

HEALTHY U CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Healthy U CHIP is a managed care health plan that provides physical and behavioral health benefits to CHIP enrollees. Members eligible for CHIP are required to enroll in a CHIP managed care health plan. The information provided in this section is designed to assist Healthy U CHIP providers recognize Healthy U CHIP members and the services that must be accessible to them.

Note: The state of Utah requires certain terms to be defined in this manual. Wherever possible, we include the definition in context. Where the term is not used in text, we include the definition at the end of this section of the Provider Manual. In cases where the definition is not provided by the state, we cite the online source of the standard definition.

Healthy U CHIP Overview

Children who are eligible for Healthy U CHIP include those whose families have incomes too high to qualify for Medicaid but too low to afford private health insurance coverage.

Service Area

Healthy U CHIP is available to eligible CHIP members throughout Utah.

Benefit Plans

The state determines whether a member is eligible for CHIP Plan B, CHIP Plan C, or a no-cost-share plan based on their income. Regardless of which plan the member is in the covered services are the same. Cost sharing requirements are the only difference. The assigned plan is listed on the member's Healthy U CHIP ID card. The benefit period is 12 months, beginning with the month the child became eligible for CHIP; however, the benefit period might be shorter than 12 months in certain situations. Also, the member's benefit plan can change during the benefit period if they meet certain qualifying events, such as meeting their maximum out-of-pocket costs, or if their income changes. Always check a member's eligibility and benefits prior to rendering services.

Covered Benefits

These are some of the CHIP services covered by Healthy U CHIP. Preventive benefits have no out-of-pocket cost to members:

- Abortions and sterilizations (with required forms and when criteria are met)
- Ambulance for medical emergencies
- Anesthesia for medical and dental services in a surgical center or hospital (requires prior authorization from your plan)
- Autism services, including Applied Behavioral Analysis (ABA), for the treatment of autism
- Behavioral health services
- Diabetes and diabetes education
- Doctor visits, including specialists
- Drugs prescribed by your doctor that are covered on the Preferred Drug List (PDL)
- Eye exams
- Emergency care, 24 hours a day, 7 days a week
- Family planning
- Hearing exams
- Home Health
- Hospice (end-of-life care)
- Hospital services, inpatient and outpatient
- Immunizations
- Labs and x-rays
- Medical equipment and supplies
- Mental health services
- Occupational therapy
- Organ transplants (bone marrow, heart, lung, pancreas, kidney, cornea, liver)
- Orthodontia with prior authorization
- Physical therapy
- Pregnancy-related services including labor and delivery
- Substance use disorder services
- Tobacco cessation

Verifying Eligibility

A **CHIP-eligible individual** or **CHIP member** means any individual who has been certified by the Utah Department of Health and Human Services (DHHS) or the Utah Department of Workforce Services (DWS) to be eligible for CHIP benefits.

Children and teens under the age of 19 years old may be eligible for CHIP if they meet ALL of the following requirements:

- If they are a Utah resident
- Have countable income less than 200% of the Federal Poverty Limit (FPL)
- Are NOT eligible for Medicaid
- Are NOT covered by other health insurance at the time of application (or review)

Healthy U CHIP members are responsible to show their Healthy U CHIP Identification Card BEFORE receiving any type of service. Providers must verify that the patient is eligible for CHIP on the date of service. Patients who fail to advise the provider of their CHIP eligibility may be liable for services rendered on that date.

CHIP eligibility can change frequently; therefore, regardless of whether a CHIP enrollee is enrolled with Healthy U's CHIP plan or with another Managed Care Organization (MCO), eligibility for every CHIP enrollee should be verified prior to every visit or service. Verify that the patient is eligible for CHIP **on the date of service** and with which CHIP plan the member is enrolled.

Eligibility information for CHIP is available via the state's [Patient Eligibility Verification](#) system, by calling Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525**, or by calling Utah Medicaid/CHIP at **800-662-9651**. Again, eligibility can change from month to month so always check a member's eligibility and benefits prior to rendering services.

RECEIVING CARE

Use of Healthy U CHIP Provider Network

Except in the case of an emergency or single case agreement, members must obtain covered services from in-network (participating) providers, facilities, or pharmacies.

- Members must receive ALL services from a provider PARTICIPATING in the Healthy U CHIP network in order to receive payment. Services rendered by a non-participating provider, without prior approval, will be denied with no payment.
- Facility services are covered when received from a PARTICIPATING facility only. Services rendered by a non-participating facility, without prior approval, will be denied with no payment.

Provider Network Directory

The [Healthy U CHIP Provider Directory](#) is available online to view or print as a PDF. U of U Health Plans provides Healthy U CHIP members with directions to request or access our Provider Directory at the time of enrollment. Since information in the directory is subject to change, Healthy U encourages members to check providers' participating status prior to obtaining services.

Directory information is also available to participating providers. We encourage providers to view our directory prior to referring members to other in-network providers for services.

Out of Network

Out of network refers to services rendered by any provider that is not a participating, contracted provider in the Healthy U CHIP plan. Out-of-network services will only be reimbursed by the plan when they are either of the following:

- Medically necessary services that were unavailable through the Healthy U CHIP network of participating providers and are approved by the plan through the referral process, under single case agreement
- Services that meet the definition of "emergency services" or urgent care services

Use of Primary Care Providers

Healthy U CHIP members are encouraged to choose a Primary Care Provider (PCP) to manage and coordinate their care. A PCP is defined as a generalist in any of the following areas:

| PCP Area of Specialty | PCP Credentials |
|---------------------------|-------------------------------------|
| Family Practice | Medical Doctor (MD) |
| General Practice | Doctor of Osteopathic Medicine (DO) |
| General Internal Medicine | Nurse Practitioner (NP) |
| Obstetrics/Gynecology | Physician Assistant (PA) |
| Pediatrics | Resident in listed PCP specialty |

Healthy U CHIP members can also select a medical clinic to act as their PCP.

Referrals to In-network Specialists

Healthy U CHIP members can consult an in-network specialist without obtaining a referral from their primary care provider.

General Policies Regarding Covered Services

All covered services must be medically necessary and all Healthy U CHIP utilization management requirements must be met for services to be reimbursed. All services must be obtained from a participating in-network provider to be covered, except in the case of “emergency services” or when a single case agreement or benefit exception has been obtained from the plan. A List of Covered Services is available in the [Healthy U CHIP Member Handbook](#). If you still have a question about whether a service or supply is covered, contact Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525**.

View the following resources for additional details on covered services, including applicable definitions, regulations, and limitations.

- [Healthy U CHIP website](#)
- [Search Codes Requiring Prior Authorization](#)
- [Utah CHIP website](#)

Crisis and Telephonic Care

Members of Healthy U CHIP have access to crisis response programs to provide immediate behavioral health crisis intervention and support services—even if their established behavioral professional is not available.

The following [Community Crisis Intervention & Support Services](#) are provided by the Huntsman Mental Health Institute (HMHI) 24 hours a day, 365 days a year:

- National Suicide & Crisis Lifeline – **988** – Calls within Utah are answered by HMHI
- Utah Crisis Line – **800-273-TALK** (8255) or **801-587-3000** – Crisis intervention and suicide prevention
- Utah Warm Line – **833-SPEAKUT** (833-773-2588) or **801-587-1055** – Triage through the Utah Crisis Line – Noncrisis support by Certified Peer Specialists offering engagement, a sense of hope, and self-respect
- HMHI Receiving Center - Triage through the Utah Crisis Line – Therapeutic crisis management, assessment, and discharge planning in a short-term setting (up to 23 hours)

Direct Billing of Services

Generally, health providers who agree to treat CHIP patients are prohibited by federal law from billing CHIP patients directly for covered services. As such, the provider is prohibited from billing and/or collecting from the member, except for state mandated patient responsibilities (such as co-payments and coinsurance) and/or noncovered services (see below for instructions on billing for noncovered services), or any amount due to provider by U of U Health Plans (refer to Provider Agreement for further details).

