

Web address: <http://health.utah.gov/medicaid>

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World Wide Web: <http://health.utah.gov/medicaid>

Medicaid Information

- S Salt Lake City area, call (801) 538-6155.
- S In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- S From other states, call (801) 538-6155.

Requesting a Medicaid publication?

Send a Publication Request Form:

- By FAX: (801) 536-0476
- By mail to: Division of MHF
Box 143106, Salt Lake City UT 84114-3106

11 - 35 New Provider Agreement

*** Effective Immediately ***

The Utah Department of Health, Division of Medicaid and Health Financing, would like to notify providers of the revised Utah Medicaid Provider Agreement. This agreement supersedes all previous Utah Medicaid Provider Agreements.

The Utah Department of Health, Division of Medicaid and Health Financing, will assume providers agree to be bound by this agreement unless they affirmatively withdraw their provider agreement. All new providers, including new locations, must sign and return this agreement.

Please note: In response to direction from CMS, paragraph I.5 has been changed to make the provider agreement conform to 42 CFR 447.45(d)(1). The period for submitting claims, including amended claims, is limited to 365 days from the original date of service.

The Utah Medicaid Provider Agreement is available online at <http://health.utah.gov/medicaid>. The agreement can also be obtained by contacting the provider enrollment team at 1-800-662-9651, option 3 then 4.

The signed Utah Medicaid Provider Agreement can be sent to Provider Enrollment via fax, email, or mail to:

Medicaid Operations
Attn: Provider Enrollment
PO Box 143106
Salt Lake City, UT 84114-3106

Fax: (801) 536-0471
Email: providerenroll@utah.gov

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11 - 36 Timely Filing Clarification

The following information is provided to clarify the February Interim MIB, article 11-34, dated February 14, 2011. Regarding the 12-month rule, all claims and adjustments for services must be received by Medicaid within 365 days from the date of service. The start date for determining the 1-year timely filing period is the date of service or "from" date on the claim. For institutional claims that include span dates of service (i.e., a "from" and "through" date on the claim), the "through" date on the claim is used for determining the date of service for claims filing timeliness.

According to the federal rule 42 CFR 447.45, it states, "The time limitation does not apply to claims from providers under investigation for fraud or abuse. The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it."

"If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months (180 days) after the agency or the provider receives notice of the disposition of the Medicare claim."

Therefore, all crossover claims will be required to have the Medicare paid date submitted on the claim, or the claim will be denied by Medicaid.

Providers may request the change to correct a claim outside of the timely filing deadline; however, no additional funds will be reimbursed.

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11 - 37 Manual Review & Emergency Only Documentation Submission Form

Effective April 1, 2011, all documentation submitted for review for the Emergency Only Program or for manual review must be sent with a completed *Utah Medicaid Documentation Submission Form*. The new form is available on the Medicaid website at <http://health.utah.gov/medicaid/provhtml/forms.htm>.

The form must be the first page of the documentation and must be filled out completely to include all necessary supporting documentation with first submission. The form must be included with all documentation regardless of submission method (i.e. mail, fax, e-mail, electronic attachment, etc). All documentation for review must be received within 365 days from the date of service.

Any documentation submitted after April 1, 2011, without the *Utah Medicaid Documentation Submission Form* will be returned.

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11 - 38 Medicaid Online Process Ending

Medicaid Online, which is HLRP accessed through BlueZone and used for the purpose of verifying Medicaid eligibility status, is being eliminated in the first quarter of 2012. All assigned logon IDs to access the Medicaid data will be disabled.

With the implementation of the Electronic Transaction Version 5010, the 270 Eligibility Inquiry and 271 Eligibility Response transactions will become available in "real time," in addition to the current "batch mode" with a two-hour turnaround time frame. Providers using Medicaid Online need to check with their system programmers to assure access to these transactions.

