

HEALTH | CHOICE  
UTAH



2018-2019  
PHYSICIAN/PROVIDER MANUAL

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# CHAPTER 1:

## INTRODUCTION TO HEALTH CHOICE UTAH

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### INTRODUCTION

This manual contains basic information about the administration of the Health Choice Utah Medicaid program. The intent of this manual is to furnish contracted providers and their staff with information about Health Choice Utah, covered services, and claim/encounter submission requirements.

This manual is designed so that providers can review and print the sections that apply to them. For instance, physicians, hospital administrators, and other medical professionals may only be interested in reviewing Chapter 1 of the manual, while providers' staff or billers should become familiar with the requirements for prior authorizations, specialty referrals, and member eligibility as well as proper billing procedures, which are contained throughout the manual.

### OVERVIEW

Health Choice Utah began operations in 2012 and along with its affiliated Medicaid plan, Health Choice Arizona, is owned by IASIS Healthcare Corporation. IASIS Healthcare is headquartered in Franklin, Tennessee. IASIS owns and operates 16 acute care hospitals and one behavioral health hospital in six states. The Utah hospitals include Davis Hospital & Medical Center, Jordan Valley Medical Center, Jordan Valley Medical Center - West Valley Campus, Mountain Point Medical Center, and Salt Lake Regional Medical Center. Health Choice Arizona and Health Choice Utah together serve over 260,000 Medicaid enrollees. Our commitment is to provide quality, cost-effective health care to Health Choice Utah Medicaid members.

We are a highly motivated and compassionate company, using advanced systems and technology to become the health care system of choice and to improve the quality of life of the individuals and communities we serve. Health Choice Utah employees and physicians share these guiding and enduring values:

- We treat our members, providers, partners, and each other with kindness and respect.
- We know that collaboration and communication are imperative to our success.
- We assume responsibility and hold ourselves accountable for our actions, products, decisions, and policies.
- We support the happiness of our team members - we invest in their professional growth and wellbeing.
- We serve and support the communities in which we live and work.

## HEALTH CHOICE UTAH NETWORK MANAGEMENT

Health Choice Utah is responsible for arranging covered services that are provided to members through a comprehensive provider network. The provider network consists of, but is not limited to: primary care physicians, specialty care physicians, hospitals and medical centers, community health centers, health departments, pharmacies, and other ancillary service providers.

Health Choice Utah's network has been strategically planned and developed to encompass health care providers who meet or exceed the Medicaid requirements for the quality of healthcare delivery.

Contracted health care providers will coordinate care within the Health Choice Utah provider network for all members. In the event a referral is needed to a nonparticipating provider, prior authorization can be obtained from Health Choice Utah. Participating Provider Directories may be requested through the Network Services Department or may be viewed online at [www.healthchoiceutah.com](http://www.healthchoiceutah.com). Questions about the Health Choice Utah network can be directed to your Provider Performance Representative.

The Network Service Department is staffed with Provider Performance Representatives. Provider Performance Representatives provide initial training and education, as well as office site visits on a regular basis. They also serve as a liaison with other departments within Health Choice Utah. The training and education includes but is not limited to claims, coding, Medicaid standards, prior authorization, and compliance issues. Please do not hesitate to contact your Provider Performance Representative whenever necessary.

## HEALTH CHOICE UTAH WEB SITE

The Health Choice Utah website includes a Provider Portal link, which was designed to reduce the time it takes for providers to research information within the Health Choice system. Providers may set up both a Master Account and Individual User Accounts. Master Accounts – one per Tax ID – are intended as an administrator account providing the capability of creating, overseeing, and managing Individual User Accounts. The information provided currently includes Claim Status Search, Member Eligibility Search, Prior Authorization Status Search, Explanation of Benefits, and Direct Electronic Claim Submission.

- Claim Status Search is an online search utility where the status of Provider claims within the Health Choice Utah system can be retrieved.
- Member Eligibility Search is an online search utility for retrieving eligibility information for members within the Health Choice Utah system.
- Prior Authorization Status Search allows providers to check the status of prior authorizations by Member ID and service date.
- Direct Electronic Claim Submission option allows providers who submit their claims electronically to do so via the web, thereby expediting the claims submission process.

Health Choice Utah provides a link from within the Provider Portal to allow providers to download a printable copy of their Remittance Advice (RA). For providers that do not have systems capable of automatically posting payments via the ERA (Electronic Remittance Advice) process but who want the

quick payment afforded by an EFT, a downloadable RA serves as an ideal complement. Each week, the RAs for that week's adjudicated claims are available for download.

In order to access the downloadable RA, follow these steps:

- 1) Go to the Health Choice Utah Provider Portal at:  
<https://www.healthchoiceutah.com/ProviderPortal/login/>
- 2) Log in using the Tax ID, User ID, and Password for the user's account.
- 3) Once logged in, look for the Claim Status Search and click on Health Choice Utah.
- 4) Select a date range and click on Begin Search.
- 5) Under the Status column, look for adjudicated claims (those with a Paid or Denied status). You may need to go to subsequent pages using the page drop-down box.
- 6) Adjudicated claims will have an underlined link under the Claim Number. Clicking this link allows you to open or save a PDF file containing the RA for not only that claim, but for all claims adjudicated in that week.

The Provider Portal has been designed with the providers in mind, allowing them to research and retrieve information at their convenience.

# CHAPTER 2:

## ENROLLEE ELIGIBILITY & MEMBER SERVICES

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### HEALTH CHOICE UTAH MEMBER SERVICES DEPARTMENT

Our members and their medical care are very important to us. To ensure their needs are met, the Health Choice Utah Member Services Department coordinates all membership activities. The primary functions of the Member Service Department include:

- Verification of member eligibility
- Primary Care Physician (PCP) assignment and changes
- General Health Plan questions
- Member resolution of issues that can be immediately resolved; referral of other issues (grievances and complaints) to the Quality Management Department for further investigation and resolution
- Arranging translation services, including hearing impaired and sign language
- Conducting Member Satisfaction Surveys

The Health Choice Utah Member Services Department is available from 7:00 am to 5:00 pm, Monday through Friday at 1-877-358-8797

### COVERED SERVICES THROUGH HEALTH CHOICE UTAH

Health Choice Utah provides medically necessary covered services specified by the Utah Department of Health (UDOH), which are mandated by federal and state law. Covered services must be provided or arranged for by a member's Primary Care Physician (PCP).

Medical necessity may be determined through professional review for appropriateness of services provided in conjunction with established criteria related to severity of illness and intensity of services.

Documentation submitted by providers is the key to the determination of medical necessity. Failure to submit documentation that substantiates medical necessity may result in a denial of your request, a denial of your claim, or both.

Coverage of services is subject to Health Choice Utah and UDOH rules, policies, and requirements, including, but not limited to:

- Prior authorization

- Concurrent review
- Claims review
- Coordination of Benefits
- Post payment review
- Special consent requirements
- Eligibility

Health Choice Utah covers a wide range of services, some of which require prior authorization. Information on prior authorization can be found in Chapter 6. The following list is a partial selection of important services Health Choice Utah covers:

- Hospital Services (Inpatient, Outpatient, and Emergency Department Services)
- Physician Services
- Pharmacy / Prescriptions
- General Preventative Services (Mammograms, Pap Smears, and Prostate Exams)
- Vision Care
- Laboratory and Radiology Services
- Physical and Occupational Therapy
- Speech and Hearing Services
- Podiatry Services
- Dialysis – End Stage Renal Disease
- Home Health Services
- Hospice Services
- Medical Supplies and Medical Equipment
- Sterilizations
- Treatment for Substance Abuse and Dependency
- Organ Transplants
- Other Outside Medical Services
- Skilled Nursing Facilities and Long Term Acute Care Stays of 30 Days or Less
- Family Planning Services
- Medical and Surgical Services
- Diabetes Education
- HIV Prevention
- Services to CHEC Enrollees (See Chapter 12 additional information)†
- Private Duty Nurse†
- High Risk Prenatal Services†
- Services for Children with Special Needs†

† *These services are not covered for Non-Traditional Enrollees.*

## CO-PAYS FOR PLAN ENROLLEES

### Inpatient Hospital

Each Enrollee must pay a \$220.00 co-insurance for non-emergency inpatient hospital admissions. The maximum co-payment per Enrollee per calendar year is \$220.00 for non-emergency inpatient hospital admissions.

### Emergency Department

Each Enrollee must pay a \$6.00 co-payment for non-emergency use of the emergency room.

### Physicians, Family Nurse Practitioners, Osteopaths, Podiatrists, Freestanding Emergency Centers, and Purchase of Eyeglasses

Each Enrollee must pay a \$3.00 co-payment per provider (or with each purchase of eyeglasses) per day.\*

### Outpatient Hospitals and Freestanding Ambulatory Surgical Centers

Each enrollee must pay a \$3.00 co-payment per provider.\*

### Prescription Drugs

Each Enrollee must pay a co-payment of \$3.00 per prescription. The maximum co-payment is \$15.00 per Enrollee per month, which includes \$9.00 per month for Health Choice Utah pharmacy claims and \$6.00 for Utah Medicaid pharmacy claims.

### Services without Co-Payments

- Family Planning (Office Visit, Pharmacy)
- Lab
- Medical Equipment and Supplies
- Mental Health when the Prepaid Mental Health Plan is used
- Covered Preventative Care or Immunizations
- Occupational and Physical Therapy
- Transportation
- Vision Services (Optometrist only)
- X-rays

*\*There is a maximum co-payment of \$100.00 per Enrollee per calendar year for any combination of services provided by physicians, podiatrists, chiropractors, outpatient hospitals, freestanding ambulatory surgical centers, and freestanding emergency centers. The co-payment for eyeglasses is also included in the \$100.00 maximum.*

Chiropractic, dental services including orthodontics, specialized mental health services, substance use disorder services other than medical detoxification in a hospital, transportation, waiver services, and several other services are coordinated by the Utah Medicaid Program and are not the responsibility of Health Choice Utah.

**Please note:** American Indian, Alaska Natives, pregnant women and Medicaid members eligible for EPSDT/CHEC do not have copays. Other insurance, including Medicare, may affect copays.

## MEMBER ELIGIBILITY VERIFICATION

In order to receive payment for covered services, it is critical that member eligibility be verified **before** providing services. If a patient presents as a Health Choice Utah member, but has lost eligibility and you do not verify their status before providing services, payment will not be made.

Health Choice Utah has an Eligibility module within the secure provider portal of the <http://www.healthchoiceutah.com> web site. This allows providers to receive member eligibility information as well as co-payment requirements. The State of Utah MMIS Eligibility Look Up available at <https://medicaid.utah.gov/eligibility> is the most accurate and up-to-date source for an enrollee's Medicaid eligibility and Medicaid health plan enrollment status.

## PRIMARY CARE PHYSICIAN (PCP) SELECTION

Health Choice Utah contracts with General Practice, Family Medicine, Geriatric Medicine, Internal Medicine, and Pediatric physicians to provide PCP services to enrolled Health Choice Utah members. If a member does not choose a PCP, the Health Choice Utah Member Services Department assigns the member to a PCP based on geographic location.

Health Choice Utah offers its members freedom of choice in selecting a PCP within its network. There are instances when Health Choice Utah may restrict a member's choice of PCP. Examples include, but are not limited to: when a member frequently changes their PCP, for medically necessary reasons, or due to the location of the member's residence.

Each new member enrolled with Health Choice Utah receives written notification of his or her PCP by mail. In addition to the welcome letter with PCP information, the member also receives a Member Handbook and Provider Directory, which are resources that provide assistance for members on how to obtain health care services through Health Choice Utah. The Provider Directory includes a list of Health Choice Utah participating providers.

The Provider Directory is also available on our website at [www.healthchoiceutah.com](http://www.healthchoiceutah.com). This online directory is regularly updated and can be used to search for PCPs, specialists, hospitals, urgent care centers, pharmacies, and other provider types within a user specified radius from either a zip code or a street address.

## PRIMARY CARE OBSTETRICIAN (PCO) SELECTION

Pregnant members may choose a Primary Care Obstetrician (PCO). Pregnant members who do not choose a PCO are assigned one by Health Choice Utah. The PCO is the primary source of care for pregnant members. For more information on PCO assignments, please refer to Chapter 12.

## OUT OF STATE COVERAGE

A member, who is temporarily out of the state, but still a resident of Utah, is entitled to receive Medicaid benefits under one of the following conditions:

- Medical services are required because of a medical emergency.
- Documentation of the emergency must be submitted with the claims to Health Choice Utah.
- The member requires a particular treatment that can only be accessed in another state and prior authorization is obtained from the health plan.
- The member has a chronic illness necessitating treatment during a temporary absence from the state or the member's condition must be stabilized before returning to the state.
- The out of state provider is willing to bill Health Choice Utah for services.

Services furnished to Health Choice Utah members outside the United States are not covered.

## PATIENT RIGHTS

All Health Choice Utah members have the following healthcare rights:

- The right to receive information about Health Choice Utah;
- The right to be treated with respect and with due consideration for his or her dignity and privacy;
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- The right to participate in treatment decisions regarding his or her health care, including the right to refuse treatment;
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, sections 164.524 and 154.526;
- The right to be furnished health care services in accordance with access and quality standards; and
- The right to be free to exercise all rights and that by exercising those rights, the member shall not be adversely treated by Health Choice Utah and its providers.

In turn, as a member of Health Choice Utah, the member has the following responsibilities to the health plan:

- To know the name of their assigned primary care physician (PCP);
- To provide, to the extent possible, information needed by the professional staff who are taking care of the member;
- To follow the advice given by health care providers, to take their medicine as prescribed, to consult with their doctor about their medical care, and to get proper PCP approval, as needed;
- To make appointments during office hours whenever possible instead of unnecessarily using urgent care facilities, emergency rooms, or both;
- To get to their appointment on time or to call their doctor ahead of time if they cannot make their appointment;
- To bring immunization records to every appointment for children who are 18 years of age or younger.

## PATIENT SATISFACTION

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask Medicaid patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to patients and focus on aspects of quality that patients are best qualified to assess, such as a provider's communication skills and the ease of access to health care services. To review specific questions that are included in the survey visit: <https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html>. CAHPS survey results are published by the Utah Medicaid Program and allow consumers to compare the various Medicaid health plans in Utah.

Members are most satisfied with their PCP when (a) they can timely schedule routine (within 30 days) and urgent (within 2 days) appointments, (b) they experience reasonable waiting times in your office, (c) when they are timely referred for necessary specialty care, and (d) you communicate with them in a friendly and effective manner. Please contact your Health Choice Utah Network Services Representative or the Quality Manager with any questions or concerns relating to the annual CAHPS survey.

# CHAPTER 3:

## PROVIDER RESPONSIBILITY

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### NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI)

HIPAA requires that all providers use their NPI number as the only provider identifier in electronic transmissions, such as claims billing and claims payment. Providers must obtain an NPI. For information regarding NPI enrollment, visit the CMS website at <https://nppes.cms.hhs.gov> or call 1-800-465-3203

### TAX IDENTIFICATION NUMBER (TIN)

A provider's tax identification number determines who the payee is and where the payment is sent to. It also allows Health Choice Utah to properly report payment information to the IRS.

### FEDERAL EXCLUSION

As a registered provider with Medicaid, you are obligated under 42 C.F.R. §1001.1901(b), to screen all employees, contractors, subcontractors, or any combination of the three to determine whether any of them have been excluded from participation in federal health care programs. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>

### HEALTH CHOICE UTAH CREDENTIALING AND RE-CREDENTIALING

All providers must be credentialed, approved, and contracted with Health Choice Utah. A provider who has not been credentialed or contracted cannot treat Health Choice Utah members and will not receive payment for services rendered to Health Choice Utah members. The credentialing process usually takes from 60 to 90 days to complete. The credentialing process begins at the time the Credentialing Department receives a completed application.

