

MEDICAID INFORMATION BULLETIN

Medicaid Information: 1-800-662-9651

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23-01 PRISM Freeze Information MIBs

Medicaid System Freeze

Medicaid is in the process of replacing the Medicaid Management Information System (MMIS) with a new system called Provider Reimbursement Information System for Medicaid (PRISM). PRISM will be fully operational with all remaining components in April 2023. To prepare for this April go-live, Medicaid systems will be down for conversion activities from March 13, 2023, through April 2, 2023. Providers will not have access to Medicaid systems during that time. This is being referred to as the PRISM Freeze. Providers can learn more about the freeze in the [Frequently Asked Questions](#) document.

PRISM Freeze Dates and Timely Filing Deadlines for Claims

In accordance with state and federal guidelines (42 CFR 447.45), providers are required to submit all claims no later than 12 months from the date of service. Medicaid strongly encourages providers to be aware of the upcoming PRISM freeze from March 13, 2023, through April 2, 2023, and to not wait until the timely filing limit to submit claims. Medicaid recommends submitting all claims, specifically aging claims, as soon as possible to avoid this situation. It is the provider’s responsibility to manage the timely filing deadline, as claims that hit timely filing edits during the freeze period will not be granted exceptions or be overridden for payment.

Unless otherwise noted, all changes take effect on January 1, 2023

Claims Submission During PRISM Freeze

Paper Claims

Effective February 23, 2023, Medicaid Fee for Service paper claims submission will no longer be accepted. A freeze will be put in place to allow adequate time to process the remaining backlog of paper claims in the queue prior to the PRISM system go-live in April 2023. Paper claims received on or after February 23, 2023, will be securely destroyed and no longer returned to providers or their vendors.

With the upcoming implementation of the PRISM system in April 2023, all paper claims processing by Medicaid will be discontinued. Providers will have options to submit electronic Medicaid claims for processing.

If providers are contracted with a clearinghouse to submit claims and the clearinghouse drops the claims to paper, providers must work directly with the clearinghouse to fix the issues and comply with submitting electronic claims.

Electronic Claims

Providers may submit electronic claims until March 8, 2023, at 5:00 pm MST. Any electronic claim submitted after that date/time will be processed after the PRISM freeze period ends. For claims submitted through UHIN, UHIN will hold electronic claims and submit them to Medicaid for processing after the PRISM freeze period ends.

Providers will have three options to submit Medicaid claims for processing in PRISM:

- X12 electronic HIPAA claim transactions
- Direct Data Entry (DDE)
- Web Batch uploaded directly to PRISM

Faxes and Other Documentation

Providers may submit their usual and customary documents to the fax lines and the cHIE until February 22, 2023. All items received on or before February 22, 2023, will be manually worked by staff and entered in PRISM after go-live in April 2023. The cHIE process will no longer be utilized.

In PRISM, providers will submit these types of documents through the PRISM upload process. Examples include:

- Hearing requests
- Emergency only program
- Provider preventable conditions
- Manual review
- Explanation of benefits
- Timely filing requests
- Consent form
- Other documentation

For more information on how to submit documents, visit <https://medicaid.utah.gov/prism-provider-training/>.

For more information about the PRISM freeze, view the [Frequently Asked Questions](#) document.

Medical and Pharmacy Prior Authorizations During PRISM Freeze

From March 13, 2023, through April 2, 2023, Medicaid will be converting data into the new PRISM system and many system operations will not function, including the input of new Prior Authorization (PA) requests.

Medicaid will adjust PA policy to accommodate the PRISM freeze period and allow for continued service delivery. Adjustments may include:

- Extending authorization date ranges or issuing two consecutive PAs
- Encouraging providers to plan accordingly for PRISM freeze period and request services prior to March 13, 2023
- Allowing flexibilities around retroactive requests for medical services and retroactive requests for medications provided during the PRISM freeze period
- Reviewing of PA requests received during the PRISM freeze period, with delayed data entry

Providers shall maintain documentation that demonstrates the medical necessity of continued services. All services are subject to post-payment review defined in 42 CFR § 456.23; reference the [Section I: General Information provider manual](#), Chapter 4-4 Access to Records for additional information regarding records requests.

Extended Authorizations and Subsequent Authorizations

For medical services that have ongoing authorizations (e.g., home health, applied behavior analysis, substance use disorder), providers may receive extended (or two consecutive) authorizations for any request that expires in March 2023. Providers do not need to request an extended PA; prior authorization staff will issue the extension, when appropriate, and send the approval.

For pharmacy-related medical services requiring a PA that are received on or after October 1, 2022, that would have been approved for six months, as per current policy, will be extended through May 31, 2023. Providers do not need to request an extended PA; pharmacy PA staff will issue the extension, when appropriate, and send the approval.

