UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

October 2019

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19-84 Statewide Provider Training November

Utah Medicaid is now offering an online Statewide Provider Training on November 6, 2019. The online training includes both a morning and afternoon session. Each session will run two hours and can be attended in its entirety or by each individual topic. Registration is located on the Medicaid website at: https://medicaid.utah.gov/medicaid-provider-training. If you are unable to register, send an email to providertrainingsupport@utah.gov and include your email address and session time.

Utah Medicaid will host the online training sessions on the date and times below.

Date	Time
November 6, 2019	9:00 - 11:00 AM
November 6, 2019	1:00 – 3:00 PM

19-85 Provider Education Corner

Utah Medicaid continues to make substantial organizational 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.

19-86 Billing Medicaid and Record Retention

The following may be found in Section I: General Information Provider Manual and in the Provider Agreement for Medicaid.

Billing Medicaid

Medicaid providers may only bill for services that are medically indicated and necessary for the member and either personally rendered or rendered incident to his professional service. The billed charge may not exceed the usual and customary rate billed to the general public, such as individual member accounts or third party payer accounts.

Utah Medicaid follows correct coding guidelines which are adopted as long as they are consistent with the application of Utah Medicaid policy.

Unacceptable Billing Practices

The use of any device or strategy that may have the effect of increasing the total amount claimed or paid for any service beyond the maximum allowable amount payable for such service is not allowed.

The following are examples of unacceptable billing practices:

- Duplicate billing or billing for services not provided
- Submitting claims for services or procedures that are components of a global procedure
- Submitting claims under an individual practitioner's provider number for services performed by the practitioner as an employee of or on behalf of a group practice or clinic when the service has been billed under the group or clinic number
- Use of more intensive procedure code than the medical record indicates or supports
- Separate charges for freight, postage, delivery, installation, set-up, instruction, fitting, adjustment, measurement, facility visits, or transportation since these services are considered to be all-inclusive in a provider's charge unless otherwise specified, e.g. shipping cost for hearing aid repair

Record Keeping and Disclosure

Medicaid providers must comply with all disclosure requirements in 42 CFR §455, Subpart B, such as those concerning practice ownership and control, business transactions, and persons convicted of fraud or other crimes. A provider must also disclose fully to Utah Medicaid, information about the services furnished to Medicaid members, as circumstances may warrant.

Every provider must comply with the following rules regarding records:

- Maintain for a minimum of five years all records necessary to document and disclose fully the extent of all services provided to Medicaid members and billed, charged, or reported to the State under Utah's Medicaid Program

- Promptly disclose or furnish all information regarding any payment claimed for providing Medicaid services upon request by the State and its designees, including the Office of Inspector General (OIG) and the Medicaid Fraud Control Unit, or the Secretary of the United States Department of Health and Human Services
    - This includes any information or records necessary to ascertain, disclose, or substantiate all actual income received or expenses incurred in providing services
    - In addition, all providers must comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B as applicable, except for individual practitioners or groups of practitioners (a copy of these requirements will be furnished upon request)
- Allow for reasonable inspection and audit of financial or member records for non-Medicaid members to the extent necessary to verify usual and customary expenses and charges

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19-87 Policy, Rules, and Regulations

Providers must be aware of and comply with policies and procedures in the provider manuals and MIB's in effect when the service was rendered. Providers have agreed to comply with all appropriate and applicable state and federal rules and regulations per the Provider Agreement. Additional information may be found in Section I: General Information, Chapter 3-1.2 Provider Agreement.

19-88 Primary Care Network (PCN)

As of April 1, 2019, all PCN members were 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.

19-89 Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT)

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

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.

19-90 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.

19-91 Hospital Services Manual Update

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

Information regarding Inpatient Hospital Intensive Physical Rehabilitation Services in the Hospital Services Manual, Chapter 8-7 Inpatient Hospital Intensive Physical Rehabilitation Services has been republished as follows:

Inpatient Hospital Intensive Physical Rehabilitation Services

Inpatient hospital intensive physical rehabilitation is an intense program of physical rehabilitation provided in an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital.

Inpatient intensive physical rehabilitation services are covered Medicaid services for acute conditions from birth through any age, require prior authorization, and are available one time per event.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible members with chronic conditions may be considered for age appropriate developmental training. All services are subject to post payment review by the Office of Inspector General (OIG).

