Medicaid Information Bulletin
July 2016

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16-54   PRISM Release 3 Go-Live: July 1

Beginning July 1, 2016, providers will be able to enroll online and make modifications to their provider record using PRISM.

What happens next?

As part of Release 3, we are asking existing providers to validate their information in PRISM. Their current enrollment record has been converted to PRISM in order to ease the transition between the MMIS and PRISM, view historical data, as well as eliminate the need for providers to complete a new application.

How will I know when to validate my information?

Providers will receive a letter specifying the PRISM web address with instructions on how to log in to PRISM to validate and modify information. Letters will be mailed in staggered groups starting July 2016 and continuing into 2017. In July, Medicaid will send validation letters to a small group of providers. The next groups of letters will be mailed starting in October, with additional letters sent to groups incrementally each month after that. Adjustments to the online validation letter schedule will be made as needed, so please check https://medicaid.utah.gov/prism-provider-training for updates if you have not received your letter.

The first steps providers will need to take once they receive their letters are:

1. View the web-based training on the validation process called *Converted Provider Validation* in PRISM at https://medicaid.utah.gov/pe-training. This training will be available a few days before the July 1 Go-Live date.
2. Access the Provider URL that is in the letter.
3. Use the login information from the letter to log in through the initial PRISM access screen.

Subsequent steps to complete validation of provider information will be in the letter. The window for validation in PRISM will also be included in the letter. The online training will assist with navigating the steps, and contact information will be included in case providers encounter problems during the process.

What if I need to make a change before I receive my validation letter?

If you need to make a modification to your current provider record before you receive your validation letter, email the change to provider enrollment at providerenroll@utah.gov or fax provider enrollment at (801) 536-0471.

Can I still fax in documents?

Uploading documents directly into PRISM is the most efficient way to send provider enrollment documents to Medicaid. However, providers will have the option to fax in documents, but **must** use a PRISM Cover Sheet beginning July 1. As of July 1, the cover sheet can be found on the Medicaid website at https://medicaid.utah.gov/utah-medicaid-forms and in PRISM in the *View Upload Attachment* Step, which is a step utilized when validating provider information, enrolling a new provider or modifying current provider information. If providers do **not** use this cover sheet, their documents will not be processed because their documents cannot be properly matched to their provider account. Providers should fill out the cover sheet online and then print a separate cover sheet for each document to ensure each document is correctly classified within the file.

Update on the Utah Medicaid EHR Incentive Program Year 2015

Eligible providers and hospitals participating in the Medicaid EHR Incentive Program will be in the first group invited to validate their information in PRISM, as described above. This validation process must be completed in

order to access the new incentive payment system. The system will be open for 2015 attestations July 1, 2016 through September 30, 2016. Updates will also be posted on the program website at https://medicaid.utah.gov/medicaid-hit. For specific questions, feel free to email program staff at ehrincentive@utah.gov or call (801) 538-6929.

How do I get trained on the July 1st changes?

As of July 1, provider training for PRISM's Release 3 is available on the Medicaid website at https://medicaid.utah.gov/prism-provider-training.

Providers should continue to submit claims as usual, as changes to claims are not part of Release 3.

We will continue to share updated information through future MIB articles, the Medicaid website, and information sent by email from Medicaid staff.

16-55   2016 Medicaid Statewide Provider Training

Utah Medicaid providers are invited to attend the 2016 Medicaid Statewide Provider Training sessions. This year's schedule includes five new locations: Intermountain Medical Center, Lakeview Hospital, St. Mark's Hospital, Tremonton, and Delta.

This year's sessions will address helpful tips on billing, common billing errors, and important changes regarding Medicaid. Information on the new updates to the provider portal, PRISM (Provider Reimbursement Information System for Medicaid), will also be provided. The Office of Inspector General will be joining each session to give advice and information on fraudulent billing. The last half hour of each session will be dedicated to prior authorization information and training.

Each session will run 2 to 2 ½ hours. We invite and encourage all office staff to attend. Please RSVP either by email at providertrainingsupport@utah.gov, or by leaving a telephone message at (801) 538-6930. Please provide your name, name of your group, how many will be in attendance, which session you plan to attend, contact name, and telephone number. Please indicate if you plan to attend the prior authorization segment of the session.

Please see pages 4 through 6 for the schedule. We look forward to seeing you!