Provider must accept the Healthy U CHIP payment as payment in full. Failure to abide by state billing rules and regulations, and/or the Policies and Procedures of Healthy U CHIP, can result in the claim(s) being denied for payment. In such cases, the Provider is prohibited from billing the member.

As noted in the Verifying Eligibility section above, Healthy U CHIP members are responsible for presenting proof of CHIP eligibility and enrollment in Healthy U CHIP at the time of service. Patients who fail to advise the provider of their CHIP eligibility may be liable for services rendered on that date.

Medically Necessary

Medically Necessary or **Medical Necessity** means medically necessary service as defined by [Utah Administrative Code R414-1-2](#).

Medically Necessary means any medical services or supplies that are necessary and appropriate for the treatment of an Enrollee's illness or injury and for the preventive care of the Enrollee according to accepted standards of medical practice in the community in which the provider practices and which are consistent with practice guidelines developed and approved by Healthy U CHIP.

Healthy U CHIP-covered services must meet the definition of medically necessary to be covered by the plan. Please contact Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525** for questions regarding medical necessity.

Emergency Services and Medical Conditions

Emergency Services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services, and that are needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result any of the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency providers are expected to use prudent judgment in determining whether the member requires treatment in the emergency room. Members with non-emergent conditions should be referred to their primary care physician for treatment and follow-up care.

The initial screening examination to make a clinical determination on whether an actual medical emergency exists is covered by Healthy U CHIP. If the emergency room provider provides treatment for the patient even after determining the condition is not for a medical emergency, CHIP will only cover a triage fee for the initial screening examination. If, however, the patient's condition does warrant emergency medical services, all services required to stabilize the patient will be covered by the Healthy U CHIP benefit plan.

The U of U Health Plans Utilization Management department should be notified within 24 to 48 hours (same day or next working day for weekends and holidays) of all emergency visits that result in an inpatient admission.

For more information regarding emergency services, visit:

- [Utah CHIP website](#)
- [Healthy U CHIP Member Handbook](#)

Translation Services

Healthy U CHIP covers interpretation/translation services, with no out-of-pocket cost for members who speak little to no English, or are deaf, hard of hearing, or sight impaired. For a list of contracted translations agencies, call Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525**.

General Policies Regarding Noncovered Services

A provider may be reimbursed for the provision of noncovered services if one of the following conditions are met:

- A benefit exception is obtained from Healthy U. To obtain a benefit exception, contact the Healthy U Utilization Management department. Where benefit exceptions are granted, the provider is bound by the billing policies established above.
- A provider may bill the Healthy U CHIP member for the provision of noncovered services if they have informed the member, **in writing**, of **all** the following:
 - The specific services to be rendered are not covered under the member's CHIP benefits
 - The total charges for which the member would be liable
 - Obtains the member's authorization signature **prior** to the services being rendered

Note: This must be done each time a noncovered service is to be rendered. A single, one-time statement covering all future services is not acceptable.

General Exclusions:

These are some services Healthy U CHIP does not cover under the medical benefit:

This list is not inclusive of all CHIP noncovered services and supplies; rather, it is intended to provide basic guidelines for determining noncovered services. Refer to our website or contact Customer Service for detailed information on noncovered services.

- Abortions, except to save a mother's life or if the pregnancy is the result of an act of rape or incest, with required forms
- Acupressure
- Allergy tests and treatment, selected types
- Anesthesia, general, while in a doctor's office
- Biofeedback
- Certain immunizations (e.g., anthrax, Bacillus Calmette-Guerin (BCG), plague, typhoid, yellow fever, travel)
- Certain pain services
- Charges/services not for medical purposes (e.g., late fees or no-show fees)
- Chiropractic services
- Claims submitted after one year from the date of service
- Complementary and Alternative Medicine (CAM)
- Experimental services
- Eyeglasses for the correction of refraction
- Eye surgery for the correction of vision (e.g., LASIK)
- Food-based treatments
- Gene therapy
- Genetic counseling
- Hearing aids (unless the child was approved for cochlear implants)
- In-vitro fertilization
- Services rendered during a period the client was ineligible with the Healthy U CHIP plan
- Services not medically necessary or appropriate for the treatment of a patient's diagnosis or condition
- Services that fail to meet the existing standards of professional practice, are investigational, or experimental
- Services obtained out-of-network that are **not** emergency services, urgent care services, or where a referral was not obtained from Healthy U CHIP

If you still have a question about whether a service or supply is covered, contact Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525**.

Some services Healthy U CHIP does not cover under the retail pharmacy benefit:

- Anabolic steroids
- Biological sera, blood, or blood plasma
- Compounded pharmacy products; compounded products are limited and may not be covered without prior authorization if a commercial product is available or if it exceeds the cost limit
- Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (c) one insulin-pump during the warranty period. Diabetic-infusion sets, pumps and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit, except where insulin pump is only provided through retail benefit.
- Food supplements, special formulas, and special diets
- Homeopathic medications
- Infertility medications to treat or enhance fertility
- Investigational, experimental, clinical trial, unproven drugs, or drugs labelled "caution – limited by federal law to investigational use," medications for cosmetic purposes (for example, but not limited to, cosmetic hair growth and removal products)
- Medications or immunizations administered to prevent disease when traveling to other countries
- Medication taken or administered while in a provider office or facility, including: medication which is taken by or administered to an individual, in whole or in part, while he or she is a patient in a doctor's office, hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, or a facility for dispensing pharmaceuticals (in some cases, this medication is covered under the Medical Benefits portion of the benefit plan)
- Medications that cannot be self-administered; provider-administered medications are generally covered under the medical benefit, although exceptions may apply for a particular drug or on a case-by-case basis
- Medications that are therapeutically the same as an over-the-counter medication
- Medications that are covered under a per diem or daily rate for a Skilled Nursing, Long-term Care, or Acute Rehab facility contract
- No-Charge medications received under worker's compensation laws, federal, state, or local programs
- Medications to treat vitiligo
- Medications to treat sexual dysfunction or impotence
- Medication samples, including any corresponding administration requirements such as intravenous infusion therapy or office visits for administration
- Medications used to treat weight loss
- Medications whose primary purpose is to correct vision
- Off-label use of medication, except as outlined in the plan's off-label-use policy
- Other-Party-Liability prescription drugs which an eligible person is entitled to receive without charge under any workers compensation laws, or any other municipal, state, or federal program

- Over-the-counter medication (OTC) or other items purchased at a pharmacy, regardless of whether there is a prescription order for the item(s), except as required under the Affordable Care Act (ACA)
- Pigmenting/depigmenting agents, except as required to treat photosensitive conditions, such as psoriasis
- Prescription drugs in excess of a 30-day supply or the plan's day or quantity limit
- Refills exceeding the number specified by the physician or any refill dispensed after one year from the physician's original prescription order
- Synagis® or other passive immunotherapies for the treatment of respiratory syncytial virus (RSV) outside of the state-reported RSV season
- Testopel® pellets
- Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments, and other non-medicinal substances, regardless of intended use (in some cases, items may be covered under the Medical Benefits portion of the plan)
- Vitamins and minerals, except as required under the ACA; vitamins may be limited to coverage by age and specific dosing requirements

For information on pharmacy benefits, call **855-203-3633**.

Care Management

Members are identified at the earliest possible point for Care Management (CM) intervention. The mechanism for identification can be through enrollment, claims, utilization trending, medical history, survey tool or notification by provider and/or the Department of Health and Human Services. HIGH-RISK patients can be identified through primary-care referral, specific diagnosis ICD-10 clustering, emergency room logs, referral requests, payer personnel, and specialty provider contracts.

