## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-29</td>
<td>PROVIDER RE-CREDENTIALING</td>
</tr>
<tr>
<td>19-30</td>
<td>CHANGES COMING TO PRISM'S PROVIDER ENROLLMENT</td>
</tr>
<tr>
<td>19-31</td>
<td>ELIGIBLE SPECIALTY CARE FOR RESTRICTED MEMBERS</td>
</tr>
<tr>
<td>19-32</td>
<td>PROVIDER EDUCATION CORNER</td>
</tr>
<tr>
<td>19-33</td>
<td>TABLES OF AUTHORIZED EMERGENCY DIAGNOSES</td>
</tr>
<tr>
<td>19-34</td>
<td>EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT PROGRAM (EPSDT)</td>
</tr>
<tr>
<td>19-35</td>
<td>MEDICAID EXPANSION</td>
</tr>
<tr>
<td>19-36</td>
<td>SECTION I: GENERAL INFORMATION PROVIDER MANUAL UPDATE</td>
</tr>
<tr>
<td>19-37</td>
<td>SPEECH-LANGUAGE PATHOLOGY AND AUDIOLGY SERVICES PROVIDER MANUAL UPDATE</td>
</tr>
<tr>
<td>19-38</td>
<td>MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT PROVIDER MANUAL UPDATE</td>
</tr>
<tr>
<td>19-39</td>
<td>PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES PROVIDER MANUAL UPDATE</td>
</tr>
<tr>
<td>19-40</td>
<td>ELECTRONIC VISIT VERIFICATION (EVV) REQUIREMENTS FOR PERSONAL CARE AND HOME HEALTH CARE SERVICES</td>
</tr>
<tr>
<td>19-41</td>
<td>LABORATORY CODE UPDATES</td>
</tr>
<tr>
<td>19-42</td>
<td>DENTAL, ORAL MAXILLOFACIAL, AND ORTHODONTIA SERVICES PROVIDER MANUAL UPDATE</td>
</tr>
<tr>
<td>19-43</td>
<td>PHARMACY PROGRAM UPDATES</td>
</tr>
<tr>
<td>19-44</td>
<td>NEW BUNDLED SERVICES PROCEDURE CODES FOR REHABILITATIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER (SUD) SERVICES AND RELATED UPDATES TO THE UTAH MEDICAID PROVIDER MANUAL FOR REHABILITATIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES</td>
</tr>
<tr>
<td>19-45</td>
<td>REASSESSMENT TIMELINE CHANGES FOR ASAM LEVEL OF CARE 3.1 AND ASAM LEVEL OF CARE 3.5 AND RELATED UPDATES TO THE UTAH MEDICAID PROVIDER MANUAL FOR REHABILITATIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES</td>
</tr>
<tr>
<td>19-46</td>
<td>NEW CHOICES WAIVER PROVIDER MANUAL UPDATE</td>
</tr>
<tr>
<td>19-47</td>
<td>PRIMARY CARE NETWORK (PCN) PROVIDER MANUAL UPDATE</td>
</tr>
<tr>
<td>19-48</td>
<td>SUBSTANCE USE DISORDER RESIDENTIAL TREATMENT SERVICES PRIOR AUTHORIZATION REQUEST FORM UPDATE</td>
</tr>
</tbody>
</table>
**19-29 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.

**19-30 Changes Coming to PRISM’s Provider Enrollment**

In March 2020, updates and changes are coming to PRISM’s Provider Enrollment System. Utah Medicaid is in the process of replacing the Utah Medicaid Management Information System (MMIS) with a new system called Provider Reimbursement Information System for Medicaid (PRISM). The Provider Enrollment component of PRISM was implemented in July 2016. Since then, providers have been using PRISM to enroll as a Medicaid provider and make changes to their enrollment information.

Current Medicaid providers’ enrollment records will be migrated to the updated PRISM Provider Enrollment System. We will alert providers when this occurs. Providers will have time to review the migrated information, validate that it is correct, and make any needed modifications to their information in PRISM. Providers will receive a letter specifying the updated PRISM web address with instructions on how to login to the updated PRISM Provider Enrollment System to validate and modify information. Online training will be available to assist with navigating the steps, along with contact information in case problems are encountered.

