in an ACO is mandatory in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties
- Enrollment in an ACO for members in other counties is voluntary
- The health plan is required to cover the same services that the fee for service network covers
- The ACO's may have their own prior authorization or other utilization review requirements

Appeals

- If the MCO denies your claim, you can file an appeal with the MCO
- The appeal needs to be filed within the timeframe specified by the MCO
- Failure to file your appeal within the required timeframe may prevent you from obtaining payment
- Additional training on appeals will be provided in the future

Emergency Services Program for Non-Citizens Language Update

- Utah Medicaid Provider Manual Section I: General Information, 8-2.11, Emergency Services Program for Non-Citizens has been updated.
- Specific policy for this program can now be found in Administrative Rule R414-518, Emergency Service Program for Non-Citizens. R414-518 defines the scope of services that are available to individuals who meet coverage criteria under the Emergency Service Program for Non-Citizens for the treatment of emergency medical conditions.

Dental Plans

- Utah Medicaid contracts with Delta Dental and Premier Access for pregnant women and children living in Davis, Salt Lake, Utah, and Weber counties
- If you serve a Medicaid member that is enrolled in one of these plans, send the claim to the dental plan
- The dental plans must cover the same services that the fee for service network covers

Dental Benefits for Visually Impaired/ Those with Disabilities

- Adults, ages 21 and older who qualify for Medicaid because of a disability or blindness are eligible for dental benefits under fee for service, and not through a dental plan
  - These members receive the same dental benefits as pregnant women
  - The claims for these services will be sent to Utah Medicaid and not to a dental plan
  - In accordance with UCA 26-18-413(2)(b), to the extent possible, services for members who are visually impaired or those with disabilities delivered in Salt Lake County shall be provided through the University of Utah School of Dentistry

Dental Benefits for Visually Impaired/ Those with Disabilities

- For Medicaid members who are visually impaired or those with disabilities and who reside within a nursing home and are 21 years of age or older, covered dental services are not allowed to reduce the nursing home liability
- Covered dental services must be rendered by a Medicaid provider and billed directly to Medicaid
- Program coverage and limitations have been updated and are available in the Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual and the Utah Medicaid Coverage and Reimbursement Code Lookup tool

Prepaid Mental Health Plans

- Under the PMHP, Medicaid contracts with local county mental health and substance abuse authorities to provide mental health and substance abuse services to Medicaid eligible members
- Prior to delivering services, providers must verify the member's PMHP through Access Now, Eligibility Lookup Tool, or ANSI 270/271
- If a member received a mental health service, or substance abuse disorder service, send the claim to the PMHP
- All Medicaid members enrolled in the PMHP may also receive services from a federally qualified health center (FQHC); PMHP authorization is not required
- American Indian and Alaska Native Medicaid members may receive services from Indian health care providers, including an Indian Health Program or an Urban Indian Organization
- Medicaid members with subsidy adoption may disenroll from the PMHP on a case-by-case basis for outpatient mental health and substance use disorder services

Medicaid Member

- A Medicaid member is required to present the Medicaid Member Card before each service
- Every provider must verify each member's eligibility every visit before rendering services
- Presentation of the Medicaid Member Card does not guarantee a member is eligible for Medicaid
- Verify the member's eligibility; determine whether the member is enrolled in a Managed Care Organization (MCO), Emergency Only Program, or the Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance
- Eligibility and health plan enrollment may change from month to month
- Retain documentation of the verified eligibility for billing purposes
- Verify member eligibility using Access Now, Eligibility Lookup Tool, or ANSI 270/271

Eligibility Lookup Tool

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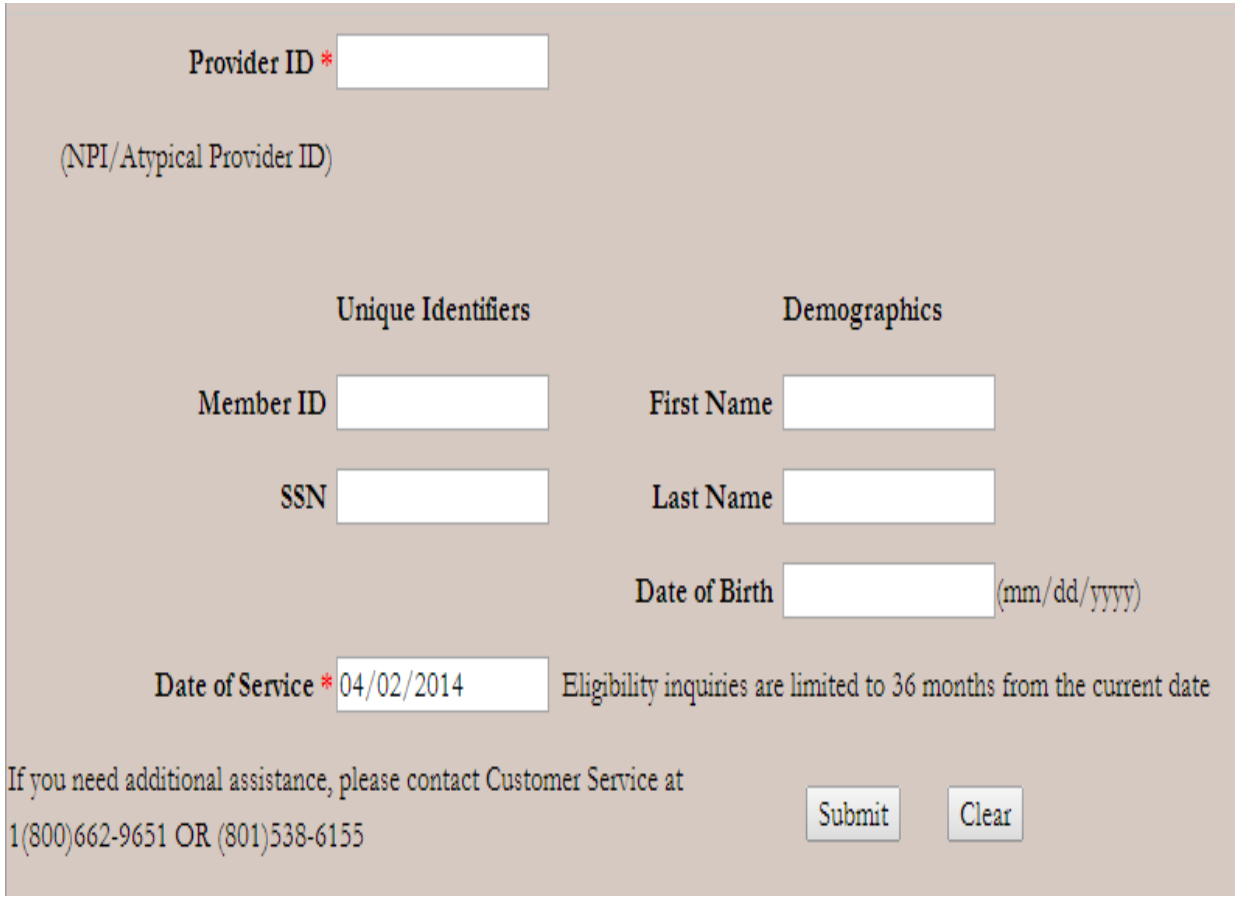
https://medicaid.utah.gov/eligibility-lookup-tool

- To submit an eligibility inquiry on a specific member, enter your Provider ID, date of service and a combination of the following search criteria:
  - One value from the 'Unique Identifiers' column, and two values from the 'Demographics' column

    OR
  - All three values from the 'Demographics' column

- Only exact matches will return results



Fee For Service Network

- Providers should note that the Eligibility Lookup Tool currently displays “Fee For Service Network” when a member is not enrolled in a managed care plan
- Fee for service claims should be billed to state Medicaid

Coverage Information

Eligibility Date Span: 06/01/2016 - 06/30/2016

Benefit Type:	Traditional	**Health Plan:**	FEE FOR SERVICE NETWORK	
Eligibility Program Type:	Child Medicaid	**Dental Plan:**	FEE FOR SERVICE NETWORK	**Phone:**
Co-Pay Information:	No Co-pay required	**Mental Health Provider:**	NORTHEASTERN COUNSELING CENTER	**Phone:** 1-435-789-6300
Eligible Services:	This member is eligible for medical, dental and pharmacy services.	**Substance Use Disorder Provider:**	NORTHEASTERN COUNSELING CENTER	**Phone:** 1-435-789-6300

Billing Medicaid Members

- Medicaid members may be billed for co-payments and co-insurance
- Medicaid members may only be billed for broken appointments if the provider has a policy in place to bill for broken appointments that applies to all patients (not just Medicaid members) and the member has signed an agreement to pay for broken appointments

Billing Medicaid Members

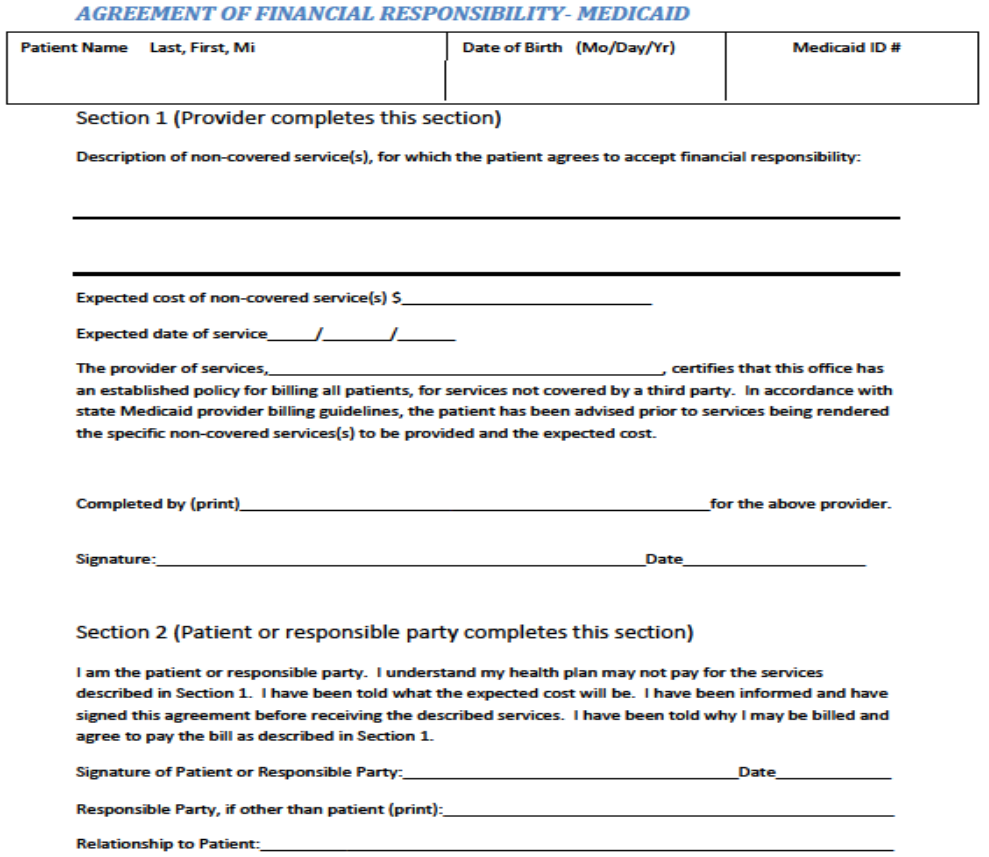
- A Traditional and Non Traditional Medicaid member may be billed for non-covered services when **all four of the conditions below** are met**:**
  - The provider has an established policy for billing all patients for services not covered by a third party
  - The member is advised **prior** to receiving a non-covered service
  - The member agrees to be personally responsible for the payment
  - That agreement is **in writing** between the provider and the member which details the service and the amount to be paid by the member
- PCN members may be billed for services that are not covered by PCN (see PCN manual for covered/non-covered services)

For complete information regarding billing Medicaid members see Utah Medicaid provider manual Section 1: 3-4 and 3-5

Billing Medicaid Members

Sample of financial agreement form is available on the website

https://medicaid.utah.gov/utah-medicaid-forms



AGREEMENT OF FINANCIAL RESPONSIBILITY- MEDICAID

Patient Name Last, First, Mi	Date of Birth (Mo/Day/Yr)	Medicaid ID #

Section 1 (Provider completes this section)

Description of non-covered service(s), for which the patient agrees to accept financial responsibility:

Expected cost of non-covered service(s) $_____

Expected date of service_____/_____/_____

The provider of services,_____, certifies that this office has an established policy for billing all patients, for services not covered by a third party. In accordance with state Medicaid provider billing guidelines, the patient has been advised prior to services being rendered the specific non-covered services(s) to be provided and the expected cost.