Statewide Provider Training Schedule 2016

CITY	DATE	LOCATION	TIME
Tooele	07/28/2016	Tooele Health Department 151 North Main Room 180 Tooele, UT	9:30 am – 12:00 pm
Riverton *2 sessions	08/02/2016	Riverton Hospital 3741 West 12600 South Riverton Room Riverton, UT	9:30 am – 12:00 pm 1:30 pm – 4:00 pm
Salt Lake City	08/04/2016	State Library for the Blind & Disabled 250 North 1950 West Multi-Purpose Room Salt Lake City, UT	9:30 am – 12:00 pm
Gunnison	08/08/2016	Gunnison Valley Hospital 64 East 100 North East Conference Room Gunnison, UT	1:00 pm – 4:00 pm
Richfield	08/09/2016	Richfield EMS Building 50 West Westview Drive (925 North) Upstairs Training Room Richfield, UT	9:30 am – 12:00 pm
Panguitch	08/10/2016	Garfield Memorial Hospital 200 North 400 East Administrative Conference Room Panguitch, UT	9:30 am – 12:00 pm
Kanab	08/11/2016	Kanab Hospital 355 North Main Conference Room Kanab, UT	9:30 am – 12:00 pm
Salt Lake City ***New Venue	08/16/2016	St. Mark's Hospital 1200 East 3900 South Lamb Auditorium Salt Lake City, UT	9:30 am – 12:00 pm
Bountiful ***New Venue	08/17/2016	Lakeview Hospital 630 East Medical Drive Bountiful, UT	9:30 am – 12:00 pm

Salt Lake City ***New Venue *2 sessions	08/18/2016	Intermountain Medical Center (IMC) 5121 Cottonwood Street Building 6 Salt Lake City, UT	9:30 am – 12:00 pm 1:30 pm – 4:00 pm
Logan	08/23/2016	Environmental Health Building 85 East 1800 North Conference Room Logan, UT	9:30 am – 12:00 pm
Tremonton ***New Venue	08/24/2016	Bear River Health Department 440 West 600 North Tremonton, UT	9:30 am – 12:00 pm
American Fork	08/25/2016	American Fork Hospital 170 North 1100 East Classroom 1 American Fork, UT	9:30 am – 12:00 pm
Provo	08/30/2016	Utah Valley Regional Medical Center 1134 North 500 West Clark Auditorium Provo, UT	9:30 am – 12:00 pm
Ogden	08/31/2016	McKay Dee Hospital 4401 Harrison Boulevard Thomas Dee Auditorium Ogden, UT	9:30 am – 12:00 pm
Taylorsville	09/01/2016	DWS – South County Center 5735 South Redwood Road Salt Lake City, UT	9:30 am – 12:00 pm
Heber City	09/07/2016	Wasatch Health Department 55 South 500 East Conference Room B Heber City, UT	9:30 am – 12:00 pm
Roosevelt	09/08/2016	Northeastern Counseling Center 285 West 800 South Roosevelt, UT	9:30 am – 12:00 pm
Delta ***New Venue	09/13/2016	Delta Community Hospital 126 White Sage Avenue Delta, UT	1:30 pm – 4:00 pm
Cedar City	09/14/2016	Iron County School District 2077 Royal Hunt Drive Cedar City, UT	9:30 am – 12:00 pm

St. George	09/15/2016	Dixie Regional Medical Center 1424 East Foremaster Select Health Auditorium St. George, UT	9:30 am – 12:00 pm
Salt Lake City (FQHC Providers Only)	09/20/2016	AUCH Association 860 East 4500 South Suite 206 Salt Lake City, UT	9:30 am – 12:00 pm
Payson	09/21/2016	Mountain View Hospital 1000 East 100 North Medical Plaza Conference Room 325 Payson, UT	1:30 pm – 4:00 pm
Nephi	09/22/2016	Central Valley Hospital 46 West 1500 North Education Room Nephi, UT	9:30 am – 12:00 pm
Monument Valley	09/27/2016	Monument Valley Clinic 30 West Medical Drive Monument Valley, UT	9:30 am – 12:00 pm
Monticello	09/28/2016	San Juan Regional Hospital 380 West 100 North Monticello, UT	9:30 am – 12:00 pm
Moab	09/29/2016	Moab Regional Hospital 450 Williams Way Education Center Moab, UT	9:30 am – 12:00 pm