More details will be communicated in the quarterly Medicaid Information Bulletin (MIB) and on the Medicaid website at [https://medicaid.utah.gov/prism](https://medicaid.utah.gov/prism).

**19-31 Eligible Specialty Care for Restricted Members**

Medicaid members found to be abusing or over-utilizing their Medicaid benefits are enrolled in the Restriction Program. Members enrolled in the Restriction Program are assigned to one primary care provider (PCP) and one pharmacy through which they receive medical services.

According to Restriction Program policy, claims for specialty services for restricted members must be submitted with the name and NPI of the assigned PCP as the referring provider in order to be eligible for payment.
Claims submitted for specialty services for restricted members with modifiers 23, 25, 26, 30, 47, 55, 62, 75, 80, 91, 82, 90, P1, P2, P3, P4, P5 or P6, are only eligible for payment with a referral from the assigned PCP.

For specific information regarding a restricted member’s assigned PCP and pharmacy, as well as approved specialty providers and prescribers, visit the online Medicaid Eligibility Lookup Tool found on the Utah Medicaid website at https://medicaid.utah.gov/eligibility.

19-32 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.

19-33 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 Utah Medicaid website at Utah Medicaid Table of Authorized Emergency Department Diagnoses.
19-34 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.

19-35 Medicaid Expansion

On February 11, 2019, Governor Herbert signed Senate Bill 96 (2019 Legislative Session) into law. This bill supersedes previous Medicaid Expansion efforts and replaces Proposition 3 (2018 General Election). The State is working closely with the Centers for Medicare and Medicaid Services (CMS) as we submit new 1115 Waiver proposals. We are optimistic that CMS will provide greater flexibility as Utah crafts its own Medicaid expansion solutions.

This new law expands Medicaid to parents and adults without dependent children earning up to 100% federal poverty level (approximately $12,490 annual income for an individual). Approximately 70,000 – 90,000 Utah residents will become newly eligible for Medicaid. Approximately 40,000 individuals from 101-138% FPL will continue to receive services through the federal Marketplace.

During March 2019, staff at the Department of Workforce Services (DWS) began converting coverage for individuals currently enrolled in the Primary Care Network (PCN) program. Effective April 1, 2019, these individuals’ PCN coverage will end and they will begin receiving Medicaid coverage.

Beginning April 1, 2019, individuals may submit their applications to DWS to enroll in Medicaid expansion: https://medicaid.utah.gov/apply-medicaid. Submitting an application for benefits does not guarantee coverage.

Under Medicaid expansion, parents will receive the Non-Traditional Medicaid benefit package. Adults without dependent children will receive the Traditional Medicaid benefit package. Coverage will generally be provided through direct payments to providers (i.e., Fee for Service) through 2019. It is anticipated that in 2020 many individuals will transition to managed care plans for their physical and behavioral health services.
This spring, the State will also submit a new 1115 Waiver to CMS called the Per Capita Cap Plan. If approved, this plan will replace the plan implemented on April 1, 2019. The Per Capita Plan covers adults up to 100% FPL and requests the following provisions: self-sufficiency requirement, enrollment cap, up to 12-month continuous eligibility, employer-sponsored insurance enrollment, lock-out for intentional program violation provision, and a per capita cap. This plan will also request 90% federal/10% state funding.

Through these waivers, many new individuals will now be eligible for Medicaid coverage in Utah. The State has prepared communication tools to help spread the word. You can download flyers, posters and FAQs on the Medicaid website: https://medicaid.utah.gov/expansion.

For more information and regular updates, visit the Medicaid website: https://medicaid.utah.gov/expansion.

19-36 Section I: General Information Provider Manual Update

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

2-1.3 Dental Health Plans

- Generally, Medicaid members eligible for full dental services are required to enroll in a dental plan. The Department contracts with MCNA Dental and Premier Access to deliver dental services.
- Adults who are eligible for Medicaid due to a disability or visual impairment who want to receive services through the University of Utah School of Dentistry may do so, regardless of the dental plan they are enrolled in.

