UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

January 2020

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20-01 Changes and Updates to PRISM Provider Enrollment Coming in Summer of 2020

What is changing?

In Summer of 2020, the PRISM system will be updated to include:

- Changes to the business process wizard steps. The business process wizard steps guide providers through all the necessary steps to complete the enrollment process. Providers will see a change to the sequence of steps or types of questions asked.
- The auto generation of letters to providers when it is time to complete the re-validation/re-credential process and when a provider's professional license expires. This will require that providers keep their information current to ensure letters are sent to the right location and/or sent at the right time when a license expires.
- Changes to the re-enrollment process for providers. To re-enroll, providers will need to contact the Provider Enrollment Team. Additional instructions will be coming on what is needed to complete the re-enrollment process.

We are working on training manuals, user guides, and other resources such as frequently ask questions to ensure providers have the necessary information to navigate the upcoming changes.

How will the PRISM changes impact CURRENT providers?

Enrollment records will be migrated to the updated PRISM system prior to Summer 2020. A letter will go out with instructions on how to log in to validate if your migrated information is correct and make any necessary modifications to your PRISM information.

How will the PRISM changes impact NEW providers?

For new providers, there will be a period prior to Summer 2020 where new providers will not be able to submit enrollment applications. The freeze allows for the migration of enrollment information for current providers. Freeze dates will be communicated in advance.

In Summer of 2020, I will be a newly enrolling provider and will want to provide service as a fee for service and as a managed care network provider, what will I need to do in PRISM?

In PRISM, if you choose the "individual/sole proprietor" and sub selection of "regular individual sole proprietor," then you can bill either fee for service or managed care, providing you are paneled with a managed care organization.

If you are enrolling as a provider and would like to participate as a managed care network only provider, please select "individual/sole proprietor" and the sub selection of "managed care network provider only" in PRISM.

Step by step instructions will be available on the Medicaid website in the Summer of 2020 to help you make the right selection.

Why is it important to update my provider addresses in PRISM?

It is important to update your provider addresses in PRISM so that you receive all of the critical correspondence that the Utah Department of Health's Medicaid program sends to you about your provider account.

The "Mailing" address of your base location will get mail with information about enrollment approvals, re-credentialing, re-enrollment, and additional information as needed. Mailing addresses for additional servicing locations will not receive any mail from Medicaid.

For instructions on how to update your provider addresses in PRISM, refer to the document entitled "Tips and Tricks: Address Validation within PRISM" under the User Guides section at: https://medicaid.utah.gov/prism-faq

In what situations will my provider enrollment auto close?

Starting Summer 2020, your Medicaid provider enrollment will auto close if:

- You do not complete the re-validation process
- Your professional license and/or CLIA license expires
- Vital records show you are deceased

Please be sure to complete the re-validation process in a timely manner. Also, please keep your license information current to avoid an auto closure on your enrollment. License information includes your provider type, provider specialty, and end dates for your license. Watch for letters from Medicaid to ensure that you respond timely to all requested information and actions from Medicaid.

Why is it important to have back up administrators?

It is highly recommended for you to have one or more back up administrators to the PRISM system. This is not a change from what you would do today. This will also apply to the updated PRISM system in Summer 2020. If you only have one individual assigned and that administrator is unable to perform their duties or if the administrator leaves, you may encounter significant delays in your ability to update any domain associated to that administrator's account. This is because a new administrator will need to be approved to obtain that ability.

If you are a domain administrator, you are responsible for the following:

- Adding administrators for that domain, as well as regular users that belong to your facility or organization.
- Maintaining the User Access Agreements (UAA's) for your group. The Utah Department of Health will maintain the UAA for the first domain administrator only.

Additional information on how to approve additional users will be located in the provider user manual online.

Is it too late for me to help test the changes to PRISM coming in Summer 2020?

No, it is not too late to participate in testing the changes to PRISM. Any participation you can offer will be highly beneficial to you and to the implementation of the PRISM system. We will begin provider testing in February through March 2020 for the changes to PRISM. Providers or administrative staff working with providers interested in participating in system testing with the PRISM project, are invited to send an email to prism@utah.gov with their contact information. We will respond to your email to coordinate testing.