16-56   Access Monitoring Review Plan

The Division of Medicaid and Health Financing (DMHF) is developing an Access Monitoring Review Plan (AMRP) for the following service categories provided under a fee-for-service (FFS) arrangement:

- Primary care services
- Physician specialist services
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

On November 2, 2015, the Centers for Medicare and Medicaid Services (CMS) published a final rule implementing the equal access provision that requires state Medicaid agencies to develop a medical assistance access monitoring review plan. The review plan must consider:

1. The extent to which beneficiary needs are fully met;
2. The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;
3. Changes in beneficiary utilization of covered services in each geographic area;
4. The characteristics of the beneficiary population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and
5. Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

Effective January 4, 2016, the new rule requires states to develop review plans and update them periodically. States must make plans available to the public for at least 30 days, finalize them, and submit them to CMS for review. The first review plan is due by October 1, 2016.

The final rule excludes access reviews for Medicaid managed care arrangements.

Public comments on Utah's AMRP will be reviewed and considered during the development phase. An initial draft of the plan will be available for public review and comment on the Utah Medicaid website in June 2016. The formal public comment period will take place between July 5, 2016 and August 5, 2016.

16-57   Physician Services Manual Updates

Sterilization and Hysterectomy Procedures

The requirements for sterilization and hysterectomy procedures have been updated with the following information. To view the manual, refer to the Medicaid website at https://medicaid.utah.gov.

Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441, Subpart F.

The following coverage criteria must be met:

A. Voluntary Sterilization (This means an individual decision made by the client, male or female, for the purpose of voluntarily preventing conception for the purpose of family planning.)
   1. A prior authorization must be obtained by the surgeon, prior to the service being provided;
   2. The sterilization consent form (Form 499-A) must be properly executed. An example of the sterilization consent form is located at https://medicaid.utah.gov/prior-authorization;
   3. At least 30 days have passed between the date of the informed consent and the date of sterilization, but no more than 180 days; and
   4. The prior authorization will not become effective until 31 days after the date the consent form is properly executed.

B. Sterilizations Incident to Surgical Procedures
   1. Prior authorization requirements must be met;

2. For hysterectomy procedures, a properly executed Utah Medicaid Hysterectomy Acknowledgement Form must be submitted for all hysterectomy procedures;
3. Refer to the Coverage and Reimbursement Code Lookup Tool for specific codes which require the hysterectomy consent form.

Labor and Delivery Policy and Billing Update

Utah Medicaid is implementing a new billing policy requiring the provider performing deliveries to:

- Report the gestational age of the fetus using the appropriate ICD10 Z3A diagnosis code on delivery claims; and
- Append a "UC" modifier to labor and delivery claims, when the delivery is 39 weeks gestation or more, whether spontaneous or elective, or when the delivery is 39 weeks or less and medically necessary.

Utah Medicaid has determined that elective deliveries, whether vaginal or cesarean, prior to 39 weeks are not medically necessary and therefore, are not a covered service. This policy is being put in place in an effort to reduce the infant mortality rate and improve birth outcomes.

If the modifier "UC" is not appended to the claim, it is understood that the claim is for an early elective delivery (EED) less than 39 weeks and 0 days and will be denied. Providers are responsible for ensuring the codes (and modifiers when applicable) submitted for reimbursement accurately reflect the diagnosis and procedure(s) performed.

Medically necessary deliveries, prior to 39 weeks and 0 days, require medical documentation justifying the early delivery. The provider is responsible for maintaining this documentation in the client's medical record, which may be subject to a post-payment review.

Global delivery claims denied as an early elective delivery may be refiled as antepartum and/or postpartum care services for separate reimbursement consideration.

All related facility claims associated with provider claims resulting from early elective deliveries will be identified and payment recouped in its entirety through a retrospective review process.

The *Utah Medicaid Physician Services Manual* has been updated to include this new policy. Refer to the Medicaid website at https://medicaid.utah.gov.

16-58   Hospital Services Manual Updates

Sterilization and Hysterectomy Procedures

The requirements for sterilization and hysterectomy procedures have been updated with the following information. To view the manual, refer to the Medicaid website at https://medicaid.utah.gov.

Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441, Subpart F.

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A. Voluntary Sterilization (This means an individual decision made by the client, male or female, for the purpose of voluntarily preventing conception for the purpose of family planning.)
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3. At least 30 days have passed between the date of the informed consent and the date of sterilization, but no more than 180 days; and
4. The prior authorization will not become effective until 31 days after the date the consent form is properly executed.