Completed by (print)_____for the above provider.

Signature:_____Date_____

Section 2 (Patient or responsible party completes this section)

I am the patient or responsible party. I understand my health plan may not pay for the services described in Section 1. I have been told what the expected cost will be. I have been informed and have signed this agreement before receiving the described services. I have been told why I may be billed and agree to pay the bill as described in Section 1.

Signature of Patient or Responsible Party:_____Date_____

Responsible Party, if other than patient (print):_____

Relationship to Patient:_____

Billing for Emergency Services Provided to a Non-Citizen

- Any payment made by Medicaid for a service is considered payment in full. Once the payment is made to the provider for covered services, no additional reimbursement can be requested from the member.
- Because the Emergency Medicaid program for non-citizens has a very restricted scope of services, it does not have some of the same restrictions on billing the member, as is the case in other Medicaid covered services. If a provider does not receive payment from Medicaid because the provider failed to follow procedure to get a service covered, the provider is prohibited from pursuing payment from the member. However if payment is not made because the service was not an emergency or the service is not covered under the program, then the member can be billed for those services.
- If a service is a covered service and meets the Medicaid definition of “emergency” Medicaid will pay for the service (subject to correct coding). However, if a non-citizen eligible for emergency services only presents at the ER with symptoms that do not appear to be emergent in nature, the provider would be prudent to inform the member prior to the service that the service might not be covered by Medicaid. In that case the member will be financially responsible for paying the bill.

Member Responsibilities

A Medicaid member is responsible for certain charges, including:

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

Member Cost Sharing

Some Medicaid members share the cost for certain services including:

- prescription drugs
- inpatient hospital services
- non-emergent use of emergency department services

Cost sharing in the Medicaid program can include co-insurance, co-payment, deductibles, and premiums

Services Exempt from Co-payment

Some services are exempt from co-payment. Even if a member ordinarily has a co-payment, do not collect a co-payment for the following services:

- Family planning
- Preventive services, including vaccinations and health education
- Pregnancy-related (including tobacco cessation)
- Emergency services
- Non-emergent use of an emergency room requires a co-pay
- Provider-preventable condition (PPC) services

Members Exempt from Co-payment

Federal regulations exclude certain services from cost sharing, including:

- Individuals through the age 18 years of age
- Any individual whose medical assistance for services are furnished in an institution
- American Indian and Alaska Native (AI/AN) individuals
- Individuals whose total gross income, before exclusions and deductions, is below the temporary assistance to needy families (TANF) standard payment allowance. These individuals must indicate their income status to their eligibility caseworker on a monthly basis to maintain their exemption from the co-payment requirements.
- Qualified Medicare Beneficiaries (QMB)
- Individuals who are receiving Medicaid due to having breast or cervical cancer

Charges That Are Not the Responsibility of the Member

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

- A claim or portion of a claim that is denied for lack of medical necessity (for exceptions refer to *Chapter 3, Provider Participation and Requirements, Exceptions to Prohibition on Billing Members*)
- Charges in excess of Medicaid maximum allowable rate
- A claim or portion of a claim denied due to provider error
- A service for which the provider did not seek prior authorization or did not follow up on a request for additional documentation
- A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed. The difference between the Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments

Charges That Are Not the Responsibility of the Member

- Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service by a responsible third party. Members are not responsible for deductibles, co-payments, or co-insurance amounts if such payments when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid amount is zero
- The member is not responsible for private insurance cost share amounts if the claim is for a Medicaid covered service by a Medicaid enrolled provider who accepted the member as a Medicaid member. Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate

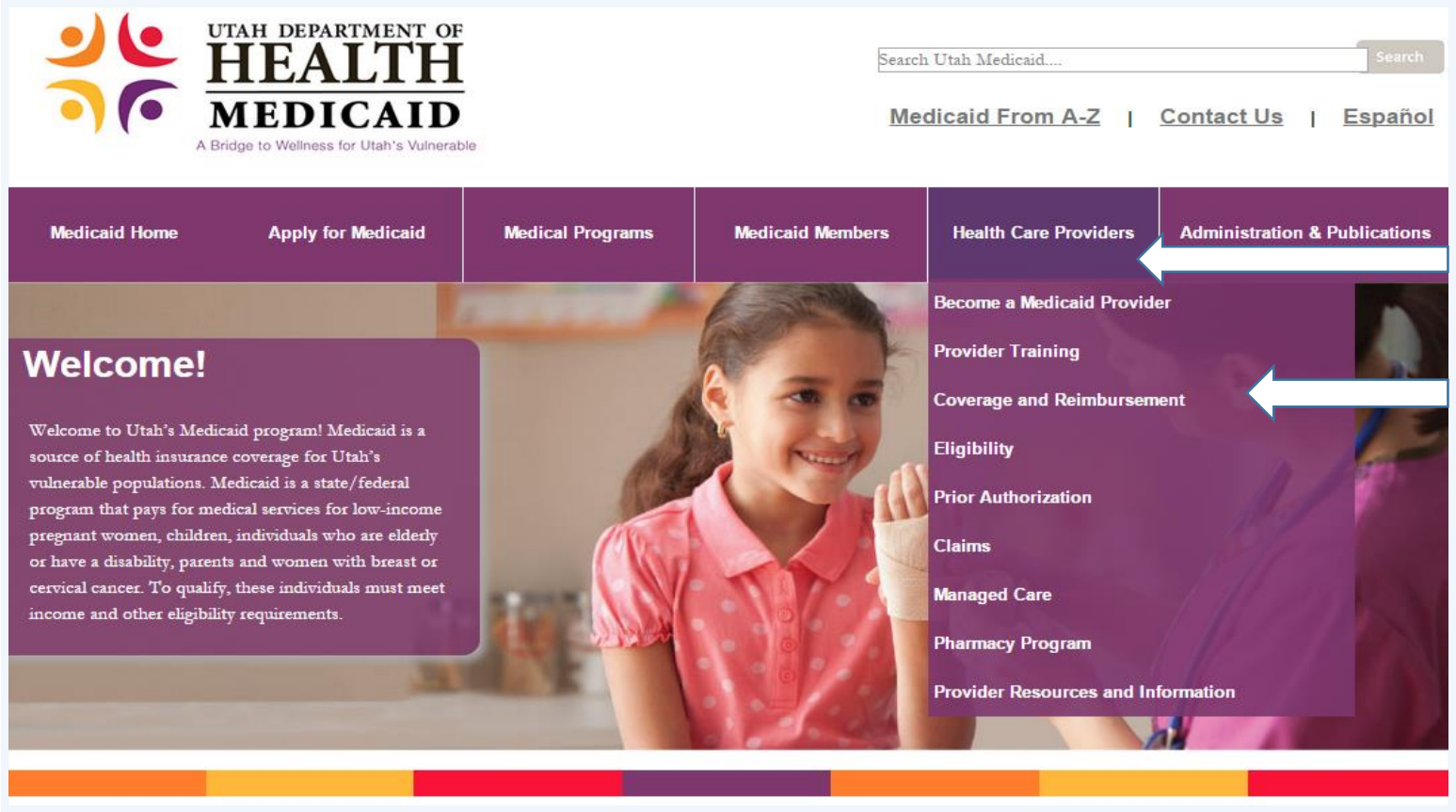
FQHC/RHC

FQHC and RHC have two options for payment:

- 100% billed charges
  - All edits apply
- By Encounter
  - Must bill T1015
  - Must bill all CPT codes that apply
  - At least one CPT code must be an approved encounter code
  - If only the T1015 or only the CPT codes are billed the claim will be denied

Coverage and Reimbursement Lookup Tool

Most information on policy and benefits can be found in the Provider Manuals at https://medicaid.utah.gov/



1. Select 'Health Care Providers'

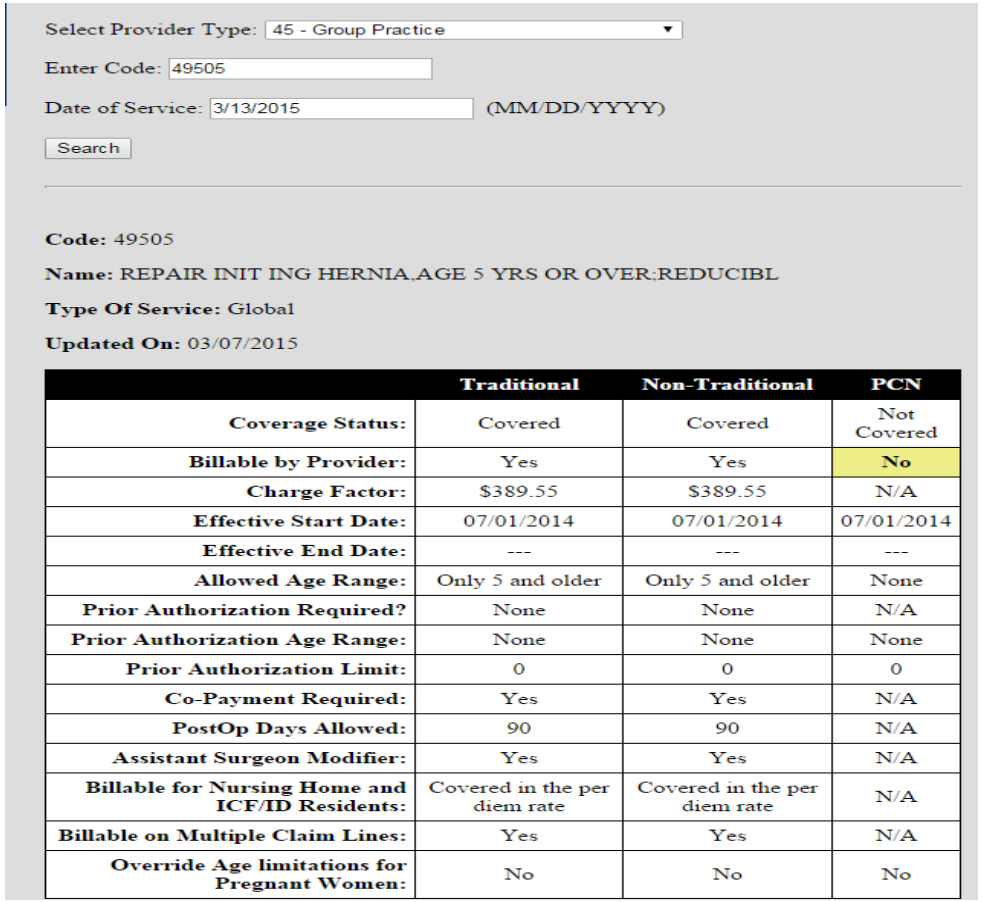
2. Select Coverage and Reimbursement

Coverage and Reimbursement Lookup Tool

UTAH DEPARTMENT OF HEALTH MEDICAID

Information found on the Lookup Tool:

- Coverage status
- Charge factor (reimbursement rate)
- Prior authorization information
- Allowed age range
- Co-payment information
- Global period information



Select Provider Type: 45 - Group Practice

Enter Code: 49505

Date of Service: 3/13/2015 (MM/DD/YYYY)

Search

Code: 49505

Name: REPAIR INIT ING HERNIA,AGE 5 YRS OR OVER;REDUCIBL

Type Of Service: Global

Updated On: 03/07/2015

	Traditional	Non-Traditional	PCN
Coverage Status:	Covered	Covered	Not Covered
Billable by Provider:	Yes	Yes	**No**
Charge Factor:	$389.55	$389.55	N/A
Effective Start Date:	07/01/2014	07/01/2014	07/01/2014
Effective End Date:	---	---	---
Allowed Age Range:	Only 5 and older	Only 5 and older	None
Prior Authorization Required?	None	None	N/A
Prior Authorization Age Range:	None	None	None
Prior Authorization Limit:	0	0	0
Co-Payment Required:	Yes	Yes	N/A
PostOp Days Allowed:	90	90	N/A
Assistant Surgeon Modifier:	Yes	Yes	N/A
Billable for Nursing Home and ICF/ID Residents:	Covered in the per diem rate	Covered in the per diem rate	N/A
Billable on Multiple Claim Lines:	Yes	Yes	N/A
Override Age limitations for Pregnant Women:	No	No	No

Coverage and Reimbursement Lookup Tool

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If you would like to view the entire fee schedule, rather than searching for a particular code, please use our Fee Schedule Download Tool.

