UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Information Bulletin

July 2020

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20-56 Provider Enrollment Automatic Closures

Utah Medicaid would like to direct your attention to the Utah Administrative Rule R414-23-4 that went into effect January 2020. The rule will have greater consequence to providers for failure to revalidate with Medicaid in accordance with federal regulations.

Providers can access the rule here: https://rules.utah.gov/publicat/code/r414/r414-23.htm

Please be advised that providers will be closed for the following reasons:

1. Failure to revalidate within the required three or five year cycle as directed by 42 CF 424.515;
    - Providers will receive notification 90 days prior to the expiration of the validation cycle via USPS to the mailing address on file for the provider notifying them that it is time to revalidate. A second notice will be sent at 30 days if the revalidation has not been started. A termination letter will be generated at the completion of the 90-day validation cycle if the provider has not completed the revalidation.
2. Expiration of professional license, or expiration of any license associated with the program for Clinical Laboratory Improvement Amendments (CLIA);
    - Providers will receive notification 45 days prior to their license expiring via USPS to the mailing address on file for the provider as a reminder of license expiry. License dates as well as a copy of the updated license will need to be submitted as a modification in PRISM. If a modification is not submitted prior to the license expiring a termination letter will be generated.
3. Upon state or federal reporting of a deceased provider; or
4. Failure to bill Medicaid for one or more years without notice.

If you have questions about this policy, please contact the Provider Enrollment Team at (801) 538-6155, option 3, then option 4, or via email at providerenroll@utah.gov.

20-57 Additional 1135 Waiver Approvals from CMS

The Centers for Medicare & Medicaid Services (CMS) granted initial approval to the State of Utah for multiple section 1135 flexibilities on April 10, 2020. On June 12, 2020, CMS granted an additional round of approvals for requests related to Medicaid and CHIP to be effective retroactively to March 1, 2020 and will end upon termination of the public health emergency, including any extensions.

The approvals from June 12 include the following:

- Extension of state fair hearing requests and appeal timelines
- Public notice requirements applicable to the state plan amendment (SPA) submission process
- Settings requirements for specific settings that apply to Home and Community Based Services waiver programs (HCBS waivers)

- Conflict of interest requirements under the HCBS State Plan and Waiver Authorities
- Requirement to obtain beneficiary and provider signatures of HCBS Person-Centered Service Plan
- 1905(a)(7) Home Health State Plan Services face-to-face timeframes

More details may be found on the Medicaid website.

1135 Waiver Approval State of Utah June 20, 2020

To streamline the section 1135 waiver request and approval process, CMS issued a number of blanket waivers for many Medicare provisions, which primarily affect requirements for individual facilities, such as hospitals, long term care facilities, home health agencies, and so on. Waiver or modification of these provisions does not require individualized approval, and, therefore, these authorities are not addressed in the approval letter. Most of these extend to Medicaid and CHIP as well. Please reach out to krisannbacon@utah.gov for questions concerning the 1135 waivers.

Please refer to the current blanket waiver issued by CMS that can be found at:

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/currentemergencies/coronavirus-waivers.

CMS and the State of Utah will continue to work on the additional waiver or modification requests, as needed, that are not currently reflected in the recent approvals from April 10 and June 12.

1135 Waivers-At-A-Glance

20-58 Telehealth Services Update

Section I: General Information Provider Manual Update - Telehealth

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

8-4.2 Telehealth

- Definitions have been updated
- Billing requirements have been clarified
- Covered services have been expanded to include Teledentistry

Telehealth Services Update

Utah Administrative Rule R414-42, Telehealth has been updated.

Medical Policy Code Updates

Effective July 1, 2020, several medical policy programs have coverage updates. Specific code coverage may be found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

20-59 Medicaid Provider Directory

Due to the COVID-19 response effort, Utah Medicaid has delayed releasing the Medicaid Provider Directory. The new online tool is intended to help Medicaid members find different providers, specialists, and clinics. More details will follow in the near future.

20-60 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.

20-61 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.

20-62 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 up on request)

- Allow for reasonable inspection and audit of financial or member records for non-Medicaid member**s to the extent necessary to verify usual and customary expenses and charges**

20-63 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 Provider Participation and Requirements.