Provide Medical Services Prior to March 2023

For medical services that may be scheduled in advance (e.g., dental, imaging, surgery), providers are encouraged to request a PA for services prior to March 13, 2023, when the PRISM system freezes.

Retroactive Authorizations

Providers will be allowed to submit retroactive authorizations for medical services provided during the PRISM freeze period. Beginning April 3, 2023, providers will be able to utilize PRISM to directly enter PA requests, as well as check the status of previously submitted requests. This will be an exception to normal Medicaid policy which disallows retroactive PAs in most situations (see [Section I: General Information provider manual](#), Chapter 10-3 Retroactive Authorization).

Authorizations Received During PRISM Freeze

Providers can continue to submit PA requests during the PRISM freeze period. These requests will be reviewed and providers will be notified of the status, but a PA number will not be provided. Beginning April 3, 2023, prior authorization staff will enter the requests into PRISM. Providers may receive a tracking number following entry into PRISM. For pharmacy PAs, approval letters will be sent containing the PA approval number.

For PA questions, please call the Office of Healthcare Policy and Authorization at (801) 538-6155 or toll free (800) 662-9651 and select options 3, 3, then the appropriate number for the program.

Provider Payments During PRISM Freeze

Provider payments are typically issued on a weekly basis. However, payments will be suspended during the PRISM freeze (March 13, 2023, through April 2, 2023). The PRISM freeze will not impact any managed care covered claims from being paid.

A freeze in provider payments during this window may create financial hardships for some providers who receive a significantly large average Fee for Service weekly cash flow from Medicaid. Providers desiring to be considered for an interim payment prior to the freeze must opt-in. To opt-in, the provider must complete the following web form no later than February 5, 2023, for consideration:

[Provider Payments Related to the PRISM Freeze Opt-in Form](#)

Approved providers who opt-in will receive a payment in early March 2023 for 80 percent of an average weekly payment times three. For example, if the provider's average weekly payment is \$10,000, then the interim payment will be \$24,000. That is calculated as $\$10,000 \times 3 \times 0.8$.

Paid claims data for providers who opt-in and are approved by division leadership will be refreshed the first of the week that payments are processed to have the most recent weekly average paid claims information. The average will be based on the prior 12 weeks payments.

Payments will be issued on March 3, 2023, two weekends prior to the PRISM freeze to allow time to address any issues that may surface. These interim payments will be reversed in the first adjudication cycle in PRISM. Claims adjudicated in that first cycle will offset the reversal of the interim payments.

Please direct any questions to arpa-hcbs@utah.gov.

Administrative Hearings During PRISM Freeze

Between March 13, 2023, through April 2, 2023, the Office of Administrative Hearings in the Department of Health and Human Services will be transitioning to PRISM. This transition should not impact the fair hearing case for a member or provider. The fair hearing fax line will remain open. During that window of time, a member or provider will still be able to file a hearing request, inquiry, motion, and evidence on their case through the hearing office fax at (801) 536-0143, or by email at utmedicaidhearings@utah.gov. The hearing office will be available to hold pre-hearing conferences and hearings. If there are questions, a member or provider can contact the hearing office at (801) 538-6576.

10A Applications from Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and Hospital Swing Beds

The last day documentation will be accepted from long term care providers for 10A applications will be February 22, 2023. Resident Assessment will review all outstanding 10A applications and finalize all that have complete documentation by March 3, 2023. Providers will still have access to UHIN in order to review past 10A applications. Once the deadline has passed, providers must wait until April 3, 2023, to submit applications through PRISM.

23-02 Autism Spectrum Disorder Services Manual Updated

The [Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals](#) provider manual has been updated to meet the style guidelines used for Utah Medicaid provider manuals.

In addition, the following policy changes have been made:

- The manual title has been changed to *Autism Spectrum Disorder Services*.
- Unnecessary and redundant information has been removed from the manual.
- Medicaid will now accept any standardized assessment tool used to diagnose the presence of ASD according to current DSM criteria.
- The PA requirement for CPT 97151 - *Behavior identification assessment* has been removed. There continues to be limitations on the number of units a provider may report.
- HCPCS code H0032 has been opened for reporting of indirect case supervision services. Direct case supervision services will continue to be reported using CPT code 97155.
- Direct and indirect supervision services will require the use of a modifier that indicates the credentials of the clinician performing supervision responsibilities.
- Restrictions placed on services that may be performed by qualified clinicians have been changed to correspond with the licensing requirements detailed in applicable practice act rule.
- Parent training reported using CPT 97156 may be performed with or without the child present.
- Providers may request alternative service hour combinations that equal less than 30 hours/week for ABA services performed by a behavior technician, in an individual or group setting, and reported with CPT codes 97153 and 97154.
- Providers may request alternative service hour combinations that equal less than 29 hours every 6-month authorization period for behavior therapist services for individual and group parental training as well as social skills groups. These services are reported with CPT codes 97156, 97157, and 97158.
- Progress data for ongoing ABA services previously reported in graphical format or utilizing specific assessment tools is no longer required. The prior authorization criterion has been updated to allow a summary of progress made during the previous authorization period.