9-3.4 Exceptions When Medicaid Will Pay For Non-Covered Procedures

- Generally, Medicaid does not reimburse non-covered procedures. However, exceptions are considered through the utilization review process in the circumstances listed below:
  - When the service is medically necessary and/or
  - When performing the procedure is more cost-effective for the Medicaid program than other alternatives, unless otherwise prohibited by the Utah Medicaid State Plan.

Specific coverage on CPT or HCPS codes may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.
19-37 Speech-Language Pathology and Audiology Services Provider Manual Update

The *Utah Medicaid Speech-Language Pathology and Audiology Services Provider Manual* has been updated noting:

- EPSDT related information has been removed. This information is located in the EPSDT Services Manual.
- No policy changes were made.

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

---

19-38 Medical Supplies and Durable Medical Equipment Provider Manual Update

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

- The quantity limits for E0443, *Portable oxygen contents, gaseous, 1 month’s supply = 1 unit*, has been updated to align with the code descriptor of one unit per month.
- The quantity limits for tracheostomy tubes (trachs) has increased from one per month to 14 per 12-month period. This update allows providers to order backup trachs for members requiring new trachs or when trach size changes are necessary.
- EPSDT related information has been removed.

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

---

19-39 Physical Therapy and Occupational Therapy Services Provider Manual Update

The *Utah Medicaid Provider Manual for Physical Therapy and Occupational Therapy Services* has been updated noting:
Providers are encouraged to become familiar with this information.

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.

19-40 Electronic Visit Verification (EVV) Requirements for Personal Care and Home Health Care Services

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under the State Plan or a 1915 (c) Home and Community Based Waiver.

The effective date is for both personal care services and home health services; however, disallowance for claims with incomplete records will not occur until January 1, 2020, for personal care services and January 1, 2023, for home health care services.

Choice of reporting systems for EVV are by provider preference but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The State will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1) type of service performed;
2) individual receiving the service;
3) date of the service;
4) location of service delivery;
5) individual providing the service; and
6) time the service begins and ends.

Utah Medicaid policy will be updated on July 1, 2019, with an administrative rule outlining all EVV requirements. General information for providers, including instructions for data specifications reporting, will be found in the Section I Utah Medicaid Provider Manual.
19-41 Laboratory Code Updates

Open Effective February 1, 2019

81373 HLA I TYPING 1 LOCUS LR
81374 HLA I TYPING 1 ANTIGEN LR
81375 HLA II TYPING AG EQUIV LR
81376 HLA II TYPING 1 LOCUS LR
81377 HLA II TYPE 1 AG EQUIV LR
81378 HLA I & II TYPING HR
81379 HLA I TYPING COMPLETE HR
81380 HLA I TYPING 1 LOCUS HR
81381 HLA I TYPING 1 ALLELE HR
81382 HLA II TYPING 1 LOC HR
81383 HLA II TYPING 1 ALLELE HR

19-42 Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual Update

The Utah Medicaid Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual has been updated. Providers are encouraged to become familiar with the updates noting:

- The following is located in 13-1 Targeted Adult Medicaid (TAM) members with Substance Use Disorders
  - Dental services are available to eligible Targeted Adult Medicaid 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 will be provided through the University of Utah School of Dentistry (SOD) or its associated statewide network.
  - Prior to dental services being performed, the SOD will obtain verification of active treatment for substance use disorder (SUD) from the substance abuse treatment program. The SOD will then submit a SUD verification form to Medicaid for each eligible TAM member.

- Policy has been moved from Dental, Oral Maxillofacial, and Orthodontia Services Manual to Utah Administrative Rule R414-49, Dental, Oral and Maxillofacial Surgeons and Orthodontia.
  - No policy changes were made.

