Medicaid Information Bulletin
January 2019

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19-01   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.

19-02   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.

19-03   Child Health Evaluation and Care (CHEC)

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

Beginning January 2019, Medicaid will start updating information referencing the CHEC program with EPSDT. These updates will occur over the next several quarters.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, formerly known as Child Health Evaluation and Care (CHEC), Provider Manual has been updated. Information specific to EPSDT services are now located in this manual.

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.

19-04   Inpatient Hospital Services Update

Utah Administrative Rule R414-2A, Inpatient Hospital Services has been updated.

Inpatient hospital services must be medically necessary and ordered by an appropriate Medicaid-enrolled provider for the diagnosis and treatment of a member's illness.

Information regarding inpatient reimbursement is located in Utah State Plan Attachment 4.19-A.

19-05   Hospital Services Manual Update

Effective January 1, 2019, the *Hospital Services Provider Manual* attachment, Inpatient Intensive Physical Rehabilitation Services, will be archived. Policies for inpatient intensive physical rehabilitation services are now found in R414-2A, Inpatient Hospital Services. Operational and informational materials from the manual are found in the Hospital Services Manual, Chapter 8-7, Inpatient Hospital Intensive Physical Rehabilitation Services.

Providers are encouraged to become familiar with the relocation of materials that formerly comprised the Inpatient Intensive Physical Rehabilitation Services attachment.

Utilization review of inpatient intensive physical rehabilitation services are found in R414-2A-9. Utilization Control and Review Program for Hospital Services.

Chapter 14, Long-Term Acute Care (LTAC), has been updated. Policy coverage information is now found in Administrative Rule R414-515, Long Term Acute Care. Operational information regarding long-term acute care hospitalizations is found in the Hospital Services Manual, Chapter 14, Long Term Acute Care (LTAC).

19-06   Vision Care Services Manual Update

The Utah Medicaid Provider Manual for Vision Care Services has been updated as follows:

- Chapter 1-1 has been updated removing "optional" and "mandatory" language
- Chapter 4-1.3 has been updated removing language concerning HCPCS Code V2025 and frames which include hearing aids in the earpieces
- Chapter 4-1.4 has been updated removing language concerning repairs due to member neglect or abuse

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

19-07   Speech-Language Pathology and Audiology Services Provider Manual Update

The Utah Medicaid Provider Manual for Speech-Language Pathology and Audiology Services has been updated. Coverage for speech-language pathology and audiology services are outlined in 42 CFR §440.110 and the Utah State Medicaid Plan. Providers are encouraged to become familiar with this updated information.

19-08   Chiropractic Services

Chiropractic visits are limited to twelve per year per member. Additional visits will require a prior authorization through Utah Medicaid. Chiropractic services are only available for pregnant women and EPSDT-eligible members ages 6 through 20 years.

19-09   Telehealth Billing Requirements for Distant Site Services

The Utah Medicaid Provider Manual Section I: General Information has been updated. Section 8-4.2 *Telemedicine* has been revised to eliminate the requirement that instructed practitioners to submit claims for telehealth services using the GT modifier. Providers must now mark their telehealth services claims with "Place of Service (POS) 02".

19-10   Rural Health Clinics and Federally Qualified Health Centers Manual Update

Effective January 1, 2019, the [Rural Health Clinics and Federally Qualified Health Centers](#) Provider Manual has been updated as follows:

13 Reimbursement
Alternative Payment Method for FQHCs

FQHCs may also adopt an alternative payment method so long as that rate results in payments that are no less than would have been received under the PPS. If an FQHC elects to change its payment method in subsequent years, it must elect to do so no later than thirty days prior to the beginning of the FQHC's fiscal year by written notice to the Department.

An FQHC is required to calculate the Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable Cost as part of its agreement with the federal government. As part of that calculation, it allocates allowable costs to Medicaid. The Department multiplies the Medicaid allowable costs by the Medicaid charge percentage to determine the amount to pay. The Department makes interim payments based on billed charges from the FQHC, which reduce the annual settlement amount. Third party liability collections by the FQHC for Medicaid patients also reduce the final cost settlement.