Each member identified is assigned a care manager and followed across the continuum of care, in inpatient and ambulatory settings. Services are also coordinated among social and community services, family, or specialty and primary care providers as indicated by member need. Coordination is achieved via phone, e-mail, fax, or through case conferences.

Care Coordination will be provided through our Care Management Department for the following medical and behavioral health services:

- Obstetrical Patients - Contact U Baby Care at **801- 587-2851**
- Out-of-area non-emergent care
- Patients with uncontrolled chronic conditions
- Patients with complex needs related to physical health and/or psychosocial issues

[Learn more about Care Management opportunities](#) or call **833-981-0212** option 2, or **801-587-2851** option 4 to speak with a member of the Care Management team.

HEALTHY U CHIP CLAIMS AND PAYMENT PROCESS

Providers contracted with Healthy U CHIP agree to submit claims to U of U Health Plans for services and supplies provided to our members. As many of these requirements and processes overlap with other U of U Health Plans network requirements, please review the Claims, Payment, and Appeals details throughout.

Claims Submission Requirements

In most circumstances, claims must be submitted under the name of the rendering provider.

Providers should submit claims via electronic 837 HIPAA-compliant transactions or on the appropriate standard paper forms (CMS 1500 for professional services and UB04 for facility services). All claims must be filed within timely filing requirements. All necessary information for correct processing of the claim should be included on or attached to the claim form, including:

- Patient Name
- Patient's Member Identification Number
- Patient's date of birth
- Patient's address
- Rendering **and** billing provider, if different
 - Provider's name
 - Provider's Tax Identification Number (TIN)
 - Provider's NPI
 - Provider's practice and billing addresses
- Other insurance information (if applicable and known)
- Date(s) of service of claim
- Diagnosis ICD-10 Code(s) - obtained from authorized ICD-10-CM reference guides for the year corresponding to the date of service
- Procedure codes (CPT/HCPCS) or revenue codes identifying services on claim – obtained from authorized reference guides for the year corresponding to the date of service
- Medical drugs (non-retail) charges administered by a professional provider billed with the appropriate HCPCS code
- Billed charges for each service on claim
- Supporting documentation including operative reports, emergency room reports, medical records supporting diagnosis when requested, etc.
- Explanation of benefits from primary payer (if applicable)

Claims are processed and remittance advices sent to the provider in accordance with the timeliness provisions set forth in the provider's Participating Provider Agreement. Please be aware that paper claims require a longer time to process. While we will accept claims submitted electronically or on paper, we strongly encourage providers to utilize the efficiencies gained through Electronic Data Interchange (EDI) transactions. EDI transactions are covered in greater detail later in this section.

If electronic claims are not an option in your practice, we will accept paper claims mailed to:

University of Utah Health Plans
Attention: Claims Department
P.O. Box 45180
Salt Lake City, Utah 84145-0180

Elements of Clean Claims

A clean claim is any claim submitted by a provider that:

- Includes substantiating documentation, if required
- Has a corresponding prior authorization, if required
- Complies with billing guidelines and coverage policies
- Has no missing or invalid information (e.g., CPT, DOB, NPI)
- Is received by U of U Health Plans within the timely filing period
- Does not require special treatment that prevents timely payment
- Includes all relevant information to determine other carrier liability
- If submitted on paper, is submitted on a UB-04, CMS-1500, or successor claim form, with all required elements
- If submitted electronically, is submitted in compliance with the applicable federal and state regulatory authority (i.e., Medicare or state Medicaid) and uses only permitted standard code sets

Corrected Claims

U of U Health Plans prefers to receive corrected claims via EDI transaction. To request a claim be corrected, submit the following information in **Loop 2300** of an **837I** (Institutional) or **837P** (Professional) electronic claim form.

1. In segment **CLM05-3**, insert the appropriate "**Claim Frequency Type**" code (these may be displayed by your software as a dropdown field):
 - a. **7** – *Replacement of prior claim*
 - b. **8** – *Void/cancel prior claim*
2. **Enter the original claim number in the REF*F8** "Payer Claim Control Number" field.
 - a. If you are submitting a **primary payer's EOB** with this corrected claim, you **must include the primary payment date**, also in **REF*F8**

3. **You must report every line associated with this claim** to ensure the full claim is reprocessed
4. Refer to your *5010 Implementation Guide* for additional information

Note: To submit an EOB for a denied Healthy U CHIP claim, **you must submit an electronic correction that includes the EOB information.** U of U Health Plans can no longer accept submission of corrected claims or EOBs on paper for Healthy U members.

Common reasons to submit a corrected claim

- Primary insurance EOB missing (**you must attach** the primary EOB to the corrected claim)
- Primary insurance EOB amount is changing
- Incorrect billed amount
- CPT/Modifier changes
- Transposed procedure or diagnosis code
- Inaccurate data entry
- Denial of claims as duplicates
- Missing or invalid ordering or referring provider

Paper Claim Forms

If you must submit a corrected claim on a **CMS 1500 (02/12)** paper claim form:

- **In box 22**, enter the appropriate Resubmission Code:
 - **7** – Correction to prior claim
 - **8** – Void of a professional claim
- **Enter the payer's original claim number in box 22** under the "Original Ref. No." field.
- Remember, if you're correcting to add an EOB, you must attach the primary EOB to the corrected claim.

If you must submit a corrected claim on a **UB-04 Facility** claim form:

- Enter the CLAIM FREQUENCY TYPE code as the **4th digit of Box 4 "Type of Bill"**
 - **7** – Correction to prior claim (e.g., 0137 indicates a correction to a Hospital Outpatient claim)
 - **8** – Void/correction to prior claim
- **Enter the payer's original claim number in Box 64** "Document Control Number."

Rejected vs. Denied Claims

A **rejected claim** is a claim that is sent back due to an error in the claim. This could be due to an input error, incorrect data, or data that does not match what the payer has on file.

A **denied claim** has been processed and adjudicated in the payer system but is **denied and deemed unpayable.** The denial could be for a variety of reasons.

When a claim has been rejected (i.e., it has not been adjudicated), you can resubmit the claim. To resubmit the claim, simply create a new claim and resubmit it through the clearinghouse. **If you resubmit a claim that has been denied, the new claim will be denied as a duplicate claim.**

If Healthy U denied the claim for missing information (i.e., primary insurance EOB not submitted or complete, missing the referring physician, etc.) you can submit a corrected claim. A corrected claim will replace the previously adjudicated claim, so ensure all charges are included on the corrected claim.

Timely Filing Requirement

The timely filing period for Healthy U CHIP primary and secondary claims is 365 days from the date of service.

Note: The exception to this rule is if any kind of Medicare is the primary insurance. When Medicare is the primary insurance, the claim must be submitted within the later of 365 days from the date of service or 180 days from the Medicare EOB date. Corrections to a Healthy U CHIP claim must also be received and/or adjusted **within the later of 365 days** from the date of service or 180 days from the Medicare EOB date.

Coordination of Benefits

Coordination of benefits (COB) ensures patients receive benefits from all health insurance plans under which they may be covered; while also ensuring that the total combined payment does not exceed the amount charged for the services provided.

When your patient has coverage under two or more payors, Healthy U CHIP will be the payor of last resort. Additional payors to consider include other health insurance plans or liability plans such as Worker's Compensation Fund or property owner's insurance for injury or illness occurring on or caused by the covered property.

When another payer is the primary plan, submit claims to that plan first; then submit the claim—complete with all payment information (i.e., remittance advice)—to other payors in order of primacy. Always include all insurance coverage information on each claim to ensure each insurance plan is aware of other potential payers.

