

2004

IHC Health Systems, Inc. d/b/a LDS Hospital v. Utah Department of Health, Division of Health Care Financing : Appellee's Brief

Utah Court of Appeals

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Recommended Citation

Brief of Appellee, *IHC Health Systems v. Utah Department of Health*, No. 200440487 (Utah Court of Appeals, 2004).
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IN THE UTAH COURT OF APPEALS

IHC HEALTH SYSTEMS, INC.
d/b/a LDS HOSPITAL,

Petitioner/Appellant,

vs.

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE
FINANCING,

Defendant/Appellee.

APPELLEE'S BRIEF

Case No. 200440487-CA

REVIEW FROM AGENCY DECISION BY UTAH DEPARTMENT
OF HEALTH, DIVISION OF HEALTH CARE FINANCING
DECISION NO. 03-224-22

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UTAH COURT OF APPEALS
BRIEF

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ORAL ARGUMENT AND PUBLISHED OPINION NOT
REQUESTED BY PETITIONER

FILED
UTAH APPELLATE COURTS
OCT 29 2004

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**ORAL ARGUMENT AND PUBLISHED OPINION NOT
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TABLE OF CONTENTS

	<u>Page</u>
TABLE OF AUTHORITIES	ii
COMPLETE LIST OF ALL PARTIES IN THE DISTRICT COURT	1
JURISDICTION	1
STATEMENT OF ISSUES/ STANDARDS OF REVIEW	2
STATUTES, RULES, CONSTITUTIONAL PROVISIONS	3
STATEMENT OF THE CASE	3
STATEMENT OF FACTS	4
SUMMARY OF ARGUMENT	6
ARGUMENT	7
I. THE PETITIONER FAILED TO PRESERVE THE ISSUES PRESENTED ON APPEAL.	7
II. THE PETITIONER HAS FAILED TO MEET THE REQUIREMENTS OF RULE 24 (a)(9), BY INADEQUATELY BRIEFING THE ARGUMENTS PRESENTED ON APPEAL.	9
III. LDS HOSPITAL HAS FAILED TO PROPERLY CHALLENGE THE FINDINGS OF THE PRESIDING OFFICER.	10
IV. THE HOSPITALS BELIEF THAT THE PATIENT WAS COVERED BY ANOTHER INSURER IN ADDITION TO MOLINA DOES NOT EXCUSE ITS FAILURE TO COMPLY WITH REQUIREMENTS FOR AUTHORIZATION.	11
CONCLUSION	13

TABLE OF AUTHORITIES

	<u>Page</u>
STATE CASES	
Badger v. Brooklyn Canal Co., 966 P.2d 844 (Utah 1998)	7
Brookside Mobile Home Park v. Peebles, 48 P.3d 968 (Utah 2002)	7
Chen v Stewart, 2004 UT 82.	10
First National Bank v. County Board of Equalization, 799 P.2d 1163 (Utah 1990) ...	11
Grace Drilling Co. v Board of Review, 776 P.2d 63 (Utah App. 1989)	11
Hart v. Salt Lake County Commission, 945 P.2d 125 (Utah App. 1997) <i>cert. denied</i> , 953 P.2d 449 (Utah 1997)	8
Intermountain Health Care, Inc. v Board of Review of the Industrial Commission, 839 P.2d 841	11
State v. Thomas, 961 P.2d 299 (Utah 1998)	9
West Valley City v. Martin, 2004 Utah App. 327	3
Zissi v. Utah State Tax Commission, 842 P.2d 848 (Utah 1992)	10
CONSTITUTIONAL PROVISIONS, STATUTES AND RULES	
42 C.F.R. § 438.114 (2003)	4
Utah Code Ann. § 63-46b-16 (2003)	1, 3, 11
Utah Code Ann. § 78-2a-2(a)	1
Utah Administrative Rule 414-1-33	5
Utah Administrative Rule 414-1-13	6
Utah Rules of Appellate Procedure 24(a)(9)	10

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REVIEW FROM AGENCY DECISION BY UTAH DEPARTMENT
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DECISION NO. 03-224-22

COMPLETE LIST OF ALL PARTIES IN THE DISTRICT COURT

The parties are accurately and completely identified in the caption.

JURISDICTION

The Petitioner appeals from a final agency order issued pursuant to a formal adjudicative proceeding in the Utah Department of Health, Division of Health Care Financing. The Utah Court of Appeals has jurisdiction pursuant to Utah Code Ann. § 78-2a-2(a) and *id.* at § 63-46b-16 (2004).

STATEMENT OF ISSUES/ STANDARDS OF REVIEW

1. Because LDS Hospital (the Hospital) failed to provide the Presiding Officer with legal authority or legal analysis regarding its failure to comply with the express terms of the agreement with Molina, did it fail to preserve the issue for appeal?

Failure to preserve an issue for appeal is a matter decided in the first instance by the appellate court. Thus, there is no standard of review.

2. Because the Hospital merely reiterates certain facts asserted below and does not provide legal analysis or argument in support of its position, has the Petitioner adequately briefed the issue consistent with the requirements of Rule 24(a)(9), Utah Rules of Appellate Procedure.

Adequacy of briefing is a matter decided in the first instance by the appellate court. Thus, there is no standard of review.

3. Because the Hospital has failed to marshal any evidence to challenge the finding by the Presiding Officer that the final hospital admission was not emergency care, can the Petitioner assert on appeal that the care was emergent?

Adequacy of marshaling is a matter decided in the first instance by the appellate court. Thus, there is no standard of review.

4. Does the Hospital's belief that there was other insurance available at the time of the final admission excuse its failure to comply with the plain language of the contract and related documents?

The interpretation of contract terms is a question of law and reviewed for correctness. *West Valley City v. Martin*, 2004 Utah App. 327, ¶ 11 (“A trial court’s interpretation of the terms of an unambiguous, integrated contract, presents a question of law and is reviewed for correctness on appeal”).