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11 - 39 Electronic Transaction Update (Version 5010)

Health care providers, clearinghouses, vendors, and other entities covered under the Health Insurance Portability and Accountability Act (HIPAA) have until January 1, 2012, to implement the federally mandated electronic health care transaction standards. The X12 Version 5010 standards for HIPAA electronic health care transactions include claims, remittance advice, eligibility inquiries, claim status, and other administrative transactions. The new electronic standards also provide the framework needed for use of the revised medical data code sets (ICD-10-CM and ICD-10-PCS), that must be implemented on October 1, 2013.

Many challenges may exist with the implementation of the 5010 format:

- Existing practice management and EDI systems may need to be upgraded to capture data for the new transaction standards.
- Coordination may need to occur with clearinghouses/vendors to ensure compliance.
- 5010 requires new translation, mapping, and data fields.
- Certain business practices and workflow processes may change, and physician practices need to allow for training.
- Adjustments need to be made for data reporting changes relating to the various transactions.
- Staff will need training in order to submit, receive, interpret, and respond appropriately using 5010 transactions.

Providers need to allow sufficient time to test with payers prior to the implementation date of January 1, 2012. Utah Health Information Network (UHIN) is offering acceptance testing to its members relating to Version 5010. Medicaid strongly encourages providers to work with UHIN for initial 5010 testing. Medicaid anticipates beginning external testing with a select group of providers beginning May 2011. Complete provider testing should be available by September 2011.

Please watch for further Medicaid Information Bulletins relating to implementation of Version 5010 electronic transactions.

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11 - 40 Electronic Health Records Incentives Registration Information

The following article consists of excerpts from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), press release dated December 22, 2010:

On January 3, 2011, there were a host of health care professionals and eligible hospitals nationwide expressing interest to participate in the CMS Medicare and Medicaid EHR Incentive Program. Utah will launch its Medicaid EHR Incentive Program in September 2011.

Under the Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009, Medicare and Medicaid incentive payments will be available to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) when they adopt certified EHR technology and successfully demonstrate "meaningful use" of the technology in ways that improve quality, safety, and effectiveness of patient-centered care.

Professionals who meet the eligibility requirements for both the Medicare and Medicaid EHR Incentive Programs must select which program they wish to participate in when they register. They cannot participate in both programs; however, after receiving payment, they may change their program selection once before 2015. Hospitals that are eligible for both programs can receive payments from both Medicare and Medicaid.

Some states will launch their Medicaid EHR Incentive Programs beginning January 3, 2011, but most will launch their programs during the spring and summer. Eligible providers with questions about their state's launch date should contact their state Medicaid agency. Eligible providers seeking to participate in the Medicaid programs must initiate registration at CMS' registration site, but must complete the process through an eligibility verification site maintained by their state Medicaid agency.

Under the EHR Incentive Programs, eligible professionals can receive as much as \$44,000 over a five-year period through Medicare. For Medicaid, eligible professionals can receive as much as \$63,750 over six years. Under both Medicare and Medicaid, eligible hospitals may receive millions of dollars for implementing and meaningfully using certified EHR technology.

"With the start of registration, these landmark programs get underway, and patients, providers, and the nation can begin to enjoy the benefits of widespread adoption of electronic health records," said CMS Administrator Donald Berwick, MD. "CMS has many resources available to help providers register and participate, and we look forward to working with eligible professionals and eligible hospitals to facilitate the process, beginning on January 3rd and going forward."

"It's time to get connected," said David Blumenthal, MD, MPP, National Coordinator for Health Information Technology. "ONC and CMS have worked together over many months to prepare for the startup on January 3rd. ONC's Certified HIT Product List includes more than 130 certified EHR systems or modules and is updated frequently. ONC also has hands-on assistance available across the country through 62 Regional Extension Centers. We look forward to continuing to work with CMS to assist eligible providers in 2011 and future years."

