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Correction of April 2019 MIB Article 19-31 Eligible Specialty Care for Restricted Members

Modifiers 82, 90, 91 and P1 – P6 were inadvertently included in the list defined as, “not eligible for payment on claims submitted for specialty services rendered to restricted members.” The corrected statement is: "Claims submitted for specialty services for restricted members with modifiers 23, 25, 30, 47, 55, 56, 62, 75, 66 and 80 are only eligible for payment with a referral from the assigned PCP."

Find A Provider (FAP) Directory

The implementation date for the Find A Provider (FAP) Directory will be delayed. More information on accessing the Provider FAP Information Tool will be available in the coming months.

Provider Re-Credentialing

If you are a provider who must re-credential with Medicaid in 2019, Utah Medicaid will send written notice to the provider’s ‘pay to’ address on file in the PRISM system. Federal regulation 42 CFR 455.414 requires Utah Medicaid providers to re-credential every three to five years, based on the CMS-defined level of risk.

Failure to comply with this requirement may result in suspension of payment, and may also result in termination of your enrollment as a provider with Utah Medicaid.
PRISM Update

CHANGES ARE COMING TO PRISM’s PROVIDER ENROLLMENT SYSTEM!

When are PRISM changes coming?

In March 2020, Medicaid will go live with changes and updates to the current provider enrollment system (PRISM).

Why is the PRISM system changing?

The original Provider Enrollment component of the PRISM system went live in July 2016. This initial phase eliminated the paper application process by allowing providers to enroll online and make online record modifications. The next phase coming in March 2020 will include updates to the enrollment steps and changes to satisfy federal mandates. Additional changes are coming in early 2022 to align with the core PRISM components going live that year.

What do I need to do now?

If you are a provider who is scheduled to re-validate/re-credential with Medicaid in 2019, Utah Medicaid recently sent written notice to the provider’s ‘pay to’ address to complete this process. If you have not already, please complete your re-validation/re-credential as quickly as possible to avoid possible termination of your contract.

To review your enrollment status, routinely check your account, especially if you have recently submitted an application or modification. You can check-in by logging into PRISM (information here) or by calling Provider Enrollment at (801) 538-6155, or toll-free 1-800-662-9651 (option 3 then 4).

How will PRISM changes impact providers?

For Current Providers - Enrollment records will be migrated to the updated PRISM system. You will be notified by letter when this occurs. The letter will specify the updated PRISM web address with instructions on how to login to the updated PRISM Provider Enrollment System to validate and modify information. You will have time to review the migrated information, validate that it is correct, and make any needed modifications to your information in PRISM.

For New Providers – There will be a timeframe prior to the PRISM updates in March 2020 where new providers will be unable to submit new applications until the migration for current providers is complete. The dates for the freeze are not known yet, but will be communicated in advance. After this period, new providers will need to use the updated PRISM Provider Enrollment System to enroll. The link for the new system will be on the Medicaid website at https://medicaid.utah.gov. There will be eLearning training courses to help navigate the new system. More details to come regarding the online trainings and their location as the go-live date approaches.

If a provider has not yet used the current PRISM system, contact the Medicaid Provider Enrollment Team at (801) 538-6155, or toll-free 1-800-662-9651 (option 3 then 4) to request your validation letter that will provide instructions on how to log in to the system for the first time.

How do I stay current on PRISM system changes?

There are a few ways to learn about the changes coming in March 2020.

1. As the March 2020 date approaches, the PRISM website, https://medicaid.utah.gov/prism, will have
information regarding the upcoming changes.
2. The quarterly Medicaid Information Bulletin (MIB) will have articles related to the changes.
3. Annual Statewide Provider Training in 2019 will include information about the changes. Specific dates will be published in a future MIB.
4. Answers to FAQs can be found at https://medicaid.utah.gov/Documents/pdfs/ProviderEnrollmentFaqs2020.pdf

Can I help test the changes to PRISM coming in March 2020?

Yes. Any participation you can offer will be highly beneficial to you and to the implementation of the new information system. We will begin user testing for the new system in December 2019. Providers or administrative staff working with providers, who are interested in participating in system testing with the PRISM Project, are invited to send an email to prism@utah.gov with their contact information. We will respond to your email to coordinate testing.