If you would like to view the entire diagnosis schedule, please use our Diagnosis Schedule Download Tool.

Select Provider Type: 20 - Physician

Enter Code: 77080

Date of Service: 6/1/2016 (MM/DD/YYYY)

Search

Please note that your search returned information for more than one Type Of Service. To view the information for a particular type of service you can click on one of the links below:

Technical

Professional

Coverage and Reimbursement Lookup Tool

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Back to Top

Code: 77080

Name: DXA BONE DENSITY,STUDY,1+SITES,AXIAL SKELETON

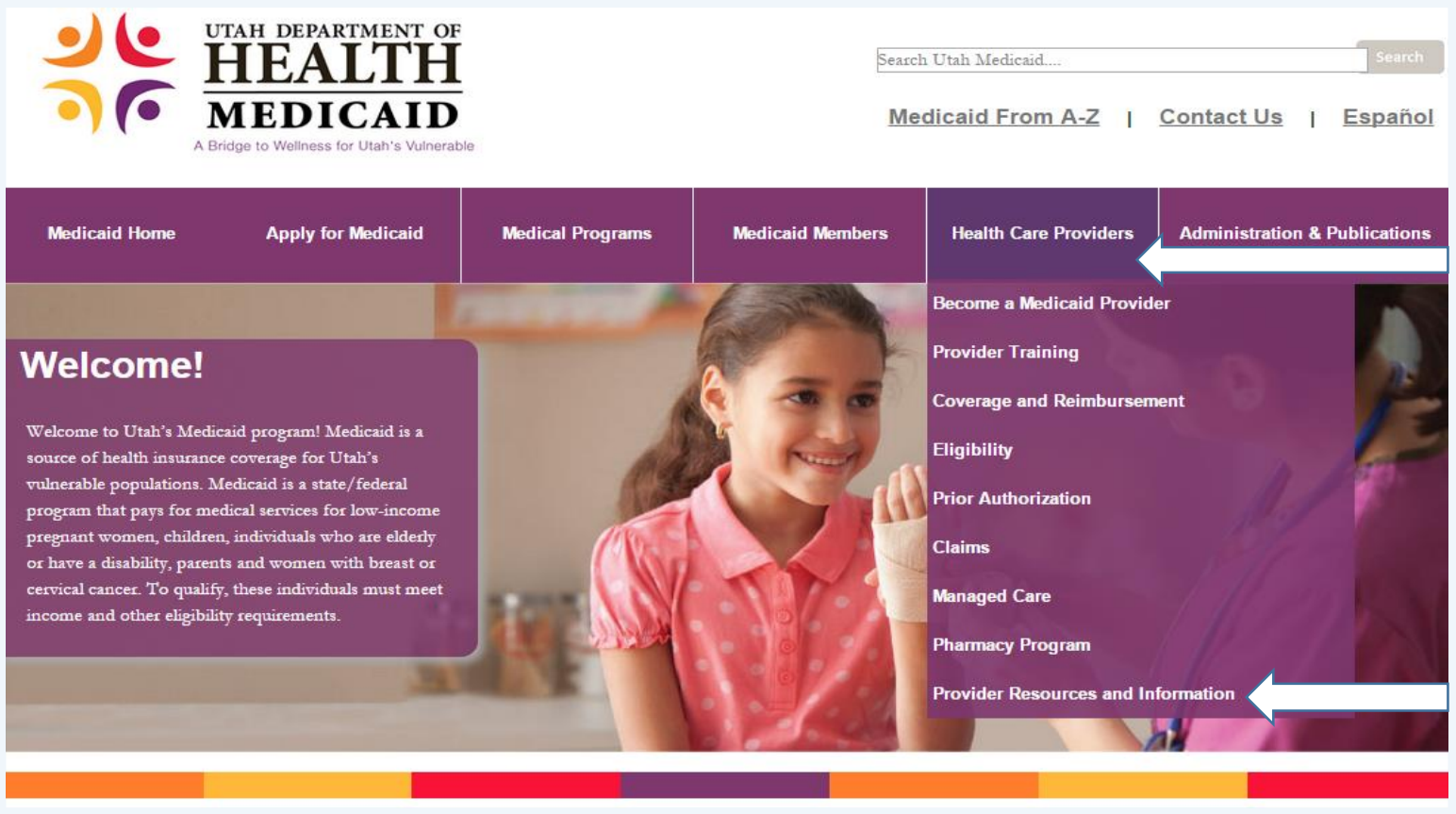
Type Of Service: Technical

Updated On: 05/28/2016

	Traditional	Non-Traditional	PCN
Coverage Status:	Covered	Covered	Not Covered
Billable by Provider:	Yes	Yes	**No**
Charge Factor:	$23.41	$23.41	N/A
Effective Start Date:	07/01/2011	07/01/2011	07/01/2011
Effective End Date:	---	---	---
Allowed Age Range:	Only all ages	Only all ages	None
Prior Authorization Required?	None	None	N/A
Prior Authorization Age Range:	None	None	None
Prior Authorization Limit:	0	0	0
Co-Payment Required:	No	No	N/A
PostOp Days Allowed:	None	None	N/A
Assistant Surgeon Modifier:	No	No	N/A
Billable for Nursing Home and ICF/ID Residents:	Covered in the per diem rate	Covered in the per diem rate	N/A
Billable on Multiple Claim Lines:	No	No	N/A
Override Age limitations for Pregnant Women:	No	No	No

Medicaid Manuals

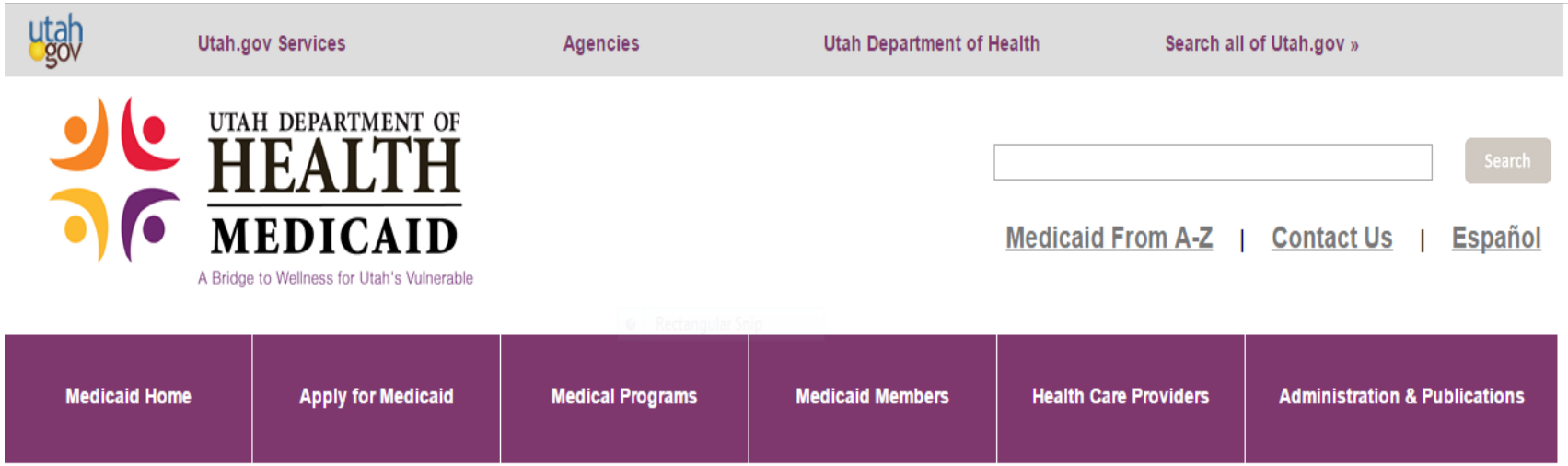
Most information on policy and benefits can be found in the Provider Manuals at https://medicaid.utah.gov/



1. Select 'Health Care Providers'

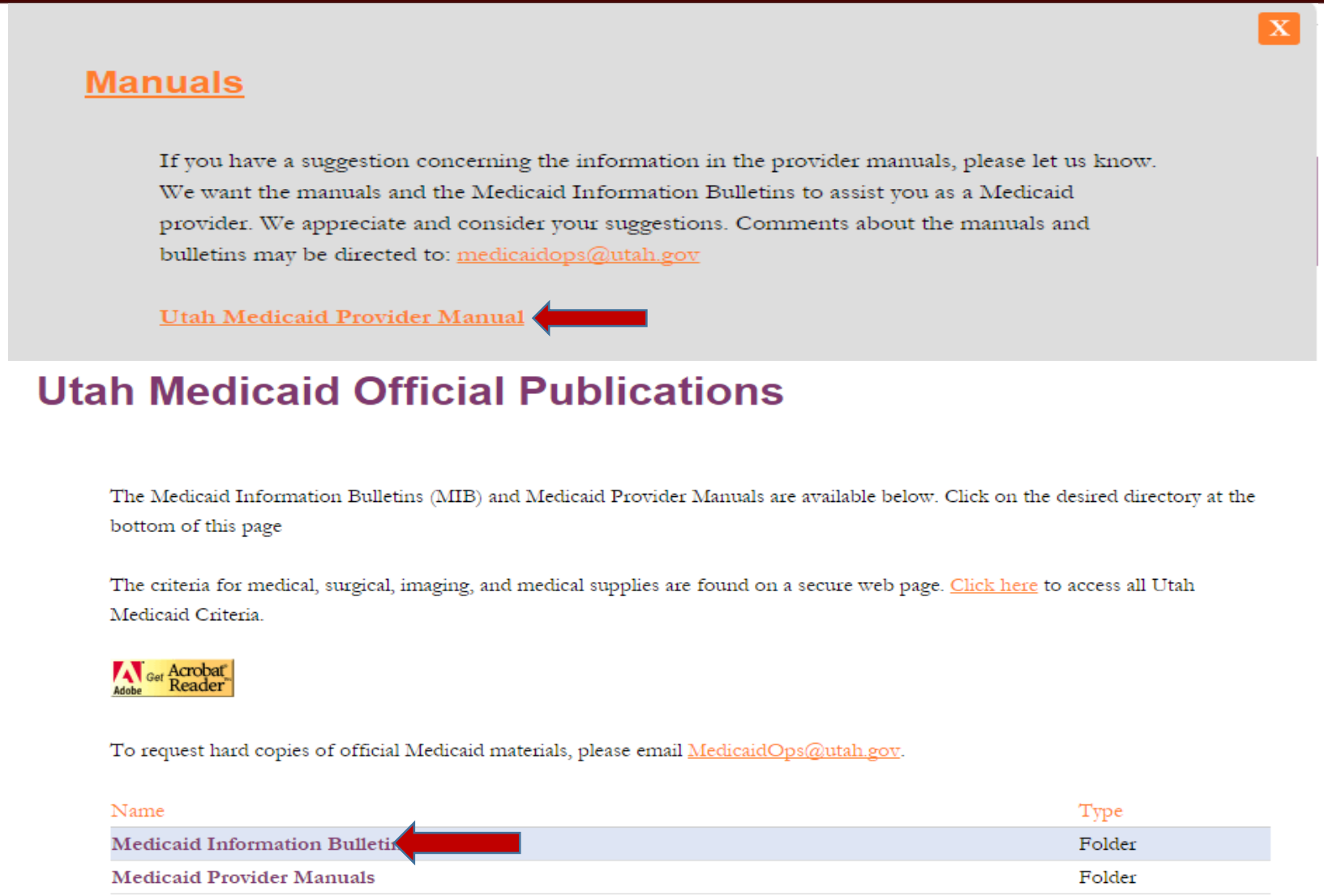
2. Select 'Provider Resources and Information'

