March 2023

Utah Department of Health & Human Services
Integrated Healthcare

MEDICAID INFORMATION BULLETIN

Medicaid Information: 1-800-662-9651 | medicaid.utah.gov

23-09 PRISM Information MIBs

PRISM Reporting and Payment of Long Term Care Facility Admissions for Members Enrolled in Managed Care Plans

Overview

The process of reporting and billing for members enrolled in a Managed Care Plan admitting into a long term care facility will change with PRISM go-live.

For long term stays with a prognosis requiring a duration over 30 days, the nursing facility or hospice agency must submit an Admission Record within PRISM. The Admission Record process in PRISM will trigger the Managed Care Plan disenrollment when the 30-day admission question is selected 'Yes'. Providers do not need to directly contact Medicaid for a disenrollment request, as done prior to PRISM.

Payment of Claims

The Managed Care Plan will be responsible for payment of the facility claims for long term care until the last day of the month of admission. For example, if the member is admitted to the facility on January 8, the Managed Care Plan will pay for claims through January 31.

The member will be disenrolled from the Managed Care Plan beginning on the first day of the month following the date of admission to the nursing facility. An Admission Record must be submitted through PRISM for any dates of service covered by Fee for Service (FFS) Medicaid. Following the example from above with an admission date of January 8, the member will change to FFS Medicaid beginning on February 1. Providers will need to split the claim and bill a portion to the Managed Care Plan, and the other portion of the claim to FFS Medicaid.

Timing Requirements

An Admission Record is required to be submitted in PRISM within 90 days of the admission date. A retroactive authorization request must be submitted following current policy. After 90 days of enrollment on FFS Medicaid, the member will once again enroll in a Managed Care Plan for subsequent months. If the member's prognosis indicates a need to remain in the facility for an extended period or until the end of life, the member should have their eligibility reviewed to seek qualification for Nursing Home Medicaid eligibility. This will result in the member remaining on FFS Medicaid continually.

Trainings

Medicaid has PRISM trainings scheduled covering the Admission Record process for long term care stays. Please visit the Medicaid Website for the training schedule.

PRISM Changes to the Allowed Leave of Absence Days for Members Residing in a Skilled Nursing Facility, ICF/IID, and Utah State Developmental Center

As providers are aware, 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 on April 3, 2023.

PRISM programming regarding Leave of Absence (LOA) days for each resident of a Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and the Utah State Development Center (USDC) has been updated as follows:

1. The allowable days to receive payment for therapeutic or rehabilitative LOA days will continue to be limited to 12 days per calendar year for each Medicaid resident in any SNF.
    a. Payment for additional LOA days may be authorized through a prior authorization process (see Prior Authorization for Additional Leave of Absence Days)
2. The allowable days to receive payment for therapeutic or rehabilitative LOA days will be changed to 100 days per calendar year for each Medicaid member in an ICF/IID.
    a. Payment for additional LOA days may be authorized through a prior authorization process (see Prior Authorization for Additional Leave of Absence Days)
3. The allowable days to receive payment for therapeutic or rehabilitative LOA days will be changed to 25 LOA days per calendar year for each Medicaid member in the USDC.
    a. Payment for additional LOA days may be authorized through a prior authorization process (see Prior Authorization for Additional Leave of Absence Days)

Billing for Allowable Leave of Absence Days in PRISM

For claims payment, when submitting a claim for LOA days for each Medicaid resident, residing in any SNF, ICF/IID, or the USDC, providers must bill for the allowable LOA days (not to exceed 12 for SNF, 100 for ICF/IID, 25 for USDC) by using Occurrence span code 74. These days will be calculated by using the residents Medicaid ID number and the provider ID number.

Prior Authorization for Additional Leave of Absence Days

When the allowable LOA days for any SNF, ICF/IID, or USDC are exhausted, more LOA days for therapeutic or rehabilitative purposes may be requested through the prior authorization (PA) process.