Health Choice Utah conducts re-credentialing at least once every three (3) years. Participating providers will be notified by the Health Choice Utah Credentialing Department or a designated entity when this occurs. It is important that providers complete the re-credentialing application as quickly as possible.

Failure to maintain a credentialed status with Health Choice Utah can result in provider termination and non-payment of claims.

## CHANGES TO PROVIDER INFORMATION ON FILE

Providers are required to notify Network Services of any change in practice name, physical address, payee address, tax identification number, or NPI 30 days prior to the change. Failure to do so may result in the denial of claim payment.

Changes in your staffing should also be reported to your Health Choice Utah Provider Performance Representative. If staff training is needed, please contact your Provider Performance Representative. Keeping your staff trained saves you time and money.

## LICENSURE AND CERTIFICATION UPDATES

Health Choice Utah requires that providers have current copies of their state license, DEA certificate, and malpractice insurance on file at all times. The Health Choice Utah Credentialing Department sends letters to providers requesting current copies of these documents when the documents on file have expired. Failure to provide Health Choice Utah with these documents can result in termination from the network.

## CONTINUITY OF CARE / LOSS OF ELIGIBILITY

Providers terminating their contract without cause are required to continue to treat members until their treatment course is completed. Authorization may be necessary for these services. Members who lose their eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. If you identify a member in this circumstance, please contact our Medical Case Management Department for assistance.

## APPOINTMENT AVAILABILITY AND WAITING TIME

In order to best serve our members, Health Choice Utah's contracted Primary Care Physicians and Specialists must maintain availability within the appointment standards prescribed by Health Choice Utah. Providers are expected to establish a procedure for waiting times so that a member does not wait more than 45 minutes, except in emergency cases or unforeseen circumstances.

Health Choice Utah monitors providers' appointment availability and members' in office waiting time on an on-going basis. Appointment availability standards are applicable to both new and established patients and are as follows:

### PCP APPOINTMENT STANDARDS:

**Emergency appointments:** Same day or within 24 hours of the member's phone call or other notification

**Urgent appointments:** Within 2 days

**Routine appointments:** Within 30 days

**School Physicals:** Within 60 days

## SPECIALIST APPOINTMENT STANDARDS:

**Emergency appointments:** Within 24 hours of referral

**Urgent appointments:** Within 2 days of referral

**Routine appointments:** Within 30 days of referral

## OB/PRENATAL CARE APPOINTMENT STANDARDS:

**Emergency (All Trimesters):** Same day of request

**Urgent (All Trimesters):** Within 2 days of request

**Routine First Trimester:** Within 14 days of request

**Routine Second Trimester:** Within 7 days of request

**Routine Third Trimester:** Within 3 days of request

**High Risk Pregnancy emergency:** Immediately

**High Risk Pregnancy urgent:** Same day of request

**High Risk Pregnancy routine:** Within 3 days of request

## TELEPHONE AVAILABILITY

Members are encouraged and expected to contact their PCP to schedule appointments or seek medical advice. Because it is critical for members to be able to reach their physicians, hold times should not exceed 5 minutes. Health Choice Utah monitors telephone accessibility to ensure that members can reach you to schedule appointments or seek advice.

## AVAILABILITY NON-COMPLIANCE

Health Choice Utah ensures contracted physicians, ancillary services, and facilities are accessible to members to provide routine and emergent care on a timely basis. Providers will be asked to implement a corrective action plan when appointment availability standards are not met.

Health Choice Utah monitors the accessibility of participating providers through:

- Member complaints
- Quality management audits
- Emergency room utilization
- Appointment availability surveys
- Site visits by Health Choice Utah staff

Failure to comply with the Health Choice Utah appointment availability standards is viewed as an access to care issue by Health Choice Utah and may result in a reduction in assigned members.

## AFTER HOURS AND PHYSICIAN VACATION COVERAGE

Each provider must have 24 hours per day, 7 days per week coverage. It is not acceptable to refer Health Choice Utah members to the emergency room as a means to provide after-hours or vacation coverage. It is the responsibility of the PCP to arrange after hours care and vacation coverage by a contracted physician with Health Choice Utah.

Acceptable Coverage includes the following:

- An answering service that picks up the physician's office telephone after hours. The operator will then contact the physician or his/her covering physician
- An answering machine that either directs the caller to the office of the covering physician, or directs the caller to call the physician at another number
- Call forwarding services that automatically send the call to another number that will reach the physician or his/her covering physician

Unacceptable Coverage includes the following:

- An answering machine that directs the caller to leave a message (unless the machine will then automatically page the doctor to retrieve the message)
- An answering machine that directs the caller to go to the emergency room, and gives no other option
- An answering machine that has only a message regarding office hours, etc., without directing the caller appropriately, as outlined above
- An answering machine that directs callers to page a beeper number
- No answering machine or service
- If your answering machine directs callers to a cellular phone, it is not acceptable for charges to be directed to the caller (i.e. members should not receive a telephone bill for contacting the physician in an emergency)

## MISSED MEDICAL APPOINTMENTS

Health Choice Utah understands that missed appointments are a disruption to your practice. We strongly encourage providers to notify us of members who frequently miss their scheduled appointments. Missed appointments may be reported to Health Choice Utah using the Missed Medical Appointment Log. The Missed Medical Appointment Log can be faxed weekly, or as needed, to Health Choice Utah Member Services at 1-855-720-5820 (toll free) or e-mailed to [comments@healthchoiceutah.com](mailto:comments@healthchoiceutah.com). Health Choice Utah contacts these members to educate them on the importance of keeping scheduled appointments and to discuss any barriers in attending the medical appointment.

Health Choice Utah encourages providers to remind members of upcoming appointments as a way to decrease missed appointments. Health Choice Utah also encourages providers to contact patients who miss appointments to educate them about the importance of receiving needed care.

## PRIMARY CARE PHYSICIAN (PCP)

Health Choice Utah's Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) perform critical functions for plan members. Health Choice Utah relies on you to provide an efficient and effective model of care that assures assigned members receive the medical care and services they require. PCPs are gatekeepers, or medical managers, and are responsible and accountable for the coordination, supervision, deliverance, and documentation of health care services to assigned members. Capitated providers are required to submit claims regardless of reimbursement.

Health Choice Utah's Quality Management Committee periodically reviews guidelines for PCP management of Health Choice Utah members.

Health Choice Utah monitors the utilization of covered services, in both inpatient and outpatient settings, with an eye to both overutilization as well as underutilization. Data gathered are used to improve overall performance of Health Choice Utah using local and national benchmarks. For example, an average Medicaid Enrollee will seek primary care related services 3.5 times each year. Health Choice Utah monitors PCP's to see if their members are seen more or less frequently and for what reasons. This helps us predict and arrange for the necessary primary care physicians, specialists, ancillary, and hospital services that members may require.

For guidance as to which specialists and services require Prior Authorization, refer to Chapter 6. Specialists are required to submit the appropriate authorization number on their claims. Health Choice Utah contracted Specialists work in concert with the member's Primary Care Physicians to coordinate the overall care for the member. Our goal at Health Choice Utah is to develop partnerships with the Specialists in our network. Specialty Physicians are critical to our success at Health Choice Utah.

## MEMBERS WITH SPECIAL NEEDS

Members with special needs may be characterized as:

- 1) Persons who have communication barriers, such as:
  - Speaking a different language
  - Low literacy
  - Visual or hearing impaired
  - Geographically isolated people
  - People who are homeless
- 2) Persons who require health and related services of a type or amount beyond that required by people in general include:
  - Common and often mild chronic health issues with unique presentations, for example, allergies, arthritis, and hypertension
  - Complex and manageable health issues, for example, asthma, diabetes, heart failure
  - Complex and difficult-to-address health issues, such as lupus, cerebral palsy, major functional disabilities
  - Chronically mentally ill adults, substance abuse
  - Diagnosis specific groups, such as HIV/AIDS cases

- Physically disabled adults, children, and frail elderly
  - Organ transplant members or waiting for transplant
- 3) Persons whose eligibility status complicates understanding of managed care and enrollment, such as:
- Dually eligible Medicare/Medicaid Enrollees
  - Uninsured families and children less familiar with the health system or managed care who may be eligible under other programs

The health care needs of this population often differ from the general population in the type, scope, frequency, coordination and duration of care needed. Should you have a member with special health care needs, please contact Health Choice Utah's Case Management Department by calling 1-877-358-8797

## HOSPITAL ADMISSIONS

Health Choice Utah uses a fully participatory hospitalist program at most of its network hospitals. The PCP may contact the appropriate Health Choice Utah contracted hospitalist group to arrange hospitalization or call Health Choice Utah for assistance. The PCP will continue to manage the patient's care after discharge.

The hospitalist program does not cover pediatric or obstetrical cases. In these situations, as well as those cases where a hospital is not covered under the Health Choice Utah hospitalist program, the PCP or obstetrician should expect to follow the member in the hospital.

The PCP or PCO should communicate directly with the Health Choice Utah Prior Authorization Department when a hospital admission is necessary. All hospital admissions require prior authorization. Correctly coordinating prior authorization also ensures the physician and hospital receive timely payment.

Health Choice Utah conducts concurrent review of all inpatient admissions. Health Choice Utah uses nationally accepted and recognized criteria when performing concurrent inpatient review.

## IMMUNIZATIONS

### CHILD IMMUNIZATIONS

Age appropriate immunizations are to be provided following the standards adopted by the Advisory Committee on Immunization Practices (ACIP), which includes the American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC). Those members who are unable to document prior immunizations should be immunized so that they become current with their appropriate age group. Utah law requires that providers report all immunizations administered to children under age 19 to the Utah State Immunization Information System (USIIS).

**Providers must participate in the Vaccines for Children (VFC) program to obtain vaccines.** Failure to maintain current standing as a VFC provider may be grounds for contract termination.

## ADULT IMMUNIZATION

Physicians are strongly encouraged to provide immunizations for influenza and pneumonia when medically indicated and in conjunction with current CDC recommendations.

## PATIENT EDUCATION

Health Choice Utah contracted providers are expected to provide appropriate prevention and disease management education. Providers may discuss medically necessary or appropriate treatment options with members even if the options are not covered services. Health maintenance education is not only expected and encouraged, it is required. Members should receive counseling about disease prevention and the importance of regular health maintenance visits, and they must be included in the planning and implementation of their care.

It is expected that providers will educate members about their unique health care needs; share the findings of physical examinations; discuss potential treatment options, side effects and management of symptoms; and, in general, recognize that the patient has the right to choose the final course of action among clinically acceptable options.

It is particularly expected that members will be advised about the difference between urgent conditions, such as earaches, or flu, and emergent conditions and be instructed to contact their PCP first before visiting an emergency room or calling an ambulance unless they have a real emergency. Refer to Chapter 5 for health education and preventive services.

## REFERRALS

The PCP is responsible for initiating and coordinating referrals to specialists within the Health Choice Utah network. It is essential that a strong communication link be maintained with specialists who treat your patients. A record of the referral and any treatment notes from specialists must be maintained in the member record. Health Choice Utah encourages PCPs to maintain communication with specialists when referring assigned members for specialty care. Health Choice Utah has a simplified referral process for PCPs. Specialists are responsible for requesting prior authorization for follow up services and for obtaining other referrals as necessary.

For a list of services that require authorization, refer to Chapter 6.

## MEMBER DEATH

Health Choice Utah providers are required to notify the Member Services Department of a member's death. Please provide the member's name, member's ID number, date of birth, date and place of death.

## EMERGENCY ROOM

An “emergency” is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could result in: a) placing the patient’s health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

**Providers may not refer members to the Emergency Room due solely to non-availability of a same day appointment.**

Health Choice Utah contracts with a number of Urgent Care Centers. Ask your Provider Representative for details and a location near you.

## FRAUD AND ABUSE

### DEFICIENT REDUCTION ACT/FALSE CLAIMS ACT

Under the Deficit Reduction Act of 2005 (Public Law 109-171 Section 6032), any employer who receives or makes \$5 million or more per year in Medicaid payments is required to provide information to its employees about the federal and state False Claims Act. Even if your practice or entity does not meet the minimum threshold, we recommend this training for all employees. It is important that claims being submitted to any payer accurately represent the services that were provided.

Health Choice Utah is committed to detecting, reporting, and preventing potential fraud and abuse. Fraud and abuse is defined as:

#### **Fraud**

Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law. (Source: 42 CFR 455.2)

#### **Member Abuse**

Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault. (Source: 42 CFR 455.2)

#### **Provider Fraud**

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Examples of Fraud and Abuse include:

*Falsifying Claim/Encounters*

Altering a Claim  
Incorrect Coding  
Double Billing  
Submitting False Data

*Falsifying Services*

Billing for Services or Supplies Not Provided  
Misrepresentation of Services or Supplies  
Substitution of Services

*Administrative/Financial*

Kickbacks  
Falsifying Credentials  
Fraudulent Enrollment Practices  
Fraudulent TPL Reporting  
Fraudulent Recoupment Practices

*Member Issues (Abuse)*

Physical Abuse  
Mental Abuse  
Emotional Abuse  
Sexual Abuse  
Discrimination  
Neglect  
Financial Abuse  
Providing Substandard Care  
Misdiagnosis

*Member Issues (Fraud)*

Eligibility Determination Issues  
Resource Misrepresentation (transfer/hiding)  
Residency  
Household Composition  
Citizenship Status  
Income  
Prescription Alteration  
Misrepresentation of Medical Condition  
Durable Medical Equipment Theft  
Failure to Report Third Party Liability

*Denial of Services*

Denying access to Services or Benefits  
Limiting Access to Services or Benefits  
Specialist Under-utilization

## REPORTING FRAUD AND ABUSE

Health Choice Utah encourages providers and provider office staff to report potential fraud and abuse to Health Choice Utah by contacting their Network Services Representative who will refer the case to the Compliance Department for investigation.

Although providers and their staff are encouraged to report potential fraud and abuse cases through Health Choice Utah as described above, they may also use the federal hotline: DHHS/Office of the Inspector General, 1-(800)-447-8477

## AMERICANS WITH DISABILITIES ACT (ADA) & TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Under Title III of the ADA, requirements for public accommodations such as a physician's office mandate that they must be accessible to those with disabilities. Physicians should ensure that their offices are as accessible as possible to persons with disabilities, and should make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways for those with disabilities. Health Choice Utah also offers over the phone interpreter services at no cost to the provider or member.

Under the provisions of Title VI of the Civil Rights Act of 1964, no person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

For more information pertaining to available ADA resources offered through Health Choice Utah, please call your Network Services Representative.

## ADVANCE DIRECTIVES

Hospitals, nursing facilities, home health agencies, hospice agencies, and organizations responsible for providing personal care must comply with federal and state law regarding Advance Directives for adult members. These providers are encouraged to provide a copy of the member's executed Advance Directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

Requirements of the Federal Law include:

- Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies.
- Provide written information to adult members regarding each individual's rights under state law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
- Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.
- PCPs that have agreements with any of the aforementioned entities must comply with paragraphs listed above.

# CHAPTER 4:

## CULTURAL COMPETENCY

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*Original Date: November 2011*

*Revision Date: April 2016*

*Effective Date: July 1, 2016*

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### NON-DISCRIMINATION

Members enrolled in Health Choice Utah have the right to be treated with respect and with recognition of the member's dignity and need for privacy; to not be discriminated against in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, mental or physical disability, sexual orientation, genetic information, or source of payment; to have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations.