Medicaid Manuals



Medicaid Manuals

UTAH DEPARTMENT OF HEALTH MEDICAID



4. Select 'Utah Medicaid Provider Manual'

5. Select 'Medicaid Provider Manuals or Medicaid Information Bulletin'

Name	Type
Parent Directory	
All Providers General Attachments	Folder
All Providers General Information Section I	Folder
Anesthesiology (Archived November 2017)	Folder
Autism Spectrum Disorder Services	Folder
Child Health Evaluation And Care (CHEC)	Folder
Chiropractic Medicine (Archived October 2017)	Folder
Dental, Oral Maxillofacial, And Orthodontia	Folder
Home And Community-Based Waiver Services	Folder
Home Health Services	Folder
Hospice	Folder
Hospital	Folder
Indian Health Services	Folder
Laboratory (Archived July 2017)	Folder
Licensed Nurse Practitioner	Folder
Long Term Care	Folder
Medical Supplies And Durable Medical Equipment	Folder
Medical Transportation	Folder
Non-Traditional Medicaid (NTM)	Folder
Personal Care	Folder
Pharmacy	Folder
Physical Therapy And Occupational Therapy	Folder
Physician Services	Folder
Podiatric Services	Folder
Primary Care Network (PCN)	Folder
Rehabilitative Mental Health And Substance Use Disorder Services	Folder
Rural Health Clinic And FQHC	Folder
School-Based Skills Development	Folder
Speech, Language, And Audiology	Folder
Targeted Case Management	Folder
Vision Care Services	Folder
Womens Services (Archived July 2017)	Folder

UTAH DEPARTMENT OF HEALTH MEDICAID

6. Locate the manual for your specialty

NOTE: Section I Applies to ALL Providers

Section I

General Information

Table of Contents

UTAH DEPARTMENT OF HEALTH MEDICAID

Date Updated: This date is applied to the manual, not the page

Table of contents is hyperlinked

Coordination of Benefits

- Before submitting a claim to Medicaid, a provider must submit and secure payment from all other liable parties such as Medicare Part A and B
- For more information, refer to the Medicaid General Information Section, 11-4
- Claims denied from Medicare as non-covered services should be submitted to Medicaid fee for service, not to the crossover mailbox
- If the primary payer made line level payments on the claim, please report line level data in addition to the claim level data to Medicaid

Coordination of Benefits

- Medicaid is the payer of last resort
- Reimbursement for crossover claims or other TPL will be limited to the Medicaid Fee Schedule for all types of service, including FQHC and Indian Health Services
  - HT000004-001 Medicaid fee for service electronic mailbox
  - HT000004-005 Utah Medicaid Crossovers (NOT when Medicare denies as non-covered) electronic mailbox
    - Corresponding EOB for Zero Pay from Medicare go to fax (801) 323-1584, not to ORS
    - Corresponding EOB for Zero Pay for other than Medicare goes to ORS fax (801) 536-8513

Void/Replacement Claims

- Providers should submit their own corrections to claims less than 3 years old by submitting either a replacement or void claim
- The data elements needed to identify a replacement or void claim are:
  - Claim Frequency Code (7 For Replacement, 8 For Void)
    - Electronic: X12 Element 2300 CLM05-3
    - Paper: UB04 - Form Locator 4, Position
    - CMS1500 - Box 22 (Code)
  - Transaction Control Number (TCN) of original claim to be replaced/voided
    - Electronic: X12 Element 2300 REF02
    - Paper: UB04 - Form Locator 37 A-C
    - CMS1500 - Box 22 (Original transaction control number)

Payment Adjustment / Over Pavment or Credit Balance

- An electronic ‘Payment Adjustment Request Form’ for **fee for service** is available for issues regarding overpayments and credit balance on claims over 3 years old
- If a payment adjustment is required on a claim that is less than 3 years old, a replacement claim must be submitted
- The form is located at: https://medicaid.utah.gov/utah-medicaid-forms
- The form may be filled out online before printing
  - One form is required per claim
  - All required fields must be appropriately filled out or it will be returned to provider

Payment Adjustment Request Form

UTAH DEPARTMENT OF HEALTH MEDICAID

- Checks for Medicaid Operations related to:
  - Credit Balance
  - Third Party Liability for crossover claim payments
  - Overpayments older than three years
- Mail to:

  Bureau of Medicaid Operations, Payment Adjustments
  PO BOX 143106
  Salt Lake City, UT 84114-3106

- Checks for Third Party Liability payments (TPL) EXCLUDING crossover claim adjustments to:

  Office of Recovery Services
  Medicaid Section Team 85
  PO BOX 45025
  Salt Lake City, UT 84145-5025

Interpretive Services

UTAH DEPARTMENT OF HEALTH MEDICAID

1. Determine if member is eligible for health care service

- Verify the member is eligible for a federal or state medical assistance program. Programs include Medicaid, CHIP, PCN, and/or services authorized on a State Medical Services Reimbursement Agreement Form (MI-706)
- To verify member eligibility use the Eligibility Lookup Tool (https://medicaid.utah.gov/medicaid-online), or call Medicaid Information to access AccessNow at (801) 538-6155 or 1-800-662-9651 or ANSI 270 and ANSI 276

2. If not eligible, the member is NOT ELIGIBLE for interpretive services

3. Determine if member is in managed care

- Is the member enrolled in an ACO, Prepaid Mental Health Plan, and/or dental plan?
  - YES: Member is enrolled in a plan, go to step 4
  - NO: Member is not enrolled in a plan, go to step 5. The member is Fee-For-Service.

4. Service covered by an ACO, Prepaid Mental Health Plan, and/or dental plan?

- YES: ACO, Prepaid Mental Health Plan and dental plans must also cover interpretive services. Contact the plan directly for more information

Interpretive Services

5. **Service covered by fee-for-service medical program for which the member is eligible?**
   - To determine CPT coverage, refer to the online Coverage and Reimbursement Lookup Tool available on the Medicaid website at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php
     - YES -The service is covered, interpretive service is also covered
     - NO - The service is NOT covered, the member does not qualify for interpretive service
6. **When both the member and the service qualify, call one of the contractors listed in the General attachments section, Interpretive guide on our website. Give the required information below:**
   - Member's first and last name spelled exactly as on the Medicaid Member Card
   - Member's date of birth: six digits only (mm/dd/yy)
   - Member's Medicaid ID number
   - Your NPI number
   - Language requested

Timely Filing Fee for service

- All claims and adjustments for services must be received by Medicaid within twelve months from the date of service
- New claims received past the one year filing deadline will be denied. Any corrections to a claim must also be received and/or adjusted within the same 12-month time frame
- If a correction is received after the deadline, no additional funds will be reimbursed. In the case of Medicare Crossovers, all claims and adjustments must be received within six months of the Medicare decision
- The one-year timely filing period is determined from the date of service or “from” date on the claim. The exception to this is for institutional claims that include a date of service span (i.e., a different “from” and “through” date on the claim). The “through” date of service on the claim is used for determining the timely filing for institutional claims
- For additional information, see 42 CFR 447.45

Record Keeping

- Medicaid providers must comply with all disclosure requirement in 42 CFR 455, Subpart B, such as those concerning practice ownership and control, business transactions, and persons convicted of fraud or other crimes
- Every provider must comply with the rules regarding records noted in Section I: General Information, Chapter 4. The provider manual is found on the Utah Medicaid website https://medicaid.utah.gov/
  - Click on the link Medicaid A-Z
  - Click on the "S"
  - Click on the link for Section I, General Information for Providers

Questions and answers

UTAH DEPARTMENT OF HEALTH
MEDICAID

DIVISION OF MEDICAID & HEALTH FINANCING

What's New

Provider Update

- Utah Medicaid is making substantial changes to the provider manuals
- Medicaid is moving policy from the provider manuals to the appropriate Utah Administrative Rule within R414, Health, Health Care Financing, Coverage and Reimbursement Policy
- These changes began on July 1, 2017 and will continue until all manuals are updated
- Moving Medicaid policy to the Administrative Rules allows providers the opportunity to review and comment on rule updates
- Providers are encouraged to become familiar with the Administrative Rule, because Medicaid coverage policy will be relocated to the appropriate rule based on service coverage

Provider Update

- The manuals are also being streamlined
  - For example, ancillary services such as laboratory services and women's services information are now located in the Utah Medicaid Physician Services Provider Manual
- As part of the manual revision process, information regarding specific code coverage will be moved from the provider manuals to the Utah Medicaid Coverage and Reimbursement Lookup Tool
  - The provider manuals will continue to be a reference for criteria and reporting instructions
- Providers are encouraged to become familiar with updated rules and manuals noting changes in the structure, formatting, and content of the manuals. Providers are still required to follow coverage policy, criteria, and prior authorization (PA) requirements

Cost Sharing

- Utah Medicaid submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to update cost sharing amounts with an effective date of October 1, 2017

Cost Sharing

- The Utah Medicaid State Plan change updated cost sharing amounts to align with requirements in 42 CFR §447.50, Sections 1902(a)(14), 1916, and 1916A of the Act. The cost sharing amounts are as follows:
- $8 for each non-emergency use of the emergency department
- $75 for each inpatient hospital stay (episode of care)
- $4 for each outpatient services visit (physician visit, podiatry visit, physical therapy, etc.)
- $4 for each outpatient hospital service visit (maximum of one per person, per hospital, per date of service)
- $4 for each prescription
- $1 for each chiropractic visit (maximum of one per date of service)
- $3 for each pair of eyeglasses

Update to Vision Care/Replacement Eyeglasses

UTAH DEPARTMENT OF HEALTH MEDICAID

- Replacement eyeglasses are allowed for pregnant women and individuals eligible under EPSDT/CHEC once every 12-months. Prior authorization is required to replace frames sooner than the allowed 12-month period. Replacement lenses do not require prior authorization. If the lenses alone need replacing, the provider must use existing frames. Prior authorization may be issued for a new pair of eyeglasses, even though 12-months have not passed since a member's last pair was dispensed, when one or more of the following reasons for medical necessity are met:
  - There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye
  - A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
  - A change in the recipient's head size warrants a new pair of eyeglasses
  - The recipient has had an allergic reaction to the previous pair of eyeglasses
  - The original pair is lost, broken, or irreparably damaged; the dispensing provider must obtain a written statement explaining this from the recipient (or the recipient's caretaker) to send with the prior authorization documentation

Hospitals Required to Obtain Prior Authorization for Fee For Service Claims

- Effective November 1, 2017, a prior authorization (PA) must be in place for any inpatient and/or outpatient hospital service to be paid where a PA is required for a procedure
- Hospitals should obtain or verify that the physician received a prior authorization before a procedure is performed in order to receive reimbursement for that service. If a hospital bills a service that requires prior authorization and one was not approved, the hospital claim will be denied

Hospitals Required to Obtain Prior Authorization for Fee For Service Claims

- If a facility submits a claim for a service requiring a PA and one was not approved, the procedure requiring PA will be denied (e.g., MRI)
- To review procedures that require a PA, refer to the Coverage and Reimbursement Code Lookup at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

Hospitals Required to Obtain Prior Authorization for Fee For Service Claims

- To verify or request a PA, contact Medicaid at:
    - Salt Lake City area, call: (801) 538-6155
    - Call toll-free: 1-800-662-9651
- Additional information related to requesting a PA may be found in the Utah Medicaid provider manuals and Medicaid Information Bulletins at https://medicaid.utah.gov/utah-medicaid-official-publications

Place of Service Claims Editing

- As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicaid must comply with HIPAA standards and their implementation guides regarding Place of Service (POS)
- To be in full compliance with national POS standards, Utah Medicaid has added an additional module to the existing prepayment editing tool
- The POS module will detect when services are billed in an inappropriate setting, resulting in a denial
- The new module affects claims that are billed with an invalid POS as of October 1, 2017

Adult Expansion

- As of November 1, 2017, Medicaid expanded to cover targeted adults, age 19 through 64, with no dependent children
- The three targeted groups are as follows:
  - Chronically homeless individuals
  - Justice involved individuals
  - Individuals needing substance abuse or mental health treatment
- This group is eligible to receive Traditional Medicaid benefits
- They will not be eligible for dental benefits, other than limited emergency dental services

Medicare Crossover Claims

Section I: General Information Provider Manual, Section 11-5.1 discusses this policy in more detail. A key provision notes:

"When a Medicaid member also has Medicare, a provider may either accept the member as having dual coverage *or* not accept either type of coverage. Federal Medicaid regulations do not permit a provider to reject Medicaid and accept only Medicare. For example, when a member has Medicare, a provider cannot bill the member for services that would have been provided under Medicaid, and accept only Medicare payment."