Training on PRISM Changes

As a reminder, eLearning training modules will be available on the PRISM website at go-live: https://medicaid.utah.gov/prism-provider-training. These modules will cover new enrollment and PRISM changes.

How can I participate in the Promoting Interoperability/Meaningful Use Program?

The Utah Promoting Interoperability Program (formerly known as Meaningful Use Incentive Program) will accept 2019 attestations January 1, 2020, through June 30, 2020. Providers are encouraged to submit their attestations as early as possible to avoid any delays due to PRISM access issues. We will process 2019 payments on an accelerated timeline in the order they are received. You will receive a system-generated email when you are able to attest for Program Year 2019.

Please call the program hotline at (801) 538-6929, or email us at ehrincentive@utah.gov with further questions.

20-02 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.

20-03 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.

20-04 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.

20-05 Billing Medicaid and Record Retention

The following and additional information 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 and 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

20-06 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.

20-07 Primary Care Network (PCN)

As of April 1, 2019, all Primary Care Network (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.

20-08 Q Codes Opened for Specific Providers

The following codes are open to provider types 01, 55, and 91:

Q4100 Skin substitute, not otherwise specified
Q4101 Apligraf, per sq cm
Q4102 Oasis wound matrix, per sq cm
Q4103 Oasis burn matrix, per sq cm
Q4104 Integra bilayer matrix wound dressing (BMWD), per sq cm
Q4105 Integra dermal regeneration template (DRT) or Integra Omnigraft dermal regeneration matrix, per sq cm
Q4106 Dermagraft, per sq cm
Q4107 GRAFTJACKET, per sq cm
Q4108 Integra matrix, per sq cm
Q4110 PriMatrix, per sq cm
Q4112 Cymetra, injectable, 1 cc
Q4113 GRAFTJACKET XPRESS, injectable, 1 cc
Q4114 Integra flowable wound matrix, injectable, 1 cc
Q4115 AlloSkin, per sq cm

Q4116 AlloDerm, per sq cm
Q4117 HYALOMATRIX, per sq cm
Q4118 MatriStem micromatrix, 1 mg
Q4121 TheraSkin, per sq cm
Q4122 DermACELL, DermACELL AWM or DermACELL AWM Porous, per sq cm
Q4123 AlloSkin RT, per sq cm
Q4124 OASIS ultra tri-layer wound matrix, per sq cm
Q4125 ArthroFlex, per sq cm
Q4126 MemoDerm, DermaSpan, TranZgraft or IntéguPly, per sq cm
Q4127 Talymed, per sq cm
Q4128 FlexHD, AllopatchHD, or Matrix HD, per sq cm
Q4130 Strattice TM, per sq cm
Q4132 Grafix Core and GrafixPL Core, per sq cm
Q4133 Grafix PRIME, GrafixPL PRIME, Stravix and StravixPL, per sq cm
Q4134 HMatrix, per sq cm
Q4135 Mediskin, per sq cm
Q4136 E-Z Derm, per sq cm
Q4137 AmnioExcel, AmnioExcel Plus or BioDExcel, per sq cm
Q4138 BioDFence DryFlex, per sq cm
Q4139 AmnioMatrix or BioDMatrix, injectable, 1 cc
Q4140 BioDFence, per sq cm
Q4141 AlloSkin AC, per sq cm
Q4142 XCM biologic tissue matrix, per sq cm
Q4143 Repriza, per sq cm
Q4145 EpiFix, injectable, 1 mg
Q4146 Tensix, per sq cm
Q4147 Architect, Architect PX, or Architect FX, extracellular matrix, per sq cm
Q4148 Neox Cord 1K, Neox Cord RT, or Clarix Cord 1K, per sq cm
Q4149 Excellagen, 0.1 cc
Q4150 AlloWrap DS or dry, per sq cm
Q4151 AmnioBand or Guardian, per sq cm
Q4152 DermaPure, per sq cm
Q4153 Dermavest and Plurivest, per sq cm
Q4154 Biovance, per sq cm
Q4155 Neox Flo or Clarix Flo 1 mg
Q4156 Neox 100 or Clarix 100, per sq cm
Q4157 Revitalon, per sq cm
Q4158 Kerecis Omega3, per sq cm
Q4159 Affinity, per sq cm
Q4160 Nushield, per sq cm
Q4161 Bio-ConneKt wound matrix, per sq cm
Q4162 WoundEx Flow, BioSkin Flow, 0.5 cc
Q4163 WoundEx, BioSkin, per sq cm
Q4164 Helicoll, per sq cm