An FQHC participating in the APM must provide the Department annual cost reports and other cost information required by the Department necessary to calculate the annual settlement within six months from the close of its fiscal year, including its calculations of its anticipated settlement. The Department reviews submitted cost reports and provides a preliminary payment, if applicable, to FQHCs. Within twelve months after the end of the FQHC's fiscal year, the Department conducts a review or audit of submitted cost reports and makes a final settlement. This allows for inclusion of late filed claims and adjustments processed after the submitted cost report was prepared. If the Department overpaid an FQHC, the FQHC must repay the overpayment. If the Department underpaid an FQHC, the Department shall pay the FQHC the underpaid amount.

The Department compares the APM reimbursements with the reimbursements calculated using the PPS methodology described and pays the greater amount to the FQHC.

19-11   Long Acting Reversible Contraceptive Post Delivery

Long-acting reversible contraceptive (LARC) devices, inserted following a delivery, will be excluded from the DRG reimbursement calculation and will be separately paid according to the fee schedule as an additional amount to the DRG reimbursement calculation. Facilities must include the appropriate LARC HCPCS code on the submitted claim in order to be adjudicated correctly. All rates can be found in the [Coverage and](#)

Reimbursement Code Lookup.

LARC devices are only reimbursable when used in accordance with manufacturers full prescribing information guidelines. Post payment reviews may be done and recoveries made if initially inappropriately paid.

This reimbursement change is pending CMS approval of Utah State Plan, Attachment 4.19-A Inpatient Hospital. Upon approval, claims with date of service January 1, 2019, or later will be reprocessed according to the revised policy.

The professional insertion fee (e.g., CPT code 58300) continues to be paid separately based on billings from the medical professional on the CMS-1500 claim.

19-12   Code Updates

Open

37182 Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)

37183 Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)

43659 Unlisted laparoscopy procedure, stomach; *Limitation*: covered for laparoscopic pyloromyotomy only

78267 Urea breath test, C-14 (isotopic); acquisition for analysis – Closed – MUE 1

78268 Urea breath test, C-14 (isotopic); analysis – Closed – MUE 1

83014 Helicobacter pylori; drug administration

83013 Helicobacter pylori; breath test analysis for urease activity, non-radioactive isotope (e.g., C-13)

83009 Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (e.g., C-13)

87339 Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Helicobacter pylori

Code Open to Provider Type 30 - Podiatrist

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of

the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

Code Open to Provider Type 01 – General Hospital

27447 Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)

Prior Authorization Removed

A4452 Tape, waterproof, per 18 sq in
V2025 Deluxe frame

Closed

90880 Hypnotherapy

19-13   2019 Code Updates

Open

10004 Fna bx w/o img gdn ea addl
10005 Fna bx w/us gdn 1st les
10006 Fna bx w/us gdn ea addl
10007 Fna bx w/fluor gdn 1st les
10008 Fna bx w/fluor gdn ea addl
10009 Fna bx w/ct gdn 1st les
10010 Fna bx w/ct gdn ea addl
10011 Fna bx w/mr gdn 1st les
10012 Fna bx w/mr gdn ea addl
11102 Tangntl bx skin single les
11103 Tangntl bx skin ea sep/addl
11104 Punch bx skin single lesion
11105 Punch bx skin ea sep/addl
11106 Incal bx skn single les
11107 Incal bx skn ea sep/addl
20932 Osteoart algrft w/surf & b1
20933 Hemicrt intrclry algrft prtl
20934 Intercalary algrft compl
27369 Njx cntrst kne arthg/ct/mri