Pharmacy Medicare Crossover Claims

A more specific example is as follows: A dual eligible recipient presents to the pharmacy with a prescription for a Part B medication. The pharmacy processes the claim to Medicare and receives payment with a co-pay/co-insurance of $75.00. The pharmacy tries to bill the copay/co-insurance to Medicaid through the point of sale system and receives a rejection. The pharmacy should dispense the medication to the member and submit the claim through coordination of benefits to the appropriate Medicaid Trading Partner Number. There is no copay/co-insurance to the dual eligible Medicaid member for Medicare crossover claims.

Coordination of benefits instructions for electronic claims are found at: https://medicaid.utah.gov/claims.

2018 Legislative Session Update

The following bills were passed during the 2018 Legislative Session:

- HB12 – Family Planning Services Amendments.
- HB42 – Medicaid Waiver for Mental Health Crisis Services
- HB100 – Medically Complex Children with Disabilities Waiver Program
- HB139 – Telepsychiatric Consultation Access Amendments
- HB435 – Medicaid Dental Benefits
- HB472 – Medicaid Expansion Revisions

Questions and answers

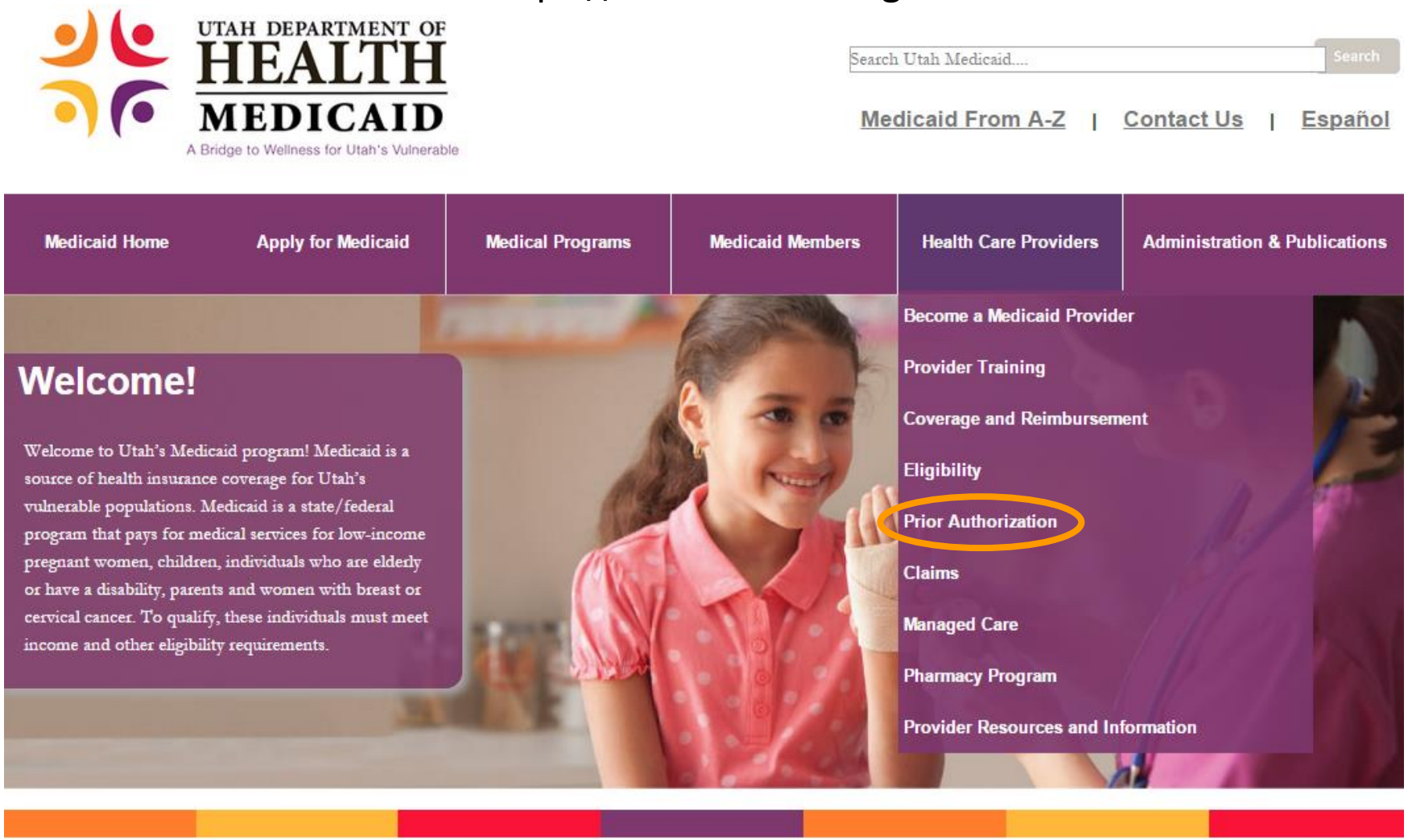
UTAH DEPARTMENT OF HEALTH
MEDICAID

DIVISION OF MEDICAID & HEALTH FINANCING

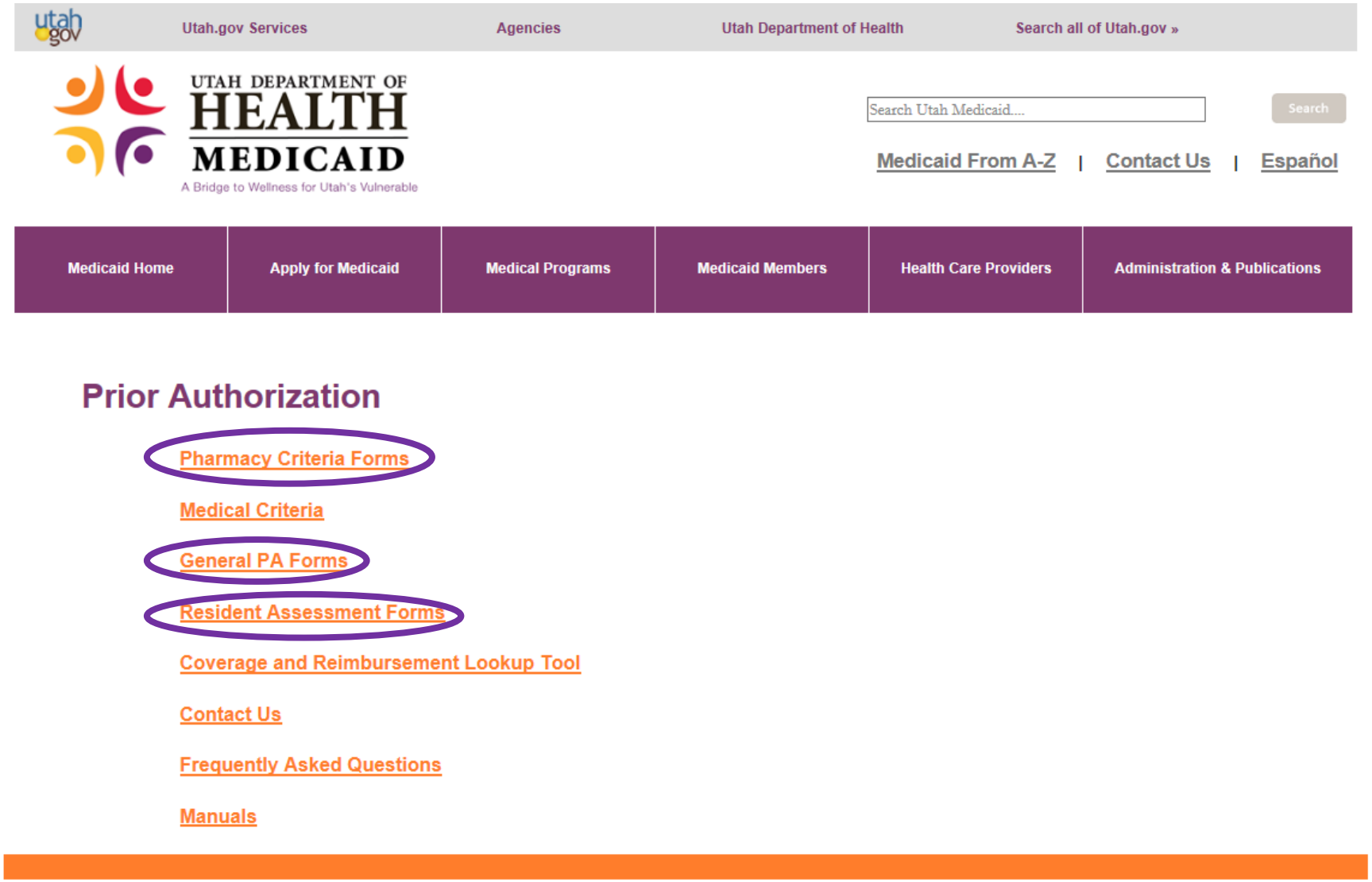
Prior Authorization

Prior Authorization on the Website

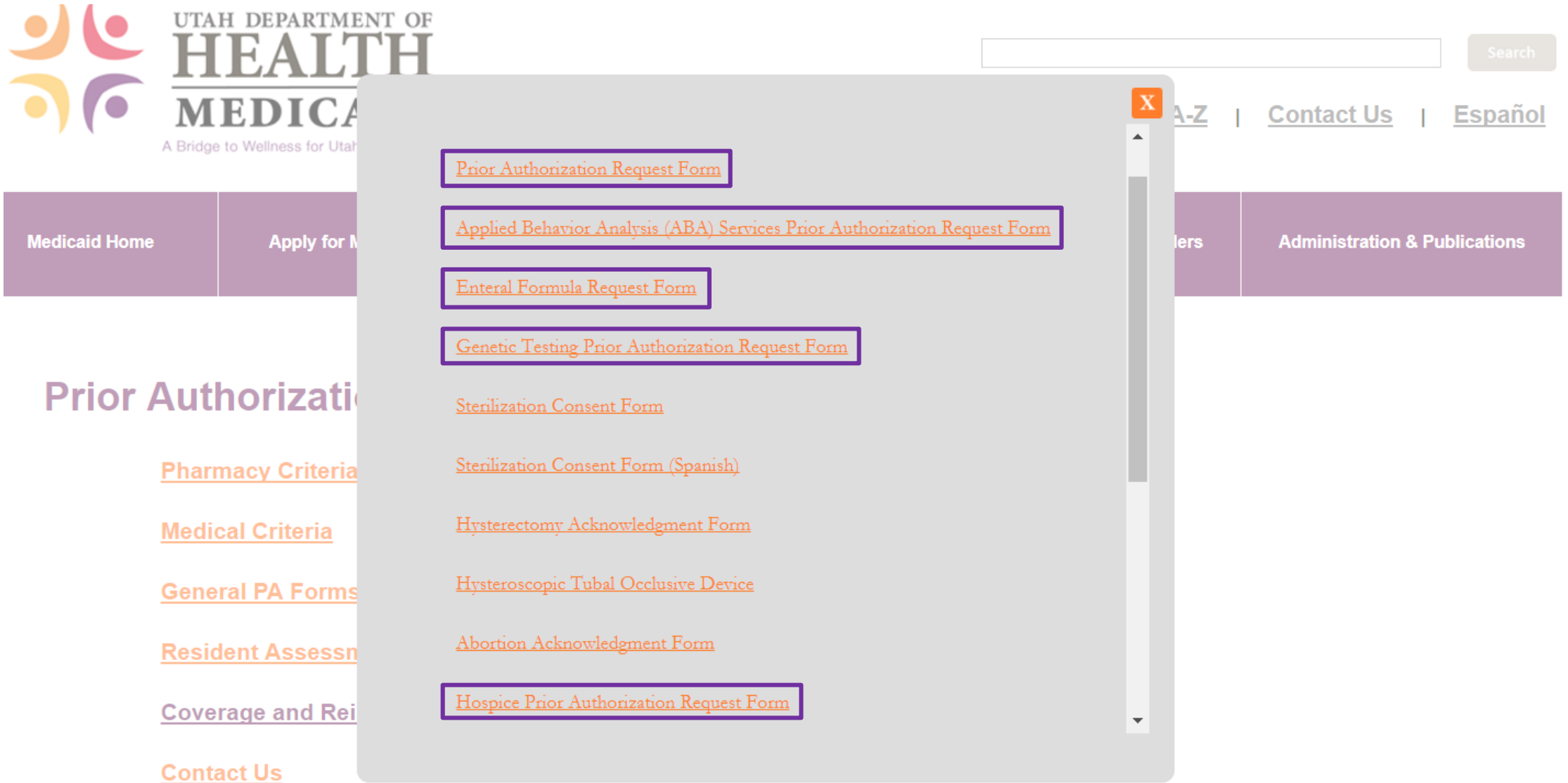
https://medicaid.utah.gov



Where Do I Locate Forms?



Prior Authorization Request Forms



Request Form Basics

UTAH DEPARTMENT OF HEALTH MEDICAID

- Use correct form for requested service
- Use updated request forms
- Fill in required fields
- Use spaces provided
- Fax to appropriate number
- Forms can be typed
- Fee for service and carve-out requests only

- **Example attachments in downloads**

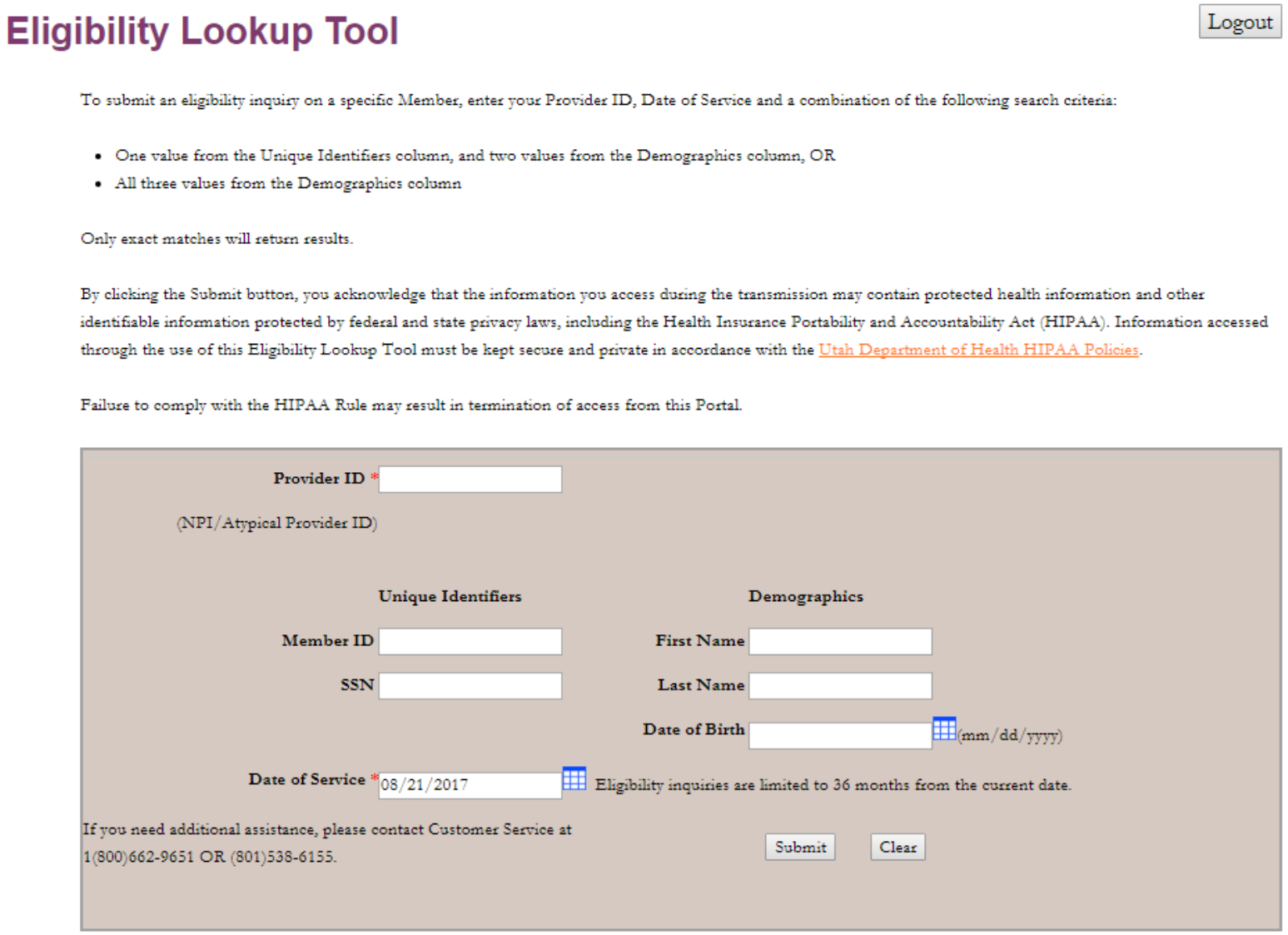
Prior Authorization Helpful Tips

UTAH DEPARTMENT OF HEALTH MEDICAID

- Check member eligibility: https://medicaid.utah.gov/eligibility-lookup-tool
- Check Coverage and Reimbursement Lookup Tool: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php
- Only submit clinical documentation that is current and relevant
- Include all required documents, forms, and/or consents
- Include required modifiers (e.g. LL, RR, RT, LT, GO, GP)
- Include conservative treatment documentation, including type of treatment and length of treatment

Lookup Tools

Eligibility Lookup Tool



Eligibility Lookup Tool

Logout

To submit an eligibility inquiry on a specific Member, enter your Provider ID, Date of Service and a combination of the following search criteria:

- One value from the Unique Identifiers column, and two values from the Demographics column, OR
- All three values from the Demographics column

Only exact matches will return results.

By clicking the Submit button, you acknowledge that the information you access during the transmission may contain protected health information and other identifiable information protected by federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). Information accessed through the use of this Eligibility Lookup Tool must be kept secure and private in accordance with the Utah Department of Health HIPAA Policies.

Failure to comply with the HIPAA Rule may result in termination of access from this Portal.

Provider ID *

(NPI/Atypical Provider ID)

Unique Identifiers		Demographics	
Member ID		First Name	
SSN		Last Name	
		Date of Birth	(mm/dd/yyyy)

Date of Service * 08/21/2017 Eligibility inquiries are limited to 36 months from the current date.

If you need additional assistance, please contact Customer Service at 1(800)662-9651 OR (801)538-6155.

Submit Clear

- Log-in required
- Provides detailed member eligibility information
- Pro Tips
  - Use Medicaid ID#, First Name, and Date of Birth
  - Make sure no spaces or characters at end
  - Verify the next month's eligibility up to 6 days prior to end of month

Coverage and Reimbursement Lookup

Bureau of Coverage and Reimbursement Policy

Coverage and Reimbursement Code Lookup

The information provided by this lookup tool does not guarantee reimbursement, but is intended to provide coverage and reimbursement information for selected procedure codes as of the "Updated On" date specified in the search results. For additional information regarding specific billing requirements and coverage or rates not managed in this Lookup tool, please consult the Medicaid Provider Manuals or contact us.

This fee schedule does not apply to hospital outpatient services paid under the Outpatient Prospective Payment System (OPPS), Indian Health Services (IHS), School Based Skills Development (SBSD), nor does it apply to Utah's 1915(c) HCBS waivers. Medicaid covered claims adjudicated through OPPS will be paid according to the applicable Medicare fee schedule, IHS providers are generally paid using the All-Inclusive Rate (please refer to the Indian Health provider manual for more specifics) and 1915(c) HCBS waiver providers should refer to the appropriate waiver-specific fee schedule.

For a list of provider types for which coverage and/or rates do not apply (as shown by this lookup tool), please click here.

Generally, the fees represented here are only for fee-for-service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

If you would like to view the entire fee schedule, rather than searching for a particular code, please use our Fee Schedule Download Tool.

If you would like to view the entire diagnosis schedule, please use our Diagnosis Schedule Download Tool.

Select Provider Type: -

Enter Code:

Date of Service: 8/21/2017 **(MM/DD/YYYY)**

Search

- Select appropriate provider type
- Enter 5 character HCPCS/CPT code
- Enter date of service (if future, keep current date)
- Inquire on retroactive coverage for the previous 2 years
- Non-covered services will show up as “not billable by provider type”

Coverage and Reimbursement Lookup

UTAH DEPARTMENT OF HEALTH MEDICAID

Code: E0329

Name: PEDICATRIC HOSPITAL BED, ELECTRIC OR SEMI-ELECTRIC

Type Of Service: DME - Rental

Updated On: 08/19/2017

Special Note: DESCRIPTION: Rental per month. LIMITATION: Rental not allowed if need is expected to exceed 12 months. OTHER: Includes 360 degree side enclosures, top of headboard, footboard, side rails up to 24 inches above the spring, and mattress. Castors not separately reimbursable for rental.

	Traditional	Non-Traditional	PCN
Coverage Status:	Covered	Not Covered	Not Covered
Billable by Provider:	Yes	**No**	**No**
Charge Factor:	$223.90	N/A	N/A
Effective Start Date:	07/01/2010	07/01/2010	07/01/2010
Effective End Date:	---	---	---
Allowed Age Range:	Only EPSDT Only	None	None
Prior Authorization Required?	**PA Required - See Special Note Above**	N/A	N/A
Prior Authorization Age Range:		None	None
Prior Authorization Limit:	0	0	0
Co-Payment Required:	No	N/A	N/A
PostOp Days Allowed:	None	N/A	N/A
Assistant Surgeon Modifier:	No	N/A	N/A
Billable for Nursing Home and ICF/ID Residents:	Ancillary for Medicaid payment (Not covered in the daily rate)	N/A	N/A
Billable on Multiple Claim Lines:	No	N/A	N/A
Override Age limitations for Pregnant Women:	No	No	No

Code: E0329

Name: PEDIATRIC HOSPITAL BED, ELECTRIC OR SEMI-ELECTRIC

Type Of Service: DME Purchase

Updated On: 08/19/2017

Special Note: DESCRIPTION: Purchase may be approved when long-term need is expected. LIMITATION: Purchase not allowed if expected need is for less than 12 months. OTHER: Includes 360 Degree side enclosures, top of headboard, footboard, side rails up to 24 inches above the spring, and mattress; (verify if castors are included in the purchase package before requesting as a separate charge).

	Traditional	Non-Traditional	PCN
Coverage Status:	Covered	Not Covered	Not Covered
Billable by Provider:	Yes	**No**	**No**
Charge Factor:	$5,874.05	N/A	N/A
Effective Start Date:	01/27/2012	01/12/2016	01/12/2016
Effective End Date:	---	---	---
Allowed Age Range:	Only EPSDT Only	None	None
Prior Authorization Required?	**PA Required - See Special Note Above**	N/A	N/A
Prior Authorization Age Range:		None	None
Prior Authorization Limit:	0	0	0
Co-Payment Required:	No	N/A	N/A
PostOp Days Allowed:	None	N/A	N/A
Assistant Surgeon Modifier:	No	N/A	N/A
Billable for Nursing Home and ICF/ID Residents:	Ancillary for Medicaid payment (Not covered in the daily rate)	N/A	N/A
Billable on Multiple Claim Lines:	No	N/A	N/A
Override Age limitations for Pregnant Women:	No	No	No

What Happens to My Request?

- **Approved**
  - You will receive a fax stating the request is approved with the Prior Authorization attached
- **Pended (temporary internal status)**
  - Requests are pended temporarily when our staff has referred the request on for a higher level review (review by physician or committee)
- **Returned**
  - You will receive a return letter addressing what is missing, upon resubmission, you must include the following:
    - Address every issue that was mentioned in the return letter and include all original documentation
    - Update your PA request (e.g. Requested date(s) of service)
- **Denied**
  - You will receive a denial letter explaining what was denied and why. A Request for Hearing form will be attached and must be submitted within 30 days of the date of denial.

Retroactive Authorization

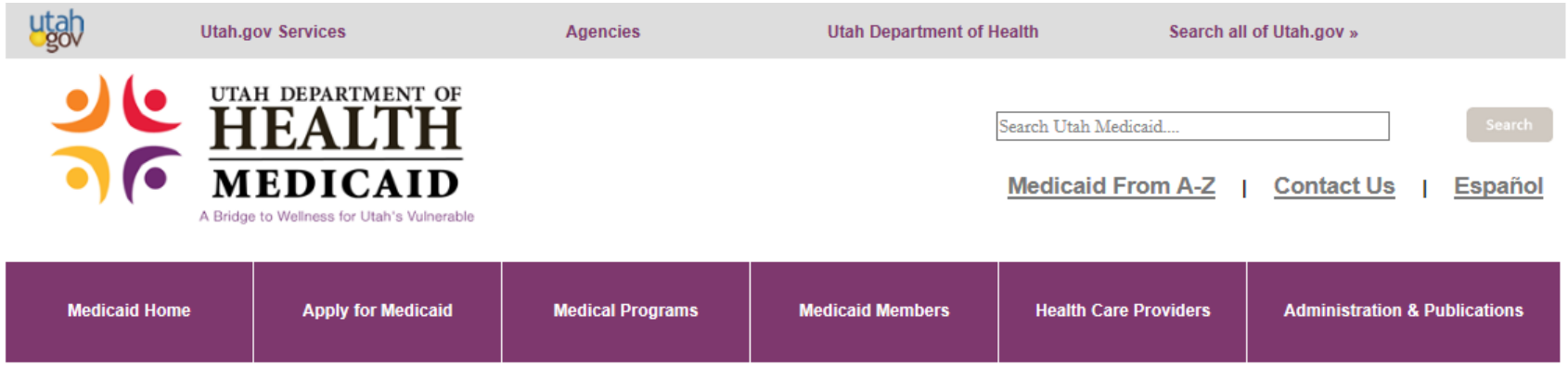
- There are limited circumstances when a prior authorization would be given after a service is rendered:
  - Retroactive Medicaid eligibility
    - Retroactive authorization must be requested within 90 days of Medicaid eligibility determination
  - Medical supplies provided in a medical emergency
    - Retroactive authorization must be requested within 90 days of the medical emergency
  - Medical emergency
    - Retroactive authorization must be requested within 90 days of medical emergency

Retroactive Authorization

- Surgical exceptions (e.g. surgical procedure changed or discovered intraoperatively)
  - Retroactive authorization must be requested within 90 days of surgical procedure
- Anesthesia exceptions (e.g. surgeon did not obtain prior authorization)

- Complete the request for prior authorization and include the reason the service was provided without prior authorization. Include all required medical record documentation and send the request to the appropriate fax number listed on the request form or form instructions. See the Section 1 Medicaid manual for complete details.

Where Can I Find Criteria?



Prior Authorization

- Pharmacy Criteria Forms
- Medical Criteria
- General PA Forms
- Resident Assessment Forms
- Coverage and Reimbursement Lookup Tool
- Contact Us
- Frequently Asked Questions
- Manuals

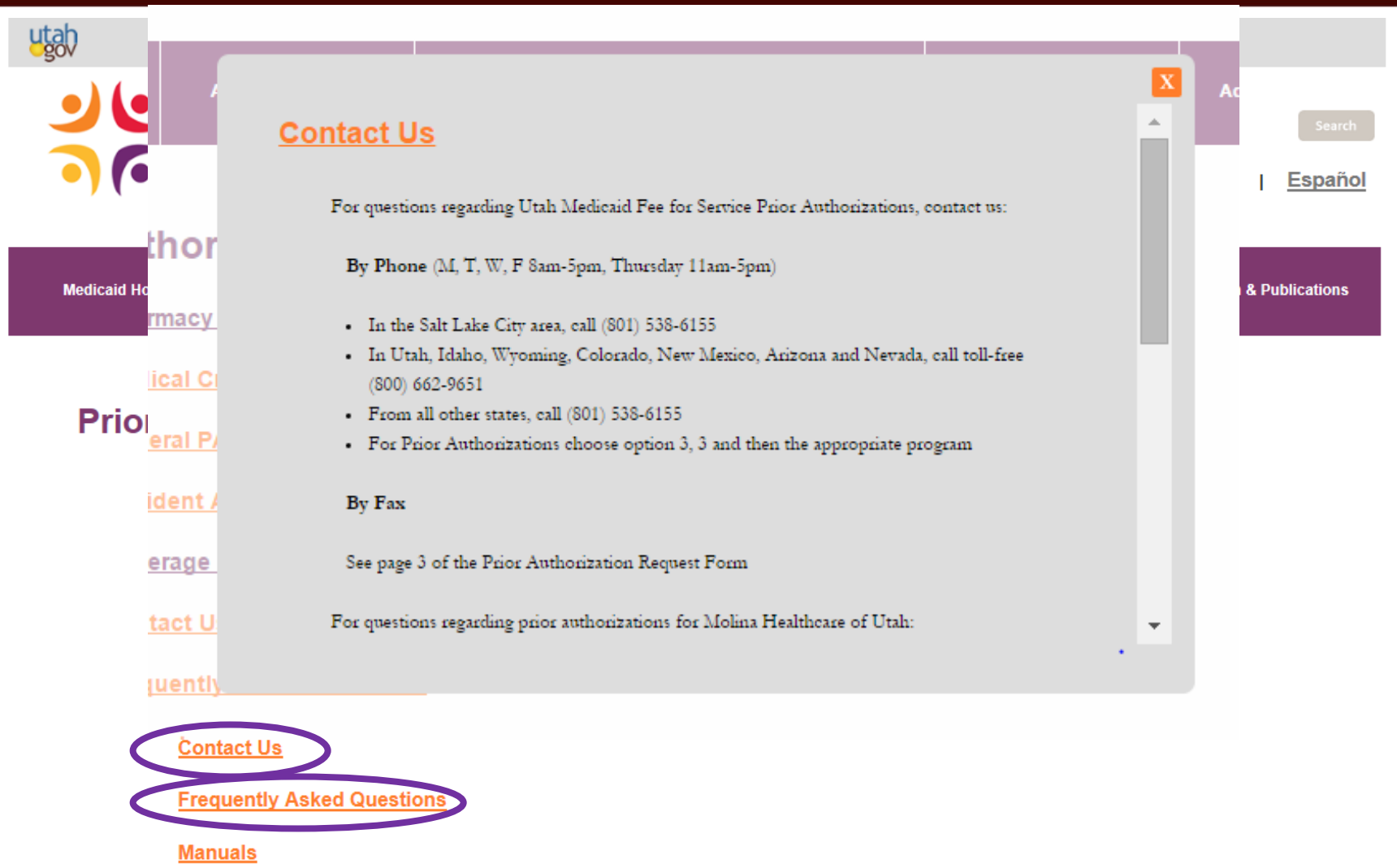
Other Sources

- Coverage and Reimbursement Lookup Tool
- Email medicaidcriteria@utah.gov for specific criteria that can't be found on the web (24 hour response time)

What's New in Prior Authorization

- Updated PA request forms
  - General Prior Authorization
  - Applied Behavior Analysis (ABA) Services
- New PA request forms
  - Enteral Formula
  - Genetic Testing
  - Substance Abuse Disorder Residential Treatment
- Update to InterQual criteria
- Updated PA requirements
- Facilities will now require PA for codes with a PA requirement

FAQ's and Contact Info



Questions and answers

Utah
Office of Inspector General
of Medicaid Services

Utah Office of
Inspector General

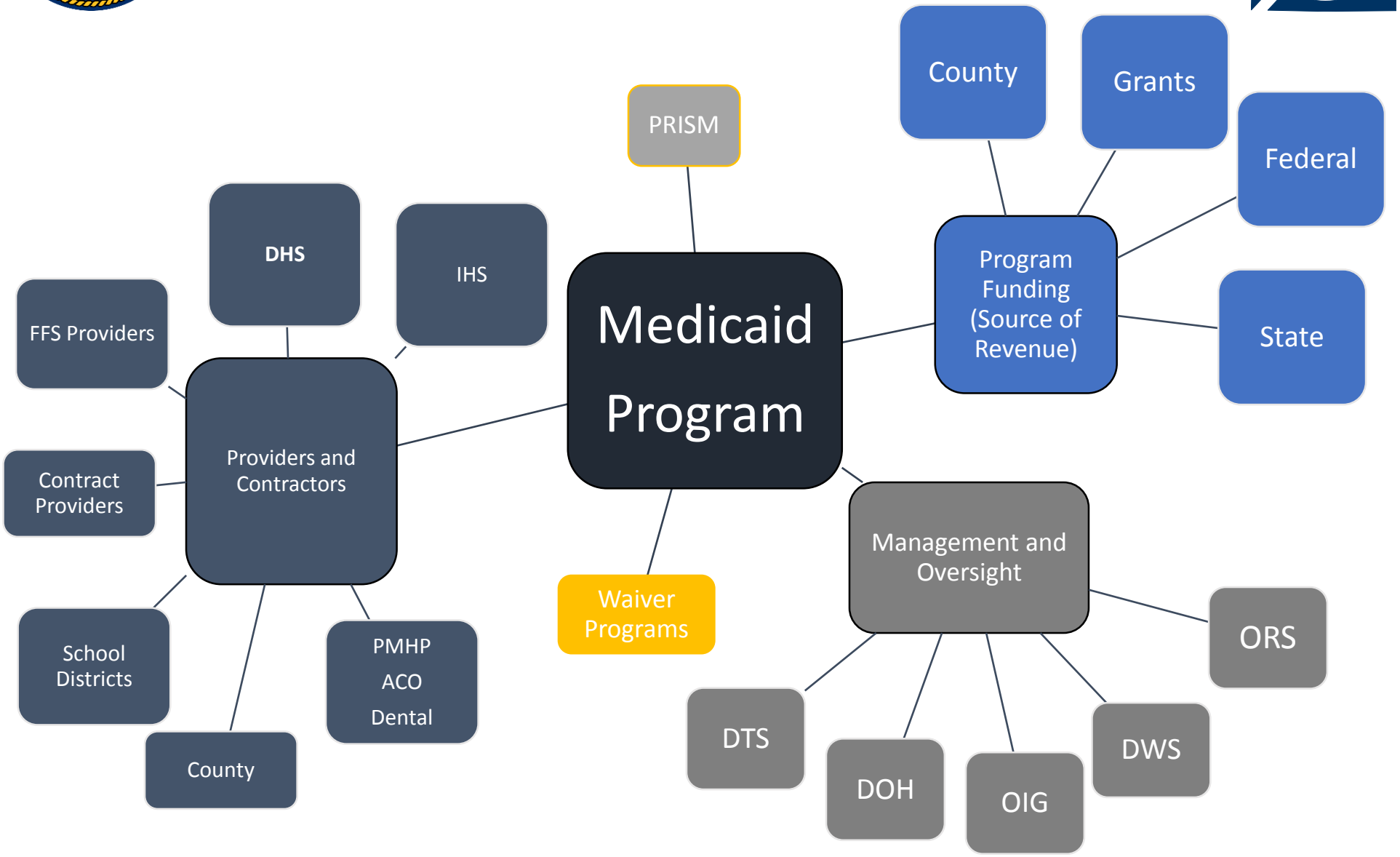
About Utah OIG

The Utah Office of Inspector General (Utah OIG) is an independent government agency tasked by statute to conduct oversight of the Utah Medicaid program. This includes oversight of all programs, funding and services associated directly or indirectly with Medicaid.

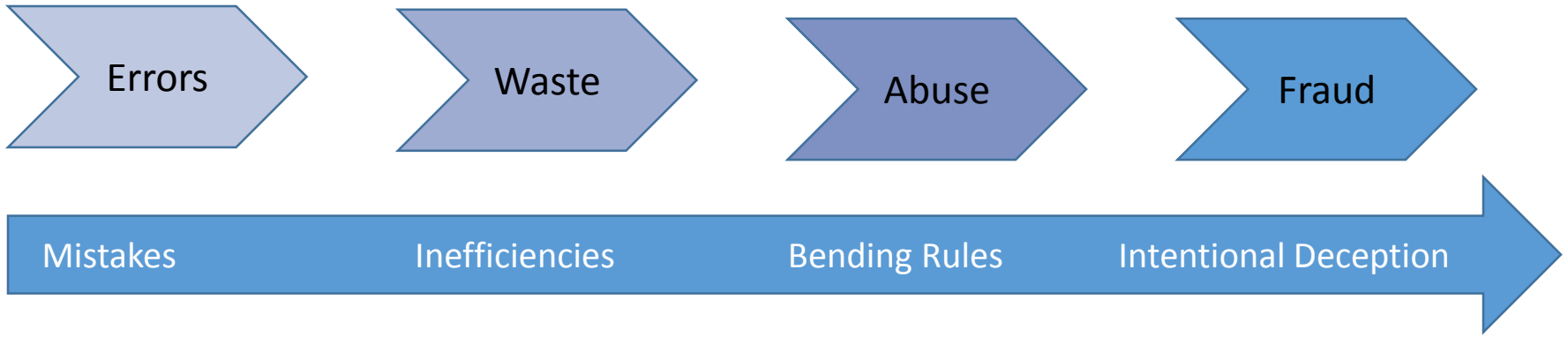
The office conducts oversight of the Medicaid program using several diverse and wide-ranging tools and resources: Audits, Inspections, Investigations, Monitoring, Education and Training, and Policy Reviews.