How will I receive training on the PRISM changes coming in March 2020?

eLearning training modules will be made available on the PRISM website at go-live here. These modules will cover new enrollment and PRISM changes.

19-56 Provider Education Corner

Utah Medicaid is continuing to make substantial changes to the provider manuals. Medicaid is moving policy from the provider manuals to the appropriate Utah Administrative Rule within R414, Health, Health Care Financing, Coverage and Reimbursement Policy. We anticipate this process to continue for several quarters.

The specific changes are detailed in the Utah State Bulletin as the changes go through the rule-making process. Providers are encouraged to become familiar with Administrative Rule in order to find Medicaid coverage policy for specific services.

Specific coverage on CPT or HCPCS codes is found in the Utah Medicaid Coverage and Reimbursement Code Lookup. The Coverage and Reimbursement Code Lookup allows providers to search for coverage and reimbursement information by procedure code, date of service, and provider type.

Information regarding modifiers can be found in the Utah Medicaid Provider Manual Section I: General Information. Provider manuals and attachments may be found at Utah Medicaid Official Publications.

Providers are encouraged to become familiar with the updated rules and manuals noting changes in the structure, formatting, and content of the manuals.
19-57  Tables of Authorized Emergency Diagnoses

The tables of authorized emergency inpatient diagnoses and authorized emergency department diagnoses are updated regularly. The current authorized diagnoses lists are available on the Medicaid website at Utah Medicaid Table of Authorized Emergency Department Diagnoses.

19-58  Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT)

The Utah Medicaid CHEC Program was renamed to align with the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. Effective January 1, 2019, the CHEC Provider Manual was renamed to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Provider Manual.

Medicaid will continue updating information referencing the CHEC program with EPSDT. These updates will occur over the next several quarters.

Specific coverage on CPT or HCPCS codes are found in the Utah Medicaid Coverage and Reimbursement Code Lookup. The Coverage and Reimbursement Code Lookup allows providers to search for coverage and reimbursement information by procedure code, date of service, and provider type.

Providers are encouraged to become familiar with this manual.

19-59  Genetic Testing

The genetic testing policy has been updated. Providers are encouraged to review the updated policy noting:

- Information regarding EPSDT eligible members is located in the EPSDT Services Provider Manual
  - The following services are open with prior authorization for EPSDT members (effective May 14, 2019):
    - 81415 Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
    - 81416 Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
  - Information regarding non-EPSDT eligible members is located in the Physician Services Provider Manual
Specific coverage on CPT or HCPS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

### 19-60 Section I: General Information Manual Update

The Section I: General Information Provider Manual has been updated. Providers are encouraged to become familiar with the updates noting:

2- Health Plans is being updated and renamed Managed Care Entities (MCE)
   - Information is being updated regarding Utah Medicaid managed care; types of managed care entities (MCEs); member enrollment and disenrollment; services covered and not covered by MCEs; and grievances and appeals related to MCEs.

8-3 Medicaid Restriction Program
   - Has been updated to clarify the Medicaid Restriction requirements.

4-6 Signature Requirements
   - Has been updated to add language and criteria to determine what is considered a valid provider signature.

11-9 Electronic Visit Verification Requirements for Home Health and Personal Care Services
   - Has been added to the chapter on Billing Medicaid.

Specific coverage on CPT or HCPS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

### 19-61 Medical Supplies and Durable Medical Equipment (DME) Manual Update

The Medical Supplies and Durable Medical Equipment (DME) Provider Manual has been updated. Providers are encouraged to become familiar with the updates noting:

- The DME Manual has undergone a major revision
- HCPCS code E0202 (Phototherapy (bilirubin) light with photometer) has a quantity limit of seven per 12 month period
- Evidence-based criteria for noninvasive airway assistive devices require documentation supporting a face-to-face evaluation. Refer to Utah Administrative code R414-1-30 for policy regarding face-to-face
- Upper extremity prosthetic codes with fixed pricing are on quantity limit of one every five years
• The policy for wheelchair coverage based on a member being bed or chair bound has been removed. Policy has been updated to align with the Utah Medicaid definition of medical necessity and evidence-based criteria.

• Reimbursement of wheelchair equipment is bundled as a complete package. When submitting claims providers are required to submit claims with each line item associated with base items. For ease of determination provider can see Table A found in chapter 8-14.5 Attachments, Accessories, Component and Options section of the DME Manual.