Specific code coverage is found in the Utah Medicaid Coverage and Reimbursement Code Lookup.
19-43 Pharmacy Program Updates

P&T Committee

The Pharmacy and Therapeutics (P&T) Committee recently reviewed rapid acting insulins, basal insulins, ACE inhibitors, and ACE inhibitor combinations. 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 recently reviewed new medications for migraine prophylaxis, medications to treat moderate to severe plaque psoriasis, and medications for the treatment of atopic dermatitis.

The March DUR meeting reviewed two medications for rare seizure conditions, Epidiolex and Diacomit. Meeting minutes are posted on the Utah Medicaid website and can be found at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board.

Mandatory 90-Day Supply of Select Drugs for Medicaid Members

Effective May 1, 2019, Utah Medicaid will institute a mandatory 90-day supply for medications on the 90-day supply list for members, following a two-month window for dose titration and stabilization. This policy does not apply to Medicaid members receiving long-term services and supports in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or those receiving services in home and community based services waivers. In addition, this policy does not apply to services provided through Indian Health Services providers. When a member 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 member 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.
Pharmacy Billing Reminder

Pharmacies are responsible for billing all prescriptions accurately. This includes billing with the correct:

- Patient
- Prescriber
- Drug (including dosage form)
- Dose
- Quantity
- Days supplied (based on quantity and directions for use)
- Date
- Diagnosis code when appropriate

Pharmacies should review claims for accuracy. Utah Medicaid will conduct periodic reviews of claims to identify potentially inappropriately billed prescriptions. Medicaid will work with the pharmacy to correct erroneous claims. Repeat issues may be referred to OIG for further investigation in accordance with Utah Code Section 63A-13-3.

Hyaluronic Acid Products

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) covers prescription medications that are prescribed by qualified practitioners enrolled with Utah Medicaid as a Medicaid benefit in compliance with federal law (42 U.S.C. 1396r-8). All covered medications must:

- Require a prescription for dispensing (Rx Only),
- Have a National Drug Code (NDC) number,
- Be eligible for the federal Medicaid drug rebate,
- Be approved by the Food and Drug Administration (FDA),
- Meet the Centers for Medicare and Medicaid Services (CMS) definition of a “covered outpatient drug” (42 CFR 447.502), and
- Be listed in the Medi-Span drug file.

Currently, Hyaluronic Acids or derivatives do not meet the criteria above. Effective April 1, 2019, the following medications will no longer be covered:

- J7318 Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
- J7320 Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
- J7321 Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
- J7322 Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
- J7323 Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
- J7324 Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
- J7325 Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
- J7326 Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
- J7327 Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
- J7328 Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg
- J7329 Hyaluronan or derivative, Trivisc, for intra-articular injection, 1 mg

The 90-day supply list can be found in our resource library at [https://medicaid.utah.gov/pharmacy/resource-library](https://medicaid.utah.gov/pharmacy/resource-library).
**Concurrent Prescriptions for Benzodiazepines and Opioids**

Utah Medicaid is implementing a multi-stage effort to identify and limit the concurrent filling of benzodiazepine and opioid medications. This initiative will support CDC safety guidance that recommends 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 peer to peer team will conduct 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.

**Opioid Policy Changes**

Effective July 1, 2019, the higher cumulative daily morphine equivalent dose (MED) threshold for “opioid experienced” individuals will be reduced 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.

At that time, two sets of daily MED thresholds were established, a threshold of 90 MED for “opioid naïve” individuals who have not had a claim for an opioid in the last 90 days, and 180 MED for “opioid experienced” individuals who have had a claim for an opioid in the last 90 days.

---

**19-44 New Bundled Services Procedure Codes for Rehabilitative Mental Health and Substance Use Disorder (SUD) Services and Related Updates to the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services**

For dates of service on or after April 1, 2019, the following bundled services procedure codes apply:

1. Licensed SUD residential treatment programs with 16 or fewer beds (ASAM levels of care 3.1 through 3.7)

   These programs must use the bundled services HCPCS procedure code, H2036, Alcohol and/or other drug treatment program, per diem. These programs may no longer bill the discrete services.
These programs must follow the prior authorization process already established for licensed SUD residential treatment programs with 17 or more beds. Refer to Chapter 5, Prior Authorization Policies and Procedures for Licensed Substance Use Disorder Residential Treatment Programs, of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* for information on the prior authorization requirements and process.