B. Sterilizations Incident to Surgical Procedures
1. Prior authorization requirements must be met;
2. For hysterectomy procedures, a properly executed Utah Medicaid Hysterectomy Acknowledgement Form must be submitted for all hysterectomy procedures;
3. Refer to the Coverage and Reimbursement Code Lookup Tool for specific codes which require the hysterectomy consent form.

Utilization Control and Review Program for Hospital Services

The utilization control and review chapter has been clarified.

#3, paragraph three now reads, "If a patient is readmitted for the same or similar diagnosis within 30 days of discharge and, if after review as described above, it was determined that readmission did not meet the criteria above, then the payment shall be combined into a single DRG payment, unless it is cost effective to pay for two separate admissions."

#3.1, a, I - Updated to reflect the ICD-10 verbiage: "Any diagnoses code with similar descriptors."

Hospital Services Manual: Inpatient Intensive Physical Rehabilitation Services

The intensive inpatient hospital rehabilitation services information was updated and moved from the Hospital Services Manual and placed in an attachment to the Hospital Services Manual titled, *Hospital Services: Inpatient Intensive Physical Rehabilitation Services*. Refer to the Medicaid website at https://medicaid.utah.gov.

Inpatient Intensive Physical Rehabilitation Services (Hospital Services: Attachment)

The following criteria has been added to the attachment to the *Utah Medicaid Provider Manual Hospital Services: Inpatient Intensive Physical Rehabilitation Services*:

DRG 8800, 8801 - The ASIA score or other standardized measurement tool score must be present in the record
DRG 8804 – Formatting correction

To view the manual attachment, refer to the Medicaid website at https://medicaid.utah.gov.

16-59   CMS 2348-F Final Rule – Face-to-Face Encounters

CMS has released a final rule (42 CFR Part 440) that adds requirements for physicians and other defined non-physician practitioner providers to document a face-to-face encounter for an order of home health care services or initiation of durable medical equipment. The rule also modifies service delivery settings for both home health services and durable medical equipment.

Providers should become familiar with the final rule to assure compliance in the future. The effective date for this rule is July 1, 2016; however, CMS allows a delay in compliance based on the date of the state legislative session, therefore Utah Medicaid will be in compliance with the final rule by July 1, 2017.

16-60   McKesson InterQual Criteria Updates

Utah Medicaid conducts medical necessity and appropriateness reviews utilizing McKesson's InterQual or Utah Department of Health criteria with precedence given to Department criteria. McKesson Health Solutions releases one major annual update for all InterQual products. Additional minor updates may be released throughout the year that address usability issues, verbiage changes, software patches or problem criteria areas.

Utah Medicaid will publish a MIB article announcing all annual updates, as well as minor updates, if the update is expected to have a significant impact on Medicaid providers or have more restrictive criteria.

2016 InterQual Criteria

Utah Medicaid will begin using the 2016 InterQual criteria for all reviews that are received for dates of service beginning July 1, 2016. There are minimal changes to the 2016 clinical content. The few notable changes that are more restrictive apply to the surgical procedures and imaging products. Many subsets now contain a trial of conservative therapy of six weeks opposed to the previous trial period of four weeks. In addition to the change in length of conservative therapy, the new criteria includes the requirement that the conservative therapy must have taken place in the previous 12 months. A change was also made in the criteria for carpal tunnel surgery to include the requirement of both electromyography (EMG) and nerve conduction studies (NCS), unless there is notable nerve damage.

For any questions regarding Medicaid criteria, send an email to medicaidcriteria@utah.gov. Do not send any PHI through unsecured email and allow a 24-hour response time for criteria requests.

16-61   Consent for Sterilization – Instructions Update

Minor formatting and verbiage changes have been made to the Consent for Sterilization Form instructions. New information has been added that includes the fax number for claims processing. There has not been any change in the procedure for requesting prior authorization for primary sterilization procedures.

The Consent for Sterilization Form, with all appropriate sections completed, must continue to be submitted with the Request for Authorization Form, to the fax number provided in the instructions, within the appropriate time frame.

After the sterilization procedure has been performed, the completed Consent for Sterilization Form, including all required information in the physician's statement section of the form, must be submitted to the claims processing fax number listed in the instructions before any claim payment will be issued.