• EPSDT policy and information related to DME has been moved into the DME manual.

• When requesting a wheelchair, the DME providers must:
  o complete and submit the required wheelchair evaluation forms
  o submit the applicable form(s) with the prior authorization (PA) request
  o maintain the original wheelchair evaluation forms within the DME provider member record
  o use the following forms:
    • **Utah Medicaid Initial Wheelchair Evaluation Form**
      • required for wheelchair PA requests
      • completed prior to requesting a wheelchair
      • performed by a physician, licensed physical therapist, or licensed occupational therapist
    • **Utah Medicaid Final Wheelchair Evaluation Form**
      • is required for submitted wheelchair claims
      • for claims submission must be faxed to 801-536-0481
      • must be completed upon delivery of wheelchair
    • **Utah Medicaid Power Wheelchair Training Checklist**
      • required for power wheelchair PA requests and claim submissions
      • performed by a physician, licensed physical therapist, or licensed occupational therapist

• **Chapter 3-5, Wheelchairs** has been updated and changed to **Chapter 8-14, Wheelchairs**

• **Chapter 1-1 Definitions** of the DME Manual has been updated and changed to **Chapter 8-1 Definitions**

• The Utah Medicaid definition of customized manual wheelchairs has been updated.

• The manual language, formally found in **Chapter 3-5.9, Motorized Wheelchairs**, regarding a minimum of two hours of training for members with delivered motorized wheelchairs has been removed. Training guidelines for members is found in the **Utah Medicaid Final Wheelchair Evaluation Form**

• Policy regarding replacement of wheelchairs that have been stolen, formally found in **Chapter 3-5.6, Replacement of Wheelchairs**, has been removed. All replacement wheelchairs follow the same prior-authorization process.

• **Chapter 3-5.10 Wheelchairs for Members in a Long-Term Care Facility** has been updated and changed to **Chapter 8-14.6, Members Residing in Long-Term Care Facilities**

• Wheelchairs that are included in the per diem rate have been identified in **Chapter 8-14.6, Members Residing in Long-Term Care Facilities**

• A link to the Utah State Plan has been added in order to assist providers in finding those benefits that are considered per diem vs ancillary for members residing in long-term care facilities.

• G9012 is no longer used when reporting evaluations, assessments, and training performed by licensed therapists related to wheelchairs as formally indicated in **Chapter 3-5.3 Reimbursement for Pre-and Post-Wheelchair Assessment to PT/OT Providers**

• Providers must now use CPT codes 97535 and 97542 for reporting evaluations, assessments, and training related to wheelchairs.

• Further guidance for reporting wheelchair evaluations can be found in **Chapter 8-14.2 Wheelchair Evaluation Forms**.
• Chapter 3-5.7 Manual Wheelchair has been updated and changed to 8-14.3 Manual Wheelchair. Updates included are additional criteria when requesting a manual wheelchair and the Manual Wheelchair Basic Equipment Package
• Chapter 3-5.9 Motorized Wheelchairs has been changed to Chapter 8-14.4 Power Wheelchairs. Updates included are additional criteria requirements when requesting a power wheelchair and the Power Wheelchair Basic Equipment Package
• Chapter 8-14.5 Attachments, Accessories, Component and Options has been added to Chapter 8-14 Wheelchairs of the DME Manual. Information within this section includes criteria for certain wheelchair related equipment
• Section 3-6 DME Repairs and Replacement has been updated to 8-15 Equipment Service Requirements
• Policy for maintenance, repairs, and replacements has been updated and are found in Chapter 8-15 Equipment Service Requirements
• Policy for warranties has been updated and moved to Chapter 8-15 Equipment Service Requirements
• Policy for modifications has been removed

Specific coverage on CPT or HCPS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

19-62 Primary Care Network (PCN) Update

Effective April 1, 2019, all PCN members were transitioned to Adult Expansion Medicaid. The PCN program is no longer active at this time although the Coverage and Reimbursement Code Lookup, the PCN provider manual, and the PCN Administrative Rule R414-100 will remain available for reference until April 2020.