Coordinating with Healthy U CHIP

Healthy U CHIP should always be treated as the payor of last resort. If the patient has any coverage in addition to CHIP, submit the claim to the primary payor first, followed by any additional payor(s) applicable, and then to Healthy U CHIP. Include the remittance advice(s) from the primary and any other payor(s) with the claim. The Healthy U CHIP payment for claims will equal the provider's contracted allowed amount, less any amounts paid by third-party payors.

Claims Editing, Review, and Audit

U of U Health Plans follows standard claims processing guidelines, including but not limited to: current coding manuals and editors, CMS and State of Utah CHIP rules and regulations, standard bundling and unbundling rules, National Correct Coding Initiative (NCCI) guidelines and edits, and FDA definitions and determinations. These coding edits are developed based on procedures referenced in the American Medical Association's (AMA) Current Procedural Terminology (CPT) Manual and the Healthcare Common Procedure Coding System (HCPCS) Manual. All claims are subject to the U of U Health Plans [coverage policies](#). We reserve the right to review and audit, adjust, and pay claims in accordance with the Participating Provider Agreement.

Electronic Data Interchange (EDI)

EDI claims and other transactions can help improve efficiency, productivity, and cash flow for providers. Approximately 80 percent of our claims pass through electronic claim processing without adjudicator intervention. This results in fewer data entry errors and faster turnaround time, 15 days on average, from the date we receive a claim to when payment is received in the provider's office.

U of U Health Plans is a member of the [Utah Health Information Network \(UHIN\)](#), a nonprofit coalition of payers, providers, government entities, accountable care organizations (ACO), managed care entities (MCE), billing services, and other interested parties in Utah. Numerous options are available for electronic claims submission through UHIN.

All electronic claims for U of U Health Plans, and other health plans for which we administer claims, are relayed through the UHIN clearinghouse. UHIN accepts and returns transactions via their Web portal, UTRANSEND; they also connect to most national clearinghouses and support all HIPAA-compliant billing software.

If a provider is not a member of UHIN, other options for sending EDI claims are available. For more information about UHIN and the services they offer, visit uhin.org.

Accepted Transactions

U of U Health Plans is HIPAA-compliant in the following transactions:

- 837 005010X224 (Dental)
- 837 005010X222A1 (Professional claims)
- 837 005010X223A2 (Institutional claims)
- 277CA Claim Acknowledgement/error report
- 999 Acknowledgement
- 835 005010X221A1 (Remittance advice)
- EFT (Electronic funds transfer) in conjunction with the 835
- COB (Coordination of Benefits)
- 270/271 0051010X279A1 Eligibility Request/Response (real-time)
- 276/277 Claim status inquiry/response (real-time)

Trading Partner Registration

If you currently submit electronic transactions through a clearinghouse, it is not necessary to register with UHIN. Established clearinghouses already have a trading partner number set up to submit electronic transactions through UHIN to Utah payers.

The U of U Health Plans trading partner number with UHIN is HT000179-002.

EDI Enrollment Process

A Provider must be enrolled with EDI for claims submission (837) to be eligible for Electronic Remittance Advices (ERA or 835) and Electronic Funds Transfer (EFT) transactions. The 835 and EFT transactions are interdependent (i.e., to receive the 835 a provider must be enrolled with the EFT, and to receive the EFT a provider must be enrolled with the 835); therefore, a Provider must enroll in both transactions. Data is associated with the billing provider's NPI.

Enrollment for Electronic Remittance Advices (ERA) is accomplished through your clearinghouse. Once your enrollment is set up, they will submit the information to U of U Health Plans on your behalf.

Once U of U Health Plans has received the EDI enrollment form, we will begin setting up the EDI connections. We will notify the provider by email once the setup is complete.

Submitting Claims through UHIN

There are several different options for submitting claims through UHIN:

- **Direct link** - Providers can transmit a HIPAA-compliant file from their billing system directly to UHIN
- **Clearinghouses** - UHIN has a connection to most national clearinghouses and supports all HIPAA-compliant billing software
- **MYUHIN** - Billing Software provided by UHIN

Other clearinghouses

The following table is a partial list of UHIN-contracted clearinghouses:

| CLEARINGHOUSE | PAYER ID | CLEARINGHOUSE | PAYER ID |
|------------------------------|----------------|----------------------|----------------|
| Apex EDI | # UHUOU | Med USA | # HT000179-002 |
| Availity | # SX155 | Office Ally | # SX155 |
| Change Healthcare/ Emdeon | # SX155 | Optum Clearinghouse | # SX155 |
| Claim MD | # SX155 | Practice Insight | # SX155 |
| ClaimRemedi | # SX155 | RelayHealth/McKesson | # SX155 |
| Eligible | # SX155 | SSI Group | # SX155 |
| Med USA | # HT000179-002 | TriZetto | # 00179 |
| Office Ally | # SX155 | Zirmed/Waystar | # Z1030 |

Note: Payer ID numbers are assigned by the clearinghouse. U of U Health Plans does not assign or maintain these numbers; therefore, contact your clearinghouse for Payer ID information.

For help with EDI questions, please email uuhpEDI@hsc.utah.edu.

Payment

Provider payments will be issued via Electronic Funds Transfer (EFT), if the provider is enrolled for this service, or via virtual credit card.

Remittance Advice

U of U Health Plans generates an explanation of how each claim was processed (remittance advice) when processing is complete. Remittance advices summarize all claims processed for that provider, by patient, during that claim period. Each claim is assigned a number and clearly identifies provider, patient, dates of service, billed charges, allowed amount, paid amount, and reason codes for any processing decisions.

Providers can view remittance advices by the following methods:

- Via our secure [Provider Portal](#)* for contracted providers – registration is required
- Via an 835 EDI transaction, if set up for this feature
- Or by postal mail if not set up for electronic transactions

Note: Because of the singular nature of the Healthy U CHIP appeal process, please view the CHIP Appeals Process information later in this section of the Provider Manual.

If you have a question on the processing or payment of a claim, please contact a Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525**.

* To learn more about our secure Provider Portal, email uofuhpproviderportal@hsc.utah.edu.

Overpayments/Refunds

In the event that U of U Health Plans determines that a claim has been overpaid, we will recover the balance due by way of offset or retraction from current and/or future claims. Provisions for repayment of refunds included in the U of U Health Plans Participating Provider Agreement supersede those contained in this manual. If necessary, U of U Health Plans may refer unresolved recovery of funds to the Utah Office of Inspector General (OIG) for collection.

If overpayments are identified through the Fraud, Waste and Abuse department, the provider will be notified in writing and will be given 60 days to dispute or refund the overpayment. If the provider fails to submit the balance due within 60 days of notification, U of U Health Plans may recover the balance due by way of offset or retraction from current and/or future claims. If necessary, U of U Health Plans may refer unresolved recovery of funds to the Utah OIG for collection.

Please notify us immediately if you discover an error requiring the claim to be reprocessed.

Billing Members

Copayments

A copayment, or copay, is a fixed amount that a member is responsible to pay to the provider at the time of service (e.g., office visits).

Copayments vary according to the member's particular benefit plan: B, C, or No Cost Sharing. Each member's ID card indicates the amount of copayment the member is required to pay. The member is responsible for only one copayment per office visit and is responsible for paying the copayment to providers participating with Healthy U CHIP at the time of service.

Preventive services are not subject to copays. Verified American Indian and Alaska Native children do not pay copays. Members who have met their maximum out-of-pocket amount also do not pay copays.

Deductibles

A deductible is an amount the member must pay out of their own pocket before benefits for a specific service are paid by the plan. Members are required to pay a deductible, based on their plan eligibility. Each plan will indicate separate deductible amounts for individual and family deductibles. A family deductible is satisfied when the combined family members' deductibles meet the amount set for the family deductible. One family member cannot satisfy the entire family deductible.