Eligible professionals and eligible hospitals must register in order to participate in the Medicare and Medicaid EHR Incentive Programs. They can do so at a registration site maintained by CMS.

To prepare for registration, interested providers should first familiarize themselves with the incentive programs' requirements by visiting CMS' Official Web Site for the Medicare and Medicaid EHR Incentive Programs. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

"The benefits of EHRs are widely recognized, and support for the incentive programs is strong in the health care field and among policymakers," Dr. Berwick said. "The changeover from paper to electronic records will be challenging for clinicians and hospitals, but CMS and ONC have taken steps to ease the transition. We've provided flexibility in meeting the meaningful use requirements, both agencies have conducted extensive outreach, and we have the resources in place to help providers acquire certified EHR technology and meet the programs' requirements. Immediate registration is not required, but we encourage eligible providers to sign up as soon as they have certified EHR technology and are prepared to participate. We are ready to help."

For more information provided on the Utah Medicaid website, please visit:
<http://www.health.utah.gov/medicaid/provhtml/HIT.htm>.

11 - 41 Criteria for Medical and Surgical Procedures

The following criteria have been updated effective April 1, 2011. The criteria can be found on the Utah Medicaid website at http://health.utah.gov/medicaid/provhtml/forms_criteria.htm.

- HBOT Criteria
- Adult Lumbar MRI Criteria
- Adult Thoracic/Cervical MRI Criteria
- Oophorectomy Criteria
- Adult Knee MRI Criteria
- Cardiac MRI Criteria
- Breast MRI Criteria
- Gastric Bypass Criteria Update

The criteria for gastric bypass has been updated to reflect the removal of the requirement for a psychiatry/psychology consultation.

Effective February 22, 2011, the criteria for #10E Vasectomy, #10C Tubal Sterilization, and #10D Tubal Sterilization (laparoscopic) have all been updated to reflect the removal of the requirement for secondary review by the sterilization committee. Prior authorization is still required on all sterilization procedures, and submission of the completed *Sterilization Consent Form* will continue to be required by the Bureau of Medicaid Operations before payment is made on any sterilization claim.

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11 - 42 Medical and Surgical CPT Code List Updated

Covered or Removed from Manual Review

- 19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma
- 33250 Operative ablation of supraventricular arrhythmogenic focus or pathway (i.e. Wolff-Parkinson-White, atrioventricular node reentry) tract(s) and/or focus (foci); with cardiopulmonary bypass
- 33251 Operative ablation of supraventricular arrhythmogenic focus or pathway (i.e. Wolff-Parkinson-White, atrioventricular node reentry) tract(s) and/or focus (foci); without cardiopulmonary bypass
- 58565 Hysteroscopic tubal occlusive device. (Open for Non-Traditional Medicaid clients effective the same date as it is for Traditional Medicaid clients).

Non-Covered

- S0199 Medically induced abortion by oral ingestion of medication including all associated services and supplies except drugs

Discontinued

- 0083T Stereoradiotactic body radiation management treatment per day

Requiring Manual Review (Removed from PA)

- 22558 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace; lumbar
Prior Approval: Not Required.....Attach documentation to claim.
- 40500 Vermilionectomy (lip shave), with mucosal advancement
Prior Approval: Not Required.....Attach documentation to claim.
- 92499 Unlisted ophthalmological service or procedure
Prior Approval: Not Required.....Attach documentation to claim.

- 99199 Unlisted special service, procedure, or report
Prior Approval: Not Required.....Attach documentation to claim.
- S3854 Gene expression profile panel for use in management of breast cancer treatment
Prior Approval: Not Required.....Attach documentation to claim.

Added to List - (There is not a change in coverage; the following codes were inadvertently deleted from the list).