16-62   Code Coverage Changes

Closed

94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g. during exercise)

Removed from Manual Review

99239 Hospital discharge day management; more than 30 minutes

Open

87902 Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus

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16-63   CLIA Update

The CLIA Certification for Laboratory Services attachment to the Physician Services Manual and Laboratory Services Manual has been updated. To view the attachment, refer to the Medicaid website https://medicaid.utah.gov.

16-64   Section I: General Information Provider Manual Update – Telemedicine

The chapter covering telemedicine has been returned to the Section I: General Information Provider Manual. Due to an oversight, the January 1, 2016 version of this manual did not bring the telemedicine information forward from the previous version. In addition to the July 1, 2016 effective date of this manual, this information applies retroactively January 1 through June 30, 2016.

16-65   Tables of Authorized Emergency Dianoses

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 http://health.utah.gov/medicaid/stplan/lookup/DXDownload.php.

16-66   Medical Supplies Manual Updates

Enteral Formula Policy Revision (Nutrition Section)

Utah Medicaid's policy regarding the coverage of enteral formula has been modified by the Department. Refer to the *Utah Medicaid Medical Supplies Provider Manual* for complete information at https://medicaid.utah.gov.

Some of the key points to the policy are:

- Enteral formula is a covered benefit for members receiving total nutrition via tube, when all coverage requirements are met. Members receiving at least 90% of their daily nutritional intake via tube are considered to be total tube fed for the purposes of the enteral formula policy.
- The supplemental nutrition policy has been modified to focus on the member's clinical condition requiring the need for enteral formula. The Medical Supplies Manual details the coverage categories for which supplemental nutrition will be a covered benefit for EPSDT eligible clients.
- Breast milk substitutes are not a covered Medicaid benefit.
- Members, 1 year of age or older, weaning from total tube feed may continue to receive enteral formula for up to 3 months. Subsequent requests for enteral formula should be made according to the supplemental nutrition policy.
- Total oral nutrition for EPSDT eligible members remains a covered benefit when all coverage requirements and clinical criteria are met.
- In accordance with Utah Medicaid's policy, the least costly, equally effective alternative formula should be provided. Documentation showing medical justification for formulas that are considered more complex than basic standard enteral formulas will be required in addition to all other required documentation.

For complete information on the policy changes, refer to the *Utah Medicaid Medical Supplies Provider Manual* at https://medicaid.utah.gov.

In addition to the update of the nutrition chapter of the Medical Supplies Manual, other minor corrections and changes have been made. Below is a summary of the changes:

- Managed Care Plan (MCP) has been corrected to Managed Care Organization (MCO) throughout manual.
- Section 2-9: Apnea Monitor instructions have been corrected to indicate the apnea monitors are a carve-out for all MCO's. Apria Healthcare is the contracted provider for apnea monitors.
- Section 2, 3: Urinary Catheters: Removed sterile catheterization criteria. Limitation of 180 per month remains the same.

- Section 7: Added requirement, "Documentation of the age of the equipment and when repair/replacement of current requested part or item last occurred."

16-67   Pharmacy Program Updates

Recent Drug Utilization Review Board Activity

Quantity limits have been established for topical lidocaine products. Prior Authorization (PA) criteria have been placed upon the following agents (see https://medicaid.utah.gov/pharmacy/prior-authorization):
- Entresto (sabuitril/valsartan)
- Movantik (naloxegol)
- Praluent (alirocumab) and Repatha (evolocumab)
- Kalydeco (ivacaftor) and Orkambi (luvicaftor/ivacaftor)

Provider Administered Drug Reimbursement Update

The reimbursement for many provider administered drugs will be updated effective July 1, 2016. The revised reimbursement rates will be available on the Utah Medicaid Coverage and Reimbursement Code Lookup Tool at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

Providers or interested parties that would like to initiate a review of a provider administered drug code's reimbursement rate may do so by submitting the review request form available at:
https://medicaid.utah.gov/pharmacy/library/files/Physician%20Administered%20Review%20Request%20Form.pdf

Pharmacy Services Manual and Policy Updates

The Pharmacy Services manual has been reformatted and includes new information related to the following initiatives:

Three Month Supply of Select Generic Medications
Effective July 1, 2016, Utah Medicaid clients enrolled in Traditional or Non-Traditional Medicaid will be allowed to receive up to a three month (90 day) supply of select generic medications per dispensing, if ordered by the prescriber. A listing of the medications included in this change is available in the Attachments section of the Pharmacy Provider Manual.