The deductible must be paid before CHIP can pay the remaining allowable amounts of inpatient or outpatient hospital claims or major diagnostic services. Once the deductible has been met, the member no longer has a deductible for the remainder of the plan year. The deductible plan year starts on July 1 and ends on June 30 in the following year.

Deductible amounts are identified on the provider's remittance advice and on the member's EOB.

Coinsurance

Coinsurance is the percentage of an eligible medical expense that is payable by the member after the deductible is met. This amount, combined with any amount paid by Healthy U CHIP, will total 100% of the provider's contracted rate. Coinsurance usually applies to the out-of-pocket maximum (e.g., ambulance, emergency room, surgery, anesthesia).

Out-of-Pocket Maximum

An out-of-pocket maximum (OOPM) is the most a member will pay in cost sharing for out-of-pocket expenses during their benefit period. The OOPM is based on 5% of their countable household income. The benefit period is the 12-month period that begins with their first month of CHIP eligibility. Premiums, deductibles, coinsurance, and copays all count toward the OOPM.

The OOPM applies collectively to all CHIP members in the same CHIP household (case number assigned by the Department of Workforce Services). Noncovered services do not apply toward the OOPM.

If a member feels they have met their OOPM or has questions regarding copayment, deductible, coinsurance, etc., contact Customer Service at **833-404-4300** or **801-213-0525**.

CHIP Copay Chart

| BENEFITS (PER PLAN YEAR) | PLAN B – COPAY* | PLAN C – COPAY* |
|--|--|---|
| OUT-OF-POCKET MAXIMUM** | 5% of family's household income | 5% of family's household income |
| PRE-EXISTING CONDITION | No waiting period | No waiting period |
| DEDUCTIBLE | \$70/Family | \$575/Child \$1,600/Family |
| WELL-CHILD EXAMS | \$0 | \$0 |
| IMMUNIZATIONS | \$0 | \$0 |
| DOCTOR VISITS | \$5 | \$25 |
| SPECIALIST VISITS | \$5 | \$40 |
| EMERGENCY ROOM | \$10 | 20% after deductible, minimum of \$150 per visit |
| AMBULANCE | 5% of approved amount after deductible | 20% of approved amount after deductible |
| URGENT CARE | \$5 | \$45 |
| AMBULATORY SURGICAL AND OUTPATIENT HOSPITAL | 5% of approved amount after deductible | 20% of approved amount after deductible |
| INPATIENT HOSPITAL SERVICES | \$150 after deductible | 20% of approved amount after deductible |
| LAB AND X-RAY | <ul style="list-style-type: none"> • \$0 for minor diagnostic test and x-rays • 5% of approved amount after deductible for major diagnostic tests and x-rays | <ul style="list-style-type: none"> • \$0 for minor diagnostic test and x-rays • 20% of approved amount after deductible for major diagnostic tests and x-rays |

| CHIP Copay Chart (Continued) | | |
|--|---|---|
| BENEFITS (PER PLAN YEAR) | PLAN B – COPAY* | PLAN C – COPAY* |
| SURGEON | 5% of approved amount after deductible | 20% of approved amount after deductible |
| ANESTHESIOLOGIST | 5% of approved amount after deductible | 20% of approved amount after deductible |
| PRESCRIPTONS <ul style="list-style-type: none"> • PREFERRED GENERIC DRUGS • PREFERRED BRAND NAME DRUGS • NON-PREFERRED DRUGS | <ul style="list-style-type: none"> • \$5 • 5% of approved amount • 5% of approved amount | <ul style="list-style-type: none"> • \$15 • 25% of approved amount • 50% of approved amount |
| MENTAL HEALTH AND SUBSTANCE USE DISORDER <ul style="list-style-type: none"> • INPATIENT • OUTPATIENT, OFFICE VISIT AND URGENT CARE | <ul style="list-style-type: none"> • \$150 after deductible • \$0 | <ul style="list-style-type: none"> • 20% of approved amount after deductible • \$0 |
| RESIDENTIAL TREATMENT | \$0 | \$0 |
| MEDICAL THERAPY <ul style="list-style-type: none"> • PHYSICAL • OCCUPATIONAL • SPEECH | <ul style="list-style-type: none"> • \$5 (20 visit limit per year) • \$5 (20 visit limit per year) • \$5 (20 visit limit per year) | <ul style="list-style-type: none"> • \$40 after deductible (20 visit limit per year) • \$40 after deductible (20 visit limit per year) • \$40 after deductible (20 visit limit per year) |
| APPLIED BEHAVIOR ANALYSIS (ABA) / TREATMENT OF AUTISM SPECTRUM DISORDER | \$0 | \$0 |
| CHIROPRACTIC VISITS | Not a covered benefit | Not a covered benefit |
| HOME HEALTH AND HOSPICE | 5% of approved amount after deductible | 20% of approved amount after deductible |
| MEDICAL EQUIPMENT AND MEDICAL SUPPLIES | 10% of approved amount after deductible | 25% of approved amount after deductible |
| DIABETES EDUCATION | \$0 | \$0 |
| VISION SCREENING | \$5 (1 visit limit per year) | \$25 (1 visit limit per year) |
| HEARING SCREENING | \$5 (1 visit limit per year) | \$25 (1 visit limit per year) |

*Copay plans are based on the family's household income. American Indian/Alaska Natives will not be charged copays, coinsurance or deductibles. CHIP members who have met their out-of-pocket maximum will not be charged copays, coinsurance or deductibles.

** CHIP (DWS) will send CHIP members an approval letter that will include the out-of-pocket maximum amount.

Women's Services

Healthy U CHIP has special programs in place to ensure that CHIP-eligible women receive the highest quality healthcare.

“U Baby Care”

Healthy U CHIP offers a specialized team of nurses to help members who are pregnant access services and support to have a healthy baby. To ensure members are aware of the resources available, please notify us of all pregnant Healthy U CHIP members in your care.

The U Baby Care program is available for all pregnant members upon notification of pregnancy. A case manager (RN) is on staff to take calls from members who have questions or concerns regarding their pregnancy and to provide care management services.

When we are notified (via state report, provider notification, member notification, hospital admit) of a pregnant Healthy U CHIP member, one of the U Baby staff will reach out to complete a pregnancy risk survey. Based on the results of the survey the risk of preterm birth is stratified as low, medium or high. The survey also evaluates psycho-social needs that may impact pregnancy. Depending on the survey results, the care manager assists the member to identify a plan of care that will support her throughout her pregnancy.

Healthy U CHIP services for members who are pregnant include, but are not limited to, prenatal, perinatal, and postpartum care coordination, connecting to community resources (WIC, Safe Kids, etc.), group prenatal education, referrals to maternal fetal medicine, and to doula services. Screening for depression is also conducted on U Baby members, with support and referrals provided as needed. The RN care managers also provide education about sexually transmitted disease and family planning, depending on member interest.

Providers may refer members for any of these services. Please call the Healthy U CHIP Care Management department at **833-981-0212**, option 2, or **801-587-2851** for questions about services or to refer a member to the U Baby Program. We want to collaborate and be part of the healthcare team.

Healthy U honors the Newborn's and Mother's Health Protection Act. Mother and baby have the right to stay inpatient for 48 hours after a vaginal delivery and 96 hours after a cesarean section.

For additional information visit [Newborns' and Mothers' Health Protection Act](#) (NMHPA).

Mammography

Mammography reminder letters and follow up calls go out to members meeting the mammogram criteria that have not had a mammogram within two years.

Mammogram screenings are covered for Healthy U members.

Cervical Cancer Screening

Healthy U recommends and covers Cervical Cancer Screening (pap test) for all female members on a yearly basis. Chlamydia Screening is also recommended and covered by Healthy U CHIP.