19-63 Non-Traditional Medicaid Plan Manual Restoration with Updates

The Utah Medicaid Provider Manual for the Non-Traditional Medicaid Plan was archived on April 1, 2018. Information regarding this program was located in the Section I: General Information provider manual and Utah Administrative rule, R414-200- Non-Traditional Medicaid Health Plan Services. For ease of access to Non-Traditional Medicaid Health Plan information, the Non-Traditional Medicaid Plan manual has been restored and updated to include the 2017 information from Utah's Section 1115 Demonstration Waiver.

Specific coverage on CPT or HCPS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.
19-64  Physical Therapy (PT) and Occupational Therapy (OT) Updates

The Physical Therapy and Occupational Therapy Services Provider Manual has been updated. Providers are encouraged to become familiar with the changes noting:

- Physical Therapist (PT) or Occupational Therapist (OT) will no longer use HCPCS code T1015 to report services
- PT and OT providers will be required to use the appropriate modality and/or therapy CPT codes to report services
- Traditional Medicaid members are eligible to receive 20 PT and 20 OT visits per calendar year
- Non-Traditional Medicaid members are eligible to receive 16 visits total in any combination of PT and/or OT in a calendar year
- A visit is defined as a date of service regardless of the number of modalities/therapies performed on that date of service

Specific coverage on CPT or HCPCS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

19-65  Home Health Services Updates

The Home Health Services Manual has been updated. Providers are encouraged to become familiar with the updates noting:

Chapter 4-1.10, Telehealth Skilled Nurse Pilot Project for Beneficiaries in Rural Areas, has been removed from the Home Health Services Manual. Information regarding telehealth services can be found in Section I: General Information, Chapter 8-4.2.

Specific coverage on CPT or HCPCS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

19-66  Home Health and Personal Care Services

The Special Notes regarding coverage of HCPCS codes Q0081, Q0084, S9123, T1030, T1031, T1002, and T1003 have been removed from the Coverage and Reimbursement Code Lookup. The Special Notes for T1002 and T1003 will retain the limitations of one visit per day. Utah Medicaid describes these codes differently than HCPCS. A per visit rate is set when reporting T1002 and T1003 by provider type 58 for skilled nursing services. Coverage for all skilled nursing is found in the Home Health Agencies Provider Manual, Chapter 4.
The Special Note regarding T1001 has been modified in the Coverage and Reimbursement Code Lookup. Provider type 54 must append the SE modifier when reporting nursing assessment for personal care services.

Personal Care Agencies, provider type 54, and Medicare/Medicaid Certified Home Health Agencies, provider type 58, are encouraged to become familiar with the applicable changes that may affect their services.

Specific coverage on CPT or HCPS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

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### 19-67 Personal Care Services Manual Update

In addition to minor technical and grammatical changes, the Utah Medicaid Provider Manual for Personal Care Services has been updated. Below is a list of the significant changes.

- **Chapter 1-2 Fee-For-Service or Managed Care** has been updated to include policy that is currently found in the Section 1: General Provider Manual
- **Chapter 1-3 Acronyms and Definitions** has been updated to included new or revised definitions for the following:
  - Custodial Care Services
  - Home Health Aide
  - Home Health Agency
  - Personal Care Aide
  - Personal Care Agency
- **Chapter 1-4 Personal Care Program Requirements** has been updated with minor clarifying language and some changes made to section B - Plan of Care and D - Record Keeping
- **Chapter 3 Member Eligibility** has been updated to include policy that is currently found in the Section 1: General Provider Manual
- **Chapter 3-1** has been retitled to Personal Care Services Eligibility Requirements. There have also been some changes to clarify the intentions of personal care services compared to services available under other Medicaid programs.
- **Chapter 4-1 Covered Personal Care Services** has been updated to remove redundant information.
- **Personal Care Procedure Codes** has been moved to Chapter 5 Billing
- **Chapter 4-2 Electronic Visit Verification Requirement** has been added to address upcoming changes, effective 7/1/2019.
- **Chapter 4-3 Limitations** has been updated to include the following changes:
  - Addition of limitations on T1001 visits. This is not a change to policy; the information was previously located in a different section of the manual.
  - Clarifying language regarding personal care aides’ interaction with medical devices. Personal care aides will not provide specific care or adjustments to any medical equipment, however it is understood there will be “contact” with some medical equipment such as wheelchairs, walkers, nasal cannula replacement, while assisting members with personal care related services such as ambulation and bathing.
  - Addition of a limitation regarding care related to a member’s pet(s)
- **Chapter 5-2 Patient Notices and Rights** (from the previous version of the manual) has been removed. The information on hearings in now locating in Chapter 5-3 Hearings and Administrative Review
• **Chapter 5-2 Medicaid as Payment in Full, Client Billing Prohibited** has been updated to include policy that is currently found in the Section 1: General Provider Manual