33285 Insj subq car rhythm mntr
33286 Rmvl subq car rhythm mntr
33440 Rplcmt a-valve tlcj autol pv
33866 Aortic hemiarch graft
36572 Insj picc rs&i <5 yr
36573 Insj picc rs&i 5 yr+
38531 Open bx/exc inguinofem nodes
43762 Rplc gtube no revj trc
43763 Rplc gtube revj gstrst trc
50436 Dilat xst trc ndurlgc px
50437 Dilat xst trc new access rcs
53854 Trurl dstrj prst8 tiss rf wv
76391 Mr elastography
76978 Us trgt dyn mbubb 1st les
76979 Us trgt dyn mbubb ea addl
76981 Use parenchyma
76982 Use 1st target lesion
76983 Use ea addl target lesion
77046 Mri breast c- unilateral
77047 Mri breast c- bilateral
77048 Mri breast c-+ w/cad uni
77049 Mri breast c-+ w/cad bi
81163 Brca1&2 gene full seq alys
81164 Brca1&2 gen ful dup/del alys
81165 Brca1 gene full seq alys
81166 Brca1 gene full dup/del alys
81167 Brca2 gene full dup/del alys
81518 Onc brst mrna 11 genes
83722 Lipoprtn dir meas sd ldl chl
92273 Full field erg w/i&r
92274 Multifocal erg w/i&r
93264 Rem mntr wrls p-art prs snr
95836 Ecog impltd brn npgt <30 d
95976 Alys smpl cn npgt prgrmg
95977 Alys cplx cn npgt prgrmg
95983 Alys brn npgt prgrmg 15 min
95984 Alys brn npgt prgrmg addl 15
96112 Devel tst phys/qhp 1st hr
96113 Devel tst phys/qhp ea addl
96121 Nubhvl xm phy/qhp ea addl hr
96130 Psycl tst eval phys/qhp 1st
96131 Psycl tst eval phys/qhp ea
96132 Nrpsyc tst eval phys/qhp 1st
96133 Nrpsyc tst eval phys/qhp ea

96136 Psycl/nrpsyc tst phy/qhp 1st
96137 Psycl/nrpsyc tst phy/qhp ea
96138 Psycl/nrpsyc tech 1st
96139 Psycl/nrpsyc tst tech ea
96146 Psycl/nrpsyc tst auto result
99451 Ntrprof ph1/ntrnet/ehr 5/>
99452 Ntrprof ph1/ntrnet/ehr rfrl
99453 Rem mntr physiol param setup
99454 Rem mntr physiol param dev
99457 Rem physiol mntr 20 min mo
99491 Chrnc care mgmt svc 30 min
A4563 Vag inser rectal control sys; *quantity limit 1 every 12-months*
A6460 Synthetic drsg <= 16 sq in
A6461 Synthetic drsg >16<=48 sq in
C1823 Gen, neuro, trans sen/stim
C9751 Microwave bronch, 3d, ebus
C9754 Perc av fistula, direct
C9755 Rf magnetic-guide av fistula
D0412 Blood glucose level test
D1516 Fixed bilat space maint, max
D1517 Fixed bilat space maint, man
D1526 Remove bilat space main, max
D1527 Remove bilat space main, man
D5876 Add metal sub to acrylc dent
D9613 Infiltration thera drug
E0467 Home vent multi-function
L8701 Pow ue rom dev ewh uprt cust; *quantity limit 1 every 5 years*
L8702 Pow ue rom dev ewhf uprt cus; *quantity limit 1 every 5 years*
Q4186 Epifix 1 sq cm*; prior authorization required*
Q4187 Epicord 1 sq cm*; prior authorization required*
Q4193 Coll-e-derm 1 sq cm
Q4200 Skin te 1 sq cm*; prior authorization required*
Q4203 Derma-gide, 1 sq cm
Q4204 Xwrap 1 sq cm*; prior authorization required*
T4545 Incon disposable penile wrap; *quantity limit 90 every 30 days*
V5171 Hearing aid monaural ite*; prior authorization required*
V5172 Hearing aid monaural itc*; prior authorization required*
V5181 Hearing aid monaural bte*; prior authorization required*
V5211 Hearing aid binaural ite/ite*; prior authorization required*
V5212 Hearing aid binaural ite/itc*; prior authorization required*
V5213 Hearing aid binaural ite/bte*; prior authorization required*
V5214 Hearing aid binaural itc/itc*; prior authorization required*
V5215 Hearing aid binaural itc/bte*; prior authorization required*
V5221 Hearing aid binaural bte/bte*; prior authorization required*

19-14   New Hospice PA Request Form

Effective January 1, 2019, a new Hospice Prior Authorization Request Form will be located in the Prior Authorization section of the Medicaid website. All requests received after April 1, 2019, which are submitted on an outdated request form will be returned.