Providers must contact their Resident Assessment nurse to request additional LOA days. Providers are required to submit appropriate and adequate documentation, which must also include approval of the additional leave days by the resident's attending physician and/or the interdisciplinary team as appropriate, to meet and support the resident's plan of care. HCPCS code A9270 will be used for prior authorization purposes for the request of the extension of LOA days. (See Billing for Prior Authorized Additional Leave of Absence Days.)

Contact the Resident Assessment nurses by calling the main Medicaid line at (801) 538-6155 or 800-662-9651 then choose option 3, option 3 again, then choose the correct nurse from those mentioned.

Billing for Prior Authorized Additional Leave of Absence Days

When billing for the additional, prior authorized, LOA days for residents of a SNF, ICF/IID, or USDC providers must submit the claim appending the following codes:

1. Occurrence span code 74
2. Revenue code 0183
3. HCPCS code A9270
4. The prior authorization number

Submitting the claim this way will allow for proper adjudication and payment of the claim.

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

The last day documentation was accepted from long term care providers for 10A applications was February 22, 2023. Resident Assessment reviewed all outstanding 10A applications and finalized all that had complete documentation. Providers will still have access to UHIN in order to review past 10A applications. Providers must wait until April 3, 2023, to submit applications through PRISM.

New Coverage and Reimbursement Lookup Tool

On April 3, 2023, Medicaid will be launching its new system known as PRISM. In some cases, PRISM will process claims differently than the old Medicaid Management Information System (MMIS). As of March 13, 2023, fee-for-service claims will be processed using the logic found in

PRISM, which incorporates the National Correct Coding Initiative (NCCI), updated policy, rules and/or regulations. Claims processed through managed care may also change, depending on which managed care plan is processing the claim. With the implementation of PRISM, the Division of Integrated Healthcare will be posting a new Coverage and Reimbursement Lookup Tool (CRLT).

As a part of the change, providers will need to interact with the new tool differently than with the old tool found at https://health.utah.gov/stplan/lookup/CoverageLookup.php. In the old tool, providers were able to enter their provider type to look up individual codes. In the new tool, providers will need to use a Provider Allowable Code (PAC) in order to look up an individual code. The fee schedule is not changing as a result of PRISM; however, the conversion from provider type to PAC is not exactly a one-to-one conversion. Because of these changes, providers should refer to the new tool for all claims adjudicated after March 13, 2023.

The old CRLT will be available on the Medicaid website for at least 12 months after go-live. The new CRLT will be available a few weeks after the launch of PRISM. Additional information and training will be available as we get closer to implementation of the new CRLT. For questions regarding coverage during the freeze, please contact PRISM@utah.gov.

Ambulatory Surgical Center Claims Processing

Some Ambulatory Service Centers (ASCs) are submitting a rendering/servicing provider on their claims. Since ASC claims are for the facility charges, and not provider charges, a rendering/servicing provider should not be submitted on an ASC claim.

In the current legacy MMIS system, the rendering/servicing provider was ignored for claims adjudication and payment was made based on the billing provider NPI of the ASC. In PRISM, the system looks to the rendering/servicing for coverage, pricing, and multiple surgical ranking. If an ASC submits a rendering/servicing provider on their claim in PRISM, the claim will process at the rendering/servicing level and will not process as an ASC claim.

To have ASC claims pay correctly, do not bill with the rendering/servicing provider information on ASC claims. This will ensure the policy and reimbursement amounts are applied correctly.

Claims Editing Update

With the implementation of the PRISM system, Medicaid will no longer process claims through the current MMIS claim system. Claims will be submitted and processed through PRISM.

Providers should be aware that claims may process and adjudicate differently than in the past. Claims will continue to be edited using correct coding principles, industry accepted standards and guidelines to identify appropriate coding for provider billing and reimbursement. This includes the National Correct Coding Initiative (NCCI) editing. Individualized editing has also been built in PRISM to accurately support existing Medicaid policy.