- Supervision and parent training may be performed by a behavior therapist via telehealth regardless of geographic location. These services are reported with CPT codes 97151, 97155, 97156, and 97157. Remote access technology may not be used for other ABA services.

23-03 DUR Board Updates

The Drug Utilization Review (DUR) Board met in September 2022 to review Mounjaro (tirzepatide). The review includes prescribing information, diabetes treatment guidelines, and Mounjaro's place in therapy.

The DUR Board also reviewed Calcitonin Gene-Related (CGRP) Antagonists prior authorization and Botox prior authorization criterion.

The DUR Board met in November 2022 to review the CDC's Sexually Transmitted Infections Treatment Guidelines 2021. The DUR Board decided that Utah Medicaid's policy allows sufficient access to the recommended treatments. The DUR Board also reviewed Spravato prior authorization criteria.

The DUR Board met in December 2022 to review Auvelity (bupropion/dextromethorphan). The review includes prescribing information and Auvelity's place in therapy.

DUR Board meeting minutes are posted on the Utah Medicaid website at <https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/>.

23-04 Pharmacy Prior Authorization Processing

Pharmacy prior authorization requests received for pharmacy services, including pharmacy related HCPCS codes, must be complete upon submission. An incomplete submission means required information is missing, which may result in the prior authorization being denied. The Utah Medicaid pharmacy team attempts to contact providers to obtain additional information for the prior authorization request at least two times. Providers and their staff are encouraged

to complete the prior authorization request to include the exact medication name the member will be using, or indicate if a substitution is not permissible.

Medication Name/ Strength:	Dose:
<input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider’s intent is for a member to use a brand product, they will check “Do Not Substitute”. In the example below, the request would be reviewed for the non-preferred name brand Percocet 5/325mg.

Medication Name/ Strength: <i>Percocet 5/325mg</i>	Dose:
<input checked="" type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider submits a prior authorization request without indicating “Do Not Substitute”, the request will be processed for the preferred Generic/Brand equivalent. In the example below, the request would be reviewed for the preferred generic equivalent, Oxycodone/APAP 5/325mg.

Medication Name/ Strength: <i>Percocet 5/325mg</i>	Dose:
<input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

In all cases, providers should submit prior authorization requests using the most current form available on the [Utah Medicaid Pharmacy Website](#), complete all fields legibly, and include all supporting documentation required for the pharmacy service requested.

23-05 Pharmacy Policy, Coverage, Prior Authorization and HCPCS Codes

The Utah Medicaid Preferred Drug List is updated monthly and is the most up-to-date source of information pertaining to drug specific pharmacy coverage, limitations, and policies, in addition to the Utah Medicaid State Plan, Utah Administrative Rule, Utah Medicaid Provider Manuals and Medicaid Information Bulletins, and Pharmacy prior authorization forms.

Pharmacy prior authorization forms and pharmacy related HCPCS codes are reviewed and updated at a minimum annually, but may be updated more frequently as drug labels are expanded.

Per the Utah Medicaid Provider Manual [Section I: General Information](#), 2-3 Member Eligibility Verification, Providers who administer and bill Utah Medicaid for pharmacy related HCPCS codes shall verify member eligibility. Pharmacy related HCPCS code coverage and the HCPCS NDC Crosswalk shall be used together to verify coverage, reimbursement, and covered NDC's for pharmacy related HCPCS.

To access the most recent pharmacy resources, go to <https://medicaid.utah.gov/>, click on Healthcare Providers, Medicaid Pharmacy Program.

23-06 DME Covered Codes

Effective January 1, 2023, Medicaid will open coverage for manual pump-operated enema systems, including the Peristeen bowel irrigation system, and replaceable catheters. The following HCPCS codes must be reported by providers for the manual pump and replaceable catheters:

A4453 – Rectal catheter for use with the manual pump-operated enema system, replacement only

A4459 – Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type

For additional information on these codes, refer to the [Coverage and Reimbursement Lookup Tool](#).

23-07 Prefabricated Stainless Steel Crown Rates - Correction

The December 2022 Interim MIB, article 22-107 Prefabricated Stainless Steel Crown Rates, was published with the incorrect implementation date of December 1, 2022. The rate change was implemented retroactively to July 1, 2022, for CDT codes D2930 and D2931.