20-64 Closed Podiatry Codes

The following codes are not covered for any provider type:

L3000 Foot insert, removable, molded to patient model, UCB type, Berkeley shell, each

L3001 Foot, insert, removable, molded to patient model, Spenco, each

L3002 Foot insert, removable, molded to patient model, Plastazote or equal, each

L3003 Foot insert, removable, molded to patient model, silicone gel, each

L3010 Foot insert, removable, molded to patient model, longitudinal arch support, each

L3020 Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each

L3030 Foot insert, removable, formed to patient foot, each

L3031 Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each

L3040 Foot, arch support, removable, pre-molded, longitudinal, each

L3050 Foot, arch support, removable, pre-molded, metatarsal, each

L3060 Foot, arch support, removable, pre-molded, longitudinal/metatarsal, each

L3070 Foot, arch support, nonremovable, attached to shoe, longitudinal, each

L3080 Foot, arch support, nonremovable, attached to shoe, metatarsal, each

L3090 Foot, arch support, nonremovable, attached to shoe, longitudinal/metatarsal, each

L3100 Hallus-valgus night dynamic splint, prefabricated, off-the-shelf

20-65 Medical Supplies and DME Policy Updates

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

- Policy requirements related to coverage of wheelchair transit systems have been updated in Chapter 8-14.5 Accessories, Attachments, Components and Options of the *Medical Supplies and Durable Medical Equipment Provider Manual.*
    - Transit systems
        - When a member utilizes personal or public transportation for their transit needs, coverage of this equipment is considered medically necessary
        - Transit systems are not covered for members residing in long-term care facilities or for members who utilize Medicaid non-emergency medical transportation broker as their primary source of transportation

- Prior Authorization Requirements Related to E0445 “Oximeter Device Measure Blood Oxygen Level Non-Invasive” is no longer required until after 30 days of use in a 90-day period and is reviewed for medical necessity using evidence-based criteria.

- The coverage criteria for T5001 “Positioning seat for persons with special orthopedic needs” has been updated. Medical necessity is met when the member meets the following criteria:
    - Member is unable to sit safely in a conventional chair, booster seat, or high chair.
    - Member requires specialized positioning to safely perform essential activities of daily living.
    - Member exhibits significant head and trunk instability and/or weakness, hypotonicity, hypertonicity, athetosis, ataxia, spasticity, muscle spasming which results in uncontrollable movement and position change, absence or latency of protective reactions, inability to maintain an unsupported sitting position independently, or other significant positional needs that cannot be met in the conventional seats listed above.

  Note: These devices are only covered once every three years to account for changes in the member’s size related to growth. If the member requires a new chair prior to the three-year limitation, then a prior authorization must be acquired before providing a new chair.

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

20-66 Pharmacy Benefit Manager

Utah Medicaid ACO Pharmacy Billing Information

Effective July 1, 2020, Healthy U and Steward Health Choice Medicaid plans changed their Pharmacy Benefit Manager (PBM) which results in updates to their billing specifications for pharmacy providers. Pharmacy billing information, effective July 1, 2020, for all Utah plans can be found in the table below.

Utah Medicaid Plan Name	BIN	PCN	Group	Pharmacy Help Desk
Healthy U*	610830	RealRxHU	**	1-855-856-5694
Molina	004336	ADV	RX0415	1-800-364-6331
SelectHealth	800008	606	U1000008	1-855-442-3234
Steward Health Choice*	004336	MCAIDADV	RX3898	1-800-364-6331

* = effective July 1, 2020

** = not required

20-67 Pharmacy Program Updates

Opioid Policy Changes

Effective July 1, 2020, the cumulative daily morphine milligram equivalent (MME) threshold for "opioid experienced" individuals will be reduced from 120 MME to 90 MME, thus aligning all opioid claims to adjudicate at a maximum of 90 MME for the treatment of non-cancer pain.

Utah Medicaid adopted morphine milligram equivalent (MME) methodology on January 1, 2019, 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.

Attention-Deficit / Hyperactivity Disorder (ADHD) Stimulant Medication Age Edits

The Drug Utilization Review (DUR) Board met in February 2020 to review safety and appropriate medication use for Attention-Deficit/Hyperactivity Disorder (ADHD) in the pediatric population and will be aligning its policy with the Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit / Hyperactivity Disorder in Children and Adolescents evidence-based recommendations. Specifically, use of ADHD Stimulant medications are not recommended in very young children, where behavioral interventions are recommended first line.[1] To support the safe and appropriate use of ADHD Stimulant medications, effective July 1, 2020, ADHD Stimulant medications will require a prior authorization when prescribed for children less than 4 years of age, unless otherwise indicated by package labeling.