Q4165 Keramatrix or Kerasorb, per sq cm
Q4166 Cytal, per sq cm
Q4167 Truskin, per sq cm
Q4168 AmnioBand, 1 mg
Q4169 Artacent wound, per sq cm
Q4170 Cygnus, per sq cm
Q4171 Interfyl, 1 mg
Q4173 PalinGen or PalinGen XPlus, per sq cm
Q4174 PalinGen or ProMatrX, 0.36 mg per 0.25 cc
Q4175 Miroderm, per sq cm
Q4176 NeoPatch, per sq cm
Q4177 FlowerAmnioFlo, 0.1 cc
Q4178 FlowerAmnioPatch, per sq cm
Q4179 FlowerDerm, per sq cm
Q4180 Revita, per sq cm
Q4181 Amnio Wound, per sq cm
Q4182 Transcyte, per sq cm
Q4183 Surgigraft, per sq cm
Q4184 Cellesta or Cellesta Duo, per sq cm
Q4185 Cellesta Flowable Amnion (25 mg per cc); per 0.5 cc
Q4186 Epifix, per sq cm
Q4187 Epicord, per sq cm
Q4188 AmnioArmor, per sq cm
Q4189 Artacent AC, 1 mg
Q4190 Artacent AC, per sq cm
Q4191 Restorigin, per sq cm
Q4192 Restorigin, 1 cc
Q4193 Coll-e-Derm, per sq cm
Q4194 Novachor, per sq cm
Q4197 PuraPly XT, per sq cm
Q4198 Genesis Amniotic Membrane, per sq cm
Q4200 SkinTE, per sq cm
Q4201 Matrion, per sq cm
Q4202 Keroxx (2.5 g/cc), 1 cc
Q4203 Derma-Gide, per sq cm
Q4204 XWRAP, per sq cm
Q4205 Membrane Graft or Membrane Wrap, per sq cm
Q4206 Fluid Flow or Fluid GF, 1 cc
Q4208 Novafix, per sq cm
Q4209 SurGraft, per sq cm
Q4210 Axolotl Graft or Axolotl DualGraft, per sq cm
Q4211 Amnion Bio or AxoBioMembrane, per sq cm
Q4212 AlloGen, per cc
Q4213 Ascent, 0.5 mg

Q4214 Cellesta Cord, per sq cm
Q4215 Axolotl Ambient or Axolotl Cryo, 0.1 mg
Q4216 Artacent Cord, per sq cm
Q4217 WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound Xplus, per sq cm
Q4218 SurgiCORD, per sq cm
Q4219 SurgiGRAFT-DUAL, per sq cm
Q4220 BellaCell HD or Surederm, per sq cm
Q4221 Amnio Wrap2, per sq cm
Q4222 ProgenaMatrix, per sq cm
Q4226 MyOwn Skin, includes harvesting and preparation procedures, per sq cm

20-09 Genetic Testing

The genetic testing policy was updated July 1, 2019. Providers are encouraged to review the updated policy noting:

Non-covered services:

- Experimental and/or investigational
- Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2. Newborn Hearing Screening), including:
    - preimplantation genetic diagnosis (PGD); or
    - prenatal genetic screening; or
    - in the absence of signs and/or symptoms
- Tests, for the member or family members, performed solely for the purposes of genetic counseling, family planning, or health screening
- Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
- Direct-to-consumer (DTC) genetic tests
- Tests of a member's germline DNA done to benefit family member(s), rather than to benefit the member being tested
- Establishment of paternity
- Genetic testing is considered not medically necessary when performed entirely for nonmedical reasons (e.g., a general interest in genetic test results)

Due to the non-covered services language, CPT 81507 (Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy) has been closed.