Cultural competency in health care refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice to ensure better communication with patients and their families to improve health outcomes and patient satisfaction.

Health Choice Utah is committed to providing access to high quality services in a culturally competent manner. Cultural competency generally refers to the provision of high quality, medically necessary health care services without regard to religious, racial, ethnic or social group, and within the context of diverse human behavior. Diverse human behavior includes thought, communication, actions, customs, beliefs, and values.

### INTERPRETATION AND TRANSLATION SERVICES

Health Choice Utah offers interpretation and translation services at no cost to you or your patients. Health Choice Utah encourages members to request translation services, instead of relying only on family, in order for the member to have the best opportunity to understand their health care. To coordinate interpretation and translation services for your patient, please contact our Member Services Department. Health Choice Utah offers a Language Interpretation Line, on-site translators, and Sign Language interpreters.

## ASK ME 3

Health Choice Utah supports and highly recommends the Ask Me 3 program. As described on the Ask Me 3 webpage, the program encourages patients to ask and understand 3 basic questions:

- 1) What is my main problem?
- 2) What do I need to do?
- 3) Why is it important for me to do this?

You can learn more about this patient education program online at: <http://www.npsf.org/askme3/>

## INTERNET RESOURCES

There are many cultural competency resources available on the Internet. The following listing is intended for informational purposes only.

- AMA Eliminating Health Disparities  
<http://www.ama-assn.org>
- Ethnomed—University of Washington: *cultural profiles, cross cultural topics, patient education*  
<http://ethnomed.org>
- Society of Teachers of Family Medicine—Multicultural Health Care and Education: *General curriculum information and listings of print, experiential exercises, games, simulations and video resources (not online)*  
<http://stfm.org/corep.html> or <http://stfm.org>
- Cross Cultural Health Care Program (CCHCP): *Site offers schedules/location/fees of cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services*  
<http://www.xculture.org>
- Health Resources and Services Administration: *Culture, Language and Health Literacy, Provider's Guide to Quality & Culture*  
<http://www.hrsa.gov/culturalcompetence/index.html>
- National Center for Cultural Competence  
<http://nccc.georgetown.edu>
- U.S. Department of Health and Human Services' office of Minority Health  
<http://minorityhealth.hhs.gov>
- Simulation Training System (218 Twelfth Street, Del Mar, CA 92014-0901) / Resources for Cross-cultural Health Care  
<http://www.diversityrx.org>
- National Urban League  
Phone: 212-310-9000 or <http://nul.iamempowered.com>
- Association of Asian Pacific Community Health Organizations  
Phone: 510-272-9536 or <http://www.aapcho.org>
- National Alliance for Hispanic Health  
Phone: 202-387-5000 or <http://www.hispanichealth.org>

# CHAPTER 5:

## QUALITY MANAGEMENT

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*Original Date: November 2011*

*Revision Date: May 2017*

*Effective Date: May 15, 2017*

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### HEALTH CHOICE UTAH QUALITY MANAGEMENT OVERVIEW

Health Choice Utah's Quality Management (QM) Program centers on continuous quality improvement (CQI) and monitors, evaluates and improves the continuity, quality, accessibility and availability of health care and services provided to Health Choice Utah members. Health Choice Utah conducts performance improvement projects that achieve demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services through ongoing measurement and intervention. These projects will benefit health outcomes and member satisfaction. Health Choice Utah maintains a formal peer review process to analyze provider quality of care issues to improve the Health Choice Utah provider network and the quality of care its members receive.

The QM program serves as the foundation for the evaluation and improvement of services. Members' and providers' care and service concerns are evaluated in order to provide prompt solutions and to inform process and care improvement. To meet or exceed members' and practitioners' expectations, this feedback will lead to actions benefitting Health Choice Utah members and practitioners. Every Health Choice Utah employee plays a unique role informing and directing quality improvement and ensuring members and providers receive excellent service. The QM program extends across all departments, integrating QM activities with other processes and programs throughout Health Choice Utah. It is Health Choice Utah's philosophy that quality does not only involve the Quality Management Department or the grievance system. Rather, excellent quality requires focus on not just the individual task at hand, but on opportunities for systemic improvement. To that end, our holistic approach enhances processes to improve outcomes.

### QM PROGRAM STRUCTURE

The Quality Management Committee (QMC) oversees the Health Choice Utah QM program. The QMC is responsible for implementation, oversight and evaluation of QM, Utilization Management and Performance Improvement Programs. Authority and responsibility for the daily operational activities of the QM program are delegated to the Chief Medical Officer, Medical Director, or both, the Chair of the QMC, and the Quality Management Senior Director. With approval of the QMC, subcommittees are created to meet specific organizational goals and needs. Examples of subcommittees include but are not limited to: the Technology Assessment Committee, the Credentialing Committee, the Peer Review Committee, and the Pharmacy and Therapeutics Committee. The Chief Medical Officer, Medical Director, or both facilitate

communication of QM activities with participating providers and serves as a liaison between the Health Plan and participating practitioners and providers.

## QM PROGRAM FUNCTIONS

- Coordination of the collection, analysis, and reporting of data used in monitoring and evaluating care. The QM Program includes monitoring of Health Choice Utah's community focused programs, practitioner availability and accessibility, coordination and continuity of care, and other programs or standards affecting health outcomes and quality of life.
- Identification and response to instances of substandard care including those affecting patient safety, access to care and coordination of care. This includes the review, research, resolution, and follow up of complaints and quality of care issues.
- Management of the implementation and outcomes of quality management interventions and programs.
- Organizational oversight to ensure compliance with accreditation standards and regulatory requirements governing managed care organizations.
- The Credentialing and re-credentialing process for individual providers, delegated providers and organizational providers.

## SCOPE AND METHODOLOGY OF THE QM PROGRAM

The program is designed to monitor, evaluate and continually improve the care and services delivered by Health Choice Utah, network practitioners and affiliated providers, across the full spectrum of services and sites of care. The particular model used in the quality process consists of: Plan–Do–Study–Act (PDSA) cycle methodology which is used to systematically test and implement changes and determine if the change is an improvement. The PDSA methodology includes the elements of: identification of the improvement opportunity; establishment of baseline measurements, interventions, performance goals and benchmarks; establishing data sources, data collection methods; measuring and analyzing data; and finally trending, making modification, as required, and re-measurement.

## QUALITY MEASURES

The Healthcare Effective Data and Information Set (HEDIS) is a tool used to measure performance on important dimensions of care and service which cannot otherwise be retrieved from claims. Annual HEDIS reporting is mandatory for all Utah Medicaid health plans in accordance with Utah Administrative Code R428-12-1 and R428-13-1 *et seq.* HEDIS medical record requests begin in February and end in May of each year. Health Choice Utah incurs significant medical record administrative and research costs in order to comply with the Utah Medicaid HEDIS reporting requirements. Health Choice Utah is also required by the Utah Medicaid Program to report on other quality measures as well.

Health Choice Utah provider and hospital services agreements state that medical records must be provided at no charge to Health Choice Utah within seven (7) days of our request. This includes medical records pertaining to HEDIS reporting. If you have decided to contract with a medical record retrieval vendor, then your office remains responsible for assuring that Health Choice Utah is (a) not charged for medical records, and (b) that medical record requests are filled within the required seven (7) day time frame. Your

vendor may ask for evidence that your provider contract includes a provision for medical records to be provided at no charge. We expect for such evidence to be provided directly to the vendor by your office staff as Health Choice Utah does not share information about our provider and hospital contracts to third parties. Please contact your Network Services Representative with any questions or concerns relating to the HEDIS and other Quality Measure reporting.

## PERFORMANCE MEASURES

Health Choice Utah will maintain clinical and service improvement projects and activities that relate to key measurements of quality and utilize data that is statistically valid, reliable, clearly defined and comparable over time. Performance measures provide a structured framework in which to target and concentrate organizational clinical and service efforts.

## PERFORMANCE IMPROVEMENT PROJECTS

Health Choice Utah identifies quality improvement opportunities through continuous quality monitoring that takes place in every department and through departmental sharing of ideas for performance improvement. Quality improvement opportunities are the result of input from internal and external sources; direction of the QMC; follow-up actions on previous projects, trends identified from clinical and service quality performance indicators, and analysis of age or gender specific diagnoses that occur frequently. Additional sources include member and provider satisfaction surveys, utilization management reports, provider profiling data, peer review, on-site reviews of providers, grievances and appeals data, and Medicaid performance measures and trends. Quality Improvement opportunities may range from those targeted as individual system improvements to those opportunities which are more ongoing and result in the development of a Performance Improvement Project (PIP). A PIP, initiated by Health Choice Utah, will measure performance in one or more focused areas; undertake system interventions to improve quality; and evaluate the effectiveness of those interventions. The project methodology includes: why the project topic was chosen, the impact that it is expected to have on Health Choice Utah members, what aspect of care the PIP addresses, and what data will be used for analysis of the project.

## QUALITY OF CARE AND SERVICE COMPLAINTS

Quality of Care and service complaints are researched, resolved and communicated back to the member through the QM Department. Potential quality of care issues and complaints, identified through referrals from internal and external sources, may range from a member's allegation that medical care did not meet their expectations to the identification of a potential deviation from the standard of care in the services rendered by a provider. All quality of care complaints are tracked in the QM database. Those incidents or trends that indicate serious safety, quality or utilization problems are immediately flagged to be addressed through Health Choice Utah's formalized peer review process. Resolution may include policy changes, education, process changes, monitoring or contract termination.

Health Choice Utah encourages reciprocal communication about quality of care issues with the Primary Care Physician. These issues may involve specific patient cases or systemic problems that are affecting

patient care. Concerns shall be directed to the Chief Medical Officer, the Medical Director(s) or the QM Department. As peer-reviewed information, these communications are protected and confidential.

The Health Choice Utah Quality Management Committee (QMC), chaired by the Health Choice Utah Chief Medical Officer or his or her designee, provides oversight for the QM and PI Programs and is responsible for the quality of care and peer review functions. Participating Physicians, representing a variety of medical specialties, serve on the Committee and are appointed by the Chief Medical Officer. If a provider issue is investigated by the QMC, and that particular specialty is not represented within the Committee, the QMC may consult on an ad hoc basis with a physician from that specialty.

The Health Choice Utah Quality Management Department strongly encourages a working relationship with providers and welcomes comments, questions, or suggestions. Participating Providers are able to participate and become engaged in quality improvement initiatives through involvement with the Health Plan's committees, participation in surveys, and directly on a face-to-face basis with the Health Choice Utah Provider Performance Representative, with the Chief Medical Officer/Medical Director, or both.

## CREDENTIALING AND RE-CREDENTIALING PROGRAM

The principle obligation of the Health Choice Utah Credentialing and Re-credentialing Program is to promote the delivery of quality healthcare services to covered members through the evaluation of the training and experience of participating healthcare providers. The Health Choice Utah Credentialing Program does not discriminate against any health care professional solely on the basis of the type of license, or on the basis of a health care professional servicing high risk populations or specializing in the treatment of costly conditions. The responsibility of credentialing and re-credentialing process oversight is delegated directly to the CMO, Medical Director, or both and to the Credentialing Committee, a subcommittee of the QMC. In order to provide a thorough assessment and reassessment of the qualifications of Health Choice Utah providers, the members of the Credentialing Committee have experience in and knowledge of the credentialing process and represent those medical and surgical specialties commonly found in the Health Choice Utah Network. The CMO, Medical Director, or both and Credentialing Committee or individual members of the Committee will consult with other providers, when necessary, for advice on the credentials of providers in specialties not represented on the committee or when additional peer review information is required.

Health Choice Utah requires that all providers who are not hospital or emergency services based, exempt from credentialing requirements, or who are not employees of a contracted facility or are members of a delegated entity, to complete a credentialing application. The application, depending upon the provider specialty, may require that the provider document the following information:

- Reasons for inability to perform the essential functions of the position, with or without accommodation;
- History of substance abuse, including illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitations of privileges or disciplinary activities;
- Attestation by the applicant of the correctness and completeness of the application;
- A copy of the current license to practice;

- A copy of a valid DEA certificate (if applicable);
- A copy of a current malpractice insurance liability certificate with a minimum of \$1 million/\$3 million coverage;
- A current curriculum vitae (CV);
- A copy of the Educational Commission for Foreign Medical Graduates (ECFMG) certification, if applicable;
- Written explanations regarding any sanction activity, malpractice judgments or settlements, restriction of privileges, etc.;
- Board certification, or if applicable, professional education if not board certified;
- Documentation of after-hours and on-call support providers.

All Health Choice Utah participating providers subject to credentialing requirements shall be re-credentialled at least once every 36 months in order to ensure their continued adherence to NCQA credentialing and quality standards.

The Credentialing Department will make a maximum of three attempts over a 60-day period to obtain re-credentialing information. Failure by the provider to submit the completed re-credentialing application following the third attempt will be considered a voluntary withdrawal of the application and may result in the provider not being retained in the Health Choice network.

In addition to the elements listed in the initial credentialing procedure and process, the Health Choice Utah re-credentialing process shall also include review of the following data:

- Quality or risk management issues in addition to an assessment of possible negative trends in the provider's activities;
- PCP's and primary care obstetrician,
- Physician panel size;
- Comparison of the provider's performance measures to their specialty averages and the plan average;
- Review of member complaints or grievances;
- Results of member satisfaction surveys or statements;
- Review of appointment availability surveys;
- Review of member PCP change trends;
- Review of general cooperation with Health Choice Utah staff,
- Compliance with policies and procedures and cooperation with other network participants.

In such cases, the QM file on the applicant will be carefully reviewed to ensure that large member panels are not compromising quality of care in any way. Approval of the re-credentialing file is for a 36 month period, or in the presence of any unusual history, approval for a shorter term or with appropriate limitations, restrictions, or supervision may be given. In the event that denial of the re-credentialing of a provider occurs, the provider may appeal the decision through the QM Appeals Process. Within 1 business day of the Credentialing Committee meeting, the Credentialing Coordinator will notify the Network Services Department Director of the Committee's credentialing decisions. The Network Services Department will notify the provider of the committee's decision within 60 days of notification from the Credentialing Coordinator.

## CREDENTIALING GUIDELINES FOR FAMILY MEDICINE PHYSICIANS PROVIDING OBSTETRICAL SERVICES

When granting the right to provide core obstetrical services to a family medicine physician the following requirements must be met:

- 1) The physician must have hospital privileges for the core obstetrical services for which the rights to provide have been requested.
  - a) Health Choice Utah will ensure that the hospital privileges have been granted and are unrestricted.
  - b) The physician must notify Health Choice Utah immediately when these hospital privileges are withdrawn, not renewed, or changed in any way.
- 2) The physician must provide proof of liability coverage for core obstetrical services.
- 3) The physician must provide a clear outline of the call coverage arrangements which have been made for their obstetrical patients.
- 4) The physician must acknowledge their understanding of the basic elements of the Health Choice guidelines for core obstetrical services for family medicine physicians, and they must agree to comply with the guidelines.
- 5) The physician must provide the name or names of the Board Certified OB/GYNs or Maternal Fetal Medicine specialists with whom they have an arrangement to provide immediate back up to them for obstetrical emergencies in the hospital. Health Choice will independently corroborate this coverage arrangement with the referenced obstetricians or specialists.
- 6) The physician must provide the name or names of the Board Certified OB/GYNs or Maternal Fetal Medicine specialists with whom they have a relationship and through which they may obtain consults regarding office and hospital patients. Health Choice will independently corroborate that these relationships exist.