Inpatient intensive physical rehabilitation services are intended to provide the therapy necessary to allow the patient to function without avoidable follow-up outpatient therapy. Therefore, the maximum therapy service the patient could receive under the Diagnosis Related Group (DRG) should be provided.

Non-Covered Services and Limitations

Rehabilitation services are non-covered when

- The patient's condition and prognosis meets the requirements of placement in a long-term facility, skilled nursing facility, or outpatient rehabilitation service
- The admission is for deconditioning (e.g., cardiac or pulmonary rehabilitation)

Prior Authorization

The PA request for inpatient intensive physical rehabilitation services must be submitted within standard timely filing requirements, using the current version of the *Request for Prior Authorization Form*. PA reviews only serve to determine appropriate DRG assignment. Post payment review of a claim by the OIG serves to determine clinical appropriateness of admission and stay.

Failure to obtain prior authorization may result in payment denial. General prior authorization information is provided in the provider manual, *Section I: General Information*.

Medicaid does not process PA requests for services to be provided to a Medicaid member enrolled in a Medicaid Accountable Care Organization (ACO) when the services are included in the ACO's contract. Providers requesting PA for services to a member enrolled in an ACO shall be instructed to refer such requests to the appropriate ACO for review.

Medical Necessity Documentation

The clinical record must be maintained on file in accordance with any federal or state law or state administrative rule, and made available for state or federal review, upon request. Based on CMS and other documentation guidelines, the clinical record of a patient admitted to an inpatient intensive physical rehabilitation hospital should support the admission as reasonable and necessary. The following items and the information contained in the Quick Reference for Rehabilitation Services table will assist to support the

admission; however, providers should adhere to all applicable standards in preparing medical documentation:

- If it is the first admission for this medical event
- Appropriate standardized measurement tool scores, including an audiology record for admissions that include speech-language pathology services
- The patient requires rehabilitation evaluation and management services of an intensity, frequency, and duration that qualify the patient for inpatient rehabilitation, based on the Functional Independence Measure (FIM) score or Primary Children's Medical Center score (for EPSDT eligible patients), and other appropriate measurement tools (e.g. ASIA score, Rancho score, Disability Rating Scale (DRS), Walking Index for Spinal Cord Injury (WISCI), Agitated Behavior Scale (ABS) or other equivalent standardized measurement tool scores)
- The patient is medically/surgically stable and requires 24-hour nursing care or supervision by a registered nurse with specialized training in rehabilitation
- The patient has a reasonable expectation of improvement in activities of daily living appropriate for chronological age and development that will be of significant functional improvement when measured against the patient's documented condition at the time of the initial evaluation
- The patient is mentally and physically ready to learn adaptive techniques, transfer skills, and equipment use appropriate for the level of injury
- The patient's physical, cognitive, and sensory capacity allows active and ongoing participation in intense, multiple therapy disciplines (physical, occupational, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy, designed to restore function rather than maintain existing function
- The generally accepted standard by which the intensity of these services is typically demonstrated in an inpatient intensive physical rehabilitation hospital is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated. Intensity of services may vary. For example, a patient admitted for a hip fracture and also undergoing chemotherapy for an unrelated issue, may have less intense therapy on those days chemotherapy is administered (Also refer to the CMS Brief Exceptions Policy)

Quick Reference for Rehabilitation Services

DRG	Diagnosis	Disease Specific Documentation
8800	Spinal injury resulting in paraplegia	Patient has paralysis of two limbs or half of the body related to trauma or disease of the spinal cord. The ASIA score or other standardized measurement tool score must be present in the record. May be complicated by: • Pressure sores • Urological complications (e.g., UTI, dysreflexia) • Respiratory complications