20-10 Transportation Services Provider Manual Updated

The Medical Transportation Services Provider Manual has been updated. Providers are encouraged to become familiar with updates noting:

- Chapter 12 *Lodging and Meal Per Diem Associated with Out-of-State Transportation* has been changed to Chapter 12 *Out-of-State Transportation*. Information within the chapter continues to include coverage of travel expenses. Requirements for prior-authorizations have been added, as well as links to additional resources.

20-11 Dental, Oral, Maxillofacial, and Orthodontia Services Provider Manual Updated

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

8.2 Prosthodontics

Dental prophylaxis services are available for eligible members' dentures through standard preventive CDT codes D1110 *prophylaxis – adult*, and D1120 *prophylaxis – child*. Services may be provided by any enrolled Medicaid dental provider. All other denture services require written prior authorization.

20-12 CPT Code Updates

Closed Code

81507 Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy

Prior Authorization Removed

91110 Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report

Codes Open Without Prior Authorization

30465 Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
91111 Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report
91112 Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

2020 New Open Codes

15769 Grfg autol soft tiss dir exc
20700 Mnl prep&insj dp rx dlvr dev
20701 Rmvl deep rx delivery device
20702 Mnl prep&insj imed rx dev
20703 Rmvl imed rx delivery device
20704 Mnl prep&insj i-artic rx dev
20705 Rmvl i-artic rx delivery dev
21601 Exc chest wall tumor w/ribs
21602 Exc ch wal tum w/o lymphadec
21603 Exc ch wal tum w/lymphadec
33016 Pericardiocentesis w/imaging
33017 Prcrd drg 6yr+ w/o cgen car
33018 Prcrd drg 0-5yr or w/anomly
33019 Perq prcrd drg insj cath ct
33858 As-aort grf f/aortic dsj
33859 As-aort grf f/ds oth/thn dsj
33871 Transvrs a-arch grf hypthrm
34717 Evasc rpr a-iliac ndgft
34718 Evasc rpr n/a a-iliac ndgft
35702 Expl n/flwd surg uxtr art
35703 Expl n/flwd surg lxtr art
46948 Int hrhc tranal dartlzj 2+
49013 Prpertl pel pack hemrrg trma

49014 Reexploration pelvic wound
62328 Dx lmbr spi pnxr w/fluor/ct
62329 Ther spi pnxr csf fluor/ct
64451 Njx aa&/strd nrv nrvtg si jt
64454 Njx aa&/strd gnclr nrv brnch
64624 Dstrj nulyt agt gnclr nrv
64625 Rf abltj nrv nrvtg si jt
66987 Xcapsl ctrc rmvl cplx w/ecp
66988 Xcapsl ctrc rmvl w/ecp
74221 X-ray xm esophagus 2cntrst
74248 X-ray sm int f-thru std
78429 Myocrd img pet 1 std w/ct
78430 Myocrd img pet rst/strs w/ct
78431 Myocrd img pet rst&strs ct
78432 Myocrd img pet 2rtracer
78433 Myocrd img pet 2rtracer ct
78434 Aqmbf pet rest & rx stress
78830 Rp loclzj tum spect w/ct 1
78831 Rp loclzj tum spect 2 areas
78832 Rp loclzj tum spect w/ct 2
78835 Rp quan meas single area
80145 Drug assay adalimumab
80187 Drug assay posaconazole
80230 Drug assay infliximab
80235 Drug assay lacosamide
80280 Drug assay vedolizumab
80285 Drug assay voriconazole
81522 Onc breast mrna 12 genes
81542 Onc prostate mrna 22 cnt gen
81552 Onc uveal mlnma mrna 15 gene
87563 M. genitalium amp probe
90378 Rsv mab im 50mg
90694 Vacc aiiv4 no prsrv 0.5ml im
92201 Opscpy extnd rta draw uni/bi
92202 Opscpy extnd on/mac draw
92274 Multifocal erg w/i&r
92549 Cdp-sot 6 cond w/i&r mct&adt
93356 Myocrd strain img spckl trck
93985 Dup-scan hemo compl bi std
93986 Dup-scan hemo compl uni std
95700 Eeg cont rec w/vid eeg tech
95705 Eeg w/o vid 2-12 hr unmntr
95706 Eeg wo vid 2-12hr intmt mntr
95707 Eeg w/o vid 2-12hr cont mntr