5. Does the failure of the Petitioner to marshal evidence in support of the findings preclude a challenge that the decision is not supported by substantial evidence?

The decision of the agency may be challenged based upon a determination of fact, made or implied by the agency, that is not supported by substantial evidence when viewed in light of the whole record before the court. Utah Code Ann. § 63-46b-16 (4)(g) (Supp. 2003).

Adequacy of marshaling is a matter decided in the first instance by the appellate court. Thus, there is no standard of review.

STATUTES, RULES, CONSTITUTIONAL PROVISIONS

The full text of the following relevant statutes and rules is included in Addendum B: Utah Rules of Appellate Procedure Rule 24.

STATEMENT OF THE CASE

LDS Hospital “the Hospital” and Primary Childrens Hospital (PCH) provided services to Keyonte Pittman, a Medicaid recipient, from July 22, 2002 through October 29, 2002. The services involved three separate admissions to LDS Hospital and two admissions to PCH. Molina Health Care of Utah, a Medicaid managed care plan, paid for

the first two LDS Hospital admissions and paid for both the PCH admissions. Molina declined to pay for the final admission to the Hospital from August 19, 2002 through October 29, 2002 because the Hospital failed to obtain authorization for that admission. Molina reviewed the initial determination and upheld the decision not to pay. The Hospital appealed the matter to the Utah Department of Health, Division of Health Care Financing for a formal hearing as part of the Medicaid fair hearing process. The Presiding Officer issued a recommended order upholding the determination not to pay. The order was affirmed by the agency. (R. 189-197). A petition for review was filed on June 11, 2004. (R. 206).

STATEMENT OF FACTS

Tawnee Chamberlain was admitted to LDS Hospital (The Hospital) on July 20, 2002 and gave birth to Keyontae Pittman on July 22, 2002 in the Hospital. (R. 31-77, 159). The child was born with a serious medical condition. During the course of treatment, the child had five discrete hospital admissions, including two separate periods at Primary Children's Hospital (PCH) and three at LDS Hospital. The final discharge was from LDS Hospital. The time periods were as follows: LDS Hospital from July 22, 2002 to July 26, 2002 for which there was no authorization; PCH from July 26, 2002 to July 30, 2002 for which there was no authorization¹; LDS Hospital from July 30, 2002 to August

¹ Medicaid rules do not require authorization for emergency care. 42 CFR § 438.114 (2003). Thus, the initial admissions in this case did not require that The Hospital obtain authorization for the birth and delivery. The Presiding Officer's finding that the final admission was not emergency care moves it outside the scope of this provision.

14, 2002 for which there was no authorization; PCH from August 14, 2002 to August 19, 2002 for which there was authorization; LDS Hospital from August 19, 2002 to October 29, 2002 for which there was no authorization Molina paid for the first four admissions. (R. 96). It is the denial of payment for the last admission to LDS Hospital that is the subject of this appeal.

The Hospital admission records listed Molina **Health** Care as a secondary insurer from the time of the initial admission on July 22, 2002 through the end of treatment on October 29, 2002. (R. 178).

The Hospital does not contest the fact that for all relevant times of service, they were subject to the provisions of Utah Administrative Rule 414-1-33, The Medicaid Provider Manual (R. 21), and the contract between IHC Hospitals and Molina Health Care (R. 22-25). The Utah Medicaid Provider Manual states “the [Medicaid] provider must follow the plan’s procedures for authorization in order to receive reimbursement.” (R. 20).

LDS Hospital did not obtain the required authorization at any time during the seventy-two day admission that is the subject of this appeal. PCH did obtain authorization from Molina on August 15, 2002. (R. 14, 15). LDS Hospital, like PCH is a Medicaid provider and so was required to obtain inpatient authorization from Molina **Health** Care in order to qualify for Medicaid payment for the admission from August 19, 2003 through October 29, 2002. (R. 21).

As the Presiding Officer found, there is no dispute that the services were medically necessary. It is also undisputed that the services provided during the final admission did not qualify as emergency care. (R. 193).

SUMMARY OF ARGUMENT

The Presiding Officer properly determined that The Hospital had not authorized with Molina Health Care for the final admission from August 19, 2002 through October 29, 2003 and therefore was not entitled to payment from Molina. The Medicaid Provider Manual (Addendum C), Utah Administrative Rule 414-1-13 (Addendum 2) and the contract between the Hospital and Molina (R. 22-23) all require that the Hospital comply with the authorization requirements for payment through Molina and the Hospital failed to do so. The Hospital has offered no reason why the contract provisions should not apply to this particular case.

In any event, the Hospital asserts no issues on appeal that can be properly addressed by this court. First, The Hospital failed to preserve the issues for appeal by failing to articulate any legal theory to the tribunal below regarding the non-applicability of the express requirements of the various agreements between Molina and the Hospital, and it failed to provide citations to any legal authority in support of its position.

Second, the issues on appeal are inadequately briefed, providing no legal reasoning in support of the Hospitals position and likewise failing to provide even a barebones citation to any legal authority in support of its position.

Third, The Hospital asserts that the findings of the Presiding Officer are not supported by substantial evidence but has not attempted to comply with the requirement that they first marshal all evidence in support of the finding to then challenge the sufficiency of the finding.

Fourth, the Hospital attempts to challenge a specific finding of the Presiding Officer that the care provided during the last admission was not emergency care. Again, it failed to marshal any evidence in support of the finding. Instead, the Hospital simply asserts that the care was emergent, despite a specific finding by the Presiding Officer that it was not.

Because The Hospital failed to preserve the issues for appeal and has not adequately briefed the issues raised on appeal, the agency's order should be affirmed..