Family Planning Services

Family planning services are CHIP-covered services and must be made available to Healthy U CHIP patients free of charge. This includes disseminating information, counseling, and treatment related to family planning services. Healthy U members can go to any provider actively enrolled in the state's PRISM system for family planning even if he or she is not a Healthy U CHIP provider.

Birth control services include information and instructions related to birth control pills including emergency contraceptive pills, Depo Provera, IUDs, the birth control patch, the ring (NuvaRing®), spermicides, barrier methods including diaphragms, male and female condoms and cervical caps, vasectomy, or tubal ligations. Office calls, examinations and counseling related to contraceptive devices are also covered and must be made available to Healthy U CHIP patients. The removal of Norplant is also a covered benefit.

Note: Elective tubal ligations and vasectomies must have the sterilization consent form signed 30 days prior to the procedure. The form expires 180 days after the consent form is signed.

Note: Any provider participating with Healthy U CHIP who does not wish to offer family planning services because of religious or personal reasons should contact Healthy U CHIP Provider Relations at **833-970-1848** or **801-587-2838** so patients can be directed to an alternate provider.

The following family planning services are not covered:

- Norplant
- Infertility drugs
- In-vitro fertilization
- Genetic counseling

Well-Child Outreach and Education

Families of CHIP-eligible children are encouraged to seek early and repeated well-child health care visits beginning, ideally, at birth and continuing through the child's 19th birthday. The Utah Department of Health and Healthy U CHIP provide outreach services to families to ensure they are informed of the importance of well-child care and that a visit is due. Healthy U also conducts education sessions for primary care provider offices to keep them up-to-date with the well-child coverage criteria. For more information about outreach education, call Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525**.

Screening and Prevention Services

- **Comprehensive Health History**- Including an assessment of physical and mental development obtained from the parent, guardian, or other responsible adult who is familiar with the child's history
- **Developmental History** – The Bright Futures [Toolkit](#) from [Bright Futures](#)TM, supported in part, by the American Academy of Pediatrics[®], is recommended by the Department of Health and Human Services (DHHS) for children

Nutritional History – To identify nutritional deficiencies or unusual eating/feeding habits

Dental History

Comprehensive Physical Examination – Standardized physical examination with an assessment of all body systems and a complete oral inspection of the mouth, teeth and gums

Measurement of Length, Height, and Weight – Measure and plot these items (and, for each child two years of age and younger, the occipital frontal head circumference) on the [CDC Growth Charts](#)

Vision Screening – Services include diagnosis and treatment for defects in vision. When needed, refer the child to the appropriate specialist. Further evaluation and proper follow-up are recommended for the following vision problems:

- Infants and children who show evidence of enlarged or cloudy cornea, cross eyes, amblyopia, cataract, excessive blinking, or other eye abnormality
- A child who scored abnormally on the fixation test, the pupillary light reflex test, alternate cover test, or corneal light reflex in either eye
- A child with unequal distant visual acuity (a two-line discrepancy or greater)
- A child less than five years of age with distant visual acuity of 20/50 or worse, or a child five years of age or older with distant visual acuity of 20/40 or worse

Hearing Services – Services include diagnosis and treatment for defects in hearing, including hearing aids. Screening should be supervised by a state-licensed audiologist

- If a newborn was not screened in the birthing facility before discharge, a screening test should be conducted as soon as possible after birth
- Conduct screening exams on all children during the first well-child exam and perform at each periodic visit if indicated by historical findings or the presence of risk factors
- When indicated, Infants require screening every six months until three years of age
- When needed, refer the child to an appropriate specialist

Speech and Language Development – Screen for appropriate development and to identify developmental delays. The following developmental landmarks for screening are recommended:

- At six months a child babbles and initiates social approach through vocalization
- At one year a child says 'mama' and 'dada' specifically and engages in vocal play
- At two years a child begins connecting words for a purpose, such as 'me go' and 'want cookie'
- At three years a child holds up her fingers to show her age and has a vocabulary of 500 to 1,000 words. She will use an average of three to four words per utterance.
- At four years a child's speech should be 90% intelligible. They can make some articulation errors with letters s, r, l, and v. They should use a minimum of four to five words in a sentence.
- Refer the child for a speech and hearing evaluation if you observe one or more of the following:
 - Child is not talking at all by age 18 months
 - You suspect a hearing impairment
 - Child is embarrassed or disturbed by his own speech
 - Child's voice is monotone, extremely loud, largely inaudible, or of poor quality
 - A noticeable hypernasality or lack of nasal resonance
 - Child fails the screening tests
 - Recurrent otitis media
 - Speech is not understandable at age four years, especially in cases of suspected hearing impairment or severe hypernasality

Blood Pressure Measurements – Measure at each exam and compare against age-specific percentiles for all children three years and older

Age-appropriate Immunizations – Assess whether the child's immunizations are up to date. Provide all appropriate immunizations according to [Childhood Immunization Timing](#) or [CDC Vaccines & Immunizations](#). For additional information, visit [Utah Immunization Program](#).

You can also refer the child to the local health department for immunizations.

Laboratory Testing – Determine the applicability of specific tests for each child. Perform the following laboratory tests at the time of the well-child screening using the recommendations of the American Academy of Pediatrics to determine the specific periodicity of each of the following tests:

- Newborn Metabolic Disease Screening
- Hematocrit or Hemoglobin Screening
- Tuberculin Screening - with annual testing for the following high-risk groups:
 - American Indian and Alaskan native children
 - Children living in neighborhoods where the case rate is higher than the national average
 - Children from Asia, Africa, the Middle East, Latin America or the Caribbean (or children whose parents have emigrated from these locations)
 - Children in households with one or more cases of tuberculosis
- Cholesterol Screening – Conduct at your discretion based on the risk of the child
- Lead Toxicity Screening – The Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend a lead risk assessment and a blood lead level test for children between the ages of 6 and 72 months. All children in this age group are considered at risk and must be screened. This component of the well-child screening is mandated by federal rules.
 - Verbal Lead Risk Assessment – Complete a verbal risk assessment for all children ages 6 to 72 months at each well-child screening. Beginning at 6 months of age, a verbal risk assessment must be performed at every well-child visit. At a minimum, the following questions must be asked to determine the child's risk for lead exposure:
 - Does the child live in or regularly visit a house built before 1978? Was his/her childcare center or preschool/babysitter's home built before 1978? Does the house have peeling or chipping paint?
 - Does the child live in a house built before 1978 with recent, ongoing or planned renovation or remodeling?
 - Do any of the child's siblings or playmates have lead poisoning?

- Does the child frequently come in contact with an adult who works with lead? (Examples are construction, welding, pottery, or other trades practiced in your community.)
 - Does the child live near a lead smelter, battery recycling plant, or other industry likely to release lead? (Give examples in your community.)
 - Do you or anyone give the child home or folk remedies that may contain lead?
 - Does the child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
 - Does the home the child lives in have lead pipes or copper with lead solder joints?
- Scoring the Verbal Risk Assessment:
 - Low Risk for Lead Exposure: If the answers to all questions are negative, a child is considered low risk and must receive a blood lead test at 12 and 24 months.
 - High Risk for Lead Exposure: If the answer to any question is positive, a child is considered high risk, and a blood lead level test must be obtained regardless of the child's age. Subsequent verbal risk assessments can change a child's risk category. If a previously low-risk child is re-categorized as high risk, that child must be given a blood lead level test.
- Complete a blood lead level testing at required intervals:
 - At 12 and 24 months: Complete for all children regardless of verbal assessment score.
 - Between 24 and 72 months: Complete a blood lead level test if the child has not had it at 12 and 24 months regardless of the verbal assessment score. In addition, complete a test anytime the verbal assessment indicates the child is at high risk for lead poisoning.
 - Reportable blood lead levels:

Blood lead level samples can be capillary or venipuncture. However, a blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen must be confirmed using a venous blood sample. In accordance with the Utah Injury Reporting Rule (R386-703), all confirmed blood lead levels greater than 15 ug/dL must be reported to the Utah Department of Health, Bureau of Epidemiology which maintains a blood lead registry. 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 Services.