95708 Eeg wo vid ea 12-26hr unmntr
95709 Eeg w/o vid ea 12-26hr intmt
95710 Eeg w/o vid ea 12-26hr cont
95711 Veeg 2-12 hr unmonitored
95712 Veeg 2-12 hr intmt mntr
95713 Veeg 2-12 hr cont mntr
95714 Veeg ea 12-26 hr unmntr
95715 Veeg ea 12-26hr intmt mntr
95716 Veeg ea 12-26hr cont mntr
95717 Eeg phys/qhp 2-12 hr w/o vid
95718 Eeg phys/qhp 2-12 hr w/veeg
95719 Eeg phys/qhp ea incr w/o vid
95720 Eeg phy/qhp ea incr w/veeg
95721 Eeg phy/qhp>36<60 hr w/o vid
95722 Eeg phy/qhp>36<60 hr w/veeg
95723 Eeg phy/qhp>60<84 hr w/o vid
95724 Eeg phy/qhp>60<84 hr w/veeg
95725 Eeg phy/qhp>84 hr w/o vid
95726 Eeg phy/qhp>84 hr w/veeg
96156 Hlth bhv assmt/reassessment
96158 Hlth bhv ivntj indiv 1st 30
96159 Hlth bhv ivntj indiv ea addl
96164 Hlth bhv ivntj grp 1st 30
96165 Hlth bhv ivntj grp ea addl
96167 Hlth bhv ivntj fam 1st 30
96168 Hlth bhv ivntj fam ea addl
96170 Hlth bhv ivntj fam wo pt 1st
96171 Hlth bhv ivntj fam w/o pt ea
D1551 Recement space maint - max
D1552 Recement space maint - man
D1553 Recement unilat space maint
D7922 Place intra-socket bio dress
D8703 Replace broken retainer max
D8704 Replace broken retainer man
E0467 Home vent multi-function

20-13 Durable Medical Equipment (DME) Provider Manual Updated

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

- The policy related to the "Wheelchair Final Evaluation From" has been updated
    - Required for claims related to power wheelchairs, ultra-lightweight wheelchairs, and manual wheelchairs equipped with tilt in space
        - When a claim is submitted without a properly executed Wheelchair Final Evaluation Form, the entire claim will be denied
        - For claims submission the provider must fax this form to (801) 536-0481
    - Completion of the form must be within 10 business days from the date of delivery
    - Forms that contain a checkbox marked as "NO" or an unanswered question will be denied as incomplete
    - A caregiver is permitted to sign the form when the member is incapable of signing for themselves due to medical related reasons
        - A caregiver is any persons working or living with the member in their place of residence while providing assistance with ADLs or MRADLs and ongoing care
        - A caregiver is not:
            - an evaluating therapist
            - an evaluating or ordering provider
            - an ATP
            - a vendor delivering the equipment
            - any person whose signature is used elsewhere on the form

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

20-14 Coding Change for Outpatient Hospital-Based Clinics (Facility)

Since July 1, 2010, outpatient hospital-based clinics have been eligible to receive reimbursement to the facility for evaluation and management (E&M) codes. Originally, the CPT codes used were 99201-99205 and 99211-99215. Since January 1, 2014, OPPS reimburses only one code, G0463, instead of the various E&M codes noted above.

Hospital-based clinics are defined as those clinics having an approval letter from CMS designating them as meeting the policy requirements for provider-based designation as described in 42 CFR 413.65. Providers having such an approval letter may submit documentation to the attention of the Reimbursement Unit Manager at BCRPAdmin@utah.gov for review. Upon review of submitted documentation, a hospital-based clinic will only be added to receive the E&M reimbursement prospectively from a date no earlier than the complete documentation was received by the Reimbursement Unit Manager.

Payments for these services will be through the usual claims process for outpatient hospital services.

20-15 Pharmacy Program Policy Updates

Antipsychotic Use in Pediatric Medicaid Recipients

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 January 1, 2020, Utah Medicaid will implement a new policy to monitor and manage AP medications prescribed to members 19 years of age and younger. Limits for these medications can be found in the Drug Criteria Limits document located in the Pharmacy Resource Library.