As stated in the *Utah Medicaid Physician Services Provider Manual*, "PA requests must be sent with complete documentation or the request will be returned with a letter indicating what is missing. The date in which a complete request, with all necessary supporting documentation, is received will be the date posted for the PA request." This includes a current prior authorization request form.

19-15   Pharmacy Program Updates

Investigational Drugs

The Utah State Plan, Attachment 4.19-B, Page 19b states, "Investigational drugs are not covered by Utah Medicaid."

Preferred Drug List

Due to changes in pricing, rebates, and drug utilization, all Preferred Drug List (PDL) classes are subject to changes effective January 1, 2019, as part of the annual PDL review process.

Additionally, based on Pharmacy and Therapeutics (P&T) Committee recommendations, Hemophilia Factor IX, Hemophilia Factor VIII/von Willebrand Factor, and treatments for Migraine Prophylaxis have been added as new classes to the PDL effective January 1, 2019.

Pharmacy and Therapeutics Committee

The P&T Committee recently reviewed anticoagulants and treatments for migraine prophylaxis. Additions and updates to these classes have been made to the Utah Medicaid Preferred Drug List (PDL) based upon recommendations from the P&T Committee.

Drug Utilization Review Board

This quarter, the DUR Board recommended clinical prior authorization criteria for Luxturna, Exondys 51, and cGRP inhibitors. DUR Board meeting minutes can be found online at:
https://medicaid.utah.gov/pharmacy/drug-utilization-review-board?p=DUR%20Board%20Minutes/

Pharmacy Prior Authorizations Update

Utah Medicaid prior authorization (PA) forms have been revised and updated. Pharmacy prior authorizations must be initiated by a Medicaid prescriber, or in consultation with an authorized Medicaid prescriber.

In order to receive a PA decision in a timely manner, providers are encouraged to use the updated prior authorization forms, complete all mandatory fields correctly and legibly, and submit all required documentation with the initial PA submission. Incomplete forms or outdated forms will be returned as "incomplete", causing delays in PA processing.

Current PA request forms can found on the Utah Medicaid Pharmacy website: https://medicaid.utah.gov/pharmacy/prior-authorization.

As a reminder, Pharmacy prior authorizations must include the quantity and days' supply on each request. Pharmacy POS claims must match the quantity and days' supply in order for claims to adjudicate appropriately.

Pharmacy Services Manual

The Pharmacy Services Manual has been updated, please review regularly.

Drugs Requiring Diagnosis Codes

Effective January 1, 2019, Utah Medicaid Pharmacy Point of Sale will begin recognizing a single ICD 10 diagnosis code for claims for opioids for the treatment of cancer-related pain:

G89.3 Neoplasm related pain (acute) (chronic)

This ICD 10 code will bypass the morphine milligram equivalent (MME) thresholds and cumulative quantity limits listed in Drug Criteria and Limits found in the Resource Library.

Pharmacy CPT Codes (Vaccines and Toxoids) Update

Utah Medicaid updated coverage for all vaccine and toxoid CPT codes effective November 1, 2018. Coverage information for these codes may be found in the Coverage and Reimbursement Code Lookup.

Physicians and other eligible medical providers must follow Vaccine for Children Program (VFC) protocols when administering vaccines to children ages 0-18 years old.

Physicians must bill for VFC administration using appropriate procedure codes, to be reimbursed appropriately. Questions regarding denied or back-dated claims can be addressed to Utah Medicaid Customer Service at (801) 538-6155, or 1-800-662-9651.

Pharmacy CPT and HCPCS Reimbursement Reminder

All pharmacy CPT and HCPCS codes will be reimbursed according to the Utah State Plan. Providers are strongly encouraged to provide CPT and NDC or HCPCS and NDC combinations on all claims.