		• Contractures • Spinal/skeletal instability
8801	Spinal injury resulting in quadriplegia	Patient has paralysis of all four limbs. The ASIA score or other standardized measurement tool score must be in the record. May be complicated by: • Pressure sores • Urological complications (e.g., UTI, dysreflexia) • Respiratory complications • Contractures • Spinal/skeletal instability
8802	Traumatic brain injury	The Rancho Classification scale must be in the medical record and must have two or more neurological deficits documented: • Dysphagia • Dysphasia • Paralysis • Visual disturbances • Cognitive deficit **NOTE:** Documentation of well-defined treatment goals for functional improvement. The patient is an evolving Rancho 3 or Rancho 4-6 with behavior management issues.
8803	Stroke (cardiovascular accident CVA)	• Treatment must begin within 60 days after onset of stroke • Patient has sustained focal neurological deficit • The rehabilitation service is for a separate focal CVA site than a previous admission
8804	Other condition which may require an intensive inpatient rehabilitation program: **Neurological Defect:** • Amyotrophic lateral sclerosis (ALS) • Guillain-Barre Syndrome	Patient with marked physical impairment secondary to a variety of problems such as trauma, surgery, chronic disease, and malnutrition or a combination of factors that can be expected to improve with a comprehensive physical restoration program.

	Other Conditions 1. Neurological disorders: • Multiple Sclerosis • Myelopathy (transverse myelitis infarction) • Myopathy • Parkinson's Disease 2. Congenital deformity (e.g. following dorsal rhizotomy) 3. Complex fractures (e.g. hip) or fracture with complicating condition 4. Amputation with complication or multiple amputation 5. Post neurosurgery of Brain or Spine (e.g. tumor) 6. Burns 7. Major multiple trauma (e.g. fractures, amputation) 8. Post meningoencephalitis	The FIM score or the Primary Children's Medical Center score must be in the record. Other standardized measurement tool scores may be required depending on the diagnosis. **Amputation:** The patient must have been mobile prior to the injury. Supportive documentation must substantiate a rehabilitation stay will be beneficial to the patient. The stump must be healed to the point that physical therapy and rehabilitation education can be accomplished. **Post neurosurgery:** Must have complicating medical condition which requires close medical supervision by a physician with resulting muscular skeletal deficit. **Burns:** Disability due to burns involving at least 15% of the body

Notice of Rights

Medicaid provides notice of agency action, in accordance with State and Federal regulations, when payment is not approved for services for which prior authorization was requested. The notice specifies the service(s) and reason(s) why the authorization was not granted, the regulations or rules which apply, and the appeal rights of the provider.

The physician or hospital may not charge the patient for services that are denied for any of the following:

- The provider failed to advise the patient that the services were not a covered Medicaid benefit, or
- The provider failed to follow prior authorization procedures, or
- Payment by Medicaid was denied

The provider may charge the patient for services that are not covered by Medicaid only as allowed in the provider manual, Section I: General Information, Exceptions to Prohibition on Billing Patients.

Multidisciplinary Treatment Team

The multidiscipline treatment team may consist of:

- A rehabilitation physician with specialized training and experience in rehabilitation services
- A registered nurse with specialized training or experience in rehabilitation
- A social worker or a case manager (or both)
- A licensed or certified therapist from each therapy discipline involved in treating the patient

Each team member must have current knowledge of the patient as documented in the medical record at the inpatient intensive physical rehabilitation hospital. A rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the inpatient intensive physical rehabilitation hospital leads the team.

Within five days of the patient's admission to the facility, the following should be complete and documented in the patients' medical record: the team evaluation, an estimated length of stay, and initiation of appropriate discharge planning, including home care assessment.

Billing for Inpatient Rehabilitation Services

Facilities are responsible for submission of accurate claims. This policy is intended to ensure that reimbursement is based on the code or codes that correctly describe the inpatient rehabilitation services provided.

This information is intended to serve only as a general reference resource regarding Medicaid policy for inpatient rehabilitation services described and is not intended to address every aspect of a situation. Accordingly, Medicaid may use reasonable discretion in interpreting and applying this policy to inpatient rehabilitation services provided in a particular case. Further, the policy does not address all issues related to reimbursement for inpatient rehabilitation services provided to Medicaid members. Other factors affecting reimbursement may supplement, modify, or in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates or the member's benefit coverage.