Other Tests - Consider other tests based on the appropriateness of the test (e.g., the child's age, sex, health history, clinical symptoms and exposure to disease)

Health Education – This is a well-child requirement that includes anticipatory guidance. It should be provided to parents/guardians and children, and include information regarding developmental expectations, techniques to enhance development, benefits of healthy lifestyles, accident, injury and disease prevention, and nutrition counseling.

Recommended: View the CDC's [Child and Adolescent Immunization Schedule by Age](#)

Mental Health – Services that support young children's healthy mental development can reduce the prevalence of developmental and behavioral disorders which have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems.

Broadly defined, screening is the process by which a large number of asymptomatic individuals are tested for the presence of a particular trait. Screening tools offer a systematic approach to this process. Ideally, tools that screen for the mental development of young children should:

- Help to identify those children with or at risk of behavioral developmental problems
- Be quick and inexpensive to administer
- Be of demonstrated value to the patient and provide information that can lead to action
- Differentiate between those in need of follow-up and those for whom follow-up is not necessary
- Be accurate enough to avoid mislabeling many children
- Screen the child for possible mental health needs. You can use a standardized behavior checklist to do this screen. We recommend the following social-emotional screening tools for screening infants 0-12 months:
 - Ages and stages questionnaire (ASQ)
 - Ages and stages questionnaire: social-emotional (ASQ:SE)
 - Parent's evaluation of developmental status (PEDS)
 - Temperament and Atypical Behavior Scale (TABs)

Screening accompanied by referral and intervention protocols can play an important role in linking children with and at-risk for developmental problems with appropriate interventions. Refer children with suspected mental health needs for mental health assessment. Mental health services include diagnosis and treatment for mental health conditions.

Dental services are not covered by Healthy U CHIP. Dental services are covered by Premier Access CHIP. For information about CHIP dental, contact Premier Access at **877-854-4242**.

Reimbursement for Wellness Services

The wellness fee includes payment for all components of the well-child exam. Services like administering immunizations, laboratory tests, and other diagnostic and treatment services can be billed along with the Wellness screening.

Use the Preventive Medicine codes listed in the table below each time you complete a well-child exam. Use these codes even if the child presents with a chronic illness and/or other health problem. Please avoid billing well-child exams using Evaluation and Management codes. If you do use an Evaluation and Management code, it should be accompanied by the appropriate ICD-10 V code in the table below to identify it as a well-child exam.

| Codes for Preventative Medicine Services | |
|--|--|
| New Patient | Established Patient |
| 99381 Infant – less than 1 year of age | 99391 Infant – less than 1 year of age |
| 99382 Early childhood – age 1 through 4 years | 99392 Early childhood – age 1 through 4 years |
| 99383 Late childhood – age 5 through 11 years | 99393 Late childhood – age 5 through 11 years |
| 99384 Adolescent – age 12 through 17 years | 99394 Adolescent – age 12 through 17 years |
| 99385 Young adult – age 18 through 20 years | 99395 Young adult – age 18 through 20 years |

To bill for a well-child screening electronically, enter the procedure code in **loop 2400 - Service Line**. The element is **SV101-2 - Product/Service ID**. In element **SV111**, enter "Y" to indicate **EPSDT/CHEC**. On a paper claim, enter the procedure code in **box 24-D** and enter "Y" in **box 24-H EPSDT**.

For additional information regarding the latest in Pediatric Health, visit [Women's Health Services](#) or [Recommendations for Preventive Pediatric Health Care](#).

Prior Authorization Reviews

Prior authorization or pre-authorization is a process used by Healthy U CHIP to assure health benefits are administered as designed, that members receive treatments that are safe and effective for the condition being treated, and that the treatments used have the greatest value. Prior authorizations require the contracted provider to receive preapproval for coverage of a particular treatment in order for the service to be covered by the health plan benefit.

The experienced staff of U of U Health Plans Utilization Management department conducts Healthy U CHIP prior authorization reviews and makes decisions in alignment with all of our other benefit plans.

The basic elements of prior authorization include eligibility verification, benefit interpretation, and medical necessity review. Services are reviewed and determinations are made by Utilization Management's licensed professional staff and referred to the Medical Director as necessary. Only the Medical Director or pharmacist can deny a service for reasons of medical appropriateness or necessity.

Prior authorization requests for a Healthy U CHIP member can be submitted via the following methods:

- [Provider Portal](#) – requires registration and log in
- [Prior Authorization Form](#) – submitted online
- [Prior Authorization Form" PDF](#) to download, complete, and fax as directed

In addition to submitting the request as outlined above, we require clinical documentation supporting the requested services, including but not limited to:

- Medical History (including treatment, diagnostic tests, examination data)
- Description of treatment plan and treatment to date
- Diagnostic/laboratory/radiology results
- Clinical notes that are necessary to certify medical necessity

Prior authorization decision timeframes

- Decision timeframes begin the date when Healthy U CHIP receives the request, even if not all necessary information is provided, and even if the request is received after normal business hours.
- A written notification of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, is made according to the following timeframes:
- Standard prior authorization requests: Healthy U CHIP provides written or electronic notification of the decision which is faxed or mailed to providers and members as expeditiously as the member's health condition requires, but no later than 14 calendar days from the receipt of the request for authorization.
- Expedited authorization requests: Healthy U CHIP provides a written or electronic notification of the decision which is faxed or mailed to providers and members as expeditiously as the member's health condition requires, but not later than 72 hours after the receipt of the request for authorization.
- Post-service review decisions – Healthy U CHIP provides a written or electronic notification of the decision which will be faxed or mailed to providers and members within 30 calendar days of receipt of request.

- Extending the UM decision-making timeframes – UUHP may extend the time frame for making standard or expedited decisions no longer than 14 calendar days from the original 14-day determination if:
- The member or the provider requests an extension
- UUHP justifies a need for additional information
- No other reason other than needing more information is used for extending authorization timelines outside the additional 14 days.
- Visit [Prior Authorization Reviews](#) for complete information about the prior authorization process.
- Visit [Search Codes Requiring Prior Authorization](#) to view all codes that require prior authorization.

Prior Authorization Review for Retail Pharmacy

Information on submitting Retail Pharmacy prior authorizations is available on our [Healthy U CHIP Pharmacy](#) page.

- Prior authorization decision timeframes for retail pharmacy:
- Decision timeframes begin the date Healthy U CHIP receives the request, even if not all necessary information is provided, and even if the request is received after normal business hours.
- A written notification of all decisions is made according to the following timeframe:
- Standard and expedited prior authorization requests: Healthy U CHIP provides written and/or electronic notification of the decision which is faxed or mailed to providers and mailed to members within 24 hours after the receipt of the request for prior authorization.

CHIP Appeals Process

With respect to CHIP plans, it is important your provider office understands the CHIP appeals process, including the right to a State Fair Hearing. Below are the definitions, standards, and timelines applicable to Healthy U CHIP. The process below applies to CHIP and Medicaid plans only.

Information regarding the appeals process for other provider networks (for Commercial group and Individual/Family exchange members) is available in the [Claims Appeals Process section](#) of our Provider Manual.