## GUIDELINES FOR CORE OBSTETRICAL SERVICES PROVIDED BY FAMILY MEDICINE PHYSICIANS

Family Medicine Physicians may be granted the right to provide the following core obstetrical services:

- Pre-natal care and post-partum care for low-risk and uncomplicated pregnancies
- Uncomplicated vaginal delivery

Obstetrical consultation should be sought and referral of care should be initiated quickly when any high-risk issue develops. High-risk conditions and complications which are not part of the Core Obstetrical Services for Family Physicians include, but are not limited to:

- Ectopic pregnancy
- Incompetent cervix
- Isoimmunization
- Recurrent spontaneous abortion ( $\geq 3$ )
- Complicated vaginal delivery
- Cesarean section delivery

- History of delivery at < 36 weeks gestation
- History of intrauterine growth restriction
- Multiple gestation
- Mal-presentation
- Prior cesarean section
- Maternal age < 17 years
- Maternal medical conditions including:
  - Chronic hypertension;
  - Diabetes;
  - Renal disease;
  - Liver disease;
  - Heart disease;
  - Anorexia;
  - Morbid obesity;
  - Seizure disorder;
  - Other chronic illnesses
- Psychiatric illness
- Substance abuse
- Pregnancy Induced Hypertension
- Pre-eclampsia, eclampsia
- Preterm labor (<36 weeks)
- Preterm rupture of membranes (< 36 weeks)
- Placental abruption
- Intrauterine growth restriction
- Oligohydramnios
- Fetal malformation

## CREDENTIALING GUIDELINES FOR ADDITIONAL (BEYOND CORE) OBSTETRICAL SERVICES PROVIDED BY FAMILY MEDICINE PHYSICIANS

When granting to a family medicine physician the right to provide additional obstetrical services which are beyond those included in the Guidelines for Core Obstetrical Services the following requirements must be met:

- 1) The physician must have hospital privileges for the additional obstetrical services for which the rights to provide have been requested.
  - a) Health Choice will ensure that the hospital privileges have been granted and are unrestricted.
  - b) The physician must notify Health Choice immediately when these hospital privileges are withdrawn, not-renewed, or changed in any way.
- 2) The physician must provide proof of liability insurance coverage for the additional obstetrical services.
- 3) The physician must provide an obstetrical case list of all cases handled by the physician during the prior two years, **and** one of the following:
  - a) A letter certifying the physician's competency to perform the requested additional obstetrical services from an accredited residency; or

- b) A letter certifying the physician's competency to perform the requested additional obstetrical services from a board certified obstetrician or maternal fetal medicine specialist on staff at the hospital where the services will be provided; or
- c) A letter certifying the physician's competency to perform the requested additional obstetrical services from a board certified obstetrician or maternal fetal medicine specialist who is a Health Choice Utah Participating Provider; or
- d) If a, b, or c above are not producible then the physician will participate in an interview with a Health Choice Utah director or appointee who is a board certified obstetrician or maternal fetal medicine specialist to determine competency to perform the requested additional obstetrical services.

Health Choice will take measures to determine that the physician has had appropriate training and sufficient experience to assure competency to perform the services requested.

## PEER REVIEW

The Peer Review Program is designed to develop, implement and evaluate required peer review activities regarding health care delivery issues that affect Health Choice Utah's members and participating providers. Member safety and quality medical care are the central goals underlying all peer review activities. Peer review is conducted using evidence-based guidelines, when available, or nationally accepted practice parameters. Specific provider concerns as well as global provider network issues are addressed by Health Choice Utah through this peer review process.

Any quality deficiency or omission of care or service by a provider is subject to peer review. Referrals of potential peer review issues to QM may be initiated by external sources or by any internal Health Choice Utah department. Internal sources include Health Choice Utah department staff members who identify potential problems in the course of daily operations, member or provider appeals, Health Choice Utah medical committees, provider profiling reports, on-site provider reviews and utilization management reports. Internal peer review referrals are sent to the QM department on a grievance/complaint form and include supporting documentation such as utilization reports, excerpts of medical progress notes, or other pertinent documents as available. External sources include state and federal agencies, media reports, other providers, members, member representatives, advocates and caregivers. Information from external sources may be received by Health Choice Utah via a letter, phone calls directly to the Chief Medical Officer, Medical Director, or both, or secure email.

Health Choice Utah also utilizes peer review processes in contracting and credentialing decisions. Peer review is conducted as part of the monthly Credentialing and Re-credentialing Committee meeting. The Committee investigates cases involving Providers that may significantly affect the safety and quality of care provided to members. If additional expertise is required for a specific peer review case, other specialists are brought in on an ad hoc basis. Then, based upon its investigation, the Committee may recommend one or more of the following actions:

- Make a recommendation for corrective action which may include additional education
- Request an outside consultation with a provider in the same specialty (if one is not on the committee) prior to making a recommendation

- Request additional information
- Request that the provider develop and implement a corrective action plan addressing the specific issues necessary to improve the quality of care provided to Health Choice Utah members
- Reduce, restrict, suspend, terminate or not renew the provider's credentials necessary to treat members as a participating provider of Health Choice Utah
- Recommend other actions necessary to adequately evaluate the issue and recommend appropriate action

The Committee is responsible for reporting quality issues and Health Choice Utah actions regarding these issues, as required or allowed by law, to the appropriate authorities including but not limited to the Physician Licensing Boards, National Practitioner

Data Bank, and the Utah Department of Health Medicaid Administration. Under the Chief Medical Officer/Medical Director's direction, agencies will be notified of the QMC Executive peer review session's decision regarding adverse actions. However, no issue or action is reported until the appeals process is exhausted.

Results of peer review activities and of the Committee's recommendations and actions are documented in the provider's file. The actions of the Committee are communicated to all appropriate Health Choice Utah staff to ensure that contracting and credentialing decisions are timely and accurate to ensure the highest quality medical care for members.

The formal peer review process at Health Choice Utah is accomplished by evaluating the clinical activities and qualifications of providers through the efforts of the QM Department and other review committees of Health Choice Utah. If an adverse action is taken against a provider as a result of the peer review process, the provider has certain rights pursuant to Health Choice Utah policy. The provider has the right to appeal:

- Any adverse action that is disputed by the provider in question may be appealed. This option shall be communicated to the provider via a certified letter from the Chief Medical Officer. The letter shall state the adverse action and the basis for the finding. The provider may appeal such actions by sending a letter to the Health Choice Utah Chief Medical Officer and requesting commencement of the appeals process.
- If the provider chooses to appeal the adverse action, an ad hoc appeals committee consisting of three (3) providers who are certified to practice in the same specialty shall be appointed to hear the provider's appeal and all evidence presented. This committee will review all information and make a formal recommendation regarding the appeal. The details of this process are available and shall be communicated to the provider upon notification of the adverse action.

## MEDICAL RECORD GUIDELINES

Providers are required to maintain medical records in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. The provider must ensure that

records are accessible to authorized persons only. Medical records must be available to Health Choice Utah for purposes of quality review or other administrative requirements.

Adequate medical records are defined as being legible and containing sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and warnings provided to the patient, and provide for another practitioner to assume continuity of the patient's care at any point in the course of treatment, if needed.

All information in the medical record and information received from other providers must be kept confidential. The PCP is responsible for ensuring that a medical record is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of actually establishing a medical record, but must be associated with the member's medical record as soon as one is established.

In order to strengthen the effectiveness of the QM Program and the members' health care, Health Choice Utah supports the National Committee for Quality Assurance (NCQA) standards for medical records. These are the minimum standards acceptable for medical record documentation within Health Choice Utah's contracted network of primary care physicians, primary care obstetricians and high volume specialists.

Providers should ensure appropriate supervision of services provided by persons other than the contracted provider as required by Utah State law.

Each visit must be documented in the medical record to support the diagnosis and to justify treatment.

Medical record documentation must include the following:

- Member name, Medicaid ID number, or both on every page;
- Records are organized and kept confidential;
- Personal information including:
  - Age
  - Gender
  - Date of birth
  - Marital status
  - Home address
  - Work and home telephone numbers
  - Medicaid identification number
  - Next of kin, and if applicable, guardian or authorized representative
- Legible writing in blue or black ink, dated and signed or initialed for each entry to identify the writer. Electronic format records must also include the date and name of the provider who made the entry;
- Documentation in the member's record showing supervision by a licensed professional who is authorized by the licensing authority to provide the supervision, whenever health care assistants are allowed to provide services;
- Clear identification of all revisions and errors. The use of whiteout is not allowed. The stricken information must be lined out, initialed, and dated by the person altering the record. If kept in an

electronic file, the provider must establish a method for indicating the initiator of information and a means to assure that information is not altered inadvertently. A system must be in place to track when, and by whom, revisions to information are made. A backup system including initial and revised information must be maintained;

- Significant illnesses and medical conditions are noted on the problem list;
- A health maintenance flow sheet must be included if there is no known medical illness or condition;
- A clear medication record
- A list of allergies and adverse reactions to medications or the absence thereof (“no known allergies”) must be noted prominently and in a uniform location;
- An initial member history including family medical history, social history and preventive laboratory screenings. The initial history for members under age 21 should also include maternal prenatal care;
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, hospitalizations, surgeries, and emergent or urgent care received.
- Documentation of tobacco, alcohol, and substance abuse history (for members age 12 and above);
- Immunization records for children. An immunization record is recommended for adult members as well;
- An appropriate subjective history including an appropriate review of systems and an assessment of member’s behavioral health needs.
- A complete physical exam must document appropriate objective information for presenting complaints.
- Any laboratory, imaging and/or other studies ordered as appropriate;
- Documentation, records and reports that have been initiated by the provider to indicate provider review of diagnostic information including:
  - Laboratory tests and screenings
  - Radiology reports
  - Physical exam notes and other pertinent data
  - Reports from referrals and other consultations and specialists
  - Emergency and urgent care reports
  - Hospital/LTC facility discharge summaries
  - Behavioral health history, and behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member’s health status changes or new medications are prescribed.
- Working diagnoses that are consistent with findings noted in each progress note;
- Plans of actions and treatments that are consistent with diagnoses;
- Documentation of preventative medicine and wellness education, including family planning counseling, if appropriate (see next section);
- Documentation of preventative services through age 20 years as appropriate;
- Recommendations and instructions to members including return office visits;
- Follow up care, calls, or visits noted on encounter forms;
- Documentation of nutritional assessment when member has a debilitating disease affected by nutritional needs;
- Documentation that problems unresolved from previous office visits are addressed in subsequent visits;

- Documentation of referrals to appropriate medical and behavioral health consultants, including consultation notes with appropriate documentation demonstrating continuity of care with pertinent laboratory and imaging study results.
- Documentation related to the transmittal of diagnostic treatment and disposition information to the PCP and other providers as appropriate.
- Records of prescriptions for medications or medical supplies;
- Records of any information or chart transfer, including member's authorization to release records and evidence of such transfer;
- Documentation of any advanced directives have been discussed with the patient and whether or not the advanced directives have been executed;
- Dental history,;
- Documentation that reflects diagnostic, treatment, and disposition information related to a specific member was transmitted to the PCP and other providers as appropriate to promote continuity of care and quality management of the member's health care;
- A risk assessment tool for obstetric patients. This tool from ACOG (the American College of Obstetrics and Gynecology) must be completed by practitioners providing obstetric care.

## HEALTH EDUCATION AND PREVENTATIVE SERVICES

Health education, preventative services recommendations and wellness counseling should be clearly noted and incorporated in the progress notes or in a designated section.

These services should be documented as applicable and based on the most recent evidence and guidelines:

- Annual Well Visit
- Cervical cancer screening
- Mammogram and other breast cancer screening and diagnostics
- Prostate cancer screening
- Alcohol use, tobacco use, and substance abuse screening and counseling
- Exercise counseling
- Addressing nutritional status including body mass index (BMI) and significant deviations
- Immunizations
- Family planning counseling.
- Children Dental Visits
- Colorectal Cancer Screening
- Diabetics: Retinal Eye Exams
- Diabetics: glucose and hemoglobin A1c records
- Diabetics: Monitoring for Nephropathy (urine microalbuminuria, creatinine clearance)
- Medication Adherence
- ED Utilization
- Medication Review and Reconciliation
- Osteoporosis Screening and Management

## PREVENTIVE HEALTH SCREENING GUIDELINES

Health Choice Utah is committed to promoting prevention and wellness and encouraging the application of evidence-based, nationally accepted standards of care. Health Choice Utah regularly reviews and incorporates these standards to prevent and manage multiple diseases. These practice guidelines can be found in the Provider Portal or by calling your Network Representative.

Ongoing updates are communicated to providers via the Health Choice Utah Provider Newsletter, website or in special mailings.

## DISEASE MANAGEMENT PROGRAMS

In an effort to improve the health status of those members assigned to Health Choice Utah, the following ongoing disease management programs are available:

- Asthma
- COPD
- Diabetes
- Hepatitis C
- HIV
- Hypertension

Providers are encouraged to utilize the Health Choice Utah Case Management Referral Form for help in managing members who require additional assistance (i.e. HIV and/or Hepatitis C) or phone Health Choice Utah case managers at 1-877-358-8797 to refer a member for assistance.

## SENTINEL EVENTS

A Sentinel Event is any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Such events are called “sentinel” as they signal the need for immediate investigation and response. These events must be reported immediately to your Health Choice Utah Provider Performance Representative, the Health Choice Utah Quality Management Department or Health Choice Utah management.

# CHAPTER 6:

## AUTHORIZATIONS AND REFERRALS

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*Original Date: November 2011*

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### OVERVIEW

The Primary Care Physician (PCP) is ideally the first and most consistent physician relationship that patients have. PCPs are capable of providing most routine medically necessary healthcare services to patients. Referrals to specialists should be made after consultation with the PCP to ensure correct management and continuity of care. The medical necessity of referrals, determined by the Health Choice Utah Chief Medical Officer, Medical Director, or their designees, are informed by nationally recognized, evidence-based standards of care within the Medicaid Program benefits coverage certificate.

Accurate and prompt medical necessity determinations depend on the quality and comprehensive content of medical documentation that Health Choice Utah (or its delegated entities) receives with each request. An effective review process depends on a provider's efforts to submit request and records in a timely manner. Health Choice Utah is committed to making the prior authorization process as efficient and simple as possible.

### MEDICAL PRIOR AUTHORIZATIONS AND MEMBER REFERRALS

For a complete listing of services which require Prior Authorization (PA) please refer to our website (<http://www.healthchoiceutah.com/docs/providers/PriorAuthorizationGuidelines.pdf>) These requirements can also serve as a reference guide and otherwise answer many questions which may arise but which are not directly referred to in the chapter text.

**Please follow these key steps when requesting a medically necessary prior authorization:**

- 1) Offices must legibly complete all necessary fields of the most current Health Choice Utah Prior Authorization Request Form. The most current Health Choice Utah PA forms are available through your Health Choice Utah Network Provider representative or can be accessed online at: <http://www.healthchoiceutah.com/docs/providers/forms/MedicalPriorAuthorizationForm.pdf>
- 2) Offices must include accurate ICD-10 or successor codes which support the request, and must provide specific CPT codes and HCPCS codes.
- 3) Offices should only request PA for services listed on the Health Choice Utah Prior Authorization Requirements Grid as requiring PA.