2. Mobile Crisis Outreach Teams (MCOT)

Crisis services provided by MCOTs may now bill using the bundled services HCPCS procedure code **H2000**, Comprehensive Multidisciplinary Evaluation, only if the MCOT meets the standards contained in Utah Administrative Rule, R523-18, and in Chapter 2-15, Mobile Crisis Outreach Team, of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

   a. This procedure code is billed on a per diem basis regardless of the number of outreach visits made to a Medicaid member on a given day.
   b. If only one member of the team is deployed to perform the crisis evaluation, then the bundled procedure code may not be billed. The provider must bill the applicable discrete mental health/SUD procedure code.

3. Assertive Community Treatment (ACT) Teams

ACT teams may bill services using HCPCS procedure code **H0040**, Assertive Community Treatment), only if the ACT team meets all requirements outlined in Chapter 2-14, Assertive Community Treatment Program, of this provider manual.

   a. Per Utah Medicaid policy, this service is billed per month.
   b. If a Medicaid member is not on the ACT team’s caseload for an entire month, then the team must bill the applicable range of dates and prorate the monthly charge accordingly.

4. In Chapter 1-2, Definitions, reference to CHEC has been removed from the EPSDT definition and removed in the manual where applicable.

5. Chapter 1-3, Medicaid Behavioral Health Service Delivery System, has been updated to clarify coverage.

6. Chapter 5, Prior Authorization Policies and Procedures For Licensed Substance Use Disorder Residential Treatment Programs, has been updated to clarify the prior authorization procedures.

Providers can access the revised provider manual at [https://medicaid.utah.gov](https://medicaid.utah.gov).
19-45 Reassessment Timeline Changes for ASAM Level of Care 3.1 and ASAM Level of Care 3.5 and Related Updates to the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services

Effective for dates of service on or after April 1, 2019, ASAM reassessments for ASAM level of care 3.1 will need to be done every 30 days. ASAM reassessments for ASAM level of care 3.5 will need to be done every 14 days. This does not change the prior authorization timelines of 60 days for adults and 30 days for adolescents.

Chapter 2-13, Substance Use Disorder (SUD) Treatment in Licensed SUD Residential Treatment Programs, and Chapter 5, Prior Authorization Policies and Procedures for Licensed Substance Use Disorder Residential Treatment Programs, have been updated in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services to reflect these changes.

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

19-46 New Choices Waiver Provider Manual Update

The Utah Medicaid New Choices Waiver Provider Manual has been updated for April 1, 2019. In chapter 4-1, the effective date of financial transaction services has been updated to March 1, 2019. Also, code T2029, specialized medical equipment, has been added to the list of waiver services so that case management agencies will no longer be able to act as a pass-through payment entity.

Chapters throughout the manual referencing service authorization forms (5-2, 6, and 7-1) have been updated to include language stating, "Case management agencies may be held 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."

19-47 Primary Care Network (PCN) Provider Manual Update

The Primary Care Network (PCN) Provider Manual has been updated. Providers are encouraged to become familiar with the updates noting:
As of April 1, 2019, all PCN members have been transitioned to Adult Expansion Medicaid. While the PCN program is not active at this time, 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.

Specific code coverage may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

---

**19-48 Substance Use Disorder Residential Treatment Services Prior Authorization Request Form Update**

Effective April 1, 2019, prior authorization (PA) requests for substance use disorder residential treatment services should be sent using the updated form (updated April 2019). The form is located in the Prior Authorization Section of the Utah Medicaid website. Changes to the form include the addition of the new code H2036 for facilities with 16 or less beds, the addition of an email address for submission of PA requests, and a field for the provider’s email address. There has also been a change to the instructions (on page 2) for submitting requests.

Requests received after May 1, 2019, that have been submitted using an outdated or inappropriate request form will be returned. The date in which a complete request is received will be the date posted for the PA request.