ARGUMENT

I. THE PETITIONER FAILED TO PRESERVE THE ISSUES PRESENTED ON APPEAL.

An issue cannot be raised for the first time on appeal but rather, must be raised at the Agency level. Issues not properly raised at trial are usually deemed waived. The Utah Supreme Court has set forth a three-part test to determine whether or not an issue was adequately raised before the tribunal: “(1) the issue must be raised in a timely fashion; (2) the issue must be specifically raised; and (3) a party must introduce supporting evidence or relevant legal authority.” *Badger v. Brooklyn Canal Co.*, 966 P.2d 844, 847 (Utah 1998); *see also Brookside Mobile Home Park v. Peebles*, 48 P.3d 968

(Utah 2002). Properly raising the issue requires more than a “mere mention of the issue in the pleadings,” *Hart v. Salt Lake County Commission*, 945 P.2d 125, 130 (Utah App. 1997) *cert. denied*, 953 P.2d 449 (Utah 1997).

The Hospital has failed to meet both the second and third prong of the test. The Hospital does not dispute the validity of the requirement for authorization as set forth in the Medicaid Manual. However, it failed at the hearing level to raise any specific argument as to why the authorization requirements should not be applied in this case, nor did it provide any legal authority or argument supporting its position. The Hospital provided nothing more than a general assertion that it was impossible to perform the required acts and, without even using the terms, they hinted at some vague theory of waiver or estoppel. The latter do not even qualify as a “mere mention” in the hearing below. The argument of impossibility is meritless on its face given that PHC did, in fact, comply with the authorization requirement with the same information available to them as was available to LDS Hospital. Thus, it would be necessary for the Petitioner to offer evidence or legal authority as to why it was somehow in a different position from PCH. It made no such showing in the hearing.

The Hospital has also failed to present any grounds for reviewing these issues that were not preserved below. Rule 24 (a)(9), Utah Rules of Appellate Procedure requires that the Petitioner present “grounds for reviewing any issues not preserved in the trial court, with the authorities, statutes, and parts of the record relied on.” The Petitioner has

provided no such argument nor any citation to relevant legal authority supporting inclusion of issues not properly raised below..

II. THE PETITIONER HAS FAILED TO MEET THE REQUIREMENTS OF RULE 24 (a)(9), BY INADEQUATELY BRIEFING THE ARGUMENTS PRESENTED ON APPEAL.

Rule 24 (a)(9) of the Utah Rules of Appellate Procedure requires that the Petitioner present the “contentions [and] reasons of the appellant with respect to the issues presented with citations to the authorities, statutes, and parts of the record relied on.”

Adequate briefing requires “not just bald citation to authority but development of that authority and reasoned analysis based on that authority.” *State v. Thomas*, 961 P.2d 299, 304 (Utah 1998). Because The Hospital has failed to adequately brief the issues, the decision below should be affirmed. *Id.* (“It is well established that a reviewing court will not address arguments that are inadequately briefed.”)

The Hospital has failed to articulate any explicit legal theory supporting their issues on appeal. They have provided no “reasoned analysis” supporting their claims and have failed even to provide a “bald citation to authority.” The Hospital has merely reiterated facts regarding their attempts to deal with IHC Plus but have not given any legal basis why those activities should excuse their failure to obtain authorization from Molina. This simply does not meet the minimum requirements of Rule 24 (a)(9).

III. LDS HOSPITAL HAS FAILED TO PROPERLY CHALLENGE THE FINDINGS OF THE PRESIDING OFFICER.

During the hearing before the agency, the Hospital asserted that the full seventy plus day final admission was emergency care and thus required no authorization. (R. 10-12, 17-18). The Presiding Officer made an explicit finding that the hospital admission at issue in this appeal was not urgent or emergent. (R. 193). The Hospital challenges this finding by repeatedly asserting in the appeal that the admission in question was, in fact, emergency care. (R. 7, 9). A party “challenging a fact finding must first marshal all record evidence that supports the challenged finding.” Utah Rules of Appellate Procedure 24(a)(9). In the instant case, The Hospital has failed to marshal evidence of any kind regarding the finding regarding emergency care. Because The Hospital failed to marshal the evidence regarding the finding should not be disturbed. *Chen v Stewart*, 2004 UT 82, ¶ 80 (“If appellants have failed to properly marshal the evidence, we assume that the evidence supports the trial courts’s findings.”).

IV. THE HOSPITALS BELIEF THAT THE PATIENT WAS COVERED BY ANOTHER INSURER IN ADDITION TO MOLINA DOES NOT EXCUSE ITS FAILURE TO COMPLY WITH REQUIREMENTS FOR AUTHORIZATION.

The findings of the Agency should not be upset by a reviewing court if they are supported by substantial evidence based upon the record as a whole. *Zissi v. Utah State Tax Comm’n*, 842 P.2d 848, 852 (Utah 1992). Substantial evidence is the quantum and quality of relevant evidence that is adequate to convince a reasonable mind to support the

conclusion. *First Nat'l Bank v. County Bd. of Equalization*, 799 P.2d 1163, 1165 (Utah 1990). In the present case, the plain language of the contract and the incorporated documents requires that LDS Hospital obtain authorization from Molina for the final hospital admission in order to qualify for payment. See Addenda C and D. The Hospital did not obtain such authorization. Other hospitals complied with the requirement, and the Petitioner failed to provide any credible legal support to excuse its non-compliance with the contract. There is substantial evidence supporting the findings.

In any event, the challenge to the finding is not properly taken. In order to challenge the Agency's findings, the Petitioner must show that the findings are "not supported by substantial evidence when viewed in light of the whole record before the court" Utah Code Ann. §63-46b-16(4)(g) (2003). This showing requires that the Petitioner first marshal all the evidence supporting the finding and show that "in spite of the supporting facts...the findings are not supported by substantial evidence." *Grace Drilling Co. v Board of Review*, 776 P.2d 63, 68 (Utah App. 1989). The Petitioner has failed to marshal any of the supporting evidence and has simply restated, without legal analysis, the assertions that they thought someone else was going to pay. Absent the proper marshaling of evidence the findings should not be disturbed. *Intermountain Health Care, Inc. v Board of Review of the Industrial Commission*, 839 P.2d 841, 848 ("Because IHC failed to properly marshal the evidence in support of the ALJ's findings, we decline to disturb those findings as ratified by the Industrial Commission.")