The UDOH will perform 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. Careful and frequent monitoring of AP-related side effects

    i. Metabolic screening
    ii. Body Mass Index, weight gain
    iii. Assessments for movement disorders

d. Use of multiple concurrent AP

System edits will be enacted to promote the safe and appropriate use, including:

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.

3. A prior authorization will be required for all antipsychotic medications prescribed for children under 6 years of age.

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.

Drug Utilization Review Board Updates

The Drug Utilization and Review (DUR) Board met in October to discuss brexanolone (Zulresso) for the treatment of post-partum depression. Prior authorization criteria was developed in conjunction with Board recommendations. In addition, a new DUR Board Chair was nominated. In November, the DUR Board reviewed Medicaid's multi-step intervention for addressing antipsychotic use in children. The December DUR meeting is cancelled. DUR Board minutes can be found at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board.

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, 2020, as part of the annual PDL review process.

Pharmacy and Therapeutics Committee Updates

The Pharmacy and Therapeutics (P&T) Committee recently reviewed cytokine modulators and treatments for muscular sclerosis.

Pharmacy Prior Authorization Updates

Effective January 1, 2020, prior authorization updates will occur for both Suboxone and Hepatitis C medications. First, branded Suboxone sublingual films will no longer require a prior authorization. This change aligns with SUPPORT Act recommendations and department goals for greater access to treatment for opioid use disorders. Other oral buprenorphine and buprenorphine/naloxone products used for opioid use disorders will continue to require a prior authorization. Second, preferred pan-genotypic treatments for hepatitis C no longer require genotype testing, and these agents no longer require prescribing by or in consultation with a specialist.

The following prior authorizations have been added to the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/prior-authorization:

- Zolgensma criteria developed
- Fluocinolone acetonide, intravitreal implant criteria developed
- Zulresso criteria developed
- Antipsychotic medications in children

Utah Medicaid Hemophilia Program Updates

Utah Medicaid supports member centric, high touch care coordination to facilitate comprehensive care management for Medicaid members with hemophilia. Effective January 1, 2020, hemophilia care management services is transitioned to the ACO care management teams; fee for service members will receive care management from the Medicaid pharmacy team. Pharmacy reimbursement for hemophilia blood factor will remain carved out to fee for service. Dispensing fee for factor will be $716.54 for clotting factor and will adjudicate according to R414-60-7; Utah Medicaid will pay one dispensing fee per twenty-four days, per medication, per Medicaid member per pharmacy (NPI). Claims for the same medication for a Medicaid member at the same pharmacy filled more frequently will pay without an additional dispensing fee. Any willing pharmacy provider will be reimbursed a dispensing fee for factor as defined in the Utah State Plan ATTACHMENT 4.19-B https://medicaid.utah.gov/stplan/.

Biologic Medications and Substitution of Biosimilars

A biosimilar is a biologic product that is highly similar to the U.S. Food & Drug Administration (FDA) approved biologic, known as reference product or parent product. In order to be FDA-approved as a biosimilar, the product must have the following: same mechanism of action, dosage form, strength, and route of administration as the reference product. Also, a biosimilar must have no clinically meaningful differences in terms of safety, purity, and potency when compared to the parent product.

Additional requirements must be met in order for a biologic to be titled as an interchangeable biosimilar. These requirements include not only showing that the product is expected to produce the same clinical result as the reference product in any given patient, but also that switching back and forth between the parent biologic product and the biosimilar causes the patient no additional risks in terms of safety or diminished efficacy as using only the reference product.

The key difference between a biosimilar and an interchangeable biosimilar is that the interchangeable biosimilar can be substituted for the reference product by the dispensing pharmacist without prescriber involvement.

The FDA publishes the "Purple Book" (https://www.fda.gov/drugs/therapeutic-biologics-applications-bla/purple-book-lists-licensed-biological-products-reference-product-exclusivity-and-biosimilarity-or) that lists FDA-approved biological products, which includes biosimilars and interchangeable biosimilars. This publication serves as a reference to healthcare providers to determine which biological products are FDA approved as reference products, biosimilars, or interchangeable biosimilars. Currently, there are 23 biosimilars and zero interchangeable biosimilars.