- 00851 Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; tubal ligation
Prior Approval: Covered when the primary surgical code receives prior authorization.
- 00952 Anesthesia for hysteroscopy and/or hysterosalpingography
Prior Approval: Covered when the primary hysteroscopy code receives prior authorization or the code does not require prior authorization. Non-covered for hysterosalpingography.
- 90474 Immunization administration by intranasal route, each added vaccine (single or combination) in addition to code for primary procedure 90471. Limited to administration of flu mist. (Code 90473 is mutually exclusive to code 90474).

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11 - 43 Inpatient Psychiatric Admission

Inpatient psychiatric admissions, in areas outside of the contracted mental health program, require prior authorization through Medicaid. The HCPCS code G0379, direct admission of patient for hospital observation (psychiatric inpatient), will be the code used by the nurse to link the hospital psychiatric inpatient acute admission to the prior authorization.

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11 - 44 Rehabilitation Policy Manual Changes

Please review the following section from the *Utah Medicaid Rehabilitation Services Provider Manual* for changes:

- C.6. For review of prior authorization approval, the following medical record documentation must be submitted:
- e. The MS-DRG requiring approval must be submitted with the request with the most specific diagnosis codes(s). The V codes, code V57.81 (orthotic training in use of artificial limbs) or code V57.89 (other specified rehabilitation), will be accepted as the diagnosis to allow rehabilitation prior authorization number entry into the system. However, V codes alone are not acceptable for claim payment. The primary condition(s) requiring rehabilitation services must be on the claim for payment. For payment, the claim would have code V57.89 and 854.0 (traumatic brain injury) at a minimum and any other condition codes affecting the rehabilitation therapy stay. Covered conditions for rehabilitation services are described in the *Quick Reference for Rehabilitation Services* table at the end of this document.

The following DRG codes have been updated in the *Quick Reference for Rehabilitation Services* table at the end of the manual:

800 to 8801
801 to 8801
802 to 8802
803 to 8803
804 to 8804

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11 - 45 Laboratory Service Covered

Utah Medicaid will cover Oncotype testing under certain circumstances for diagnoses related to cancer. The use of Oncotype DX™ in women with breast cancer, to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy, may be considered medically necessary.

For reimbursement, use code S3854. This laboratory test will require prior authorization. For specific criteria, see the *Utah Medicaid Laboratory and Radiology Provider Manual*, Section 2, page 7 of 11, and also the *Utah Medicaid Physician and Anesthesiology Provider Manual*, Section 2, page 45.

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11 - 46 Home Health Services Manual

The *Utah Medicaid Home Health Agency Provider Manual* has been renamed, the *Utah Medicaid Home Health Services Provider Manual*. The manual has been updated to reflect language changes from “care” to “services” as applicable.

Please review the *Private Duty Nursing Grid*, an attachment to the manual, as there have been additional updates made.

Covered Service

Q0084 Chemotherapy by infusion technique, in home, per visit. Limited to infusion of the drug 5-FU after initial dose administration, under physician supervision, when the home is the most clinically appropriate cost-effective place of service. 5-FU is the only drug considered for coverage in the home.

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11 - 47 Medical Supplies Policy Manual Changes

Please review the following sections from the *Utah Medicaid Medical Supply Provider Manual* for changes:

- Section 1** D: Clarifies which DME items can be reimbursed to a DME provider for clients residing in a long term care or ICF-MR facility. (Oxygen, specialized beds, overlays, mattresses, customized wheelchairs, motorized wheelchairs, and prosthetic devices).
- Section 1** E(1)(a): Clarifies that standard wheelchairs are the responsibility of the long term care facility.
- Section 1** F(2): Clarifies exception to the five-year rule for prosthetic devices if the recipient has outgrown a prosthesis.
- Section 2** #1 and #3 (B): Minor editing and correction to supply limit for sterile catheterization, respectively.
- Section 6** #3: Clarification to prior authorization documentation required for approval of DME equipment impacted by the size of the client. For DME items that are impacted by the size of the client, documentation must include the height and weight of the client, as well as appropriate measurements to support the approval of the DME item. Requests that do not include this information will be considered incomplete and will not be processed. When a DME item is replacing an equivalent DME item, information regarding the current equipment must be included. Requests must include the date the equipment was obtained, model and size, and documentation supporting the reason the DME item needs to be replaced.