The fundamental argument made by LDS Hospital in the agency hearing and repeated here is that they believed the child was covered by another insurer, IHC Health Plans, thus they could not have known to confirm coverage. They also speculate that they could not have confirmed coverage through Molina because there was no coverage. This is neither accurate nor relevant. As the Hospital's own records show, Molina was listed as a secondary insurer. (R. 167). A careful reading of the evidence shows that for the full period of treatment LDS Hospital never bothered to check with Molina regarding eligibility.

It is important to note that LDS Hospital's sister hospital, PCH, had precisely the same information regarding potential coverage with IHC Plus and Molina during this same time period. PCH chose to follow the requirement for authorization and the authorization was granted. It is simply not the case that it was impossible to obtain the proper authorization.

The Petitioner chose instead to rely on payment from one source, IHC Plus, and chose not to bother with Molina Health care. The existence of a primary insurer does not excuse the requirements for notifying Molina as a secondary insurer. The fact that subsequent events showed that it may not have been a good business decision for LDS Hospital not to follow up with Molina when it received ambiguous "verification" of coverage with IHC Plus on August 20, 2002 has no legal bearing on whether or not the requirements for coverage were followed. The Presiding Officer properly found that the

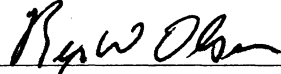
Medicaid rules and the contract between Molina and The Hospital were in full force and effect at the time of the last admission, that The Hospital did not comply with the authorization requirements therein, and that The Hospital provided no legal reason why it should not be required to comply with the Medicaid rules.

CONCLUSION

For the foregoing reasons, the State of Utah asks that the Administrative order be affirmed.

RESPECTFULLY SUBMITTED this 29th day of October, 2004.

MARK SHURTLEFF
Attorney General



REX W. OLSEN
Assistant Attorney General

CERTIFICATE OF MAILING

I hereby certify that, on the 29th day of October, 2004, I caused to be mailed, with first-class postage prepaid, two true and exact copies of the foregoing BRIEF OF

APPELLEE STATE OF UTAH to:

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The Turek Law Firm, PLLC
25231 Grogan's Mill Road, Suite 110
The Woodlands, Texas 77380

Amy Casterdine

ADDENDA

ADDENDUM A



OLENE S WALKER
Governor

GAYLE F McKEACHNIE
Lieutenant Governor

State of Utah Utah Department of Health

Scott D Williams, M D , M P H
Executive Director

A Richard Melton, Dr P H
Deputy Director

Allen Korhonen
Deputy Director

Michael J Deily
Division Director
Division of Health Care Financing

IHC HEALTH PLANS (PITTMAN))
Petitioner)
)
vs.)
)
UTAH DEPARTMENT OF HEALTH)
DIVISION OF HEALTH CARE FINANCING,)
Respondent.)

FINAL AGENCY ORDER
Case No. 03-224-22

IF YOU ARE NOT SATISFIED WITH THIS DECISION, YOU MAY REQUEST A RECONSIDERATION FROM THE DIRECTOR OF HEALTH CARE FINANCING WITHIN TWENTY (20) DAYS AFTER THIS DECISION IS SIGNED. IF YOU WOULD LIKE TO APEAL THIS DECISION, YOU MAY FILE A PETITION IN THE UTAH COURT OF APPEALS WITHIN THIRTY (30) DAYS AFTER THIS DECISION IS SIGNED. IF YOU DECIDE TO APPEAL, YOU ARE NOT REQUIRED TO ASK FOR A RECONSIDERATION FIRST, BUT YOU MAY DO SO IF YOU WISH. IF YOU HAVE QUESTIONS, CALL (801) 538-6576.

The enclosed Recommended Decision has been reviewed pursuant to Section 63-46b-12 Utah Code Ann. 1953, as amended, entitled "Agency Review - Procedure," and Department of Health Administrative Rule R410-14, entitled "Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients, and Providers."

I hereby adopt Recommended Decision No. 03-224-22 in its entirety.

RIGHT TO JUDICIAL REVIEW

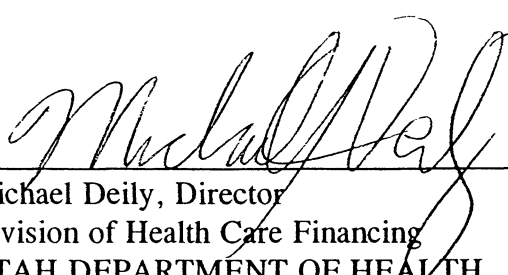
Within twenty (20) days after the date that this Final Agency Order is issued, you may file a written request for reconsideration with the Director of the Division of Health Care Financing. Any request for reconsideration must state the specific grounds upon which relief is requested. The filing of such a request is not a prerequisite for seeking judicial review.

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Final Agency Action or, if a request for reconsideration is filed and denied, within thirty (30) days of the denial for reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal the Final Agency Order.

A copy of this Final Agency Order shall be sent to Petitioner or representative at the last known address by certified mail, return receipt requested.