Reference:

1. Wolraich ML, Hagan JF, Jr., Allan C, et al. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics. 2019;144(4).

Pharmacy Prior Authorization Updates

Pharmacy prior authorizations can be found at: https://medicaid.utah.gov/pharmacy/prior-authorization.

PA Form	Status	Effective Date	Information
ADHD Stimulant Exceptions	New	07/01/20	Inclusion of new ADHD safety edits
Ayvakit (avapritinib)	New	06/08/20	New drug to market
Cialis (tadalafil)	New	05/18/20	Inclusion for Benign prostatic hyperplasia (BPH) usage
HER2 Therapies	New	07/01/20	New form for appropriate medication use
Immunoglobulin	New	07/01/20	May be dispensed through Medical Buy and Bill or through the Point of Sale
Isturisa (osilodostat)	New	07/01/20	New drug to market
leuprolide acetate, subcutaneous	New	07/01/20	Inclusion for multiple indication
Rare Disease Medications	New	07/01/20	New form to address medication use for rare disease
Reyvow (lasmiditan)	New	07/01/20	New drug to market
Rybelsus (semaglutide)	New	07/01/20	New drug to market
Tepezza (teprotumumab)	New	06/09/20	New drug to market
Anti-vascular Endothelial Growth Factor Therapy	Update	07/01/20	Inclusion of medication indication table
Buprenorphine & Buprenorphine/Naloxone	Update	05/18/20	Inclusion of new criteria discussed from April's DUR meeting
Growth Hormone	Update	07/01/20	Inclusion of medication indication table
Lidoderm, ZTlido	Update	06/08/20	Inclusion of ZTlido to prior authorization form

(Lidocaine Topical Patch)			
Medication Coverage Exception	Update	07/01/20	Inclusion of new clarifying information
Opioid and/or Opioid-Benzodiazepine Combinations	Update	07/01/20	Inclusion of concurrent opioid and Opioid Use Disorder criteria
Orilissa (elagolix)	Update	07/01/20	Inclusion of dosing criteria
Pulmonary Arterial Hypertension	Update	06/04/20	Inclusion of Federal Regulation information regarding medication use for sexual dysfunction
Spravato	Update	06/09/20	Inclusion of dosing table for appropriate titration
Synagis (palivizumab)	Update	07/01/20	Inclusion of new package insert information

Drug Utilization Review Board

The Drug Utilization Review (DUR) Board met in April to review opioid use disorder medications. SUPPORT Act requirements were discussed in addition to modifications to the *Oral Buprenorphine & Buprenorphine/Naloxone Products* prior authorization form. After careful deliberation, the following modifications were made: 1) allow certain patient populations to temporarily exceed the maximum buprenorphine daily dose under specific circumstances, 2) allow certain patient populations to receive single ingredient buprenorphine with qualifying diagnoses or temporarily during the induction phase.

The DUR Board met in May for the Spravato (esketamine) prior authorization 9-month review. For further information please visit the DURB Meeting minutes that have been posted on the Utah Medicaid website, https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/.

The DUR Board met in June to review the new oral glucagon-like peptide-1 (GLP-1) agonist, Rybelsus (semaglutide). The Board discussed Rybelsus's place in diabetic therapy and utilization management. The Board also reviewed the new oral abortive migraine therapies calcitonin gene-related peptide (CGRP) receptor antagonist [Ubrelvy (ubrogepant) and Nurtec (rimegepant)] and serotonin-1F receptor agonist [Reyvow (lasmiditan)]. The Board discussed the medication's place in therapy in the acute treatment of migraine with or without aura. DURB Meeting minutes have been posted on the Utah Medicaid website and can be found at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/.

Strengthened FDA Warning for Singulair® (Montelukast) Use

As of March 3, 2020, the Food and Drug Administration (FDA) strengthened the boxed warning for Singulair® (montelukast) and all montelukast generics due to existing warnings about serious behavior and mood-related changes. Although this information was available in the prescribing information prior to March 3rd, the FDA reevaluated the benefits and risks of montelukast use and determined a stronger warning is necessary. Singulair® (montelukast) is FDA approved for asthma and allergies.

It is recommended that Health Professionals do the following:

- Inquire about any patient history of psychiatric illness prior to initiating therapy.
- Inform all patients of the risk of neuropsychiatric events related to montelukast.
- Advise patients to discontinue therapy and contact a health professional immediately if the following occurs: changes in behavior, new neuropsychiatric symptoms, or any suicidal thoughts or behavior occur.
- Monitor and assess all patients treated with montelukast for neuropsychiatric symptoms. FDA has noted that neuropsychiatric symptoms have occurred in patients with and without pre-existing psychiatric health conditions.