Utah Medicaid Changes to Align with CDC Opioid Guideline

There is an epidemic of opioid deaths in the United States with the number of deaths from opioid overdose exceeding those from suicides or auto accidents. Over half of opioid overdose deaths are related to medications obtained legally through a prescription. Excessive opioid prescribing (higher than needed quantity), high-dose prescriptions, and chronic use increase the risk for opioid dependency, overdose, and death.

The Centers for Disease Control developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain (https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1er.htm) to provide recommendations for the prescribing of opioid pain medication.[i] Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the risk of opioid use disorder, overdose, and death.

Opioid Policy Changes

Effective January 1, 2019, Utah Medicaid will adopt morphine milligram equivalent (MME) and cumulative daily morphine equivalent dose (MED) methodology for adjudication of all opioid claims for the treatment of non-cancer pain. This initiative will be added to existing **individual** opioid quantity limits and days' supply limitations, and will support CDC safety guidance and best practice standards. The MME approximates the "potency" of any opioid relative to morphine. The MME is calculated for each individual dose of prescribed opioid product. The CDC source conversion table can be found on the Utah Medicaid Pharmacy website. Additionally, daily MED limits will be placed on newly prescribed opioid medications, as described in the "Opioid Updates" MIB. The MED is the sum of the cumulative MME within a 24 hour period, which may include multiple drugs.

Two sets of daily MED thresholds will be 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. The higher MED threshold will be reduced over time to achieve one common MED standard for all Utah Medicaid members.

Providers will need to submit a prior authorization (PA) request on behalf of members who require opioid doses that exceed the MED limits. The PA request form can be found on the Utah Medicaid website here.

With the introduction of daily MED limits as noted above, **cumulative** quantity limits on short-acting opioids, long-acting opioids, and combination opioids will no longer apply. Quantity limits will continue to apply to individual drugs.

Treatment of Opioid Use Disorder Therapies (Sublocade/Vivitrol)

In an effort to expand access to effective treatment options for opioid use disorder, both Sublocade and Vivitrol will have preferred status on the preferred drug list. Both of these medications will be available without a prior authorization, effective January 1, 2019.

Methadone Pharmacy Prior Authorization

The prior authorization (PA) form for methadone has been updated to allow no more than 20 mg /day (80 MME) for the treatment of non-cancer pain. Prescription requests that exceed 20 mg/day will not be approved. The current methadone PA form can be found on the Utah Medicaid website here.

Please note: This does not apply to methadone used for the treatment of opioid use disorder.

19-16   New Choices Waiver Provider Manual Updates

The *New Choices Waiver Provider Manual* has been updated with substantive changes made to the Incident Reporting Protocol. Section 9 describes types of negative events all waiver service providers are required to report to case management agencies, the types of negative events case management agencies are required to report to the New Choices Waiver program office, and the timeframes in which incidents should be reported. Updates have also been made describing potential corrective action when the Incident Reporting Protocol is not followed.

Non-substantive clarifications have been made to Section 5-4 where updated terminology for Medicaid Fair Hearings was needed.

19-17   Medically Complex Children's Waiver Manual Updates

The *Utah Medicaid Medically Complex Children's Waiver Provider Manual* has been revised to include updates and policy clarification, effective October 1, 2018.

Updates have been made to the general eligibility criteria which include clarification of program eligibility (which requires an evaluation of the applicant's ability to perform age-appropriate activities of daily living), and the establishment of a minimum medical acuity score from the program application. Updates also include additional program application clarifications and the addition of new respite providers.

19-18   Policy Manual Updates to Rehabilitative Mental Health and Substance Use Disorder Services

Effective for dates of service beginning January 1, 2019, the 2019 edition of the Current Procedural Terminology (CPT) Manual contains changes to psychological testing codes.