DATED this 18 day of May 2004

BY: _____


Michael Deily, Director
Division of Health Care Financing
UTAH DEPARTMENT OF HEALTH

BEFORE THE UTAH DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING
STATE OF UTAH

-----ooOoo-----		
IHC HEALTH PLANS (PITTMAN)	:	
Petitioner,	:	
vs.	:	RECOMMENDED DECISION
	:	
UTAH DEPARTMENT OF HEALTH,	:	Case No. 03-224-22
DIVISION OF HEALTH CARE	:	Margaret J. Clark
FINANCING,	:	Administrative Law Judge
Respondent.	:	

Pursuant to Utah Administrative Code R410-14, and 26, Chapter 18, and Title 63, Chapter 46b, a telephonic prehearing conference for the above-captioned case was held on September 2, 2003. Participating were: Douglas Turek, Attorney for LDS Hospital; Darlene Bensen, Barbara Christensen, and Craig Devashrayee for the Division of Health Care Financing; and Margie Rogers, and Shauna Abbatiello for Molina Healthcare of Utah. A second in-person prehearing was held on January 5, 2004 with Darlene Bensen, Barbara Christensen, Craig Devashrayee present for the Division of Health Care Financing (DHCF); Margie Rogers, and Shauna Abbatiello for Molina Health Care; and Emily Fisher for LDS Hospital. DHCF was represented by Rex W. Olsen, Assistant Attorney General. Douglas Turek, Attorney for LDS Hospital, participated by telephone.

Since there were no disputed issues of material facts, a Recommended Decision is hereby issued without a hearing based upon the parties' pleadings, pursuant to Utah Administrative Code R410-14-4.

A Recommended Decision was submitted to Michael Deily, Director of Health Care Financing, on February 11, 2004. Mr. Deily issued an Interim Remand Order asking the parties to brief the timeliness issue raised by Mr. Turek in his letter dated March 18, 2004. Mr. Deily has directed this presiding officer to issue a recommended decision, striking the untimely information submitted by DHCF and issuing a decision based upon the remaining admissible evidence.

BACKGROUND

Keyontae Pittman was born on July 22, 2002, with complications. The treatment of Keyontae was in five stages:

1. July 22, through July 26, 2002, at LDS Hospital (LDSH);
2. July 26, 2002, through July 30, 2002, at Primary Children's Medical Center (PCMC);
3. July 30, 2002, through August 14, 2002, at LDSH;
4. August 14, 2002, through August 19, 2002, at PCMC;
5. August 19, 2002, until October 29, 2002, at LDSH.

Molina Healthcare (Molina) paid for all treatment except the last stage from August 19, 2002, until October 29, 2002.

ISSUE

WAS MOLINA CORRECT IN DENYING PAYMENT TO LDS HOSPITAL FOR KEYONTAE PITTMAN'S HOSPITAL STAY FROM AUGUST 19, 2002, THROUGH OCTOBER 29, 2002?

FACTS

1. Petitioner, Baby K.P., ("the baby") was born prematurely on July 22, 2002, at LDS Hospital ("LDSH") with serious and life-threatening medical conditions, including a hole in her heart (LDSH Exhibits A, B, C, D, and E).
2. The baby was treated in five stages beginning at her birth, on July 22, 2002. The fifth stage, the only one for which payment is an issue, began with the baby's hospitalization at LDSH on August 19, 2002, ending on October 29, 2002.
3. IHC Care Plus was the mother's primary insurance through her employment with the law firm of Vancott, Bagley Cornwall, and McCarthy. Eligibility for IHC Plus Plans began July 1, 2002.
4. The baby's mother added the baby to the IHC Health Plans on October 8, 2002 [see LDSH Exhibit D].

5. The baby's mother signed an IHC Health Plans "employee change form" on October 24, 2002, deleting the baby from IHC coverage [see LDSH Exhibit E].
6. Since the mother added the baby to IHC Care Plus plans within 90 days of its birth, the baby would have been covered for 90 days after its birth [See LDSH Exhibit C, p. 2], had it not been deleted.
7. On July 22, 2002, LDSH called IHC Plans (rather than Molina), to determine coverage. LDSH was informed that the baby had not yet been added to the mother's policy and that the mother needed to add the baby "right away." [see Molina's Exhibit 2, a letter from Emily Fisher, LDSH, appealing to Molina].
8. LDSH did not coordinate with Molina or obtain a prior authorization from Molina for the baby's last hospital stay.
9. On July 17, 2003, Molina denied payment for lack of inpatient authorization for the baby's last admission to LDSH from August 19, 2002, until October 29, 2002.
10. There was no dispute between the parties that, although the services provided were medically necessary, the admission was not urgent or emergent.

RECOMMENDED CONCLUSIONS OF LAW

I recommend that Molina's decision to deny payment for the baby's last admission to PCMC from August 19, 2002, until October 29, 2002 be UPHeld based upon Utah Administrative Rule R414-1-13, the Utah Medicaid Provider Manual Section 1, Subsections 4 and 5, and LDS's contract with Molina.

REASONS FOR PRESIDING OFFICER'S DECISION

I recommend that Molina's decision to deny payment for the baby's last admission to PCMC from August 19, 2002, until October 29, 2002 be UPHeld based upon the fact that LDS is a Utah Medicaid provider. As such, the following law applies to LDSH.

Utah Administrative Rule R414-1-13, entitled, "Provider and Client Agreements," provides in relevant part:

- (2) By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and

procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

Pursuant to the above cited rule, LDS Hospital, as a Medicaid Provider, is bound to follow all Utah Medicaid policies and procedures that are contained in the Utah Medicaid Provider Manual.

(1) Utah Medicaid Provider Manual Section 1, 4-4, states that, “Each managed care plan specifies that the provider must follow the plan’s procedures for authorization in order to receive reimbursement since information as to what plan the client must use is available to providers; [see Molina’s Exhibit 5; emphasis added];

(2) Utah Medicaid Provider Manual, Section 1, Subsection 5 [see Molina’s Exhibit 1 (January 16, 2004 document)] states in relevant part: “**VERIFYING MEDICAID ELIGIBILITY:** a Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient’s eligibility, EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in a managed care plan, Emergency Services or the Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance [emphasis added]. Eligibility and HMO enrollment may change from month to month. The information needed is printed on the client’s Medicaid Identification Card at the Interim Verification of Eligibility (form 695). The provider may wish to copy the card to substantiate the Medicaid claim. Information is also available through Medicaid Online, ACCESSNOW, and Medicaid Information.