• **Chapter 5-3 Exceptions to Prohibition on Billing Member** has been updated to include policy that is currently found in the Section 1: General Provider Manual

• **Chapter 5-3 Hearings and Administrative Review** has been updated to include policy that is currently found in the Section 1: General Provider Manual

• **Chapter 5-4 Prior Authorization** has been updated with minimal changes in verbiage. There has not been any changes to the prior authorization process. Information has been removed from this section that is located on the prior authorization request form.

### 19-68 Code Updates

#### Open with Prior Authorization (Effective May 14, 2019)

81415 Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81416 Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)

#### Prior Authorization Removed

D2751 Crown - porcelain fused to predominantly base metal

### 19-69 Health Educators for Extended Services to Pregnant Women

Health Educators that meet one of the following criteria may enroll as providers for extended services to pregnant women:

• Bachelor’s degree in health education with a minimum of three years’ experience, at least one of which must be in a medical setting
• Master’s degree with a minimum of one year of experience working in a medical setting or with pregnant women
• Bachelor’s degree and a certificate showing completion of a certification examination in health education

For assistance on how to enroll as a new Medicaid provider, please refer to the Enrolling as a New Medicaid Provider Web-Based Trainings. These trainings describe how to enroll as a new Utah Medicaid Provider depending on the enrollment type.

The following references in the Utah Medicaid Physician Services provider manual have been updated with the health educator criteria:
8-10.6.1 Perinatal Care Coordination
8-10.6.2 Prenatal and Postnatal Home Visits
8-10.6.3 Group Prenatal and Postnatal Education

In addition, the HCPCS S9446 time description of 'one unit is one class at least one hour in length' has been removed in 8-10.6.3 Group Prenatal and Postnatal Education.

Providers can access the revised provider manual at https://medicaid.utah.gov. Specific coverage on CPT or HCPS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

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19-70 Free Standing Birthing Centers

Effective May 1, 2018, Free Standing Birthing Centers are to report facility services with revenue code 0724 (Birthing Center).

The Physician Services Provider Manual has been updated to reflect this information.

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19-71 Targeted Adult Medicaid (TAM) Dental Coverage

Limited emergency dental services are available for all TAM members. Services may be provided by any enrolled Medicaid dental provider.

Limited emergency dental services include:

- D0140 Limited oral evaluation, problem focused
- D0220 Intraoral periapical, first film
- D0230 Intraoral periapical, each additional film, if needed
- D7140 Extraction, erupted tooth or exposed root
- D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- D7510 Incision and drainage of abscess, intraoral soft tissue

Additional dental services are available to eligible TAM members who are actively receiving treatment in a substance abuse treatment program as defined in Utah State Code Section 62A-2-101, licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

Dental services for this population shall be provided through the University of Utah School of Dentistry and their statewide network of contracted dentists.
19-72  Pharmacy Program Updates

Opioid Policy Changes to Address Pediatric Opioid Utilization

Effective July 1, 2019, Utah Medicaid will restrict short-acting opioid quantity limits to 7 days or less for children 18 years of age and younger. If a claim for a short-acting opioid is submitted through the point of sale system for a patient 18 years and younger the system will reject that claim. This days’ supplied limit can be overridden when a valid “cancer pain diagnosis code” is placed on the claim. For all opioid claims billed for 8-day supply or greater, a reject message will display to the pharmacy that states, “Opioid claims for > 7 day supply for children 18 and younger require a prior authorization.” This edit will be in addition to all existing opioid quantity limits and days’ supply limitations.

Opioid Policy Changes to Reduce High-Dose Opioids

Effective July 1, 2019, the cumulative daily morphine equivalent dose (MED) threshold for “opioid experienced” individuals (patients receiving an opioid within the last 90 days of 2018) will be reduced from 180 MED to 150 MED. This will support ongoing efforts to achieve one common MED standard for all Utah Medicaid members over time. On January 1, 2019, Utah Medicaid adopted morphine milligram equivalent (MME) and MED methodology for adjudication of all opioid claims for the treatment of non-cancer pain. This initiative was added to existing opioid quantity limits and days’ supply limitations to support CDC safety guidance and best practice standards. A daily threshold of 90 MED for all other patients (“opioid naïve”) individuals will continue.