The following codes have been discontinued, effective 12/31/2018:

96101, 96102, 96103, 96118, 96119, and 96120

The new psychological testing codes are:

96112 with add-on code 96113;

96121 which is a new add-on code to 96116;

96130 with add-on code 96131;

96132 with add-on code 96133;

96136 with add-on code 96137;

96138 with add-on code 96139; and

96146

Please note that CMS's National Correct Coding Initiative (NCCI) has set Medically Unlikely Edits (MUE) limits on these codes, as well as some Procedure-to-Procedure (PTP) limits. See Chapter 1-11 for information on accessing the NCCI MUE and PTP quarterly modules.

Also, effective for dates of service beginning January 1, 2019, existing psychological testing procedure code 96125 will be opened.

The psychological testing code revisions are contained in the updated Chapter 2-4, Psychological Testing, of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.*

Providers may also use Medicaid's Coverage and Reimbursement Look-Up Tool for information on these procedure codes. See Chapter 2-1, General Limitations, of the provider manual for information on accessing the Look-Up Tool.

The other revision to this provider manual is:

In Chapter 2-1, General Limitations, in 1.b. clarification has been provided regarding the State's 1115 Primary Care Network Demonstration Waiver which allows payment to Institutions for Mental Diseases (IMDs) when the IMD is a licensed substance use disorder residential treatment program with 17 or more beds.

In Chapters 1-4 and 1-10, telemedicine policy has been updated to delete reference to use of the GT modifier to show that the service was provided via telehealth. Instead, providers must use place of service code '02' in the place of service field on the claim to show that the service was provided via telehealth.

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

19-19   Policy Manual Updates to Targeted Case Management for Individuals with Serious Mental Illness

Effective for dates of service on or after January 1, 2019, targeted case management services for individuals with serious mental illness are included in the per diem rate for licensed substance use disorder residential treatment providers (procedure code H0018) and cannot be billed separately.

In the *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness*, Chapter 1-7 has been revised to reflect this change.

In the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*, in Chapter 2-13, #6 of the Limits section has been updated to remove the wording, "Targeted case management services specified in the Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness".

Another update to the *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness*, is found in Chapter 1-2, Target Group. The section on other targeted case management target groups has been corrected to include pregnant woman as a targeted case management target group.

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

19-20   Accountable Care Organization (ACO) County Update

Effective January 1, 2019, the SelectHealth Community Care Medicaid ACO plan will be available statewide to all voluntary and mandatory enrollment counties. As a reminder, Medicaid members living in voluntary counties have the option to choose an available ACO health plan or use the Fee for Service Network, while those living in mandatory counties must choose an ACO health plan or they will be assigned to one. An updated ACO plan chart by county, effective January 1, 2019, is listed in the table below:

County	Health Choice Utah 1-877-358-8797 HealthChoiceUtah.com	Healthy U 1-888-271-5870 uhealthplan.utah.edu	Molina 1-888-483-0760 molinahealthcare.com	SelectHealth Community Care 1-855-442-3234 selecthealth.org	Fee for Service (FFS) 1-866-608-9422 medicaid.utah.gov
Beaver	•	•	•	•	•
Box Elder	•	•	•	•	
Cache	•	•	•	•	
Carbon		•	•	•	•
Daggett		•	•	•	•
Davis	•	•	•	•	
Duchesne		•	•	•	•
Emery		•	•	•	•
Garfield		•	•	•	•
Grand		•	•	•	•
Iron	•	•	•	•	
Juab	•	•	•	•	•
Kane		•	•	•	•
Millard	•	•	•	•	•
Morgan	•	•	•	•	
Piute		•	•	•	•
Rich	•	•	•	•	
Salt Lake	•	•	•	•	
San Juan		•	•	•	•
Sanpete	•	•	•	•	•
Sevier	•	•	•	•	•
Summit	•	•	•	•	
Tooele	•	•	•	•	
Uintah		•	•	•	•
Utah	•	•	•	•	
Wasatch	•	•	•	•	
Washington	•	•	•	•	
Wayne		•	•	•	•
Weber	•	•	•	•	

Members living in yellow-highlighted counties must be enrolled in a health plan.
Other members can choose a health plan or use FFS.