- 4) Offices must include all necessary documentation to support medical necessity in order to avoid unnecessary denials or inappropriate delays in the medical review/approval process.
- 5) Offices must clearly indicate in the check boxes provided on the Health Choice Utah PA forms whether the request is “Standard” or “Expedited” (see below for details). Offices must not abuse Expedited service requests. Inappropriate “Expedited” requests result in slower response times for truly urgent medical authorizations from all network providers. Inappropriate “Expedited” requests will be downgraded to “Standard” by Health Choice Utah, based on the Utah Medicaid Program’s definition. Standard requests may take up to 14 calendar days to complete.
- 6) Offices must fax the Health Choice Utah Prior Authorization Request Form (24 hours a day/7 days per week) to the appropriate Health Choice Utah fax number. Health Choice Utah has designated fax numbers for provider Prior Authorization requests. The office should confirm the fax receipt and this confirmation record should be kept for your documentation.

➤ *Health Choice Utah Medical PA Fax Line 1-877-358-8793*

#### NOTE:

- Receipt of an authorization from Health Choice Utah does not guarantee payment of services. The claim must be billed correctly and timely.
- Services rendered must be covered under the Utah Medicaid program.
- The member must be determined to be eligible on the date of service. Medicaid is generally the payer of last resort, and primary insurance, other credible coverage, or both must be billed first, regardless of primary benefit coverage.
- Only one medical service may be requested per PA form.
- All Out of Network (OON) providers require prior authorization. OON providers should only be requested because of a compelling medical need. (e.g. location and availability of services)
- Health Choice Utah does not require Prior Authorization of Emergency Services.
- Health Choice Utah does not pay for experimental or investigational services.

## TIME FRAMES FOR HEALTH CHOICE UTAH PRIOR AUTHORIZATION REVIEW

../ **“Standard”**: Up to 14 calendar days — Standard means a request for which a Contractor must provide a decision as expeditiously as the member’s health condition requires, but not later than 14 calendar days following receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member’s best interest.” PA department will provide their best efforts to complete the standard request before the 14 calendar days.

../ **“Expedited”**: 3 business days — Expedited means a request for which a provider indicates or a Contractor determines that using the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as

expeditiously as the member's health condition requires no later than three business days following the receipt of the authorization request, with possible extension of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest."

## PRIOR AUTHORIZATION DETERMINATIONS

Authorizations which are correctly submitted to Health Choice Utah will be processed and completed in one of the following standard methods:

1) **Approved**

The information received met all Health Choice Utah requirements, and authorization is granted. No further action is required by the office except to notify the member or facility and facilitate the member in obtaining the approved services.

2) **Denied**

The information received did not meet all Health Choice Utah requirements, and authorization is not granted. The requesting Provider and the member will receive a denial notification letter.

3) **14-day Extension:**

a) In some instances where PA has been requested, the documentation received by Health Choice Utah may suggest that medical necessity for the service exists but the records provided are insufficient to render an authorization. When this occurs, additional information may be requested via fax or direct phone contact. When additional information cannot be obtained, Health Choice Utah will issue a "14-day Extension" letter to both the member and the requesting provider.

b) This 14-day extension will afford both Health Choice Utah and the requesting Provider up to 14 additional calendar days to obtain the additional information necessary to render a final determination. If, at the end of the 14-day Extension, Health Choice Utah has not received the necessary additional information, the request will be denied, and both the provider and member will be notified.

c) **Note:** In no case will the Health Choice Utah decision be issued any later than a total of 28 days for Standard requests, or 17 days for Expedited requests, from the date the PA request was received.

4) **Reduction**

The information received met all Health Choice Utah medical necessity requirements, and a partial authorization is granted. Requested services may be reduced when the documentation provided does not support the full amount, duration, scope of service, or any combination of the three at the time of request.

5) If Health Choice Utah does not respond to the authorization request within the required timeframe, the request is considered "denied", as stated above.

## SUPPORTING DOCUMENTATION

Documentation of medical necessity must accompany all requests for prior authorization. For most PA requests, supporting documentation should include:

- Current diagnosis and treatment already provided by the PCP or requesting provider;
- All pertinent medical history and physical examination findings;
- Diagnostic imaging and laboratory reports (if applicable);
- Indications for the procedure or service;
- Alternative treatments, risks and benefits (including evidence of such discussions with patient);
- For Out-of-Network (OON) providers, facilities, or services, specific information which explains the medical necessity for an OON service is required. PA is required in order for any service to be covered by OON providers or facilities.

## AUTHORIZATION DENIALS

Members must be notified of a denial of service request within three (3) business days for Expedited requests, and within 14 calendar days for Standard requests (excluding situations in which a 14-days extension is exercised). When a denial is issued, the health plan must inform the member of the denial of service and the reason for denial in clearly understood language in the form of a “Notice of Action” (NOA) letter. Please be aware that UDOH requires NOA letters to communicate the basis for a denial in ‘easily understood’ language. Therefore NOA letters will be written in a simple fashion in order to comply with this specific agency requirement. For more information about what a member can do if they receive an NOA, please see Chapter 9.

Written information which communicates a denial of service will also be sent to the requesting Provider (or their designee). Provider denial letters are sent to the physician or facility who initiated the request for prior authorization and will contain varying degrees of detail in order to explain the basis for denial.

### **Special considerations and information regarding Medical Prior Authorizations:**

- The Primary Care Physician (PCP) should initiate the referral process. Specialists should not generally refer directly to other specialists. Although this practice is not expressly prohibited, it may fragment care coordination performed by the PCP and reduce the capacity of the PCP to provide a ‘Medical Home’ for your patient.
- Health Choice Utah members should be instructed not to self-refer to specialists without the express recommendation of their PCP.
- Health Choice Utah will provide notice of approval or denial within the allowable time frames via fax, phone, or both to the requesting provider.
- If the service required prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied.
- The authorization number or denial should be noted in the member medical record.
- Prior Authorization approval number(s) should be provided by the requesting provider to the specialist, facility, or vendor prior to the member’s appointment.

- Specialists, facilities, and vendors are responsible to ensure that necessary authorizations have been issued prior to rendering service.
- The PCP (or ordering provider) is responsible to facilitate coordination of care and assist or alert the member to make the necessary appointments for approved services.
- When difficulty arises in coordinating or facilitating care, the referring provider should contact the plan for additional assistance.
- Authorization is not a guarantee of payment for services.
- Authorizations are valid for 90 days, unless otherwise specified.
- Contracted health professionals, hospitals, and other providers are required to comply with Health Choice Utah Prior Authorization policies and procedures.

## RETROSPECTIVE PRIOR AUTHORIZATIONS

Health Choice Utah requires that prior authorization be obtained for some non-emergent and non-urgent services, as defined by this Chapter and the Health Choice Utah PA Grid. Health Choice Utah does not generally entertain requests for ‘retro’ prior authorization as these are, by definition, contradictory. It is the responsibility of the Provider or Facility rendering care to verify insurance eligibility as well as benefit coverage, authorization requirements and status.

**Exception:** In the event that PA is not obtained, and a non-authorized service is rendered as a direct result of an urgent or emergent medical condition, the Health Choice Utah Medical Services Department (or its designated subcontractors) will accept submission for “Prior Authorization” within three (3) business days of when the service was rendered. The request should be accompanied by medical documentation to support PA of the service and documentation to support that the service rendered was required on an urgent or emergent basis.

An exception will also be allowed for retroactive eligibility enrollment.

All other forms of “Retro” PA will be entered into the health plan claims and medical management information system and deemed **cancelled** at the time they are processed. There are no defined Medicaid time-frames or requirements for processing **retrospective** prior- authorization requests where services have already been provided to the Health Choice Utah member.

### **Health Choice Utah uses the following protocol to resolve informal reconsiderations regarding authorizations:**

- The requesting provider may resubmit a new PA request with new or additional information pertinent to the original non-authorized request to the Prior Authorization Department.

**Please Note:** Requests should only be resubmitted to the Health Choice Utah PA Department if new or additional pertinent information is being provided with the resubmission.

- The original information (denial packet) will be retrieved from storage, when possible, and combined with the current request which contains new or additional information, and will be presented to the Health Choice Utah Chief Medical Officer, Medical Director, or their designee for reconsideration.

- If no new or additional information is received, the resubmitted request will be **cancelled (C)** and the office notified by telephone or facsimile. New or additional information is needed to constitute a new PA request. If the member wishes to file a formal appeal on a denied authorization, please refer them to their Member Handbook, Member Services, or Chapter 9 of this Manual for details.

## PROVIDER PORTAL

For assistance, the Provider area of the Health Choice Utah website directs registered provider offices to log in to the Health Choice Utah Provider Portal and use helpful features, such as checking:

- Claims status;
- Prior Authorization status;
- Member eligibility;

Health Choice Utah Prior Authorization Clinical Review Criteria (PA CRC) Guidelines in order to give providers the information that they need to complete a successful a prior authorization.

The Provider Portal will soon allow offices to submit a PA Form for “Standard” service requests online and get immediate feedback of plan receipt. Instructions will be provided on how to submit supporting documentation via fax until such time that Health Choice Utah can also accept online submission of electronic or scanned medical records.

## HOSPITAL SERVICES

All facility admissions including, but not limited to, Acute Inpatient, Observation status, Rehabilitation, Long Term Care, and Skilled Nursing admissions require prior authorization.

Facilities must notify Health Choice Utah and obtain an authorization prior to, or at the time of, all admissions. Plan authorization and notification is accepted and approved by the Health Choice Utah Medical Services PA Department.

In the event that acute inpatient hospitalization services delivered are to evaluate and stabilize an emergency medical condition, concurrent plan notification and authorization is not required for payment for medically necessary, Medicaid-covered services. However, the plan must be notified of emergent inpatient services within 2 business days of emergent member presentation. Health Choice Utah strongly recommends that plan notification from the facility occur as quickly as possible to help guarantee full coverage of medical services rendered.

**Note:** For pre-planned, medically reviewed or prior-authorized admissions, the facility must fax notification to Health Choice Utah PA Department at the time of admission to activate the authorization number when the member presents for admission to the facility. For procedures not requiring prior authorization and done at a contracted facility by a contracted provider, no notification is needed.

## OBSTETRICAL (OB) SERVICES

No Prior Authorization is required for obstetrical services. Health Choice Utah Health Services Department provides support for all pregnant members that need care coordination assistance or that meet high risk Case Management criteria. An OB Registered Nurse is available by phone during office hours.

The contact information for the OB RN will be given to each member who is identified as pregnant and eligible for benefits through Health Choice Utah. In order to identify high risk indicators among the Health Choice pregnant population it is critical that the members visit their provider as early as possible. Our Health Choice Utah staff is available to support the Obstetrician and office staff in the effort to bring about a healthy and safe pregnancy outcome for both mother and baby.

During the pregnancy period, the member should receive Primary Care services as directed by the obstetrical provider who acts as their **Primary Care Obstetrician (PCO)**. During the period of the pregnancy, the PCO is responsible for directing medically necessary care for the Member. Should the member require services which are specifically excluded from the Global OB package, it is the responsibility of the obstetrician to obtain any necessary authorizations and coordinate with the member's PCP in order for the member to receive the requested services. Reimbursement for obstetrical services provided through the term of the pregnancy is dictated by contract and the Global OB reimbursement methodology.

Contracted Health Choice Utah Obstetrics Providers are required to meet minimum appointment availability standards. **The obstetrician must make a 'best effort' to expedite the earliest entry into prenatal care for all members and see all postpartum visits within 6 weeks of delivery.**

The following minimum time frames must be met for successful early entry into prenatal care by appointment availability standards:

- If the patient is in her 1st trimester – Appointment within 14 days of contacting the office.
- If the patient is in her 2nd trimester – Appointment within 7 days of contacting the office.
- If the patient is in her 3rd trimester – Appointment within 3 days of contacting the office.
- High risk pregnancies – Appointment within 3 days of identification of high risk condition by Health Choice Utah or the PCO, or immediately if an emergency condition exists.

## IMPORTANT NOTICE TO ALL HEALTH CHOICE UTAH PROVIDERS

Participating providers must hold the member, Health Choice Utah, and UDOH harmless if coverage is denied for failure to adhere to the Health Choice Utah prior authorization and referral guidelines as outlined in this Chapter

# CHAPTER 7:

## GENERAL BILLING RULES

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*Original Date: November 2011*  
*Revision Date: April 2016*  
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### GENERAL INFORMATION

This chapter contains general information related to Health Choice Utah's billing rules and requirements.

In addition to Medicare requirements, Health Choice Utah follows the coding standards described in the **Uniform Billing Manual; Classification of Disease, (current ICD-10) Manual**; current editions of the **AMA Current Procedural Terminology (CPT) Manual** and **CMS Common Procedure Coding System (HCPCS II) Manual**; and the **First Data Bank Blue Book** for pharmacy information.

### NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI)

Providers currently contracted with Health Choice Utah can submit their NPI number to the Health Choice Utah Network Services Department. To submit the NPI number, providers can mail or fax a copy of their NPI notification to:

Health Choice Utah  
406 W South Jordan Parkway, Ste 600  
South Jordan, UT 84095  
Fax: 801-758-3120

The documentation must include the provider's name and signature. NPI Numbers will also be accepted via written notification mailed or faxed to the address or fax number listed above.

### CLAIM SUBMISSION REQUIREMENTS

Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or not submitted on the correct form will be returned to the provider without processing. If you receive a returned claim, the provider must re-file a legible copy of the claim on the correct claim form type and it must be re-filed within the appropriate time frame.

## Mailing Address for Paper Claims

Health Choice Utah  
Claims Department  
410 N 44th St, Ste 500  
Phoenix, AZ 85008

## ELECTRONIC BILLING / HEALTH CHOICE UTAH WEBSITE

Health Choice Utah encourages you to send claims electronically. There are two methods by which this can be accomplished:

- Send claims directly from your office to UHIN or Emdeon (WebMD)
- Send claims from your clearinghouse to our clearinghouse, Emdeon

*Health Choice Utah ECSID (Electronic Payer ID): 45399*

Health Choice Utah has a claims module within the secure provider portal of our web site, <http://www.healthchoiceutah.com>. This claims module allows our providers to upload their HIPAA Compliant ASC X12N 837 Health Care Claims directly to Health Choice Utah. This will expedite the claims submission process significantly. If you choose to use this method of submission, please contact your Provider Performance Representative.

## CLAIM SUBMISSION TIME FRAMES

All claims must be submitted within twelve (12) months of the date of service (or date of discharge in the case of an inpatient stay). Claims received outside these time limits will be denied.

## PROMPT PAY

Health Choice Utah adjudicates claims that include all information necessary for processing (i.e., a "clean claim") within thirty (30) days or less of receipt. UDOH defines a clean claim as one that may be processed without obtaining additional information from the provider of service or from a third party. Claims that require review for medical necessity or claims that are under investigation for fraud and abuse are not considered clean claims.

## GENERAL BILLING RULES

Billing must follow completion of service delivery. A claim may cover a time span over which services were provided, but the last date of service billed must be prior to or on the same date that the claim is signed.

### Billing multiple units:

- If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form with the appropriate number of units.
- The units field is used to specify the number of times the procedure was performed on the date of service.
- The total billed charge is the unit charge multiplied by the number of units.
- By law, Medicaid has liability for payment of benefits after all other third party payers, including Medicare.
- Providers must determine the extent of third party coverage and bill all third party payers prior to billing Health Choice Utah.