Opioid Policy Changes to Reduce Concurrent Opioid-Benzodiazepines

Utah Medicaid continues our multi-stage effort to identify and limit patients from inappropriately receiving concurrent benzodiazepine and opioid medications. This initiative will support CDC safety guidance that recommend against combined use which is associated with risk of fatal overdose. Currently, an automated process monitors and reports when an individual is co-prescribed opioids and benzodiazepines. The Utah Medicaid peer–to-peer team is conducting outreach to identified prescribers to alert them of patients receiving concurrent therapy, provide education around concurrent use avoidance, and encourage prescription drug monitoring program (PDMP) use before prescribing a Schedule II controlled substance, in accordance with the Federal HR6, SUPPORT for Patients and Communities Act found at [https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf](https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf).

**Change happening July 1, 2019:** concurrent prescribing of long-acting opioid medications and benzodiazepines will be restricted through the pharmacy point of sale system. When a claim for either a long-acting opioid or a benzodiazepine is submitted, the system will look back 45 days to find any paid claims for either benzodiazepines or long-acting opioids. If a paid claim for a benzodiazepine is found the long-acting opioid claim will reject. Likewise, if a paid claim for a long-acting opioid is found the benzodiazepine claim will reject. Any exceptions to this concurrent use restriction will be evaluated through the prior authorization process, using the Opioids prior authorization form, found on the Utah Medicaid Pharmacy Prior Authorization Website [here](#).
P&T Committee

The Pharmacy and Therapeutics (P&T) Committee recently reviewed ADHD stimulants and sedative hypnotics (non-benzodiazepines, non-barbiturates). Minutes for P&T Committee meetings can be found at https://medicaid.utah.gov/pharmacy/pt-committee.

DUR Committee

The Drug Utilization and Review (DUR) Board met in June to review the annual retrospective drug utilization review work done by the Utah Medicaid peer to peer pharmacy team and by the University of Utah Drug Regimen Review Center (DRRC). Retrospective drug utilization review is a requirement of Medicaid DUR programs, and in federal fiscal year 2018 focused on high-risk medication combinations (including dangerous opioid combinations), adherence initiatives, and antibiotic overuse. In July, the DUR Board will review Medicaid performance on pharmacy outcome measures for high dose opioids, concurrent use of benzodiazepines and opioids, continuation of medication treatment for opioid use disorder, and continuation of therapy for the treatment of chronic hepatitis C. Meeting minutes are posted on the Utah Medicaid website and can be found at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board.

Prior Authorization Exceptions to the Mandatory 90 day Supply Requirement for Maintenance Medications

Effective May 1, 2019, Utah Medicaid instituted a mandatory 90-day supply for medications on the 90-day supply list following a two-month window for dose titration and stabilization. When a patient presents with a new prescription or a refill of a maintenance medication, the point of sale system will look back 75 days to identify two consecutive fills of the same medicine at the same dose, indicating a stable maintenance dose has been achieved. If found, the claim will reject if billed for less than a 90 day supply. Once a 90-day supply of a medication has been filled, all subsequent fills of the same medicine at the same dose will fill for 90 days, assuming sufficient refills of the prescription remain.

For example, when a patient presents to the pharmacy with a prescription for metformin 500 mg twice daily with a year of refills, the first two prescriptions may fill for a 30-day supply. On the third fill of metformin, the claim will reject if billed for less than a 90-day supply. The 90-day supply will apply to all future refills for metformin 500 mg on this and future prescriptions.

For a 90-day supply, Utah Medicaid fee for service members who are subject to cost-sharing will pay a single co-pay. Additionally, pharmacies will receive a single dispensing fee on prescriptions filled for a 90-day supply.

Pharmacy staff are encouraged to work with prescribers to make any necessary changes to prescriptions to conform to this requirement. For example, when a pharmacy receives a prescription written for a 30-day supply with refills for a drug on this program, the pharmacy may contact the prescriber and recommend a modification to the original prescription for a 90-day supply with refills, as appropriate.