Clarification of MS-DRG billing for inpatient rehabilitation services

Due to changes to ICD-10-CM, there has been confusion on the correct way to code inpatient rehabilitation stays. Since correct coding is essential to determine appropriate payment, Utah Medicaid is providing the following guidance:

- MS-DRG 945 or 946 (Rehabilitation with CC/MCC and without CC/MCC, respectively) is assigned if the patient has a principal diagnosis on the MDC 23 (Factors influencing Health Status and Other Contacts with Health Services) list and a rehabilitation procedure code listed under MS-DRGs 945 or 946
- If the patient has a rehabilitation procedure code but does not have a principle diagnosis code from MDC 23, the principle diagnosis would determine the MS-DRG used

Additional information may be found at:

- Federal Register/Vol. 81, No. 162/Monday, August 22, 2016/Rules and Regulations/11. pages 56826 & 56827
- MDC 23 principal diagnosis codes may be found at; ICD-10-CM/ PCS MS-DRG v36.0 Definitions Manual
- Rehabilitation procedures may be found at: https://www.cms.gov/ICD10Manual/version36-fullcode-cms/fullcode_cms/P0354.html

Make sure to use the correct Definitions Manual version based on the date of discharge. The Definitions Manual provides information related to the Major Diagnostic Categories (MDCs). Within each MDC, the MS-DRGs are listed in the order in which the grouper recognizes them. This enables users to see instances where grouper logic order differs from strict numerical order.

19-92 Personal Care and Home Health Agencies

Provider Type 54, Personal Care Agency, has been removed from the following codes:

H2010 Comprehensive medication services, per 15 minutes
T1013 Sign language or oral interpretive services, per 15 minutes

Provider Type 58, Mcare/Mcaid Certified Home Health Agency, has been removed from the following codes:

H0033 Oral medication administration, direct observation
H2032 Activity therapy, per 15 minutes

19-93 Electronic Visit Verification (EVV)

Information regarding Electronic Visit Verification (EVV) has been added to the Home Health Services and Home and Community-Based Services (HCBS) provider manuals. Providers are encouraged to become familiar with the updates noting the following:

In accordance with Utah Administrative Code R414-522 and section 12006 of the 21st Century CURES Act, providers of Home Health and Personal Care Services (including similar services offered through the Home and Community-Based Waiver programs) must comply with Electronic Visit Verification (EVV) requirements.

Home Health, Personal Care, and HCBS providers may select the system of their choosing, provided it captures the following data elements and is compliant with the standards set in the Health Insurance Portability and Accountability Act. EVV systems must collect the minimum information:

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;
6) time the service begins and ends; and
7) the date of creation of the electronic record.

Additional information, including technical specifications for file creation/submission can be found at https://medicaid.utah.gov/evv.

19-94 Code Updates

Codes Open to Provider Type 33- Occupational Therapist

97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes

97761 Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

97763 Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

Codes Open to Provider Type 35- Physical Therapist

97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes

97761 Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

97763 Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

19-95 Dental, Oral, Maxillofacial, and Orthodontia Services: Craniofacial Anomalies

The following codes may be allowed with prior authorization approval for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) members with craniofacial anomalies, cleft lip or palate:

D5936 Obturator prosthesis, interim
D5952 Speech aid prosthesis, pediatric
D5988 Surgical splint
D5999 Unspecified maxillofacial prosthesis, by report designated for nasal stent/nasal stent activator
D8210 Removable appliance therapy
D8999 Unspecified orthodontic procedure, by report designated for rapid palate expander

These services are not covered by the Dental Managed Care Plans and should be billed directly to Medicaid as fee for service. Criteria includes the substantiation of medical necessity of services through description of medical condition, dentist's treatment plan and schedule, and radiographs fully depicting existing teeth and associated structures.

Program coverage and limitations have been updated and are available in the Dental, Oral Maxillofacial, and Orthodontia Services provider manual and the Utah Medicaid Coverage and Reimbursement Code Lookup.

19-96 Pharmacy Program

FluMist Covered for the 2019-2020 Flu Season

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) released the 2019-2020 Influenza Vaccine Recommendations. A notable change was the addition of the live attenuated influenza vaccine (LAIV) or "FluMist". The immunization schedule for all individuals between the ages of 2 and 49 years includes the LAIV unless the individual has a contraindication. ACIP also added a recommendation that any licensed influenza vaccine that is appropriate for the age and health status of a patient may be used. No specific preference was given to the use of either the LAIV or the inactivated influenza vaccine. Utah Medicaid recognizes the ACIP recommendations and will cover "FluMist" for administration during the 2019-2020 flu season.