Psychotropic Medications on Preferred Drug List
Effective July 1, 2016, Utah Medicaid will place ADHD stimulants on the Preferred Drug List. Additional psychotropic medication classes will be added to the Preferred Drug List in October 2016.

Psychotropic medications are defined as atypical antipsychotics, anti-depressants, anti-convulsants/mood stabilizers, anti-anxiety medications, and attention deficit hyperactivity disorder stimulants. If a prescriber writes "dispense as written" on a prescription for a non-preferred psychotropic drug, the pharmacy may submit a Dispense As Written (DAW) Code of "1" on the claim. The DAW code will allow the claim to bypass the prior authorization requirement for the non-preferred drug at the point-of-sale. The DAW Code

will not allow claims for the brand-name version of multisource drugs to process, even if the brand-name version of the drug is listed as non-preferred and the prescriber writes "dispense as written" on the prescription.

In order for a prescription to be eligible for the pharmacy to submit the DAW Code of "1" to bypass the edit for a non-preferred medication, the prescriber must write "dispense as written" on the prescription. Check boxes or pre-printed forms that include "dispense as written" are not acceptable substitutes for the prescriber writing "dispense as written" on the prescription.

16-68   Payment Adjustments for Pharmacy Claims

Beginning July 1, 2016, all payment adjustments for pharmacy claims occurring within one year of the date of service must be completed by the provider by reversing the original claim and resubmitting a replacement claim (if applicable) through the GHS point-of-sale system. Payment adjustments for pharmacy claims after one year from the date of service must be submitted on a *Payment Adjustment Form for Pharmacy*. Only one NPI is allowed to be submitted per form with a corresponding check for the total amount.

For questions or directions how to reverse a pharmacy claim through the GHS point-of-sale system, please contact your software vendor.

The *Payment Adjustment Form for Pharmacy* can be found online in the Forms Directory on the Utah Medicaid website under the Healthcare Provider Resources link at https://medicaid.utah.gov/provider-resources-and-information.

For assistance, please call the Utah Medicaid Customer Service team:

- In the Salt Lake City area, call (801) 538-6155 choose option 3, 2.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free (800) 662-9651 choose option 3, 2.
- From all other states, call (801) 538-6155 choose option 3, 2.

16-69   Home and Community Based Services Waiver for Individuals Age 65 or Older Provider Manual Updated

The *Home and Community Based Services Waiver for Individuals Age 65 or Older Manual* has been updated with an effective date of July 1, 2016. The following items were added or modified:

- CMS approved effective dates of the waiver
- Clarification of the current TN modifier for rural enhancement rates policy
- Use of the U3 modifier
- Use of the TE modifier
- Fair hearing information

- Special circumstance disenrollment information was modified to reflect the current written Notice of Decision (NOD) process indicating that DAAS or their designee will provide the participant, or their legal representative (when applicable), with the required written NOD and right to fair hearing information

If you have any questions, contact Linda Robinson at (801) 538-6132 or lindarobinson@utah.gov.

Providers can access the revised provider manual at https://medicaid.utah.gov.

16-70   1915(c) HCBS Physical Disabilities Waiver Provider Manual Updated

The Home and Community-Based Services Physical Disabilities Waiver Program has a current expiration date of June 30, 2016. The State submitted the renewal application to CMS on March 31, 2016.

In conjunction with the renewal, the *PD Waiver Provider Manual* has been updated. The non-substantive updates include formatting modifications, terminology changes, and language revisions consistent with the current waiver.

The updated manual is available on the Medicaid website at https://medicaid.utah.gov.

16-71   Medically Complex Children's Waiver Provider Manual Updated

The *Utah Medicaid Medically Complex Children's Waiver Provider Manual* has been revised to include updates and policy clarification.

Updates include clarifications to the open enrollment procedures outlining a requirement to apply for Medicaid with the Department of Workforce Services (DWS) within 30 days of the applicant being selected for enrollment. Updates also include procedures for those being served in facilities during the open application period, and required timeframes for participants in the person-centered care planning process.

Additional updates clarify billing requirements for siblings when one respite provider is utilized. If it is determined by the nurse case manager during the person-centered care planning process that a single respite provider may safely care for siblings, the provider must bill with the "UN" HCPCS Modifier.

The revised provider manual is available on the Medicaid website at https://medicaid.utah.gov.