The mandatory 90-day policy does not apply to Indian Health Service providers, or Medicaid members receiving long term services and supports in nursing facilities, intermediate care facilities, or home and community based waiver programs. While not mandatory, 90-day supply fills will remain optional for these groups.

If an exception to the Mandatory 90-day Supply Requirement is needed for a patient not otherwise excluded from the requirement, a prescriber may submit the “Exception to Required 90 Day Maintenance Medication Fill” prior authorization form.
19-73  Rehabilitative Mental Health and Substance Use Disorder Services Manual Update

For dates of service on or after May 1, 2019, Clinically Managed Residential Withdrawal Management, ASAM 3.2-WM (Social Detoxification) is authorized under Utah’s approved 1115 Waiver. Under this waiver, the service is available only to Salt Lake County Medicaid members, and payment is limited to Volunteers of America.

The Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services manual has been updated to include Clinically Managed Residential Withdrawal Management; ASAM 3.2-WM. Chapter 2-16 details the new service.

Providers can access the revised provider manual at [https://medicaid.utah.gov](https://medicaid.utah.gov).

19-74  Home and Community Based Services Waiver for Individuals Age 65 or Older Manual Updated

Section 2-1, Provider Enrollment has been updated to reflect the enrollment process within the PRISM Provider Portal.

Section 2-2, Provider Reimbursement has been updated to remove the requirement for providers to complete a Negotiated Rate Sheet with the Area Agency on Aging (AAA) office. This section also holds the AAA offices financially responsible for issuing a service authorization form to a provider that does not match the services, start and end date, number of service units, frequency of service, HCPCS code and/or provider name listed on an individual’s approved care plan with an end date of July 1, 2019, or later.

Chapter 4-4, Conflict Free Case Management is a new chapter that was added to address the Conflict Free Case Management rule. The rule can be found at [https://www.govinfo.gov/content/pkg/FR-2014-01-16/pdf/2014-00487.pdf](https://www.govinfo.gov/content/pkg/FR-2014-01-16/pdf/2014-00487.pdf). This chapter also includes information on the newly implemented Financial Transaction Services (FTS) process.

19-75  Home and Community Based Services Settings Rule Update

On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) implemented new federal regulations that provides clarification concerning the required characteristics of home and community based service (HCBS) settings. In accordance with these regulations, Utah Medicaid created an HCBS Setting Transition Plan.
The State recently received CMS approval of its Statewide Transition Plan. To continue to receive federal Medicaid funds for 1915(c) HCBS Waiver services, all HCBS providers must be compliant with this rule by March 17, 2022. Additional information regarding the Settings Rule, Statewide Transition Plan and current remediation plan activities are located on the HCBS Transition Planning webpage at [http://health.utah.gov/ltc/hcbstransition/](http://health.utah.gov/ltc/hcbstransition/).

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### 19-76 Prepaid Mental Health Plan (PMHP) – Reporting of Interpreter Services and Transportation Services in PMHP Encounter Data

Effective for dates of service on or after July 1, 2019, Medicaid requests that PMHPs begin reporting the following PMHP-covered services in encounter data using the following HCPCS procedure codes:

**Interpreter Services**

Use HCPCS procedure code, T1013, Sign language or oral interpretive services, per 15 minutes

**Transportation**

When PMHPs furnish transportation to PMHP enrollees with Traditional Medicaid (as opposed to enrollees using Medicaid's transportation provider), use HCPCS procedure code T2003, nonemergency transportation: encounter/trip

Since the Medicaid transportation benefit is limited to Medicaid members with Traditional Medicaid, if PMHPs furnish transportation to PMHP enrollees with Non-Traditional Medicaid, these transportation services must not be included.

Also, continue to report interpreter services and PMHP-furnished transportation to Traditional Medicaid enrollees in the PMHP Financial Report.

If there are questions, please contact Karen Ford at (801) 538-6673.

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### 19-77 Targeted Case Management for Individuals with Serious Mental Illness Manual Updated

The Targeted Case Management for Individuals with Serious Mental Illness manual has been updated to remove references to the Children’s Health Evaluation and Care (CHEC) program. This program has been renamed Early Periodic Screening Diagnosis and Treatment (EPSDT).

Providers can access the revised provider manual at [https://medicaid.utah.gov](https://medicaid.utah.gov).