- Section 7** Limit on Repairs #1: Correction to codes (K0739 and K0740) that may be used by the provider for repairs and the description for both codes. This section was not properly updated when the change occurred last year in the *Medical Supplies List Attachment*.
- Section 7** Limit on Repairs #3 (b): Removed hearing aid repair information and referred to the *Audiology Provider Manual*.
- Section 7** Limit on Replacements: Durable medical equipment will not be replaced more often than once in a five-year period. Certain exceptions may occur (e.g., when the DME equipment is no longer size-appropriate for the recipient). All exceptions to the established guidelines will require prior authorization.

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11 - 48 Medical Supplies List Updated

Covered Codes

- E2609 Custom fabricated wheelchair cushion, any size. Prior authorization required.
- E2617 Custom fabricated wheelchair back cushion, any size, including any type of mounting hardware. Prior authorization required.
- L3204 Orthopedic shoe, high-top with supinator/pronator; infant. Prior authorization required.
- L3206 Orthopedic shoe, high-top with supinator/pronator; child. Prior authorization required.

Code Clarifications

- A6222 Gauze, impregnate with other than water. Code incorrectly listed in manual as code A6422.
- E2284 No such code, removed from manual.
- E2402 Negative pressure wound therapy electrical pump. Noted in limitations; prior authorizations are given in increments of 21 days, up to four months.
- L1900 Not an open code, removed from manual.

Open Codes, Previously Not Listed

- A5507 Diabetic shoe, NOS modification shelf/custom, per shoe. Prior authorization required.
- E0500 IBBP Mach, all type, with nebulizer; valves; power source. Rental required.

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11 - 49 **Audiology Policy Manual Changes**

Please review the following sections from the *Utah Medicaid Audiology Provider Manual* for changes:

Section 2-4 Modifications have been made to cochlear implants.

Section 4-2 Hearing aid repair is available only for EPSDT eligible children and pregnant women.

Open Code, Previously Not Listed

L8618 Cochlear implant transmitter cable replacement

Non-Covered Code

L8619 Cochlear implant external speech processor replacement. Removed from manual as it is a closed code.

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11 - 50 **Oral Maxillofacial Surgeon Services**

Effective October 1, 2010, the following codes are covered for oral maxillofacial surgeon services:

99201 Office visit consultation, new patient

99213 Office visit consultation, established patient

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11 - 51 **Vision Services**

Covered Code with Prior Authorization

V2755 UV lens, per lens. Allowable if the lenses will be glass or with documentation of chronic photophobia symptoms for plastic lenses. V2755 will not be allowed when lenses are polycarbonate or photochromic, as these lenses have 100 percent UV protection built in. Prior authorization is required.

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11 - 52 Pharmacy Policy Highlights

The following Medicaid policies regarding pharmaceuticals have been added to the provider manuals:

- Medicaid clients may receive brand name Tegretol, Dilantin, and Coumadin without prior authorization in all three Medicaid programs due to the narrow therapeutic index of these three drugs.
- Cymbalta doses greater than 60mg per day require a documented eight-week trial and failure of a 60mg daily dose.
- Low molecular weight Heparin derivatives will be available for up to 14 days for post-operative DVT prophylaxis for surgeries below the waist for Non-Traditional Medicaid clients.
- Neupogen, Neulasta, and Leukine will be available by telephone prior authorization for clients receiving cancer chemotherapy. Prior authorizations for all other purposes will continue to require faxed requests.
- Compounded Proton Pump Inhibitors for oral solution are not a covered benefit. Patients who cannot swallow tablets or capsules must use the commercially available orally disintegrating tablets.
- Protonix generics are available first-line to patients who are taking Plavix.
- Prodigy Glucose Test Strips for the voice-operated Prodigy Blood Glucose Meters are available by prior authorization for blind individuals.
- Ventolin HFA is the preferred Albuterol inhaler. Patients who wish to receive Xopenex must have a trial of Ventolin HFA.