Utah Medicaid will continue to use the FDA "Purple Book" as a reference and unless otherwise limited through the prior authorization process, the State will not mandate interchange of biosimilars unless they are listed as interchangeable.

Opioid Policy Changes to Reduce High-Dose Opioids

Effective January 1, 2020, the cumulative daily morphine equivalent dose (MED) threshold for "opioid experienced" individuals (patients receiving an opioid within the last 90 days of 2018) will be reduced from 150 MED to 120 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. A daily threshold of 90 MED for all other patients ("opioid naïve") individuals will continue.

20-16 Updates to the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services

In Chapter 1-2, *Definitions*, a definition of integrated care plans has been added.

In Chapter 1-3, *Medicaid Behavioral Health Service Delivery System,* the following revisions have been made:

Information about the table contained in this section has been revised for clarity.

In the *Additional Provider Options* section, clarification has been made regarding provision of services by Indian health care providers to better align with federal regulation.

In the *Exceptions to Prepaid Mental Health Plan Enrollment* section, a new *Adult Expansion Medicaid Members* section has been added.

Effective January 1, 2020, Adult Expansion Medicaid members residing in Davis, Salt Lake, Utah, Washington, and Weber counties will be enrolled in integrated care plans. Integrated care plans cover both physical and behavioral health (mental health and substance use disorders) services. Integrated care plans are Health Choice, Healthy U, Molina, and SelectHealth.

Adult Expansion Medicaid members living in other counties are enrolled in the Prepaid Mental Health Plan (PMHP) serving their county of residence according to the table contained in this Chapter 1-3.

To verify a Medicaid member's managed care plan enrollment, please visit Medicaid's Eligibility Lookup Tool.

Please note that if before January 1, 2020, Medicaid issued prior authorization to a substance use disorder residential treatment program for an Adult Expansion Medicaid member, the program must obtain subsequent prior authorizations (as applicable) from the member's PMHP or integrated care plan.

In Chapter 1-5, Provider Qualifications, a minor revision has been made to Section A, *Providers Qualified to Prescribe Behavioral Health Services,* in A.1 to use the exact wording from the Mental Health Practice Act.

In this same section, a minor revision has been made in A.1.f regarding advanced practice registered nurses (APRN) to use the exact wording from the Nurse Practice Act. The same revision has been made throughout the manual as applicable.

In this same section, in B.2.b, "working within the scope of the Nurse Practice Act and competency", has been added to align with existing provisions throughout the manual.

In Chapter 2-5, *Psychotherapy*, in the *Limits* sections under 'Group psychotherapy and multi-family group psychotherapy', and in Chapter 2-10, *Therapeutic Behavioral Services*, in the *Limits* section, the number of families in attendance have been updated.

In Chapter 2–13, *Substance Use Disorder (SUD) Treatment in Licensed SUD Residential Treatment Programs*, in the *Limits* section and the *Prior Authorization* section, references to integrate care plans have also been added.

Providers can access the revised provider manual and the Eligibility Lookup Tool at https://medicaid.utah.gov.

20-17 Mental Health and Substance Use Disorder Fee Schedule Revision

Effective for dates of service on or after January 1, 2020, the mental health and substance use disorder (SUD) fee schedule for mental health and SUD providers has been updated for procedure code T1001, which is used for mental health/SUD nurse medication management services. When the mental health/SUD fee schedule was updated effective April 1, 2019, an incorrect base fee was used to determine the increase for this code.

Mental health and SUD providers can access the mental health and SUD fee schedule using the Coverage and Reimbursement Lookup Tool.

20-18 Accountable Care Organization (ACO) Service Area Update

Effective January 1, 2020, the Steward Health Choice Utah ACO plan will be available statewide to all voluntary and mandatory enrollment counties. With this change, each of the four ACO plans are available statewide, to eligible Medicaid members as an enrollment option. 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, 2020, is listed in the table on the following page:

ACO Health Plans and Fee-for-Service					
County	**Health Choice Utah** 1-877-358-8797 stewardhealthchoiceut.org	**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) Network** 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 purple-highlighted counties must have a health plan. Other members can choose a health plan or use FFS.
Call a Health Program Representative (HPR) at 1-866-608-9422 to make your plan choice.
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