The Utah Medicaid Provider Manual, Section 1, Subsection 4-4 is entitled “Managed Care Plans and Prior Authorization.” That Section provides as follows:

Each managed care plan specifies which services require prior authorization (PA) and the conditions of authorization. When a provider contacts Medicaid to request PA for services to a patient covered by a managed care plan, Medicaid must refer the provider to that plan. Medicaid cannot authorize PA requests for services for patients enrolled in managed care plans, unless the services are not included under the Medicaid contract with the plan.

Because information as to what plan the client must use is available to providers, the provider must follow the plan’s procedures for authorization in order to receive reimbursement. When the client is enrolled in a managed care plan, and Medicaid staff prior authorize a service in error, instead of referring the provider to the client’s plan, Medicaid cannot pay for the service. If the provider fails to follow the plan’s procedures for authorization, the managed care plan may also refuse to pay for the service [emphasis added].

Section 5 of the Utah Medicaid Provider Manual, under “General Information, provides:

A Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient’s eligibility EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in a managed care plan, Emergency Services or the Restriction Program, assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance [emphasis added]. Eligibility and HMO enrollment may change from month to month. The information needed is printed on the client’s Medicaid identification Card or the Interim Verification of Eligibility (form 695)....”

A contract setting forth IHCS Responsibilities [see Molina’s Exhibit 6, September 3, 2003 document], states in relevant part: “Compliance with Quality and Utilization Management Program: IHCHS agrees to notify AFC [now called “Molina”] of any urgent or emergent hospital admission by the second working day after such admission (Monday through Friday 8:00a.m. to 5:00 p.m. Mountain Standard Time).

Molina’s Exhibit 7, (September 3, 2003 document), is a copy of an amendment, effective April 1, 2002, adding LDSH to an agreement allowing Molina Medicaid members to assess Molina at a discounted rate. Under a Section, entitled, “IHCHS, RESPONSIBILITIES” paragraph G states:

Compliance with Quality and Utilization Management Program: IHCHS agrees to provide clinical information as authorized by the Member to the AFC [now Molina] when the Member has reached an outlier status during a hospital stay. Outlier status is defined as the recommended average length of stay by Millman and Robertson, and shall apply to all IHCHS facilities. 5 IHCHS agrees to notify AFC of any urgent or emergent hospital admission by the second working day after such admission (Monday through Friday 8:00 a.m. to 5:00 p.m. Mountain Standard Time). A clinical review of any emergent or urgent admission will be provided upon request within two (2) working days of the request. The information in the clinical review will include: date of service, reason for admission, primary diagnosis, diagnostic testing, abnormal lab values and medication review

LDSH contended that it “acted reasonably, considering all the facts known to it at the time.” However, even excluding the untimely evidence that LDSH’s own admission records indicate it knew from July 22, 2002, that the baby’s secondary coverage was Utah Medicaid through Molina, the Utah Administrative Code, the Utah Medicaid Provider Manual and LDSH’s contract with Molina require that providers take the responsibility of verifying the client’s coverage each time and before services are rendered, following whatever requirements are applicable to that particular plan.

In Primary Children’s Hospital (Daugaard) v Utah Department of Health, 993 P.2d 882 (Utah

Ct. App.1999) the petitioner hospital discovered that the database of Respondent Department of Health, Division of Health Care Financing, (the Medicaid agency), indicated that the petitioner patient was no longer eligible for Medicaid. Because of this, the petitioner did not submit a request for prior authorization. The petitioner hospital, not knowing that respondent had resumed the petitioner patient's coverage later in the day, performed a bone marrow transplant and requested a retroactive prior authorization. DHCF denied the request and petitioners appealed. The Court of Appeals reversed the decision because: (1) it determined that based upon prior practice with DHCF, the provider had never been required to request a prior authorization when DHCF's system showed no eligibility; (2) a section of the administrative rule for transplants authorized retroactive prior authorizations for unusual circumstances, which the court determined were met; and (3) because DHCF advised the provider who relied upon it to its detriment, that the patient's Medicaid eligibility had lapsed when in fact it had not.

The present case is distinguishable from the Primary Children's Hospital/Daugaard because there is no estoppel issue. Neither DHCF nor Molina did anything to mislead LDSH.

Furthermore, the law is clear. A contrary decision would have the effect of nullifying R414-1-13, the Utah Medicaid Provider Manual, and the contract between LDSH and Molina for a reduced cost of care for LDSH. The contract between LDSH and Molina was an arm's length transaction between two sophisticated parties and should be upheld.

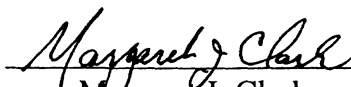
RECOMMENDED AGENCY ACTION

I recommend that Molina Healthcare of Utah's decision be UPHELD.

RIGHT TO REVIEW

This Recommended Decision will be automatically reviewed by the Department of Health, Division of Health Care Financing, prior to its release. Both the Recommended Decision and a Final Agency Action, which represent the results of that review, will be released simultaneously by the Department of Health, Division of Health Care Financing.

DATED this 26 day of April 2004



Margaret J. Clark
Administrative Law Judge

No: 03-224-22

CERTIFICATE OF MAILING

I hereby certify that on the 18 day of May 2004, I mailed a true and correct copy of the foregoing RECOMMENDED DECISION AND FINAL AGENCY ORDER, to the following parties:

POSTAGE PREPAID

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MICHAEL DEILY, DIRECTOR
DIVISION OF HEALTH CARE FINANCING
UTAH DEPARTMENT OF HEALTH


CHRIS SMITH

ADDENDUM B

(a) *Brief of the appellant.* The brief of the appellant shall contain under appropriate headings and in the order indicated:

(a)(1) A complete list of all parties to the proceeding in the court or agency whose judgment or order is sought to be reviewed, except where the caption of the case on appeal contains the names of all such parties. The list should be set out on a separate page which appears immediately inside the cover.