The following drugs will require prior authorization effective April 1, 2011, under the following criteria:

Pradaxa

- Documentation of one of the following diagnoses:
 - a. atrial fibrillation, or
 - b. another condition requiring anticoagulation.
- Documented failure to maintain a therapeutic INR or Warfarin, or intolerance to Warfarin.
- Authorization period is one year, or anticipated duration of treatment if shorter than one year.
- Renewal is given by telephone request from the prescriber's office or pharmacy.

Butrans

- Minimum age requirement: 18 years old.
- Diagnosis of moderate to severe chronic pain requiring continuous, around-the-clock opioid analgesic for an extended period of time:
 - a. documented trial and failure of \geq one oral non-opioid agent(s)
 - b. documented trial and failure of \geq one oral opioid agent.
- Initial authorization period is for three months. Reauthorization periods of up to one year require documentation that the patient is using the drug appropriately, and documentation of satisfactory pain control.
- Prior authorization will be granted for up to 4 patches per 28 days. Additional quantities may be granted with satisfactory prescriber explanation during the first and last months of therapy to allow for dose titration.

11 - 53 Metformin Safety

Due to a black-box warning for lactic acidosis, the lack of evidence supporting the use of Metformin doses over 2550mg daily, and the unclear relationship between Metformin overdose and lactic acidosis, the DUR Board has recommended that a dose limit of 2550mg daily be placed on Metformin-containing products as a safety measure.

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11 - 54 Attn: Mental Health Centers

The Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Mental Health Centers*, has been updated as follows:

- Chapter 1-3, the definition of Non-Traditional Medicaid Plan has been clarified.
- Chapter 1-3, the definition of Traditional Medicaid Plan has been added.
- Chapter 2-10, the definition of psychosocial rehabilitative services has been revised based on revisions made by Centers for Medicare and Medicaid Services (CMS).

Providers may access the current and revised manual at www.health.utah.gov/medicaid. If you do not have Internet access or have questions, contact Merrila Erickson at (801) 538-6501, or email merickson@utah.gov.

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11 - 55 Attn: Department of Human Services (DHS) Mental Health Providers Serving Children in State Custody (Foster Care) and Subsidized Adoptive Children Exempted from the Prepaid Mental Health Plan for Outpatient Mental Health Care

The Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Rehabilitative Mental Health Services for Children Under Authority of the Division of Child and Family Services or Division of Juvenile Justice Services*, has been updated as follows:

- Chapter 1-2, the definition of Non-Traditional Medicaid Plan has been clarified.
- Chapter 1-2, the definition of Traditional Medicaid Plan has been added.
- Chapter 2-9, the definition of psychosocial rehabilitative services has been revised based on revisions made by Centers for Medicare and Medicaid Services (CMS).

Providers may access the current and revised manual at www.health.utah.gov/medicaid. If you do not have Internet access or have questions, contact Merrila Erickson at (801) 538-6501, or email merickson@utah.gov.

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11 - 56 Attn: Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse Providers

The Medicaid provider manual entitled, *Utah Medicaid Provider Manual for Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse*, has been updated as follows:

- Chapter 1-3, the definition of Non-Traditional Medicaid Plan has been clarified.
- Chapter 1-3, the definition of Traditional Medicaid Plan has been added.
- Chapter 2-10, the definition of psychosocial rehabilitative services has been revised based on revisions made by Centers for Medicare and Medicaid Services (CMS).

Providers may access the current and revised manual at www.health.utah.gov/medicaid. If you do not have Internet access or have questions, contact Merrila Erickson at (801) 538-6501, or email merickson@utah.gov.

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