If a provider makes an adjustment to a claim, on or after April 3, 2023, that was previously processed under the old editing logic, the adjusted claim will process using the PRISM editing logic and could result in a variance from the original.

23-10 Autism Waiver Provider Manual Archived

The Utah Medicaid Autism Waiver Provider Manual has been archived as of March 1, 2023. If providers have questions about this policy change, please contact jambrena@utah.gov.

23-11 Adult Vaccine Coverage

Adult vaccines that are recommended by the Advisory Committee on Immunization Practices are covered through Fee for Service Medicaid with no cost-sharing in accordance with section 11405 of the Inflation Reduction Act of 2022.

23-12 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee reviewed non-stimulant treatments for ADHD in February. Committee recommendations regarding updates to the preferred drug list (PDL) goes into effect with the April 2023 PDL.

P&T Committee meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/pt-committee.

23-13 DUR Board Updates

The Drug Utilization Review (DUR) Board meeting was canceled for January 2023.

The DUR Board met in February 2023 to review Lybalvi (olanzapine/samidorphan). The review includes prescribing information and Lybalvi'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/.

23-14 Utah Medicaid Provider Manuals Access

We are experiencing issues with the provider manuals website. Please access the current PDF manuals temporarily at https://medicaid.utah.gov/utah-medicaid-official-publications/. For questions, email medicaidops@utah.gov.

23-15 Hospice Provider Manual Updated

The Hospice Care Services Provider Manual has been updated. The following reflects the changes made to the manual:

- Removed the definition for consecutive months under Chapter 8-1 *Definitions*.
- Removed Chapter 8-2.1 *Managed Care Entities (MCE)* as MCE information is presented later in the manual.
- Added information to Chapter 8-9.2 *Election of Hospice* to help meet the requirements laid out in the CFR.
- Modified Chapter 8-9.9 *Notifications* and Chapter 10 *Prior Authorization* to remove "Hospice Prior Authorization Form" and include "Hospice Admission Records Request" to meet the needs of the PRISM system.
- Removed the "independent physician review" section of Chapter 10 *Prior Authorization* due to lack of enforcement.
- Removed most of Chapter 13-1 *Hospice Care Rates* and all of Chapter 13-2 *Date of Discharge* due to duplicative information found in the CFR.

23-16 Transportation Modifiers

To align with the National Correct Coding Initiative (NCCI), Utah Medicaid is updating policy to remove the two-digit, numeric modifiers used for non-emergent medical transportation. Instead, Utah Medicaid will adopt the same two-letter, alphabetic modifiers currently used for emergency transportation.

Effective April 1, 2023, *Chapter 10 Non-Emergency Transportation Procedure Code Modifiers* of the Medical Transportation Services Provider Manual is updated to state:

All claims billed to Medicaid for non-emergent transportation must have a two-letter modifier. The modifier may be any combination of the one-letter codes listed below. The first letter indicates origin of transportation. The second letter indicates destination of transportation.

Code	Location
D	Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled nursing facility
P	Physician’s office
R	Residence
S	Scene of an accident or acute event
X	(Destination code only) intermediate stop at physician’s office on the way to the hospital

23-17 New Medicaid Card

On July 1, 2022, the Utah Department of Health (UDOH) and Department of Human Services consolidated and became one agency, the Department of Health and Human Services (DHHS) with a new logo and colors.

Beginning May 1, 2023, DHHS will issue a new Medicaid card to replace the existing UDOH card for new Medicaid members. The new Medicaid Member Card will have the DHHS branding standards with the member’s name, Medicaid ID number, and date of birth. The card will be used whenever the member is eligible for Medicaid. Each new Medicaid member will get their own card. Existing members will continue using their old UDOH Medicaid card. Please accept both DHHS and UDOH Medicaid cards.

Below is a sample of the front and back of the new Medicaid card: