FAQ: MEMBERS
Medicaid Restriction Program

1- How do I contact Medicaid Restriction?

a) **Fee for Service (FFS) Members**
   i) Hours of Operation:
      (1) Monday – Friday (excluding State and Federal Holidays)
      (2) 8:00 AM to 5:00 PM
      (3) Phone: 801-538-9045
      (4) Outside of hours of operation, you may leave a message on the secure line and the Medicaid Restriction Staff will return your call on the next working day.
      (5) b. Email: medicaidrestriction@utah.gov
      (6) c. Website: https://medicaid.utah.gov/resources/

b) **Accountable Care Organization (ACO) Members**
      (1) Health Choice: 877-358-8797 option 3 or pharmacy services: 855-864-1404
      (2) Healthy U: Central phone (833) 981-0212 option 2, then option 3 for care management Care Management: 801-587-2851, opt 4
      (3) Molina: 888-483-0760 or member services after hours 888-275-8750
      (4) Select Health: 801-442-5305 or 1-800-538-5038

2- Can Utah State Medicaid Restriction help me if I am enrolled with a health plan such as Molina, Healthy U, Health Choice, or Select Health?

a) For anything other than a request for a change of health plan, Utah State Medicaid Restriction will not be able to help you. You must work with your health plan for all healthcare management needs.
   i) If you do call Utah State Medicaid Restriction for help with medical needs or to dispute your restricted status, you will be referred to your assigned health plan for help.
      (1) You can dispute your restriction by submitting a grievance or appeal to your health plan. Contact your health plan for assistance.
      (2) If your health plan denies your grievance or appeal, then you can submit an appeal to Utah State Medicaid Restriction.
         (a) Your health plan can help you submit an appeal to Utah Medicaid Restriction.
         (b) You can also contact the Utah Medicaid Hearing Office for assistance at:
            (i) Email: utmedicaidhearings@utah.gov.
            Phone: 801-538-6576
            Fax: 801-536-0143.
         (c) The website for Utah Medicaid Hearings Office is: https://medicaid.utah.gov/hearings/

b) State Medicaid Restriction can only help you if you want to request a change of health plan.
   i) Restricted members are not eligible for changes to the health plan upon request as long as the member remains restricted.
      (1) **Exceptions to this are rare**. However, you may contact Utah Medicaid Restriction to ask for a change of health plan at 801-538-9045**.**
      (2) You can always request a hearing if you feel that a change of health plan was denied to you in error.
         (a) See # i)-(2)-(b) and (c) above for appeals and hearings contact information.
   ii) Restricted members are not eligible for a change of health plan during open enrollment.

iii) If you are restricted and a change of health plan is granted, it will not affect the length of your restriction. You will remain restricted if you are currently restricted and you change health plans.

3- Why am I enrolled in the Restriction Program?

a) The Department may enroll a member in the Restriction Program if the member meets one or more of the restriction criteria within the most recent 12 months of Medicaid eligibility as outlined in administrative Rule R414-29.

i) Criteria:

(1) accesses four or more non-affiliated primary care providers (PCP) and specialists.
(2) accesses four or more pharmacies for the purchase of abuse potential medications.
(3) accesses three or more non-affiliated providers who prescribe abuse potential medications in a consecutive two-month period.
(4) accesses six or more prescriptions for abuse potential medications in a consecutive two-month period.
(5) accesses emergency department services for five or more non-emergent emergency department visits.
(6) fills concurrent prescriptions for abuse potential medications, written by different prescribers.
(7) pays cash for Medicaid-covered services; or
(8) accesses concurrently prescribed abuse potential medications written by different prescribers without medical necessity or the knowledge or consent of the different prescribers.

b) Once a member is found to meet or exceed restriction criteria, the Department shall perform an additional review to determine if overutilization of services was the result of limited access to care or medical necessity.

c) When an individual is placed in the Restriction Program, the member shall have one assigned PCP and one assigned pharmacy.

(1) If a member is with an accountable care organization (ACO) contact health plan for additional information about your restriction. (See # 1 for contact information)
(2) If member is with Fee for Service (FFS) contact the Restriction Program for additional information about your restriction. (See # 1 for contact information)

4- How long will I be enrolled in the Restriction Program?

i) Length of Restriction is outlined in R414-29-7

(1) A restricted member shall remain in the Restriction Program for a total of **12 months of Medicaid eligibility**. The months of eligibility need not be continuous.

(2) If a restricted member becomes ineligible for Medicaid, and subsequently reestablishes Medicaid eligibility, the Department shall require the member to continue enrollment in the Restriction Program, unless the restricted member's loss of Medicaid eligibility is greater than one year.

(3) The Department shall perform a review of a member's placement in the Restriction Program once the member has been enrolled in the Restriction Program for 12 months of Medicaid eligibility.

(4) The Restriction Program shall remove a restricted member if an annual review demonstrates the restricted member no longer meets the restriction criteria.

(5) The Department shall inform a restricted member in writing of the member's removal from the Restriction Program.
(6) If at the time of annual review, a Medicaid member still meets the criteria for the Restriction Program, the Department shall inform the restricted member of continued enrollment in the Restriction Program for an additional 12 months of Medicaid eligibility.
(7) The Department shall provide notice to a Medicaid member of continuation in the Restriction Program in accordance with Section R414-29-6

5- How can I change my approved Primary Care Provider (PCP) on my restriction case?

a) For members in an accountable care organization (ACO), the member needs to call the appropriate health plan for a change request. (See # 1 for contact information). PCP changes can only be made under certain circumstances.
b) For members with Fee for Service (FFS), call and talk with your case manager on the restriction team. (See # 1 for contact information. PCP changes can only be made under certain circumstances. As per Utah State Rule R414-29 (listed below).
c) As per Utah State Rule R414-29, the Medicaid member may select a PCP within 30 days of notification of placement in the Restriction Program.
d) An approved PCP remains the restricted member's PCP for the length of the Restriction unless the provider is no longer willing to act as the approved PCP for the restricted member or a member has a verified change of address, which impacts access to the assigned PCP.

6- How can I add or change a pharmacy or primacy pharmacy to my restriction case?

a) **Approved pharmacy for a Fee for Service (FFS) Medicaid Member:** Either a restricted member or pharmacy with a Medicaid contract may contact the Medicaid Restriction Program to be added to an FFS restricted members restriction. (See # 1 for contact information)
b) **Approved pharmacy for an accountable care organization (ACO) enrolled Medicaid Member:** Either a restricted member or a pharmacy with a Medicaid contract may contact the appropriate ACO health plan to be added to an ACO restricted members restriction. (See # 1 for contact information)
c) A temporary pharmacy with a Medicaid contract may be added to restriction members case there is a special need. (i.e. compounding or other specialty pharmacies). The restricted member or temporary pharmacy with a Medicaid contract may contact FFS Restriction team or ACO health plan (See # 1 for contact information).

7- Why are my prescriptions not being paid for by Medicaid?

a) If your prescription requires Prior Authorization, contact your primary care provider (PCP) as soon as possible so that they can fill out the necessary forms online and submit them to the prior authorization pharmacy team.
b) If the prescriber and or pharmacy is not added to your restriction case, the prescription(s) will not pay. Your PCP can call to add additional providers if approved to the members restriction case. The PCP may contact Fee for Service (FFS) Restriction team or accountable care organization (ACO) health plan (See # 1 for contact information).
c) Under certain extenuating circumstances cash payments may be necessary such as an urgent care visit, discharge from a Hospital Stay or an Emergency Room visit. The member should contact the FFS Restriction team and or ACO health plan as soon as possible to assist with

prescription(s) obtained in the urgent care visit, discharge from hospital stay or emergency room. (See # 1 for contact information).

8- How can I schedule a visit with a specialty provider such as an Orthopedic or Pain Management Provider?

a) **Approved Provider for a Fee for Service (FFS) Medicaid Member:** the approved primary care provider (PCP) must contact the Medicaid Restriction Program to provide the name of any approved provider or prescriber. This will allow payment to an approved provider when the provider submits claims for services provided to the restricted Medicaid member. This will also allow members to obtain prescriptions from the provider.

b) **Approved Provider for an accountable care organization (ACO) Enrolled Medicaid Member:** the approved PCP must contact the appropriate ACO health plan to provide the name of any approved provider or prescriber. This will allow payment to an approved provider when the provider submits claims for services provided to the restricted Medicaid member. This will also allow members to obtain prescriptions from the provider.

9- How do I make an appointment with a behavioral health provider?

a) Mental health benefits are provided for most Medicaid members through Prepaid Mental Health Plans (PMHP). An overview of mental health services covered by Medicaid can be found at https://medicaid.utah.gov/managed-care/

b) Mental health providers can be added to the restriction case if the members or provider calls to request the provider be added to the restriction case. Contact Fee for Service (FFS) or the accountable care organization (ACO) health plan. (See # 1 for contact information).

10- How do I schedule a visit with a dentist if I have a dental benefit?

a) Members can make an appointment with a dentist who accepts Medicaid or is on your dental plan network. If you need assistance finding a dentist, please call a Medicaid Health Program Representative (HPR) at 1-866-608-9422.

b) The State of Utah currently has two managed care dental plans statewide:
   i) MCNA 1-877-904-6262
   ii) Premier Access 1-877-541-5415

c) Members who are on the following Medicaid programs will receive dental benefits through fee for service Medicaid and are not required to be enrolled in a dental plan:
   i) Foster Care Medicaid
   ii) Nursing Home Medicaid
   iii) Refugee Medicaid
   iv) Targeted Adult Medicaid (TAM) members who are age 19 and 20
   v) Adult Expansion Medicaid members who are age 19 and 20

d) The following members have dental benefits and must choose a dental plan:
   i) Pregnant Women
   ii) Medicaid members who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits

e) The following Medicaid members will receive dental benefits through the University of Utah School of Dentistry and their network of providers: For appointments or information, contact the University of Utah Dental Medicaid Call Center at: 801-587-7174.
   i) Targeted Adult Medicaid (TAM) members who are receiving treatment in a Substance Use Disorder Treatment Program (age 21 and older)
   ii) Adults, 21 and older, who are on Medicaid because of a disability or blindness
   iii) Adults, age 65 and older, eligible for Traditional Medicaid

11- If my dentist writes a prescription, will Medicaid pay for it?

a) The approved primary care provider (PCP) must contact the Medicaid Restriction Program or accountable care organization (ACO) health plan (See # 1 for contact information) to provide the name of the approved dentist that has a Medicaid contract to the restricted member's case. This will allow prescriptions to be paid.

12- What if I don't have a dental benefit?

a) Services to be provided by any enrolled Medicaid dental provider
b) Limited emergency dental services include:
   i) Limited oral evaluation, problem focused
   ii) Intraoral periapical, first film
   iii) Intraoral periapical, each additional film, if needed
   iv) Extraction, erupted tooth or exposed root
   v) Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
   vi) Incision and drainage of abscess, intraoral soft tissue

13- How do I get help finding an approved provider?

a) If you are enrolled in an accountable care organization (ACO) health plan, please contact your health plan for provider information. (See # 1 for contact information).
b) If you live in Utah, Salt Lake, Davis, Weber, Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, Wasatch, or Washington Counties, you must choose a health plan for your medical care. If you live in any other county in Utah, you may have a choice of selecting a health plan or using the Fee for Service network.
c) Contact a Health Program Representative (HPR) at 1-866-608-9422. Your HPR can help you find a provider or health plan. An HPR can provide education so you can learn about your Medicaid benefits and provider options.
d) Contact (Fee for Service) FFS Medicaid Restriction for additional provider information or ACO health plan (See # 1 for contact information).

14- When is it ok to go to the Emergency Room?

a) Use urgent care clinics when the primary care provider (PCP) is not available for an immediate medical need and the need is not an emergency.
b) "Emergency service" means immediate medical attention and service performed to treat an emergency medical condition. Immediate medical attention is treatment rendered within 24 hours of the onset of symptoms or within 24 hours of diagnosis.

c) "Emergency medical condition" means a medical condition showing acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:
   (1) placing the patient's health in serious jeopardy (such as fever, shortness of breath and chest pain).
   (2) serious impairment to bodily functions.
   (3) serious dysfunction of any bodily organ or part; or
   (4) death

15- What if I need more information about the Restriction Program?

a) Contact Fee for Service (FFS) or accountable care organization (ACO) health plans (See # 1 for contact information).
b) Website: https://medicaid.utah.gov/resources/