### Emergency services claims:

- All claims are considered non-emergent and subject to applicable prior authorization unless the provider clearly identifies the service billed on the claim form as an emergency.
- On the UB claim form, the Admit Type must be “1” (emergency) or “4” (newborn) on all emergency inpatient and outpatient claims.
- All other Admit Types, including a “2” (urgent), designate the claim as non-emergent.
- On the CMS 1500 claim form, Field 24I must be marked to indicate that the service billed on a particular claim line was an emergency or the place of service that the procedure was billed with must be “23” for emergency room or “20” for urgent care facility.

### Recoupment:

- Under certain circumstances, Health Choice Utah may find it necessary to recoup or take back money previously paid to a provider.
- Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupment.
- Upon completion of the recoupment, Health Choice Utah will send a remittance advice explaining the action, date of action, member, date of service, date of original remittance advice, and reason for recoupment.

## RESUBMISSIONS, ADJUSTMENTS, AND VOIDS

Providers must resubmit requested documentation on all claim submissions. Many claim submissions do not require records.

Resubmitting a denied CMS 1500 claim or requesting adjustment to a previously paid claim:

- Write or stamp the word “resubmission” and enter the claim reference number found on the remittance advice (CRN) of the denied claim in the field labeled "Original Ref.No."
- Resubmit the claim in its entirety, including all original lines if the claim contained more than one line. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

- **Example:** Provider submits a three-line claim. Lines 1 and 3 are paid, but Line 2 is denied. When resubmitting the claim, the provider should resubmit all three lines. If only Line 2 is resubmitted, it will be determined that lines one and three were submitted in error and they will be recouped.

Resubmitting a denied UB claim or requesting adjustment to a previously paid claim:

- Write the word “Resubmission” and the CRN of the denied claim in the “Remarks” field (Field 84). Any other hand written information or corrections on the UB form is not accepted and will be denied with remark code, HU - Handwriting not allowed on UB04 Claims.
- Use the appropriate bill type to indicate a replacement claim.

## OVERPAYMENTS

A provider must notify Health Choice Utah of an overpayment on a claim by submitting an adjustment to the paid claim. Providers can also send a letter, copy of the claim and EOB to the plan indicating that an overpayment has occurred. Providers should attach documentation substantiating the overpayment.

## DOCUMENTATION REQUIREMENTS

Medical Review is performed to determine if services are provided according to the UDOH and Health Choice Utah policy related to medical necessity and emergency services. Claims may also be sent to Health Choice Utah Medical Review when there are questions on coding, high levels of care, risk issues, minimal or no authorizations, etc.

In order for Medical Review to take place, providers may be required to include specific documentation when the claim is submitted. This documentation is necessary to allow the Health Choice Utah Medical Review staff to determine whether services provided fall within the stated policy. If no documentation is submitted with the claim, the claim will be denied with a denial reason indicating what documentation is required. The denial codes are communicated to the provider on the remittance advice.

## BILLING ON A CMS 1500 FORM

The CMS 1500 claim form is used to bill for non-facility services, including professional services, freestanding surgery centers, durable medical equipment, ambulatory surgery centers, and independent laboratories. Providers must follow Utah Medicaid CMS 1500 claim form guidelines as specified on the Utah Health Information Network website ([www.uhin.org](http://www.uhin.org))

## SUCCESSFUL CMS 1500 CLAIM SUBMISSION TIPS

### Format

- Do not print, hand-write, or stamp any extraneous data on the form.
- No hand-written corrections, and no highlighting.
- Enter all information on the same horizontal plane within the designated field.

- Ensure data is in the appropriate field and does not overlap into other fields.
- Use individual's name in the provider signature field, not a facility or practice name.

### Accurate Information is Key

- Put member's name and ID numbers as it appears on member card.
- Include all applicable NPI numbers.
- Indicate the correct address, including zip code, where service was rendered. Ensure that the correct address was reported to the Health Choice Utah Provider Performance Representative and added to the Health Choice Utah provider database.
- Ensure that the # of units and days and the dates of service range are not contradictory.
- Ensure that the quantity indicated in the procedure codes description is not contradictory.

### Coding Tips:

- Use current valid ICD-10 diagnosis codes and code them to the highest level of specificity (maximum number of digits) available.
  - Primary diagnosis
    - The primary diagnosis should describe the main condition or symptom of the patient.
    - For inpatient services, the primary diagnosis is the condition which was determined to be chiefly responsible for the inpatient stay, usually the discharge diagnosis.
  - Secondary or Additional Diagnosis
    - This field should be used if there is a secondary condition or additional conditions and symptoms that affect the treatment.
    - It is important that the secondary or additional diagnosis be indicated on inpatient stays when the length of stay or ancillary services has been affected.
    - Diagnoses which relate to a previous illness and which have no bearing on the current encounter should not be reported.
- The number of anesthesia minutes should always be reported on each claim in Field 24G.
- Use current valid CPT and HCPCS codes.
- Use current valid modifiers when necessary.
- DSM-5 diagnosis codes and behavioral health services are not covered.

## BILLING ON A UB FORM

The UB claim form is used to bill for all hospital inpatient, outpatient, emergency room services, dialysis center, nursing home, free-standing birthing center, residential treatment center, and hospice services. Providers should follow Utah Medicaid UB claim form guidelines as specified on the Utah Health Information Network website ([www.uhin.org](http://www.uhin.org))

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.

- Revenue codes also must be valid for the bill type on the claim. For example, hospice revenue codes 0651, 0652, 0655, and 0656 can only be billed on a UB with a bill type 81X-82X (Special Facility Hospice).
- ICD-10 diagnosis codes or their successor are required and must be valid on the date of admission.
- ICD-10 procedure codes or their successor must be used to identify surgical procedures billed on the UB for inpatient services.
- CPT/HCPCS and modifiers (as appropriate) must be used in combination with revenue codes to identify services rendered on the UB for outpatient services.

The pay to and practice addresses on the claim form must match the information in the Health Choice Utah claims payment system. Your network services representative can assist with corrections if needed.

## DOCUMENTATION REQUIREMENTS

Providers must include all required documentation with the claim submission. Failure to do so may result in denial of the claim. Health Choice Utah reserves the right to request additional documentation of the claim.

All pertinent records are required for the following:

- Weekend admit or discharge
- Out-of-state claims
- Authorization on file does not match services being billed

# CHAPTER 8:

## UNDERSTANDING THE REMITTANCE ADVICE

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### GENERAL INFORMATION

A Remittance Advice (RA) is sent so that you receive it within a few days of receiving your Electronic Funds Transfer (EFT) for claims payment with each payment cycle. The paper RA is mailed to the billing provider.

If you would prefer an Electronic Remittance Advice (ERA), please contact your Health Choice Utah Provider Performance Representative or your clearinghouse representative to be set up on an ERA schedule. ERAs are available in HIPAA-compliant format. You may also download a PDF version of the paper RA through our Provider Portal on the Health Choice Utah website. See Chapter 1 for more information about the Provider Portal.

Providers should routinely review and reconcile their accounts receivable to all remittance advices. Each RA will contain a payment status or reason for denial. All claims adjudicated during the processing cycle are listed on the RA along with the payment status or reason for denial. The provider should use the RA in order to identify reasons for denial(s) and to determine whether to resubmit the claim or take alternative action.

If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each.

### REMITTANCE ADVICE

Each paper RA contains the following information:

- Paid claims
- Adjusted claims
- Denied claims

The last page provides an alphabetical listing of denial reason codes and pricing explanation codes. Each code is listed only once, even if it applies to multiple claims.

Information reported on the paper RA page includes:

- Billing provider ID number

- Check date
- Invoice number, which links payments to the services that generated the payment
- Service code
- Quantity billed
- Amount billed
- Excluded and non-allowed amounts
- Allowed amount
- Amount of other payer's payment
- Member co-pay amount
- Contractual write off amount
- Amount paid
- Adjustment code, denial code, or both
- Health Choice Utah Claims Reference Number (CRN), which is unique to each claim

## REVIEWING REMITTANCE ADVICE

Here are some suggestions for reviewing the Health Choice Utah Remittance Advice to reconcile claims billed to the Health Choice Utah Claims Department and the status of those claims:

- Review the RA to determine which claims have been paid and whether the claims were paid correctly. Any errors, such as claims that have not paid the correct number of units, should be marked for resubmission, noting associated CRNs. (See Chapter 7, for information on resubmitting a paid claim.)
- Review the RA to determine if any claims submitted by the provider as adjustments are adjusted correctly. If problems still exist with a claim, it may be submitted again.
- Review the RA for any claims that were recouped. There are many reasons a claim payment may be recouped. These may be claims that should have been paid by other insurance and now need to be corrected so that Health Choice Utah can pay as secondary. The RA will also report any claims that were recouped by Health Choice Utah as a result of an audit or medical review decision.
- Review the RA for denied services. Review each denial reason and determine the action necessary to correct the claim. (See Chapter 7 for information on resubmitting a denied claim.)

Providers who have questions about the Remittance Advice or about resubmitting, adjusting, or voiding a claim should contact the Health Choice Utah Claims Resolution Services Unit at 1-877-358-8797

# CHAPTER 9:

## APPEALS

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*Original Date: November 2011*  
*Revision Date: April 2016*  
*Effective Date: July 1, 2016*

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### CLAIMS RESOLUTION

Health Choice Utah encourages providers to contact Health Choice Utah to resolve claims issues. In addition to the assistance of your Network Representative, you may use these tools:

#### Provider Portal

The provider portal offers many features including claim status checks, EOB and check inquiry, member rosters, and the ability to request prior authorization. This tool puts the control in the provider's hand and allows staff the opportunity to check claims status on their time, without waiting on hold.

#### Claims Customer Service

The Health Choice Utah Claims Customer Service line is a group of dedicated personnel trained to answer provider questions about claims. Providers may contact the Health Choice Utah Claims Resolution Services Unit at 1-877-358-8797 to resolve claims reimbursement issues informally.

The Claims Resolution Services Unit provides assistance with claim issues, including denied claims and incorrectly paid claims. Providers and office staff may also contact Claims Resolution Services to discuss questions about a remittance advice, to check the status of a claim, or both.

#### Claim Resubmissions

If your claim was denied for additional information or for necessary corrections, it is considered a **Resubmission**. Claim resubmissions should be sent back to the plan for reconsideration with a stamp or legible notice that the claim is a "Resubmission". If the services were performed by a facility, the appropriate bill type must be used to indicate a replacement claim. Appropriate documentation is required to re-evaluate the claim's original disposition in addition to the correct claim form with the services listed in detail. All claim resubmissions can be mailed to:

Health Choice Utah  
Attn: Claims Department -Resubmissions  
410 N 44th St, Ste 500

Phoenix, AZ 85008

## PROVIDER CLAIMS APPEALS

If a provider cannot resolve their claims issues informally as described above, the provider may file claims appeals in accordance with Section 31A-22-617 of the Utah Code.

All claims appeals can be mailed to:

Health Choice Utah  
Attn: Appeals  
410 N 44th St, Ste 500  
Phoenix, AZ 85008

## APPEALS AND GRIEVANCES (FOR MEMBERS)

Occasionally a member may ask you how to file a grievance (complaint) or an appeal with Health Choice Utah. You may also be asked to represent the member in the appeal. Information about appeals and grievances is also available in the Member Handbook and on the Health Choice Utah website.

## MEMBER APPEALS

A member may file a Member Appeal with Health Choice Utah in response to an action. Action means:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part of payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances;
- Denial of a rural member's request to obtain services outside the Contractor's network when the contractor is the only Contractor in the rural area.

Most member appeals are because Health Choice Utah has denied a request for a service (authorization for future service). Please refer to Chapter 6 for details on Authorizations. If Health Choice Utah does not make a decision on an authorization within the required time (as outlined in Chapter 6), then the member can consider the request "denied" and he or she can file an appeal.

When Health Choice Utah denies a request for authorization, a Notice of Action (NOA) is mailed to the member, and an explanation letter is mailed to the requesting provider. The member's NOA will advise the member on how to file an appeal.

If Health Choice Utah is reducing, suspending, or terminating an existing service, there are additional rights and rules that apply, other than just being able to file an appeal. Please refer to the Member

Handbook on the Health Choice Utah website, [www.healthchoiceutah.com](http://www.healthchoiceutah.com), or call our Member Services Department for details.

## HOW A MEMBER FILES AN APPEAL

The member must file the appeal, verbally or in writing, to Health Choice Utah within ninety (90) days from the date on the written Notice of Action. Only members can request an appeal of a prior authorization decision. However, a member is allowed to ask a physician, or anyone else such as a family member, to represent him or her in his or her appeal, hearing, or both. However, the member must give written permission for the doctor to represent him or her. Health Choice Utah has no policy that would prevent the provider from advocating on behalf of a member.

If a physician is representing the member in the appeal, he or she must include a copy of the member's written permission. Submit the appeal, and the representation authorization, directly to the Member Appeals Department at the address listed below:

Health Choice Utah  
Attention: Member Appeals  
410 N 44th St, Ste 900  
Phoenix, AZ 85008

Once the Appeal process has been initiated, Health Choice Utah will send the member (and their representative, if applicable) an acknowledgment letter by regular mail. Health Choice Utah will respond to all Appeals within thirty (30) days from the date that Health Choice Utah received the Appeal. Health Choice Utah will mail a final written decision to the member (and their representative, if applicable). If an extension is necessary, Health Choice Utah will notify the member (and their representative, if applicable).

Most members file their appeals themselves. Even in this case, before we make our decision, we will ask the requesting provider for additional information to assist us in our determination of the Appeal. To help Health Choice Utah respond to the member in a timely manner, please return this questionnaire to us as quickly as you can.

If waiting 30 days for a decision could seriously jeopardize a member's life, health, or the ability to attain, maintain, or regain maximum function, the member, or the member's physician, can request an Expedited Appeal. In these instances the appeal will be decided in 3 working days from the date the appeal is received. If Health Choice Utah denies the Expedited Appeal and the member requests a hearing, the hearing will also be expedited.

Extensions to the Decision, of up to 14 additional calendar days, can be requested by the member or Health Choice Utah if the extension is in the member's best interest.

## MEMBER GRIEVANCES (COMPLAINTS)

A member may file a grievance with Health Choice Utah regarding the dissatisfaction with any aspect of their care (other than the appeal of actions). If a member wants to file a grievance, please direct him/her to Health Choice Utah Member Services at 1-877-358-8797, or inform him/her that he/she can submit a grievance in writing to:

Health Choice Utah  
Attention: Member Grievance  
410 N. 44th St., Ste 800  
Phoenix, AZ 85008

If the grievance is against your office, Health Choice Utah will contact you to obtain your input.

# CHAPTER 10:

## HOSPITAL SERVICES

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### INPATIENT HOSPITAL SERVICES

Health Choice Utah covers medically necessary inpatient hospital services provided by, or under the direction of, a physician which are ordinarily furnished in a hospital. Inpatient services are covered for Health Choice Utah members when the member's condition requires hospitalization because of the severity of illness and intensity of services required.

#### Covered hospital inpatient services

- Medical and surgical care
- Maternity care
- Rehabilitation care
- Nursery and neonatal intensive care unit
- Intensive care and coronary care unit
- Nursing services necessary and appropriate for the member's condition
- Medical supplies, appliances, and equipment ordinarily furnished to hospital inpatients that are billed as part of the daily room and board charge

#### Covered ancillary services

- Labor, delivery, observation rooms, and birthing center
- Surgery, operating, and recovery room
- Laboratory services
- Radiology and medical imaging service
- Anesthesiology services
- Rehabilitation services, including physical, occupational, and speech therapies
- Pharmaceutical services and prescribed drugs
- Respiratory therapy
- Services and supplies necessary to store, process, and administer blood and blood derivatives
- Central supply items, appliances, and equipment ordinarily furnished to all patients and customarily reimbursed as ancillary services
- Maternity services
- Nursery and related service

- Chemotherapy
- Dialysis

## BILLING OF INPATIENT HOSPITAL CLAIMS

Hospital claims submitted on paper must be billed on a UB-04 billing form or its successor. The claim form must be completed correctly with valid revenue, procedure, and diagnosis codes. Health Choice Utah will match inpatient and outpatient UB-04 claims for the same member for the same date of service. If a member is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

## REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS

Health Choice Utah reimburses acute general care hospital providers based upon the services rendered.