If any adverse events do occur, health professionals and patients are encouraged to report these events to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Reference:

1. https://www.fda.gov/safety/medical-product-safety-information/singulair-montelukast-and-all-montelukast-generics-strengthened-boxed-warning-due-restricting-use

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) committee met in May to review Cystic Fibrosis Gene Therapies to consider the addition of this class to the Utah Medicaid Preferred Drug List (PDL) effective July 1, 2020. Note that this meeting had been scheduled for March, but was cancelled due to COVID-19.

The P&T Committee met in June to review abortive therapies for migraines. Updates to the (PDL) based on recommendations from the committee will be made in coming months. The P&T Committee meeting minutes have been posted on the Utah Medicaid website and can be found at https://medicaid.utah.gov/pharmacy/pt-committee/.

Preferred Drug List and Pharmacy Resource Library

Utah Medicaid Preferred Drug List and Pharmacy Manual Attachments including Drug Criteria Limits, 3 Month Supply List, Brand over Generic List, and the OTC Drug List have been combined into a single document which will be located on the Utah Medicaid website under the Pharmacy Resource Library https://medicaid.utah.gov/pharmacy/resource-library.

Pharmacy Code Updates

The following codes are new effective July 1, 2020:

C9059 Injection, meloxicam (Anjeso)
C9061 Injection, teprotumumab-trbw (Tepezza)
C9063 Injection, eptinezumab-jjmr (Vyepti)

J0223 Inj givosiran 0.5 mg (Givlaari)
J0691 Inj lefamulin 1 mg (Xenleta)
J0742 Inj imip 4 cilas 4 releb 2mg (Recarbrio)
J0791 Inj crizanlizumab-tmca 5mg (Adakveo)
J0896 Inj luspatercept-aamt 0.25mg (Reblozyl)
J1429 Inj golodirsen 10 mg (Vyondys 53)
J1558 Inj. xembify, 100 mg
J7169 Inj andexxa, 10 mg
J7204 Inj recombin esperoct per iu
J9177 Inj enfort vedo-ejfv 0.25mg (Padcev)
J9198 Inj. infugem, 100 mg
J9246 Inj., evomela, 1 mg
Q5119 Inj ruxience, 10 mg
Q5120 Inj pegfilgrastim-bmez 0.5mg
J3399 Inj onase abepar-xioi treat (Zolgensma)

The following codes have been updated:

J1459 INJ, IMMUNE GLOBULIN, INTR, NON-LYOPHILIZED, 500 M
J1460 INJECTION, GAMMA GLOBULIN-INTRAMUSCULAR, 1 CC
J1555 INJ CUVITRU, 100 MG
J1556 INJ, IMM GLOB BIVIGAM, 500MG
J1557 GAMMAPLEX INJECTION
J1559 INJ, IMMUNE GLOBULIN, 100 MG (HIZENTRA)
J1560 INJECTION,GAMMA GLOBULIN-INTRAMUSCULAR,OVER 10 CC
J1561 INJEC,IMMUNE GLBLN,INTRA,NON-LYOPHILIZED 500 MG
J1566 INJECTION,IMMUNE GLOBULIN,IV,LYOPHILIZED,500 MG
J1568 INJEC, IMMUNE GLBLN, INTRA, NON-LYOPHILIZED 500 MG
J1569 INJEC, IMMUNE GLBLN, INTRA, NON-LYOPHILIZED 500 MG
J1571 INJEC, HEP B IMMUNE GLBLN, INTRAMUSCULAR, 0.5 ML
J1572 INJ, IMMUNE GLBLN, INTRA, NON-LYOPHILIZED, 500 MG
J1573 INJEC, HEP B IMMUNE GLBLN, INTRA, 0.5 ML
J1575 HYQVIA 100MG IMMUNEGLOBULIN
J1599 INJ, IMMUNE GLOBULIN, IV, NON-LYOPHLZD,NOT SPCFD
J7180 FACTOR XIII ANTI-HEM FACTOR
J7181 FACTOR XIII RECOMB A-SUBUNIT
J7182 FACTOR VIII RECOMB NOVOEIGHT
J7183 WILATE INJECTION
J7185 INJ, FACTR V111 (ANTIHEMO,RECOMB(XYNTHA), PER I.U.
J7186 INJ, ANTIHEMOPHILIC VIII/VWF CMPL, PER FCTR VII I.
INJ,VONWILLEBRAND FACTOR COMPLX,HMN,RIST COFACT
J7187 IU
J7188 FACTOR VIII RECOMB OBIZUR

J7189 FACTOR VIIA,PER 1 MICROGRAM
J7190 FACTOR VIII,(ANTIHEMOPHILIC FACTOR,HUMAN)PER I.U.
J7192 FACTOR VIII(ANTIHEMOPHILIC FACTOR,RECOMBIN)PER IU
J7193 FACTOR IX (PURIFIED, NON-RECOMBINANT) PER IU
J7194 FACTOR IX, COMPLEX, PER I.U.
J7195 FACTOR IX (RECOMBINANT) PER I.U.
J7200 FACTOR IX RECOMBINAN RIXUBIS
J7201 FACTOR IX FC FUSION RECOMB
J7202 FACTOR IX IDELVION INJ
J7203 FACTOR IX RECOMB GLY REBINYN
J7205 FACTOR VIII FC FUSION RECOMB
J7207 FACTOR VIII PEGYLATED RECOMB
J7208 INJ. JIVI 1 IU
J7209 FACTOR VIII NUWIQ RECOMB 1IU
J7210 INJ, AFSTYLA, 1 I.U.
J7211 INJ, KOVALTRY, 1 I.U.
J9312 INJ., RITUXIMAB, 10 MG
Q5111 PEGFILGRASTIM-CBQV, BIOSIMILAR, (UDENYCA), 0.5 MG
J7199 HEMOPHILIA CLOTTING FACTOR,NOT OTHERWISE CLASSIFI

The following codes are not covered for any provider type:

C9122 Mometasone furoate (sinuva)
J0591 Inj deoxycholic acid, 1 mg (Kybella)
J1201 Inj. cetirizine hcl 0.5mg (Quzytiir)
J1562 INJECTION, IMMUNE GLOBULIN (VIVAGLOBIN), 100 MG
J3399 Inj onase abepar-xioi treat (Zolgensma)
J7191 FACTOR VIII, (ANTIHEMOPHILIC FACTOR) PER I.U.
J7333 Visco-3 inj dose
S0028 INJECTION, FAMOTIDINE, 20 MG

20-68 Changes in Prepaid Mental Health Plan in Utah County

Effective July 1, 2020, there is a change in the Prepaid Mental Health Plan (PMHP) in Utah County. Utah County Department of Drug and Alcohol Prevention and Treatment (Utah County aDDAPT) is no longer the PMHP contractor responsible for the provision of outpatient substance use disorder services.

Effective July 1, 2020, Wasatch Mental Health is the PMHP contractor responsible for the provision of both mental health and substance use disorder services for Utah County PMHP Medicaid enrollees. Along with this change,

Wasatch Mental Health's name is changed to Wasatch Behavioral Health. Wasatch Behavioral Health will maintain the same provider panel that Utah County aDDAPT had.

Please note that this change does not affect:

- Physical health plan (ACO) enrollment.
- Services from an Indian Health Care provider. Wasatch Behavioral Health Medicaid enrollees can continue to get services directly from these providers.
- Methadone services by opioid treatment programs. These services are still carved out of the PMHP contracts.
- Children in foster care. These children will continue to be enrolled with Wasatch Behavioral Health only for inpatient mental health care in a hospital.
- Children with subsidized adoption Medicaid who have been disenrolled from Wasatch Mental Health for outpatient services. These children will continue to be enrolled with Wasatch Behavioral Health only for inpatient mental health care in a hospital.

If there are questions about this change, or how to refer Utah County Medicaid PMHP enrollees to substance use disorder services or mental health services, providers can call Wasatch Behavioral Health at (801) 373-4760 or 1-866-366-7987.

The *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated to reflect this change. See Chapter 1-3. Table 1.

20-69 Clarification of Prepaid Mental Health Plan (PMHP) Coverage of Services for Medicaid Members Dually Eligible for Medicare

Medicaid members enrolled in the PMHP, who are also Medicare beneficiaries, may obtain mental health and substance use disorder services directly from providers who accept Medicare. Authorization from the member's PMHP is not required. For providers also enrolled as Medicaid providers, crossover claims will be processed through fee-for-service Medicaid, and will be subject to crossover adjudication logic for payment of co-insurance and deductible, if applicable.