Utah OIG is able to make recommendations to Medicaid about how to improve operations and efficiency of the program. The office works to identify, prevent and recover taxpayer monies that are expended as the result of fraud, waste and abuse.

Utah OIG Oversight Universe



Causes of Improper Payments



- Common errors include insufficient documentation:
  - CMS reported in 2015 that insufficient documentation was the “most common error.”
  - Overpayments may have been proper, but lack of documentation caused recovery as overpayment
- Majority of improper payments are unintentional errors (CMS, 2015)
- Utah OIG identifies all causes of improper payments:
  - From mistakes to intentional deception

Utah OIG Statute – §63A-13-102 Definitions

- **Fraud**:
  - "intentional or knowing:
    (a) Deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a claim, reimbursement, or services; or
    (b) a violation of a provision of Sections 26-20-3 through 26-20-7."
- **Waste**:
  - "Overutilization of resources or inappropriate payment."
- **Abuse**:
  - "(a) an action or practice that:
    (i) is inconsistent with sound fiscal, business, or medical practices; and
    (ii) results, or may result, in unnecessary Medicaid related costs; or
  - (b) reckless or negligent upcoding."

National Fraud Cases

- **Home Health Agency**: Owner and operator of a Miami HHA sentenced to 8 years prison and $21 million restitution associated with a fraud scheme. ***Services were not provided or were not medically necessary***.
- **Home Health Agency**: Four people sentenced to up to 10 years prison for $6 million fraud scheme of ***billing for services not provided***.
- **Pharmacy**: Pharmacist forged provider names and credentials, used names of children of customers, to bill prescriptions for an expensive drug (TOBI – cystic fibrosis drug).
- **DME**: Louisiana provider billed for DME and orthotics that members did not need or want, and in some cases were not provided. $3.2 million in fraudulent claims.

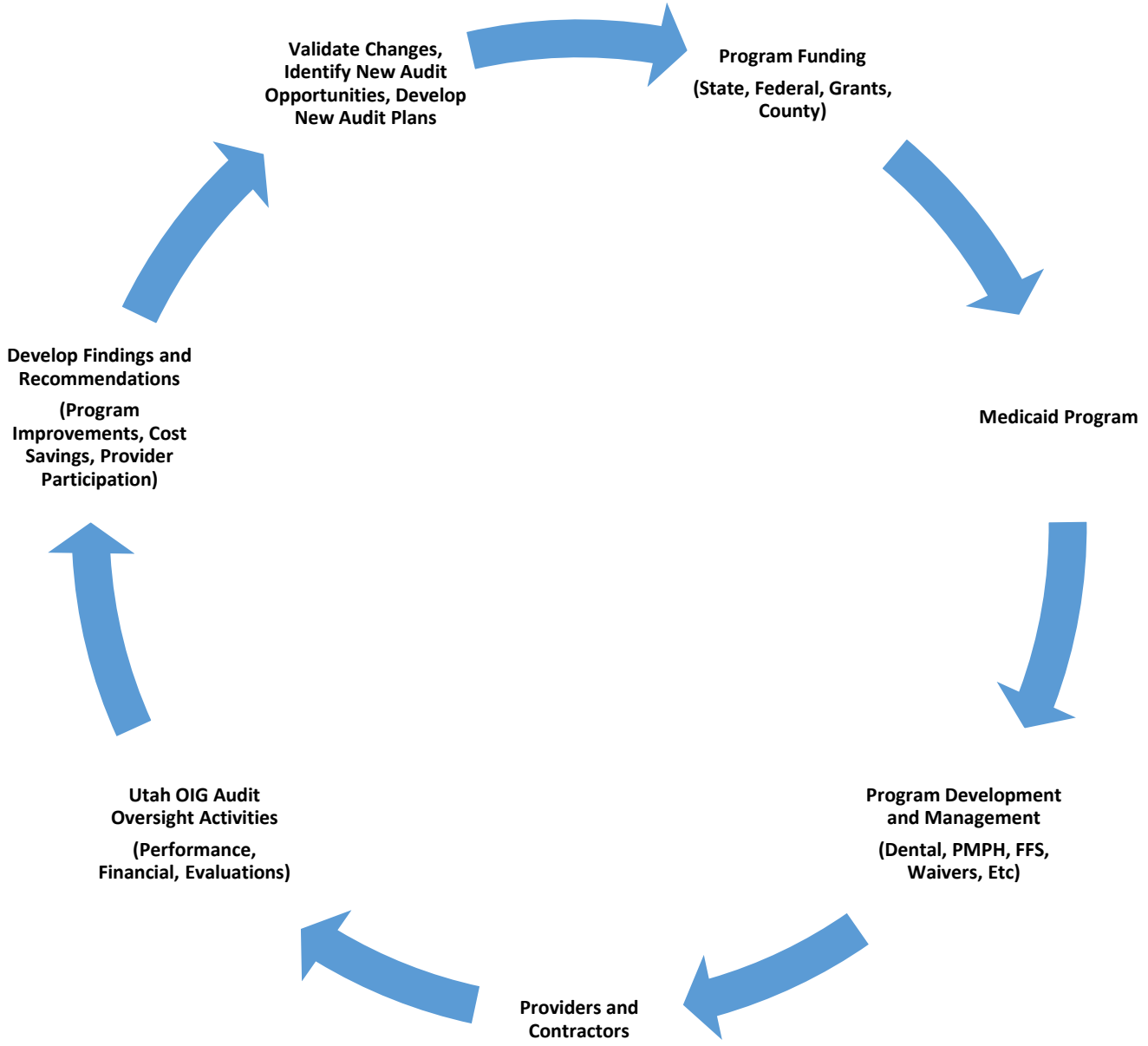
Common Recipient Fraud

- **Eligibility Fraud**:
  - Misrepresenting circumstances to qualify
- **Card Sharing**:
  - Compromises beneficiary's medical record
  - Danger of identify theft
  - Payment for services for person other than beneficiary
- **Doctor Shopping**:
  - Obtaining multiple prescriptions for the same or similar drug
- **Drug Diversion**:
  - Deflection of prescription drugs from medical sources into the illegal market
  - Use of prescription drugs for non-medical purposes
  - Forging or altering prescriptions
  - Obtaining prescriptions under false pretense
  - Colluding with willing prescriber/provider

Audit Department Overview

- Performs audits (i.e. determines the nature, scope and direction of the audit; reviews and analyzes available information, identifies potential issues, schedules audit, prepares audit work papers, etc.)
- Analyzes, summarizes and/or reviews data; reports findings, interprets results and/or makes recommendations.
- Writes or drafts correspondence, reports, documents and/or other written materials.
- Ensures compliance with applicable federal and/or state laws, regulations, and/or agency rules, standards and guidelines, etc.
- Plans and manages projects and/or programs. Writes (or discusses) project/program plan(s), recommendation(s) and/or finding(s) with departments or organizations.

Utah OIG Audit Cycle



Data

- Access to Medicaid Claims data
- Data can confirm credible allegation of fraud
- Assist nurse investigators and auditors in investigations
- Have ability to look at data for reported or suspected billing inconsistencies
- Pull monthly random samples to check for billing inconsistencies
- Data is not a standalone tool for fraud detection, but can identify patterns of fraudulent behavior not otherwise apparent. Together with other tools, can help identify suspected fraud

Program Integrity Team

Medicaid Program Integrity is a system of reasonable and consistent oversight of the Medicaid program. Program Integrity effectively:

- Encourages compliance
- Maintains accountability
- Protects public funds, both federal and state
- Supports awareness and responsibility
- Ensures that providers meet participation requirements
- Ensures that services are medically necessary
- Ensures payments are for the correct amount and for covered services

The goal of Program Integrity is to reduce and eliminate fraud, waste, and abuse in the Medicaid program. The program integrity function seeks to fulfill that goal through prevention, investigations, education, audits, recovery of improper payments, and cooperation with the Medicaid Fraud Control Unit (MFCU)

Program Integrity

- 42 CFR § 455.13 – Methods for identification, investigation and referral. The UOIG must ***create methods and criteria for identifying suspected fraud cases***.
- 42 CFR § 455.14 – Preliminary Investigation. The UOIG ***investigates all allegations of fraud, waste, or abuse referred to the office.***
- 42 CFR § 455.15 – Full Investigation. If the preliminary investigation leads the agency to believe that fraud or abuse has occurred, we must ***refer the case to the Medicaid Fraud Control Unit (MFCU)***
- 42 CFR § 455.20 – ***Beneficiary Verification***. The UOIG fields referrals from recipients who received an EOMB from Utah Medicaid, but are concerned that they did not receive the services.
- 42 CFR § 455.21 – Cooperation with State Medicaid Fraud Control Unit. ***The UOIG must refer all suspected cases of provider fraud to the MFCU***.
- 42 CFR § 455.23 – Suspension of payments in cases of fraud. The UOIG must ***suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud*** for which an investigation is pending, unless the agency has good cause to not suspend payments or to suspend payment only in part.
- 42 CFR § 456.23 – Post payment review process. The UOIG must ***develop and review beneficiary utilization profiles, provider service profiles, and exceptions criteria***. This allows us to correct misutilization practices of beneficiaries and providers.

Special Investigations Unit (SIU)

- Intake of complaints
- Conducts preliminary reviews to verify complaints
- Makes referrals to other entities and makes termination recommendations
- Performs comprehensive reviews on providers
- Conducts site visits
- Educates providers
- Participates in OIG-initiated focused reviews and special projects

Policy and Training Coordinator

Policy Reviews:

- Required by Utah OIG Statute
- Review and advise on Policy questions for audits and investigations
- Conduct reviews of draft Medicaid policies prior to publication:
  - MIBs, Provider Manuals, Rules and State Plan Amendments
  - Identify potential conflicts or concerns in policy

Policy Resources

- Provider Manuals and MIBs:
  - https://medicaid.utah.gov/publications
- Utah Code:
  - http://le.utah.gov/documents/code_const.htm
- Utah Administrative Code (Rules):
  - https://rules.utah.gov/publications/utah-adm-code/
- Utah OIG Website:
  - https://oig.utah.gov/

Training

Provider Training:

- Partnership Building:
  - Improve the program for the providers and recipients – protecting taxpayer resources through efficiencies
- Share policy recommendations and changes
- Information sharing about current oversight trends
- Develop audit, policy and investigation leads and contacts

Utah OIG can participate in training, seminars and conferences. Contact the Policy and Training Coordinator to schedule a provider or partner presentation.

Reporting to the Utah OIG

SUSPECTED FRAUD, WASTE OR ABUSE MAY BE REPORTED TO THE UTAH OFFICE OF INSPECTOR GENERAL. REPORTS CAN COME FROM ANYBODY AND CAN BE ANONYMOUS. PLEASE CALL THE UTAH OIG HOTLINE:

(855) 403-7283

OR COMPLETE A REFERRAL ON THE UTAH OIG WEBSITE:

https://oig.utah.gov/

Reporting Medicaid Fraud, Waste, Abuse or Neglect

Utah Office of Inspector General of Medicaid Services

Provider & Recipient
Fraud, Waste & Abuse
Telephone: 801-538-6087/855-403-7283
https://oig.utah.gov/

Medicaid Fraud Control Unit (MFCU)

Provider Fraud, Waste, Abuse, Neglect & Financial Exploitation
Telephone: 801-281-1259
https://attorneygeneral.utah.gov/uncategorized/mfcu/

Utah Department of Workforce Services

Recipient Eligibility Fraud
Email: wsinv@utah.gov
Telephone: 800-955-2210

Utah Adult Protective Services

Abuse, Neglect & Exploitation of Vulnerable Adults
Telephone: 800-371-7897
https://daas.utah.gov/adult-protective-services/

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Questions?

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