CPT Code: 90672
NDCs: 66019030601 and 66019030610

Pharmacy Prior Authorization Updates

Medication Coverage Exception Request

The Utah Medicaid Pharmacy Team, in consultation with the Drug Utilization Review Board, has created the Medication Coverage Exception Request prior authorization form that will replace the following pharmacy prior authorization forms:

- Brand Name Medication
- Combination Products
- Dosing Kit
- Non-Preferred
- Off Label Use of FDA Approved Drugs
- Quantity Limits
- Step Therapy

The consolidation of multiple, non-clinical prior authorization request forms to one common form will streamline the prior authorization review process. The Medication Coverage Exception Request Form can be found on the Utah Medicaid website or at https://medicaid.utah.gov/pharmacy/prior-authorization.

Antiemetic Prior Authorization Request

Effective October 1, 2019, non-preferred antiemetic medications will require a prior authorization. Utah Medicaid's Preferred Drug list can be found here.

Botox

Effective October 1, 2019, Botox prior authorization requests must list all muscles/sites where Botox will be injected and list the number of units being injected (e.g., 30 units in trapezius muscle) and will only be approved using the HCPCS code. Claims submitted through pharmacy point of sale will not be covered.

Antipsychotics in Children- Policy Updates

Children enrolled in Medicaid receive antipsychotic medications (AP) at a substantially higher rate than non-Medicaid pediatric populations.[1] AP use in children is frequently "off label" and are often prescribed before safer, first-line options.[2] AP medications are associated with serious side effects, including metabolic changes, weight gain, and movement disorders, which can cause irreversible harm.[3]

Effective October 1, 2019, Utah Medicaid will implement new policy to monitor and manage AP medications prescribed to members 19 years of age and younger.

The Utah Department of Health (UDOH) will launch retrospective Drug Utilization Review (DUR) peer to peer educational interventions that support American Academy of Child and Adolescent Psychiatry best practices for use of AP in children and will address the following:[4]

a. Use of other first-line services (psychosocial counseling and safer medications) prior to initiation of AP
b. Dosing of AP should follow the "start low and go slow" approach
c. Identification of "higher than recommended" doses for AP
d. Careful and frequent monitoring of AP-related side effects
    i. Metabolic screening
    ii. Body Mass Index, weight gain
    iii. Assessments for movement disorders
e. Use of AP in very young children (e.g., younger than 6 years old)
f. Use of multiple concurrent AP

Future prospective work will include:

1. Utah Medicaid will require a diagnosis code on all prescription claims for AP medications. Prescribers must include the diagnosis codes with each prescription for an AP given to a child 19 years of age and younger. Pharmacies will be required to enter the diagnosis code into the point of sale system when processing a claim for an AP. Retrospective peer to peer outreach will address off label use of AP in this vulnerable population.
2. High dose limits for AP will be established in the pharmacy point of sale system. Very high doses of AP have not been proven effective in children, and may be associated with a greater incidence of adverse effects, including movement disorders. Claims for AP submitted to Utah Medicaid that exceed the pre-established limits will reject at the pharmacy point of sale and require a prior authorization.

References:

1. Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents. March 2019. https://store.samhsa.gov/system/files/pep19-antipsychotic-bp.pdf.
2. Olfson M, King M, Schoenbaum M. Treatment of young people with antipsychotic medications in the United States. *JAMA Psychiatry.* 2015;72(9):867-874.
3. Gohlke JM, Dhurandhar EJ, Correll CU, et al. Recent advances in understanding and mitigating adipogenic and metabolic effects of antipsychotic drugs. *Front Psychiatry.* 2012;3:50-62.
4. American Academy of Child and Adolescent Psychiatry. Practice parameter for the use of atypical antipsychotic medications in children and adolescents. 2011.

Concurrent Use of Opioids with Benzodiazepines

Combined use of opioids and benzodiazepines potentiate respiratory depression, which may result in nonfatal overdose or death. Utah Medicaid supports FDA labeling and CDC best practice and safety standards which advise against concurrent use (https://www.cdc.gov/drugoverdose/prescribing/guideline.html).

Utah Medicaid encourages filling pharmacists to incorporate these standards when filling opioid – benzodiazepine prescriptions.