(a)(2) A table of contents, including the contents of the addendum, with page references.

(a)(3) A table of authorities with cases alphabetically arranged and with parallel citations, rules, statutes and other authorities cited, with references to the pages of the brief where they are cited.

(a)(4) A brief statement showing the jurisdiction of the appellate court.

(a)(5) A statement of the issues presented for review, including for each issue: the standard of appellate review with supporting authority; and

(a)(5)(A) citation to the record showing that the issue was preserved in the trial court; or

(a)(5)(B) a statement of grounds for seeking review of an issue not preserved in the trial court.

(a)(6) Constitutional provisions, statutes, ordinances, rules, and regulations whose interpretation is determinative of the appeal or of central importance to the appeal shall be set out verbatim with the appropriate citation. If the pertinent part of the provision is lengthy, the citation alone will suffice, and the provision shall be set forth in an addendum to the brief under paragraph (11) of this rule.

(a)(7) *A statement of the case.* The statement shall first indicate briefly the nature of the case, the course of proceedings, and its disposition in the court below. A statement of the facts relevant to the issues presented for review shall follow. All statements of fact and references to the proceedings below shall be supported by citations to the record in accordance with paragraph (e) of this rule.

(a)(8) *Summary of arguments.* The summary of arguments, suitably paragraphed, shall be a succinct condensation of the arguments actually made in the body of the brief. It shall not be a mere repetition of the heading under which the argument is arranged.

(a)(9) *An argument.* The argument shall contain the contentions and reasons of the appellant with respect to the issues presented, including the grounds for reviewing any issue not preserved in the trial court, with citations to the authorities, statutes, and parts of the record relied on. A party challenging a fact finding must first marshal all record evidence that supports the challenged finding.

(a)(10) *A short conclusion stating the precise relief sought*

(a)(11) *An addendum to the brief or a statement that no addendum is necessary under this paragraph.* The addendum shall be bound as part of the brief unless doing so makes the brief unreasonably thick. If the addendum is bound separately, the addendum shall contain a table of contents. The addendum shall contain a copy of:

(a)(11)(A) any constitutional provision, statute, rule, or regulation of central importance cited in the brief but not reproduced verbatim in the brief;

(a)(11)(B) in cases being reviewed on certiorari, a copy of the Court of Appeals opinion; in all cases any court opinion of central importance to the appeal but not available to the court as part of a regularly published reporter service; and

(a)(11)(C) those parts of the record on appeal that are of central importance to the determination of the appeal, such as the challenged instructions, findings of fact and conclusions of law, memorandum decision, the transcript of the court's oral decision, or the contract or document subject to construction.

(b) *Brief of the appellee.* The brief of the appellee shall conform to the requirements of paragraph (a) of this rule, except that the appellee need not include:

(b)(1) a statement of the issues or of the case unless the appellee is dissatisfied with the statement of the appellant; or

(b)(2) an addendum, except to provide material not included in the addendum of the appellant. The appellee may refer to the addendum of the appellant.

(c) *Reply brief.* The appellant may file a brief in reply to the brief of the appellee, and if the appellee has cross-appealed, the appellee may file a brief in reply to the response of the appellant to the issues presented by the cross-appeal. Reply briefs shall be limited to answering any new matter set forth in the opposing brief. The content of the reply brief shall conform to the requirements of paragraph (a)(2), (3), (9), and (10) of this rule. No further briefs may be filed except with leave of the appellate court.

(d) *References in briefs to parties.* Counsel will be expected in their briefs and oral arguments to keep to a minimum references to parties by such designations as "appellant" and "appellee." It promotes clarity to use the designations used in the lower court or in the agency proceedings, or the actual names of parties, or descriptive terms such as "the employee," "the injured person," "the taxpayer," etc.

(e) *References in briefs to the record.* References shall be made to the pages of the original record as paginated pursuant to Rule 11(b) or to pages of any statement of the evidence or proceedings or agreed statement prepared pursuant to Rule 11(f) or 11(g). References to pages of published depositions or transcripts shall identify the sequential number of the cover page of each volume as marked by the clerk on the bottom right corner and each separately numbered page(s) referred to within the deposition or transcript as marked by the transcriber. References to exhibits shall be made to the exhibit numbers. If reference is made to evidence the admissibility of which is in controversy, reference shall be made to the pages of the record at which the evidence was identified, offered, and received or rejected.

(f) *Length of briefs.* Except by permission of the court, principal briefs shall not exceed 50 pages, and reply briefs shall not exceed 25 pages, exclusive of pages containing the table of contents, tables of citations and any addendum containing statutes, rules, regulations, or portions of the record as required by paragraph (a) of this rule. In cases involving cross-appeals, paragraph (g) of this rule sets forth the length of briefs.

(g) *Briefs in cases involving cross-appeals.* If a cross-appeal is filed, the party first filing a notice of appeal shall be deemed the appellant for the purposes of this rule and Rule 26, unless the parties otherwise agree or the court otherwise orders. The brief of the appellant shall not exceed 50 pages in length. The brief of the appellee/cross-appellant shall contain the issues and arguments involved in the cross-appeal as well as the answer to the brief of the appellant and shall not exceed 50 pages in length. The appellant shall then file a brief which contains an answer to the original issues raised by the appellee/cross-appellant and a reply to the appellee's response to the issues raised in the appellant's opening brief. The appellant's second brief shall not exceed 25 pages in length. The appellee/cross-appellant may then file a second brief, not to exceed 25 pages in length, which contains only a reply to the appellant's answers to the original issues raised by the appellee/cross-appellant's first brief. The lengths specified by this rule are exclusive of table of contents, table of authorities, and addenda and may be exceeded only by permission of the court. The court shall grant reasonable requests, for good cause shown.