Definitions

Adverse Benefit Determination means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered service
- The reduction, suspension, or termination of a previously authorized service
- The failure to provide services in a timely manner, as defined as failure to meet performance standards for appointment waiting times
- The failure of Healthy U CHIP to act within the time frames established for resolution and notification of Grievances and Appeals
- For a resident of a rural area with only one MCO, the denial of an enrollee's right to exercise his or her right to obtain services outside the network
- The denial of an enrollee's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities
- A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is **not** an adverse benefit determination

Appeal means a review of an adverse benefit determination made by Healthy U CHIP.

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination made by Healthy U CHIP. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or an employee, failure to respect the enrollee's rights regardless of whether remedial action is requested.

Appeals Filing Process

- The Member must be eligible on the date of service.
- The member or provider can file an appeal. The appeal form and instructions are included in the Notice of Adverse Benefit Determination (NOABD) for a prior authorization denial, partial authorization, or reduction in service. Appeals can be submitted online, or printed and faxed or mailed. Complete information is available on the [University of Utah Health Plans Appeal Form](#). Timeframe instructions and reference to appeals information and the website address is also included in the EOB.
- The appeal must be filed within 60 calendar days of the date on the adverse benefit determination notification. §438.402
- Appeals not received within 60 calendar days of the notification date will be returned with a letter noting the receipt date of the appeal, and that it is past the timely filing deadline for submitting an appeal. A State Fair Hearing Form and instructions on filing a State Fair Hearing Request will be included with the letter.

- Providers, enrollees and authorized representatives may call Healthy U Customer Service at **833-404-4300** or **801-213-0525** to resolve claim or service concerns by phone; however, this does not replace or extend the timely filing of an appeal. If the member or provider does not agree with a decision, they should [submit an appeal](#).
- Members/Providers may submit any information that they feel is relevant to the appeal.
- Reasonable language assistance is available through Translation Services or Utah Relay Services, upon the member's request.

U of U Health Plans will accept oral (telephone) or written (fax, mail, email, online) appeals from providers, members, or a member's authorized representative. Oral inquiries requesting review of an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal.

- Oral appeal requests can be made by calling Healthy U CHIP Customer Service at **833-404-4300** or **801-213-0525**.
 - The Customer Service Advocate will enter oral appeals on the online [Appeal Form](#) that automatically records the receipt date.
 - If a member is requesting an oral appeal, they can give their verbal consent to the Customer Service Advocate assisting them so that the oral appeal can be considered as a valid appeal.
- Written appeal requests are made by mailing or faxing the completed [Appeal Form](#) to:

University of Utah Health Plans Appeals Department
P.O. Box 45180
Salt Lake City, UT 84145
Fax: 801-587-9985
- Appeals received via mail, in person delivery, or fax will be stamped with the date received.
- For online appeal requests, use the [University of Utah Health Plans Appeal Form](#).
- Parties to the Appeal include U of U Health Plans; as well as the enrollee and their representative—who may include legal counsel, treating provider, a relative, a friend or other spokesperson, or the representative of a deceased enrollee's estate.

Appeal Classifications and Decision Timeframes

Routine Standard Appeal

An appeal regarding the initial determination of coverage of care or services in advance of the member obtaining services, or services that have already been received by the member. A written notice of the appeal decision will be sent to the member within 30 days of receipt of the appeal.

Expedited Appeal

An appeal for coverage of urgent care. An expedited appeal is available if the member or provider indicates that taking time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

- A written notification of the expedited appeal decision will be sent to the member within 72 hours of receipt of the appeal.
- U of U Health Plans must ensure that no punitive action is taken against a provider who requests an expedited appeal resolution or supports a member appeal.
- If U of U Health Plans denies the request for expedited resolution, the appeal request will be transferred to a standard timeframe appeal. [§438.408(b)(2)]. U of U Health Plans will make reasonable efforts to give the enrollee and provider prompt, oral notice of the denial, and will follow up with written notice in 72 hours.
- The notification to members will include information about the member's right to file a grievance if they disagree with the downgrade.

Timeframe Extension

U of U Health Plans may extend the time frames for resolution of appeals (expedited and standard) by up to 14 calendar days if:

- The member requests or agrees to extend the appeal timeframe
- U of U Health Plans can document (to the satisfaction of the Utah Department of Health, upon request) that there is need for additional information and how the delay is in the member's interest
- If U of U Health Plans extends the timeframes, it must give the member written notice of the reason for the extension within two business days and inform the member of the right to file a grievance if they disagree with that decision
- U of U Health Plans must act as quickly as the member's health condition requires, and no later than the date the extension expires

If U of U Health Plans extends the time frames, it must, for any extension not requested by the member:

- Make reasonable efforts to give the member prompt, oral notice of the delay
- Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a Grievance if they disagree with that decision
- If U of U Health Plans fails to adhere to the notice and timing requirements for extension of the appeal resolution time frame, the member may initiate a State Fair Hearing

Continuing Coverage

Requirements for continuing or reinstating benefits while an appeal is pending are as follows:

- The member or provider files the appeal request timely
- The appeal involves the termination, suspension, or reduction of a previously approved service
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- An enrollee requests an extension of benefits within 10 calendar days of the NOABD

Continued benefits will end when one of the following occurs:

- The member or provider fail to file a State Fair Hearing Request Form requesting continuation of benefits within 10 calendar days of the NOABD
- The state fair hearing request is withdrawn
- The state fair hearing office issues a decision adverse to the member
- If the final resolution of the hearing is adverse to the member (U of U Health Plans decision is upheld), U of U Health Plans may recover the cost of the services provided to the member while the hearing was pending, to the extent that they were provided solely because of the requirements §438.420

State Fair Hearing

- The Healthy U Appeals process must be exhausted before the member or provider can request a state fair hearing.
- A member, their representative (or legal representative of a deceased member's estate), or provider may request a state fair hearing within 120 days from the date on the Notice of Appeal Resolution.

- The [State Fair Hearing Request Form](#) will be included with the Notice of Appeal Resolution.
- Visit [Hearings](#) on the Medicaid website for additional information about filing for a state fair hearing and access the “State Fair Hearing Request Form,” in English or Spanish.
- In addition, a copy can be requested from our office by calling **833-404-4300** or **801-213-0525**.

Mailing Address:

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

Email: utmedicaidhearings@utah.gov

Fax: 801-536-0143

- Parties to the state fair hearing include U of U Health Plans; as well as the enrollee and their representative—who may include legal counsel, treating provider, a relative, a friend or other spokesperson, or the representative of a deceased enrollee's estate.
- The parties to the state fair hearing are given opportunity to: examine the content of the enrollee's file and all documents and records to be used by U of U Health Plans at the hearing, bring witnesses, establish all pertinent facts and circumstances, and present an argument without undue interference. They may question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.
- Requirements for continuation or reinstating benefits while a state fair hearing is pending are as follows:
 - The member or provider files the hearing request timely
 - The request involves the termination, suspension, or reduction of a previously approved service
 - The services were ordered by an authorized provider
 - The original period covered by the original authorization has not expired
 - An enrollee requests an extension of benefits within 10 calendar days of the NOABD
- Continued benefits will end when one of the following occurs:
 - The member or provider fail to file a State Fair Hearing requesting continuation of benefits within 10 calendar days of the NOABD
 - The state fair hearing request is withdrawn
 - The state fair hearing office issues a decision adverse to the member
- If the final resolution of the hearing is adverse to the member (U of U Health Plans decision is upheld), U of U Health Plans may recover the cost of the services

provided to the member while the hearing was pending, to the extent that they were provided solely because of the requirements §438.420.

Coverage Policies

Visit [Coverage Policies](#) to view guidelines for our coverage determinations.

Additional Resources

- [U of U Health Plans Provider Manual](#)
- [Healthy U CHIP](#)
- [Healthy U CHIP Member Handbook](#)
- [CHIP Website – State of Utah](#)