- ✓ Routinely check the controlled substance database with the filling of each opioid prescription
- ✓ Proactively counsel patients about the risks of respiratory depression when combined use is identified
- ✓ Proactively offer naloxone and educate on appropriate use
- ✓ Proactively outreach to prescribers to consider other, safer combinations

Effective October 1, 2019, Utah Medicaid will employ a Drug Utilization Review (DUR) hard edit when a short-acting opioid claim is filled concurrently with a benzodiazepine. The DUR hard edit will require pharmacist input of an NCPDP override code, documenting the intervention made, before the claim will process. All other existing opioid edits will apply to the processing of opioid claims. Please refer to the Utah Medicaid pharmacy manual for all Utah Medicaid opioid policies and procedures at https://medicaid.utah.gov/utah-medicaid-official-publications?p=Medicaid%20Provider%20Manuals/Pharmacy/.

Opioid Use in Pregnancy- Policy Updates

Effective October 1, 2019, Utah Medicaid will restrict opioid quantity limits to 7 days or less for pregnant individuals. If a claim for an opioid is submitted through the point of sale system for more than a 7-day supply for a pregnant individual, the system will reject that claim.

In March 2016, the FDA strengthened warnings about the risks related to opioid use and potential misuse, abuse, and addiction. One of those risks is neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS) which may occur in infants who are chronically exposed to opioids in utero.[1] NAS/NOWS is a withdrawal syndrome that occurs in infants who were exposed to opioids in utero. The syndrome is characterized by tremors, irritability, poor feeding, respiratory distress, and seizures, all of which develop shortly after birth. From 2004 to 2014, the incidence of NAS in the United States increased from 1.5 to 8.0 per 1,000 hospital births, a more than fivefold increase.[2] Carefully consider any use of opioids in the management of pregnant individuals. This policy does not apply to pregnant women on methadone maintenance for the treatment of opioid use disorder.

1. Commissioner, O. O. (2016, March 22). FDA announces enhanced warnings for immediate-release opioid pain medications related to risks of misuse, abuse, addiction, overdose and death. Retrieved from https://www.fda.gov/news-events/press-announcements/fda-announces-enhanced-warnings-immediate-release-opioid-pain-medications-related-risks-misuse-abuse.
2. Winkelman, T. N., Villapiano, N., Kozhimannil, K. B., Davis, M. M., & Patrick, S. W. (2018, April 01). Incidence and Costs of Neonatal Abstinence Syndrome Among Infants With Medicaid: 2004–2014. Retrieved from https://pediatrics.aappublications.org/content/141/4/e20173520.

Drug Utilization Review Board

The Drug Utilization and Review (DUR) Board met in July 2019 to review prior authorization criteria for Zolgensma, a novel gene therapy to treat spinal muscular atrophy, and to review the annual retrospective drug utilization review work done by the University of Utah Drug Regimen Review Center (DRRC). Retrospective drug utilization review is a requirement of Medicaid DUR programs, and in federal fiscal year 2018 focused on high-risk medication

combinations (including dangerous opioid combinations), adherence initiatives, and antibiotic overuse. In August, the DUR Board reviewed Medicaid performance of pharmacy outcome measures for high dose opioids, concurrent use of benzodiazepines and opioids, and continuation of medication treatment for opioid use disorder. In September, the DUR Board will evaluate the use of antipsychotic medications in pediatric Medicaid recipients. Meeting minutes are posted on the Utah Medicaid website and can be found at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board.

P&T Committee

The Pharmacy and Therapeutics (P&T) Committee reviewed cytokine modulators and gene therapy for spinal muscular atrophy at the quarterly meeting. Minutes for P&T Committee meetings can be found at https://medicaid.utah.gov/pharmacy/pt-committee.

Preferred Drug List

Based on recommendations from the P&T Committee, therapies for spinal muscular atrophy have been added to the preferred drug list as a new class effective October 1, 2019.

3 Month Supply List

Effective October 1, 2019, Utah Medicaid will update the 3 Month Supply List (previously known as the 90-Day Supply list). New additions will be highlighted. The following drugs will be deleted from the list and no longer eligible for three month fills: sennosides, sennosides/docusate, amitriptyline, baclofen, diclofenac Na DR, ibuprofen, imipramine HCl, meloxicam, naproxen.

The 3 Month Supply List can be found at https://medicaid.utah.gov/pharmacy/resource-library.

19-97 Personal Care Services Manual Updated

In addition to minor technical and grammatical changes, the *Utah Medicaid Provider Manual for Personal Care Services* has been updated. Below is a list of the clarifications since July 1, 2019.

- ***Chapter 1-2 Fee For Service or Managed Care*** has been updated to include policy that is currently found in the Section 1: General Provider Manual.