(h) *Briefs in cases involving multiple appellants or appellees.* In cases involving more than

one appellant or appellee, including cases consolidated for purposes of the appeal, any number of either may join in a single brief, and any appellant or appellee may adopt by reference any part of the brief of another. Parties may similarly join in reply briefs.

(i) *Citation of supplemental authorities* When pertinent and significant authorities come to the attention of a party after that party's brief has been filed or after oral argument but before decision, a party may promptly advise the clerk of the appellate court, by letter setting forth the citations. An original letter and nine copies shall be filed in the Supreme Court. An original letter and seven copies shall be filed in the Court of Appeals. There shall be a reference either to the page of the brief or to a point argued orally to which the citations pertain, but the letter shall without argument state the reasons for the supplemental citations. Any response shall be made within 7 days of filing and shall be similarly limited.

(j) *Requirements and sanctions* All briefs under this rule must be concise, presented with accuracy, logically arranged with proper headings and free from burdensome, irrelevant, immaterial or scandalous matters. Briefs which are not in compliance may be disregarded or stricken, on motion or sua sponte by the court, and the court may assess attorney fees against the offending lawyer.

ADDENDUM

Utah Medicaid Provider Manual	GENERAL INFORMATION
Division of Health Care Financing	Page Updated January 2002

4 - 2 Mental Health Services

In most areas of the state, Medicaid covers outpatient and inpatient mental health services **ONLY** when provided through a Prepaid Mental Health Plan. Medicaid clients who live in certain counties of the state **must receive all** mental health services from community mental health centers which have contracted with the Medicaid agency as a Prepaid Mental Health Plan (PMHP).

Physicians or psychologists treating individuals who **may become eligible for Medicaid** should contact the appropriate Prepaid Mental Health Plan to ensure payment or arrange for the patient to be transferred to the contracting mental health center for continued services. Even if the individual is not yet enrolled with a PMHP, he or she may be entitled to retroactive Medicaid eligibility. (See Chapter 1 - 3, Retroactive Medicaid), and the PMHP contractor will be responsible for services. A list of Prepaid Mental Health Plans by county and telephone numbers is provided in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

4 - 3 Other Managed Care Plans

Effective for dates of service on or after September 1, 1997, chiropractic providers must contact the Chiropractic Health Plan (CHP) directly for details of provider participation, claim submission, payments and requests for prior authorization. All chiropractic services are covered by a capitated reimbursement contract with CHP.

4 - 4 Managed Care Plans and Prior Authorization

Each managed care plan specifies which services require prior authorization (PA) and the conditions for authorization. When a provider contacts Medicaid to request PA for services to a patient covered by a managed care plan, Medicaid must refer the provider to that plan. Medicaid cannot authorize PA requests for services for patients enrolled in managed care plans, unless the services are not included under the Medicaid contract with the plan.

Because information as to what plan the client must use is available to providers, the provider must follow the plan's procedures for authorization in order to receive reimbursement. When the client is enrolled in a managed care plan, and Medicaid staff prior authorize a service in error, instead of referring the provider to the client's plan, Medicaid cannot pay for the service. If the provider fails to follow the plan's procedures for authorization, the managed care plan may also refuse to pay for the service.

Utah Medicaid Provider Manual	GENERAL INFORMATION
Division of Health Care Financing	Page Updated October 2002

5 VERIFYING MEDICAID ELIGIBILITY

A Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient's eligibility EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in a managed care plan, Emergency Services or the Restriction Program, assigned to a Primary Care Provider, covered by a third party, or responsible for a co-payment or co-insurance. Eligibility and HMO enrollment may change from month to month. The information needed is printed on the client's Medicaid Identification Card or the Interim Verification of Eligibility (Form 695). The provider may wish to copy the card to substantiate the Medicaid claim.

Information is also available through **Medicaid Online**, **ACCESSNOW** and **Medicaid Information** (Refer to Chapter 12, Medicaid Information). Explanation of the information required for Medicaid and how to access that information is given in the sub-chapters which follow.

NOTE 1 Medicaid staff make every effort to provide complete and accurate information on all inquiries. However, federal regulations do not allow a claim will not be paid even if the information given to a provider by Medicaid staff was incorrect.

NOTE 2 Temporary Proof of Eligibility

When a temporary proof of eligibility expires, Medicaid will no longer pay claims, unless the client has since been issued a Medicaid Identification Card for the month of service. Two temporary proofs of eligibility are the Baby Your Baby Card and the Interim Verification of Eligibility (Form 695).

- When a client's Medicaid Identification number ends with the letter 'V', the client is eligible ONLY for the Baby Your Baby Program. ALWAYS require the Baby Your Baby Card and check the dates of eligibility. Refer to Chapter 13 - 1, Presumptive Eligibility Program (Baby Your Baby).
- When a client's Medicaid Identification number ends with the letter 'X', the client has an Interim Verification of Eligibility (Form 695). Refer to Chapter 5 - 2, Interim Verification of Medicaid Eligibility (Form 695).

5 - 1 Medicaid Identification Card

Each family or individual eligible for Medicaid receives a Medicaid Identification Card each month. The card is typically received on the first of the month. It lists the following information:

- the month of eligibility
- any limitation of benefits, such as Emergency Services Only
- the name of each eligible individual
- the individual's ten digit Medicaid Identification number
- the individual's sex, date of birth and age
- enrollment in a managed care plan or selection of a Primary Care Provider
- co-payment or co-insurance owed, if any
- the designated Prepaid Mental Health Plan
- the designated dental provider
- the designated pharmacy provider and
- third party liability coverage

Examples of Medicaid Identification Cards and verifications for other medical assistance programs administered by the Department of Health are included in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

ADDENDUM D

R414-1-13. Provider and Client Agreements.

(1) To meet the requirements of 42 CFR 431.107, the Department contracts with each provider who furnishes services under the Utah Medicaid Program.

(2) By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

(3) By signing an application for Medicaid coverage, the client agrees that the Department's obligation to reimburse for services is governed by contract between the Department and the provider.