## MEDICAL REVIEW OF INPATIENT HOSPITAL CLAIMS

For inpatient claims that require medical review, Health Choice Utah may ask for medical records such as:

- An itemized statement
- An admission history and physical
- A discharge summary or an interim summary if the claim is split
- An emergency record, if admission was through the emergency room
- Operative report(s), if applicable
- A labor and delivery room report, if applicable

## OBSERVATION SERVICES

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met. Covered observation services include:

- Use of a bed.
- Periodic monitoring by a hospital's nursing staff or, if appropriate, other staff necessary to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

Observation stays must be provided in a designated "observation area" of the hospital unless such an area does not exist.

It is not an observation stay when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours. This is an

outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight.

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation status must be ordered in writing by a physician or another individual authorized to admit patients to the hospital or to order outpatient diagnostic tests or treatments. The following factors must be taken into consideration by the physician or authorized individual when ordering observation status:

- Severity of the signs and symptoms of the member.
- Degree of medical uncertainty that the member may experience an adverse occurrence.
- Need for diagnostic studies that appropriately are outpatient stays (i.e., they do not ordinarily require the member to remain at the hospital for 24 hours or more) to assist in assessing whether the member should be admitted.
- The availability of diagnostic procedures at the time and location where the member presents for medical treatment.

The following services are not Health Choice Utah covered observation services:

- Substitution of outpatient services provided in lieu of observation status for physician ordered inpatient services.
- Services that are not reasonable, cost-effective, and necessary for the diagnosis or treatment.
- Services provided for the convenience of the member or physician.
- Excessive time and/or amount of services medically required by the condition of the member.
- Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation for observation status.

In general, observation status should not exceed 24 hours. This time limit may be exceeded, if medically necessary, to evaluate the medical condition and/or treatment of a member. Extensions to the 24-hour limit must be prior authorized.

Observation services, without labor, billed on the UB-04 claim form must be billed with a 0762 revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code 99218, 99219 or 99220 (note that 99217 is not appropriate for hospital billing). Each hour or portion of an hour that a member is in observation status must be billed as one unit of service.

Observation services without labor billed on the UB-04 claim form must be billed with a 0762 revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code G0378. Each hour or portion of an hour that a member is in observation status must be billed as one unit of service.

Observation services with labor billed on a UB-04 claim form must be billed with a 0721 revenue code (Labor Room Delivery - Labor) and the appropriate observation HCPCS procedure code G0378. Each hour or portion of an hour that a member is in observation status must be billed as one unit of service.

Health Choice Utah will review the immediate and continuing observation status by assessing the severity of illness and intensity of services. Medical review for continued observation status requests will consider each case on an individual basis and include, at a minimum, the following documentation:

- Emergency room record, if applicable
- Progress notes
- Operative report, if applicable
- Diagnostic test results, if applicable
- Nursing notes, if applicable
- Labor and delivery records, if applicable
- Physician orders

The following are required for documenting medical records:

- Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify "admit to observation." Rubber stamped orders are not acceptable.
- Follow-up orders must be written at least every 24 hours.
- Changes from "observation status to inpatient" or "inpatient to observation status" must be made by a physician or authorized individual.
- Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as an inpatient.
- Inpatient/outpatient status change must be supported by medical documentation.

## OUTPATIENT HOSPITAL SERVICES

Health Choice Utah covers preventive, diagnostic, rehabilitative, and palliative items or services ordinarily provided in hospitals on an outpatient basis for all members within certain limits based on member age and eligibility. Covered hospital outpatient services include:

- Outpatient Surgery
- Dialysis
- Emergency room services
- Laboratory services
- Medical supplies and equipment ordinarily furnished to persons receiving outpatient services to the extent that they are covered services and ordered by a physician
- Pharmaceutical services and prescribed drugs
- Services of allied health professionals when referred by or under the supervision of a physician
- Radiology and medical imaging services

If a member is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

## BILLING OUTPATIENT HOSPITAL SERVICES

When billing outpatient services, the following information must be included on the UB-04 outpatient claim:

- Bill Type must be 13X, 14X, 7XX or 85X for Critical Access Hospitals (appropriate second and third digits as listed in the UB-04 manual).
- Service begin date and start of care date should be the same date.
- Revenue code(s), CPT/HCPCS code(s), modifier and units must be appropriate and reflect all services provided.
- Revenue codes which are valid only for inpatient services cannot be used for services reimbursed on an outpatient basis.
- If the service is an emergency, the Admit Type (field 14) must be a "1"

## PROFESSIONAL SERVICES

- Health Choice Utah requires that physician and professional services provided in a hospital setting be billed on a CMS 1500 claim form.
- Revenue codes for professional services are not covered on a UB-04 claim form.
- Health Choice Utah does not allow hospitals and/or clinics to bill Health Choice Utah for physician/mid-level practitioner services using the hospital and/or clinic NPI number.
- Hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners.
- In these cases, the claim will carry both the physician/mid-level practitioner ID as the service provider and the hospital group biller ID.

# CHAPTER 11:

## MEDICARE AND OTHER INSURANCE LIABILITY

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### COST SHARING / MEDICARE COVERAGE

Health Choice Utah, as a Medicaid contractor, has liability for payment of benefits after Medicare and all other third party payer benefits have been paid. Health Choice Utah follows the Utah Department of Health Medicare Cost Sharing policies. Providers must determine the extent of the third party coverage and bill Medicare and all private insurance carriers prior to billing Health Choice Utah.

If a claim is received and the primary insurance has not been billed, Health Choice Utah will deny the claim, unless it is a service which is commonly known to be non-covered by the primary payer.

### “LESSER OF” PAYMENT RULE

Health Choice Utah will reimburse the lesser of either the Health Choice Utah contracted amount, Medicaid Allowable amount or the primary insurer’s allowed amount, less any payment amount by the primary insurer. If the primary insurance payment exceeds the Health Choice Utah contracted rate or the Medicaid allowable amount, no additional reimbursement will be made by Health Choice Utah.

Health Choice Utah will not pay for more than the member’s financial responsibility for the service (e.g., any deductible, coinsurance, or co-pay). The provider must contact the commercial insurance, Medicare HMO, or Medicare Advantage plan for information regarding covered services and prior authorization as well as Health Choice Utah prior authorization requirements must be followed.

**Note:** Services covered by Medicaid that are not covered by Medicare may be reimbursed by Health Choice Utah, provided the services are medically necessary and all reimbursement requirements have been met.

Upon receipt of reimbursement or denial from Medicare, third party payers, or both, providers should submit the Explanation of Benefits (EOB) from the primary insurer along with the claim form (UB04, CMS 1500 or electronic equivalent) to Health Choice Utah.

## PAYMENT METHODOLOGY

Health Choice Utah shall pay the **lesser** of the **difference** between 1) The Primary Insurance Paid amount and the Primary Insurance rate, i.e., the member's copayment required under the Primary Insurance **OR** 2) The Primary Insurance Paid amount and Health Choice Utah's Contracted Rate or the Medicaid Fee for Service rate.

### Example: Scenario 1

Medicaid Rate \$50  
Health Choice Utah Rate \$55  
Primary Insurance Rate \$45  
Primary Paid \$30

Health Choice Utah Payment to Contracted Provider in this example	\$15 (This is calculated from the lesser of: \$45 - \$30 vs. \$55 - \$30)
Health Choice Utah Payment to Non-Contracted Provider in this example	\$15 (This is calculated from the lesser of: \$45 - \$30 vs. \$50 - \$30)

### Example: Scenario 2

Medicaid Rate \$50  
Health Choice Utah Rate \$55  
Primary Insurance Rate \$60  
Primary Paid \$40

Health Choice Utah Payment to Contracted Provider in this example	\$15 (This is calculated from the lesser of: \$60 - \$40 vs. \$55 - \$40)
Health Choice Utah Payment to Non-Contracted Provider in this example	\$10 (This is calculated from the lesser of: \$60 - \$40 vs. \$50 - \$40)

### Example: Scenario 3

Medicaid Rate \$50  
Health Choice Utah Rate \$55  
Primary Insurance Rate \$70  
Primary Paid \$60

Health Choice Utah Payment to Contracted Provider in this example	\$0 (This is calculated from the lesser of: \$70 - \$60 vs. \$55 - \$60)
Health Choice Utah Payment to Non-Contracted Provider in this example	\$0 (This is calculated from the lesser of: \$70 - \$60 vs. \$50 - \$60)

## MOTOR VEHICLE (MVA) OR WORK RELATED INJURIES

If a member requires services for an injury or condition resulting from circumstances involving a third party (e.g., automobile accident or work related injuries), the provider must notify Health Choice Utah's Recoveries/TPL Department at 1-877-358-8797. Providers may be required to furnish the following information such as:

- Name of provider
- Address of provider
- Name of patient
- Patient's social security number or Medicaid identification number
- Address of patient
- Date(s) of hospitalization, outpatient services, or both
- Amount due for care of patient
- Date of accident
- County in which injuries were sustained
- Names, if known, of liable persons, firms, corporations, and insurance carriers claimed by the patient or patient's legal representative to be liable for damages

# CHAPTER 12:

## WOMEN AND CHILDREN'S SERVICES

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### EPSDT: CHILDREN'S HEALTH EVALUATION AND CARE (CHEC) PROGRAM

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for Medicaid Enrollees under the age 21. The Utah implementation of EPSDT is the Children's Health Evaluation and Care (CHEC) Program. The purpose of EPSDT is to ensure that availability and accessibility of health care resources as well as to assist Health Choice Utah members in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for Medicaid Enrollees less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 USC 1396 d (a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in the EPSDT screening whether or not the services are covered under the Utah Medicaid State Plan. Limitation and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit (synonymous with an EPSDT visit or CHEC appointment) includes all screenings and services available to EPSDT-aged members.

### AMOUNT, DURATION AND SCOPE

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in Federal Law Subsection 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan." This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "Medical Assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 28 categories of service in the Federal Law even when they are not listed as covered services in the Utah Medicaid State Plan, Utah statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of:

- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Physician services, nurse practitioner services
- Medications
- Therapy services
- Behavioral health services
- Medical supplies
- Prosthetic devices
- Eyeglasses
- Family planning services

EPSDT services include diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR 441.58). Providers must ensure members receive required health screenings in compliance with the EPSDT Periodicity Schedule. The Periodicity Schedules for EPSDT are intended to meet reasonable and prevailing standards of medical practice and specifies screening services at each stage of the child's life. The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary must be provided, regardless of the interval. EPSDT focuses on continuity of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

## EPSDT DEFINITIONS

- 1) **Early** means an eligible child is enrolled in Health Choice Utah as early as possible in the child's life, or as soon as the member is eligible for Medicaid.
- 2) **Periodic** means the child is examined and treated at intervals established by Medicaid and informed by national, evidence-based guidelines for screening, diagnosis and treatment.
- 3) **Screening** means the child is regularly examined and evaluated to assess the general physical health, growth, behavioral and physical development, and nutritional status of infants, children, and youth. Screening identifies children needing of more definitive evaluation and intervention. (For the purpose of the EPSDT program, screening and diagnosis are not synonymous.)
- 4) **Diagnosis** is the determination of the nature or cause of a condition, illness, or injury through an appropriate health history, a physical examination, developmental and psychological assessments, laboratory tests, and imaging tests.
- 5) **Treatment** means any of the 28 mandatory or optional services described in Federal Law 42 USC 1396d(a), even if the service is not covered under the Utah Medicaid State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

## SCREENING REQUIREMENTS

Comprehensive periodic screenings must be performed by a provider according to the timeframes identified in the EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Periodicity Schedule and inter-periodic screenings as appropriate for each member. The Contractor will encourage providers to use Medicaid approved standard developmental screening tools and complete training in the use of the tools.

The EPSDT Periodicity Schedule is based on recommendations by the American Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. EPSDT screenings must include the following:

- 1) A comprehensive health and developmental history, including growth and development screening (42 CFR 441.56(B)(1) which includes physical, nutritional and behavioral health assessments. Every Health Choice Utah member under the age of 21 must have a complete EPSDT Health History Form in the medical record, with appropriate updates.
- 2) A comprehensive unclothed physical examination.
- 3) Appropriate immunizations according to age and health history.
- 4) Laboratory tests (including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test).
- 5) Health education.
- 6) Appropriate oral health screening, intended to identify oral pathology, including tooth decay or oral lesions, conducted by a physician, physician's assistant or nurse practitioner.
- 7) Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate medically necessary therapies, including speech therapy, are also covered under EPSDT.
- 8) Tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:
  - a) Confirmed or suspected as having TB
  - b) In jail or prison during the last five years
  - c) Living in a household with an HIV-infected person or the child is infected with HIV, and
  - d) Traveling or emigrating from, or having significant contact with persons indigenous to, TB-endemic countries

## EPSDT VISITS

Every attempt should be made to provide EPSDT services even during a sick child visit. If a child is seen for illness and preventive services during the same visit both illness and preventive procedure and diagnosis codes should be documented on your claim. This includes the use of the immunization diagnosis codes if immunizations are administered during a sick visit. When performing an EPSDT visit during a sick visit (E&M visit), a modifier-25 should be appended to the visit to ensure appropriate payment.

## EPSDT NOTIFICATION

Upon enrollment, the member receives a New Member Handbook, which includes a section that explains the benefits of the EPSDT program. Health Choice Utah mails a notice to the parent/guardian of each EPSDT eligible member, informing them when an EPSDT exam is due with instructions to contact their PCP to schedule an appointment. Health Choice Utah mails a second reminder to the parent/guardian of members who have no EPSDT encounter reported 90 days after the initial EPSDT notice was mailed. Parents are again asked to contact their PCP to make an appointment.

Please use the following codes to ensure proper reporting for well-child visits:

Age	New Patient	Established
Under 1 year	99381	99391
1-4 years	99382	99392
5-11 years	99383	99393
12-17 years	99384	99394
18-20 years	99385	99395

- If you identify an issue that requires follow up from you or another physician or provider, append a modifier “TS” to the CPT code to indicate that follow up services were necessary.
- Providers are expected to use the designated ICD-10 CODES for ages 17 years, and for 18 years and older.
- The PCP must report all services performed by submitting a CMS 1500 or an electronic 837P or their successors.
- The PCP must initiate and coordinate referrals to other providers for extended services, as necessary.

## HELPFUL TIPS AND RESOURCES

### Blood Lead Screening

EPSDT eligible members between 6 and 72 months of age must be screened for exposure to lead. The guidelines are as follows:

All children in Utah, that live in a zip code that has >27% pre-1950 housing\*, should have at least one venous or capillary blood lead test, at 12 and 24 months of age, and children 36-72 months of age who have not been screened previously:

#### Zip Codes With Greater Than or Equal to 27% of Housing Built Before 1950 (2000 Census):

Beaver	84713, 84751, 84752
Box Elder	84301, 84306, 84307, 84309, 84311, 84312, 84313, 84314, 84316, 84324, 84329, 84330, 84331, 84334, 84336, 84340
Cache	84304, 84305, 84320, 84326, 84328, 84333, 84335, 84338, 84339
Carbon	84501, 84520, 84526, 84529, 84539

Daggett	% housing built before 1950 is less than 27% in all zip codes.
Davis	% housing built before 1950 is less than 27% in all zip codes.
Duchesne	84073
Emery	84522, 84523
Garfield	84712, 84718, 84726, 84759, 84776
Grand	% housing built before 1950 is less than 27% in all zip codes.
Iron	84753, 84760, 84761, 84772
Juab	84628, 84639, 84648
Kane	84758
Millard	84631, 84635, 84636, 84637, 84638, 84640, 84650, 84656
Morgan	84018
Piute	84723, 84732, 84740, 84743, 84750
Rich	84064, 84086
Salt Lake	84006, 84101, 84102, 84103, 84104, 84105, 84106, 84108, 84111, 84115
San Juan	84530
Sanpete	84621, 84622, 84623, 84627, 84629, 84630, 84632, 84634, 84642, 84643, 84646, 84647, 84662, 84667
Sevier	84620, 84652, 84654, 84657, 84701, 84724, 84730, 84744, 84754, 84766
Summit	84024
Tooele	84034, 84069, 84071, 84080
Uintah	84076
Utah	84626, 84633
Wasatch	% housing built before 1950 is less than 27% in all zip codes.
Washington	84733
Wayne	84715, 84747, 84749
Weber	84401

In addition, since age of housing has been identified as the major risk factor for childhood lead poisoning in Utah, all children in Utah living in Pre-1978 housing should have at least one venous or capillary blood lead test between the ages of 12 and 24 months and children 25-72 months of age should have a blood lead test if the child has not been previously screened.

Whenever a parent or health care provider suspects that a child is at risk for lead exposure, a blood lead test should be performed regardless of health department recommendation.

In determining if a child is at risk of lead poisoning the child's health care provider should use the following basic-risk questionnaire at each EPSDT visit. If a parent/guardian responds "yes" or "don't know" to any of the questions the child should be screened.

#### Lead Toxicity Risk Assessment

- Does your child live in or regularly visit a house built before 1978? This includes day care centers, preschools, a relative's or a babysitter's home?

- Does your child live in or regularly visit a house built before 1978 with peeling paint, recent or ongoing renovations or remodeling (within the last 6 months?)
- Does your child have a sibling or playmate who has or did have lead poisoning?
- Does your child frequently come in contact with an adult who works with lead, such as in smelting, electronics, recycling, construction, welding, pottery or paint or plastics manufacturing?
- Does your child live near a heavily traveled major highway, smelter, metal or battery recycling plant, tailings from mining or milling operations or other industry likely to release lead?
- Do you give your child any home or folk remedies that may contain lead, such as: azarcon, greta, or pay-loo-ah?
- Does your home's plumbing have lead pipes or copper with lead solder joints?

Ask any additional questions that may be specific to a situation, which may exist in a particular community.

A child's risk for lead exposure should be longitudinally assessed. Screening should be done at any time a child is believed to be at risk of lead exposure.

### Results of Blood Lead Test

EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. Assessment and appropriate screening is federally mandated

If the result of the blood test is greater than or equal to 10 ug/dL, a venous blood sample must be obtained to confirm the results. Report all lead poisoning with lead levels equal to or greater than 15 ug/dL to the Utah Department of Health, Bureau of Epidemiology. Reports of children with blood lead levels of 20 ug/dL or greater will be shared with the Utah Department of Health, Bureau of Environmental Health Services.

Patients with tests resulting in lead levels 10-19 ug/dL (micrograms per deciliter) must be re-tested in three months. Lead levels measuring 20-44 ug/dL also need to be re-tested in one month to 1 week. Patients with lead levels measuring 45-59 ug/dL should have the blood levels re-tested in 48 hours. Any lead levels measuring 60-69 ug/dL should be re-tested in 24 hours. Blood lead levels over 70 ug/dL are considered a medical emergency and should be treated immediately. The patient will need a full medical work-up and treatment immediately.

## VACCINE FOR CHILDREN (VFC) PROGRAM

Health Choice Utah, in accordance with Medicaid and federal requirements, provides immunization services for EPSDT eligible children and young adults under the age of 19. All PCPs treating members under the age of 19 must enroll every year with the Vaccine for Children (VFC) Program through the Utah Department of Health (UDOH) in order to deliver EPSDT immunizations. Through the VFC Program, the federal government purchases and makes available to the states, free of charge, vaccines for children under age nineteen (19) who are Title XIX and CHEC eligible, Native American or Alaskan Native, not insured, and some underinsured. Health Choice Utah pays an administration fee for each VFC vaccine administered to a Health Choice Utah member. Per Utah Medicaid guidelines, administration codes should be billed using the SL modifier when VFC vaccines are used.

Health Choice Utah, in cooperation with its providers, is required to ensure that members receive early and age appropriate immunizations. Health Choice Utah is committed to improving the immunization status of its members between the ages of birth to 2 years in accordance with Federal Center for Disease Control (CDC), Healthy People 2010 and Utah Medicaid immunization goals.

PCPs should use every opportunity to assess the immunization status of assigned members and provide necessary immunizations. Providers shall notify members of overdue immunizations and encourage visits for EPSDT services including immunizations.

*To learn more about VFC in Utah, please refer to their web site at <http://www.immunize-utah.org/vaccines%20for%20children%20program/providers/index.html>*

## THE UTAH STATEWIDE IMMUNIZATION INFORMATION SYSTEM (USIIS)

Each PCP/PCO must document all immunizations administered to Health Choice Utah members, as well as update and maintain a complete immunization record in the member's medical record.

Utah requires the reporting of all immunizations given to children under the age of 19. As of October 1, 2011, immunizations must be reported quarterly using the Utah Statewide Immunization Information System (USIIS) online Doses Administered Reporting application.

*To learn more about USIIS, please refer to their web site at <http://www.usiis.org>*

Health Choice Utah follows the Standards for Pediatric Immunization Practices, as published by the U.S. Department of Health & Human Services. These guidelines state:

- Providers should question the parent or guardian about contraindications before immunizing a child and inform them in specific terms about the risks and benefits of the immunizations their child is to receive;
- The Vaccine Information Pamphlets should be provided and reviewed with parents or guardians. (Alternative vaccine information materials that meet all the requirements of the law can be used). Providers must ensure that information materials are current and available in appropriate languages;
- Providers are required by statute to record what vaccine was given, the date the vaccine was given (month, day, and year), the name of the manufacturer, the lot number, and the signature and title of the person who gave the vaccine. This should be documented on an Immunization Administration Record, along with the signature of the person who receives the vaccine or the person authorized to make the request. This serves as informed consent for the immunizations received.

## OBSTETRICAL SERVICES

Health Choice Utah emphasizes the critical importance of prenatal health care. The Maternal Child Health Unit at Health Choice Utah assists obstetrical members by facilitating access to community services and programs for pregnant women. Health Choice Utah participating obstetrical providers must adhere to the

American College of Obstetrics and Gynecology (ACOG) standards of care that include referrals to community resources, patient education, and maintenance of the medical record. Health Choice Utah is eager to assist you in the optimal care of pregnant patients.

## OB ASSIGNMENT

A pregnant Health Choice Utah member will choose a Health Choice Utah Primary Care Obstetrician provider (PCO). The PCO serves as the member's Primary Care Provider throughout the course of pregnancy and six (6) weeks postpartum after a vaginal delivery or eight (8) weeks postpartum following a Cesarean section delivery. Services of a PCP include: routine illnesses, referrals to specialists not necessarily related to pregnancy and requests for specialty medications.

The member's choice of a PCO may be determined by, but is not limited to the:

- Referral by the member's PCP. The PCO must be to a contracted OB. No authorization is required;
- Geographic location of the member and provider;
- Availability or limitations of the PCO;
- Assessment of medical risk.

## PRIMARY CARE OBSTETRICIAN (PCO) RESPONSIBILITY

### Education for Pregnant Women

During your patient's pregnancy, be sure to document any and all education done by you and your staff. Important topics to discuss with your patient include proper nutrition, breast feeding, smoking cessation, physiology of pregnancy, labor and delivery process, warning signs, drug and alcohol avoidance, postpartum depression, and family planning options.

### Prior Authorization and Referrals

It is the responsibility of the PCO to obtain prior authorization, if indicated by Health Choice Utah prior authorization requirements, for services not related to the pregnancy. In the event that a PCO feels the member needs to be referred to a maternal fetal medicine doctor, it is the responsibility of the PCO to contact the maternal fetal medicine doctor's office, discuss the member's condition, and set up the initial appointment.

All prior authorization requests must include a copy of the member's up-to-date medical record. (Standard ACOG OB reporting forms are the preferred documentation.)

Please refer to Chapter 6 for detailed information on prior authorizations outside of the Global OB services and referrals. Prior Authorization is not required for routine OB care.

## Women, Infants and Children

PCOs are required to educate all Health Choice Utah pregnant members on the WIC Program as well as other appropriate community based resources geared toward healthy pregnancy outcomes. For information regarding available services in your area, please call the Utah State WIC Program at 801-273-2991 or toll free 877-942-5437

## MOTHER'S PCP ASSIGNMENT

Six to eight weeks after the member has delivered her baby, she is reassigned to her previous PCP. If the member did not have a previous PCP assignment, she may select one at this time. If the member does not choose a PCP, she will be assigned to one by Health Choice Utah Member Services. If the member is not happy with this assignment, she may call Health Choice Utah Member Services Department at 1-877-358-8797 to choose another PCP.

## TRANSFER OF CARE

If a member chooses to transfer care to another PCO or to a maternal fetal medicine specialist who is not participating with Health Choice Utah, then a prior authorization will need to be obtained. Supportive documentation justifying the out of network request will need to accompany the request.

## PRENATAL APPOINTMENTS

PCOs must make it possible for Health Choice Utah members to obtain initial prenatal care based on the standards listed in Chapter 3. Providers are encouraged to use an appointment system that monitors missed appointments. Health Choice Utah monitors appointment availability through various means. Providers who do not meet the Medicaid standard may have a cap placed on their membership or a reduction in assigned members.

## EPSDT/CHEC SERVICES FOR OB MEMBERS

At the initial OB visit, the PCO will perform a risk assessment on all pregnant members, and perform an Early and Periodic Screening Diagnostic and Treatment (EPSDT) exam for members under the age of 21.

## LABORATORY SERVICES FOR OB MEMBERS

Laboratory services for pregnant members must be referred to a Health Choice Utah contracted laboratory. Please refer to the Provider Directory for the contracted laboratory in your area. Laboratory requisitions must include all appropriate diagnostic codes and all required digits.

## HIV TESTING FOR OB MEMBERS

ACOG recommends that every pregnant woman, regardless of risk, be tested for HIV as a routine part of prenatal care. Pre-test and post-test counseling should be provided to all members. Documentation in the medical record of member refusal is required.

## REPORTING NON-COMPLIANT OB HIGH RISK MEMBERS

PCO's are encouraged to notify the Health Choice Utah Maternal Child Health Unit at 1-877-358-8797 if an OB member:

- Has a positive drug screen or a history of substance abuse
- Does not set up an initial appointment within a 4 week period
- Fails to appear for two or more prenatal visits and doesn't attempt to reschedule, or reschedules and does not show up for the rescheduled visit
- Is diabetic and is consistently non-adherent with dietary guidance or medication usage
- Does not adhere to prescribed activity restriction, such as bed rest
- Has preterm labor and does not take tocolytics as prescribed or does not adhere to home monitoring schedules
- Uses tobacco, alcohol or illicit substances, or misuses prescription medication
- Frequently makes inappropriate emergency room, urgent care, or maternity outpatient visits
- Frequently requests prescriptions for controlled analgesics or mood altering drugs
- Is at risk for domestic violence
- Exhibits or self-reports emotional distress which could influence well-being

PCO are also encouraged to contact OB Case Management regarding any member identified as "High-Risk". Health Choice Utah follows ACOG guidelines when determining "High-Risk" for OB members. Notify the Health Choice Utah Case Management department if member is being referred to a perinatologist so that the member can be assigned to an RN Case Manager.

The following conditions may be identified as "high risk":

- Incompetent Cervix
- Isoimmunization
- Recurrent spontaneous abortion
- History of preterm delivery: earlier than 36 weeks EGA
- History of delivery of an infant weighing less than 2500 grams
- History of intrauterine growth restriction
- Previous cesarean delivery or previous uterine surgery
- Maternal age less than 17 years if first pregnancy; Maternal age less than 18 years if second pregnancy or greater
- Advanced maternal age:  $\geq 35$  years of age
- Significant social issues such as homelessness, domestic violence, poor adherence with plan of care, substance abuse, or recurrent sexually transmitted diseases

- Maternal medical conditions such as chronic hypertension, diabetes, renal disease, liver disease, heart disease, pulmonary disease, anorexia, morbid obesity, seizure disorder, immune deficiency or disease, chronic infectious disease, etc.
- Psychiatric illness
- Multiple gestation
- Malpresentation
- Pregnancy induced hypertension, preeclampsia, eclampsia, HELLP syndrome, etc.
- Preterm labor: less than 36 weeks EGA
- Preterm rupture of membranes: less than 36 weeks EGA
- Intrauterine growth restriction
- Oligohydramnios
- Placental abruption or placenta previa
- Fetal malformation or evidence of chromosomal abnormalities

Health Choice Utah is contracted with home health agencies that can provide many services for the obstetrical patient. The following services can be provided with prior authorization through the Maternal Child Health Manager:

- Gestational Diabetes Case Management
- Management of Preterm Labor
- Nutritional therapy
- Hyperemesis Management

For more information on home care services, please contact the Health Choice Utah Maternal Health Hotline.

## MATERNAL HEALTH HOTLINE

The Health Choice Utah Maternal Health Hotline was developed as a direct line allowing members and providers access to nurses within the Health Choice Utah Maternal Child Health Unit. Members can call and notify staff of their newly diagnosed pregnancy. Providers can call to report non-compliant or at-risk members, or to ask questions about the Maternal Child Health benefits. The Health Choice Utah Maternal Health Hotline is answered Monday – Friday 7:00 am to 4:00 pm. After hours, the number has a recording, which prompts the caller to leave information.

*The number to call for Maternal Health Hotline is 1-855-712-5090*

## GENETIC CONSULT AND TESTING

Genetic counseling requires authorization. PCPs or PCOs must submit documentation to support medical necessity when requesting prior authorization. A specialist in Perinatal Medicine may be authorized to identify a fetus at risk for medical conditions that would require a planned delivery at a high-risk facility.

## INFERTILITY

Treatment for infertility is not a Medicaid covered service.

## BILLING AND REIMBURSEMENT

Claims should not be submitted until after the delivery of the newborn or until after the care is transferred to another provider. Each provider should submit all prenatal services, ancillary services, and delivery of the newborn on a CMS 1500 form. Health Choice Utah will reimburse the physician in accordance with the Participating Physician Agreement. If applicable, review your Health Choice Utah Participating Physician Agreement for the required minimum number of prenatal visits in order to receive the Total Global OB Package fee. Reimbursements for carve-out services, if any, are listed separately on the CMS 1500. The authorization number, if required, should be listed on all claims submitted for reimbursement.



Toll-Free: 1-877-358-8797 (TTY 711)

Monday – Friday, 6 a.m. – 6 p.m.

[www.StewardHealthChoiceUT.org](http://www.StewardHealthChoiceUT.org)



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