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

19-98 Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services Updates

In Chapter 2-9, Nurse Medication Management, the definition of CPT code 96372 has been updated to match the CPT definition.

In Chapter 1-3, Behavioral Health Delivery System, the table has been updated to show Healthy U Behavioral as the new Prepaid Mental Health Plan (PMHP) in Summit County. This change was effective September 1, 2019. The link for accessing PMHP contact information has also been added.

In Chapter 5, PRIOR AUTHORIZATION POLICIES and PROCEDURES FOR LICENSED SUBSTANCE USE DISORDER RESIDENTIAL TREATMENT PROGRAMS, the timeline under Clinical PA Request, 2 a., has been changed to 14 days to align with the ASAM assessment timeline for ASAM level of care 3.5.

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

19-99 Attention: Prepaid Mental Health Plans (PMHPs)

Effective September 1, 2019, the PMHP waiver has been amended to allow provision of 1915(b)(3) services to PMHP enrollees receiving services for substance use disorders only. In Chapter 3, of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*, under Exceptions, the third exception has been removed.

19-100 Nursing Facilities Required to Complete Assessment

Medicaid enrolled nursing facility providers are required to complete the MDS (Minimum Data Set) Optional State Assessment (OSA) beginning October 1, 2019. The OSA is a standalone assessment and cannot be combined with any other type of assessment.

After October 1, the OSA must be completed in addition to any Federal OBRA type of MDS assessment. Specifically, if section A0310 A of the MDS is coded 01 – 06 and A0310 B is coded 99 then an OSA must be

completed for Utah. For the OSA to be correctly included in the case mix calculations for Medicaid, section A0300 A must be coded “1. Yes” and A0300 B must be coded “5. Other payment assessment”.

Questions related to completing the OSA should be directed to the State Resident Assessment Instrument (RAI) Coordinator, Erin Lloyd, at erinlloyd@utah.gov.

19-101 Durable Medical Equipment

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

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

The table has been updated noting the following changes:

Table A

Coverage of equipment in Column 1 (base equipment) includes any item in Column II (add on equipment). Equipment in Column II that is medically necessary must be provided to the member at the time of initial issue of equipment found in Column I. For equipment not identified within the table, use the standard process for requesting wheelchair related items.

Column I	**Column II**
Manual Wheelchair E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007	E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2224, E2225, E2226, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072, K0077
Power Wheelchair Group 2 K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098

Power Wheelchair Groups 3 & 5 K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0858, K0860, K0861, K0862, K0863, K0864, K0890, K0891	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098
Adjustable height, detachable armrest, complete assembly E0973	K0017, K0018, K0019
Tray E0950	E1028
Foot box, any type, includes attachment and mounting hardware, E0954	E1028
Elevating legrest, complete assembly E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline seating systems E1002, E1003, E1004, E1005, E1006, E1007, E1008	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
Leg elevating systems E1009, E1010, E1012	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
Sip and puff E2325	E1028
Residual limb support system E1020	E1028
Leg strap, H style K0039	K0038
Footrest, complete assembly, replacement only K0045	K0043, K0044
Elevating leg rest, lower extension tube, replacement only K0046	K0043
Elevating leg rest, upper hanger bracket, replacement only K0047	K0044
Elevating footrests, articulating (telescoping) K0053	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047
Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only K0069	E2220, E2224
Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only K0070	E2211, E2212, E2224
Front caster assembly, complete, with pneumatic tire, replacement only K0071	E2214, E2215, E2225, E2226
Front caster assembly, complete, with semi-pneumatic tire, replacement only K0072	E2219, E2225, E2226
Front caster assembly, complete, with solid tire, replacement only K0077	E2221, E2222, E2225, E2226

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

19-102 Eligibility Lookup Tool Update

Beginning late October 2019, an updated version of the Eligibility Lookup Tool will be available. The design of the tool has been improved to enhance the user experience. As part of the update, providers will be able to view more detailed information regarding a member's eligibility without having to return to the form and submit another query.

In addition, a calendar tool has been added which displays the member's coverage over a three-year period. Providers will also have the ability to select a date on the calendar for a more comprehensive look at the eligibility for that date. When a date is selected, the results section will update automatically with the new coverage information. With these changes, it is expected that the improved tool will further support Utah's Medicaid providers.