The *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated to include this policy. See Chapter 1-3, Medicaid Behavioral Health Service Delivery System, Additional Provider Options for Prepaid Mental Health Plan Enrollees. In addition, minor clarifications have been made in this chapter for consistency.

20-70 Opioid Treatment Programs – Medicare Reimbursement of Bundled Codes for Dual-Eligible Medicare/Medicaid Members

Effective January 1, 2020, CMS directed Opioid Treatment Programs (OTPs) to enroll with Medicare and to bill Medicare the applicable bundled codes, G2067 through G2078, for Medicare beneficiaries, including beneficiaries who have both Medicare and Medicaid (dual-eligible Medicaid members). The Medicare bundled procedure codes include both the medication (e.g., methadone) and other substance use disorder services the OTP provides.

Therefore, effective for dates of service on or after August 1, 2020:

- If OTPs bill Medicaid first (before Medicare) for methadone or other substance use disorder services, Medicaid will deny payment. (Medicaid is the payer of last resort.)
- If OTPs have been receiving payments from Prepaid Mental Health Plans (PMHPs) for substance use disorder services provided to dual-eligible PMHP enrollees, OTPs must instead bill Medicare using the bundled procedure codes.
- Once Medicare adjudicates the OTPs' claims for dual-eligible Medicaid members, claims cross over from Medicare into Medicaid's fee-for-service payment system for payment of Medicare's co-insurance and deductible, if applicable.

Medicare and Medicaid payments are payment in full. The dual-eligible Medicaid member may not be billed.

20-71 Home and Community Based Services Critical Incident Reporting

The following Home and Community Based Services Waiver manuals have been updated to reflect the current critical incident reporting policy:

- Individuals Aged 65 and Over
- Individuals with Brain Injury, Age 18 and Over
- Individuals with Intellectual Disabilities
- Individuals with Physical Disabilities
- Medically Complex Children
- New Choices
- Tech Dependent Children

These manuals can be found on the Medicaid website at: https://medicaid.utah.gov/utah-medicaid-official-publications/?p=Medicaid%20Provider%20Manuals/Home%20And%20Community-Based%20Waiver%20Services/.

20-72 New Choices Waiver Provider Manual Updates

Updates to the New Choices Waiver Provider Manual have been made and include the following changes:

Additions to Section 3-1, Application and Assessment to include, "Applications for the program will be denied when an applicant refuses to consent to quality assurance monitoring of assessments and service coordination."

Addition to Section 3-1, Application and Assessment, describing that additional documentation requested by the NCW Program Office for the purposes of screening applications received during the open application periods must be submitted within 5 business days.

Addition to Section 3-3 Selection of Entrants to the Waiver to include, "If an application is incomplete when it is received and remains incomplete 5 business days after a request for additional information, the application will be denied and hearing rights provided."

Addition to Section 4-2 Termination of Home and Community-Based Waiver Services to include, "Refusal to participate in quality assurance monitoring is considered voluntary disenrollment."

Addition to Section 7-1 Participant-Centered Care Planning, Other Care Plan Requirements that describes quality assurance monitoring by the NCW Program Office, goals and strategies, and how the information collected may be used.

Additions to Section 7-1 Participant-Centered Care Planning that describes significant change care plans and the requirement that amendments to a care plan be submitted within the 90 days following the care plan expiration date. Requests for adjustments beyond that time period will be denied.

Updates to Section 9 Incident Reporting Protocol with clarifying information and new categories of critical incidents including:

- "Injury requiring medical treatment" now includes aspiration and self-injurious behavior
- "Exploitation" now includes theft of medications
- "Waste, fraud, or abuse of Medicaid funds" has been clarified to apply to both participants and providers
- "Substance abuse requiring medical treatment" (new category)
- "Law enforcement involvement" has been clarified to include instances where charges are filed against the client and/or staff
- "PHI/PII security breach" (new category)

20-73 School-Based Skills Development Services Eligibility Requirements and Provider Manual Updated

Effective July 1, 2020, the following eligibility requirements for student participation in the Medicaid School-Based Skills Development Services program is changed:

- Students will no longer be required to have 180 minutes (1st grade – post high) or 90 minutes (kindergarten) of average daily combined special education and related services identified in an IEP.
- Students meeting all other requirements, are eligible for billing through age 21.

Effective July 1, 2020, there is an updated School-Based Skills Development Services Provider Manual to reflect these updated eligibility requirements and clarify other relevant policies and procedures.

Please contact Kelly Garcia, kgarcia@utah.gov, with any questions you have about the eligibility requirements or provider manual changes.