April 2021

UTAH DEPARTMENT OF HEALTH MEDICAID

MEDICAID INFORMATION BULLETIN

Medicaid Information: 1-800-662-9651 | medicaid.utah.gov

Unless otherwise noted, all changes take effect on April 1, 2021

21-19 2021 Medicaid Statewide Provider Training

Utah Medicaid will be offering Statewide Provider Training in an online live webinar format. The training this year will focus on new updates or changes to Medicaid and answer provider questions. When registering, please provide specific questions you would like addressed during the training. This will assist staff in preparing the slides and obtaining answers ahead of time.

Topics:

- General Overview
- What's New in Medicaid
- Office of Inspector General
- Provider Questions

To add your email to the distribution list to receive training information, complete the form at https://forms.gle/x4mminGHDmKXsutA9.

Or, you can email providertrainingsupport@utah.gov.

Registration is located on the Medicaid website at https://medicaid.utah.gov/provider-training-0/.

The following dates and times are scheduled for the 2021 Medicaid Statewide Provider Training:

Date	Time
Tuesday, August 17	9:00 am -11:00 am
Wednesday, August 25	1:00 pm -3:00 pm

Please note that the 2020 Statewide Provider Training is still available on the Medicaid website at https://medicaid.utah.gov/provider-training-0/.

21-20 Electronic Visit Verification (EVV)

Compliance with Federal Regulations Effective January 1, 2021

The Centers for Medicare and Medicaid Services (CMS) required that state Medicaid agencies and their enrolled providers come into compliance with federal regulations for Electronic Visit Verification (EVV) on January 1, 2021. In October 2020, Utah Medicaid sent a letter seeking providers' information about their agency's EVV adoption. To date, many providers have failed to respond to this request.

In February 2021, Utah Medicaid emailed a letter requesting providers demonstrate EVV compliance. Providers were asked to complete the brief EVV Readiness Survey by February 19, 2021, to verify EVV readiness and allow for time to train and test data transmission methods.

Personal Care Providers

Because non-compliance with EVV requirements results in a decrease in the amount of federal Medicaid funding the State receives for the services your agency provides, beginning April 1, 2021, Utah Medicaid began withholding payments to providers who failed to complete the survey. Additionally, if a provider has still not come into compliance with EVV requirements by July 1, 2021, the provider will no longer be eligible to perform Medicaid Personal Care Services and may ultimately be disenrolled as a Utah Medicaid Provider.

Home Health Care Providers

The EVV compliance date for Home Health Services remains January 1, 2023. Despite the different compliance dates, Utah Medicaid will begin collecting and reviewing both Personal Care and Home Health Services records effective July 1, 2021. We believe requiring both Personal Care and Home Health Services agencies to submit EVV data beginning on July 1, 2021, will reduce confusion and assist agencies in identifying any technical issues that may arise in providers' EVV systems.

Utah Medicaid requires your assistance to assure the requirements of EVV are met. Additional questions regarding EVV may be sent to dmhf_evv@utah.gov. EVV requirements, user guides, and technical information is available at https://medicaid.utah.gov/evv. The EVV Readiness Survey takes approximately 5 minutes and can be accessed at EVV Readiness Survey.

21-21 InterQual Updates

InterQual® criteria updates were implemented on March 1, 2021. These updates primarily affected the Bariatric or Metabolic surgery subset. For questions related to prior authorization criteria, email Medicaidcriteria@utah.gov.

21-22 Prior Authorization Transparency Tool

The InterQual® Transparency – Cloud tool provides read-only access to the InterQual® criteria. This tool will be available to registered Medicaid providers in the coming months and will allow providers to view InterQual® criteria. Providers will be encouraged to utilize this tool to assist in determining what documentation is required for prior authorization requests. The tool should be used in conjunction with other Medicaid policies and resources such as Code of Federal Regulations (CFR), Utah State Plan, Utah Code, Administrative Rules, manuals, MIBs, and the coverage and reimbursement lookup tool.

21-23 Durable Medical Equipment

Effective April 1, 2021, HCPCS code B9998 *NOC for enteral supplies* will be closed. Providers are directed to use HCPCS code B4088 *Gastrostomy/jejunostomy tube, low-profile, any material, any type, each* to bill for low-profile g-tubes and j-tubes.

21-24 Utah Medicaid Telehealth Policy

The following Telephone Evaluation and Management Service codes have been opened to Physicians and other Qualified Health Care Professionals:

99441 *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*

99442 *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion*

99443 *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion*

These codes will not be open to behavioral health providers and will not change their current billing practices.

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

21-25 Code Updates

The following new procedure codes are open, effective April 1, 2021:

C9776 Fluo bile duct imaging w/icg
C9777 Esophag mucosal integ add-on
K1013 Enema tube, any, replac only
K1014 Ak 4 bar link hydl swg/stanc
K1015 Foot, adductus position, adj
S1091 Stent non-coronary, temp w/delivery system (Propel)

21-26 Non-Covered Ambulance Transportation Updates

Chapter 11.1, Reimbursement for Ground Ambulance, of the *Medical Transportation Services Provider Manual* has been updated to clarify when transportation to and from external appointments and treatments is covered and reportable by transportation providers. The following chapter updates have been made to the manual:

11.1-1 Non-covered Ambulance Transportation

Round-trip ambulance services from one hospital to another hospital or clinic to obtain necessary diagnostic and/or therapeutic services when the member remains registered as an inpatient at the originating facility is non-covered. It is the responsibility of the originating hospital to cover the transportation. Rural hospitals and Long-term Acute Care facilities (LTACs) are excluded from this policy. In this instance, Medicaid will reimburse an ambulance service provider for round-trip facility transportation from a rural hospital and LTAC facilities.

21-27 Utah Medicaid Pharmacy Program Updates

DUR Board

The Drug Utilization Review (DUR) Board met in January, 2021, to review long-acting injectable and orally disintegrating formulations of second-generation antipsychotics. The review included product descriptions, pharmacokinetics, and place in therapy. The Board also reviewed Trodelvy Prior Authorization. DUR Board Meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/.

The Drug Utilization Review (DUR) Board met in February, 2021, to review asthma guidelines in children and the Anti-Vascular Endothelial Growth Factor Therapy. DUR Board Meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/.

The DUR Board met in March, 2021, to review Continuous Glucose Monitoring (CGM). The review included all the available CGMs on the market, place in therapy for Type 1 and Type 2 diabetes, and proposed Prior Authorization criteria. DUR Board Meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee reviewed Continuous Glucose Monitoring products in February. Committee recommendations regarding updates to the preferred drug list (PDL) goes into effect with the April 2021 PDL. Minutes for P&T Committee meetings can be found at https://medicaid.utah.gov/pharmacy/pt-committee.

Pharmacy Prior Authorization Updates

The following Pharmacy Prior Authorization forms have been updated and can be found here https://medicaid.utah.gov/pharmacy/prior-authorization/.

PA Form	Status	Effective Date	Information
Immunoglobulin	Update	1/01/21	Minor updates to criteria
Opioid and/or Opioid-Benzodiazepine Combo	Update	1/01/21	Opioid Use Disorder (OUD) criteria added to form
Trodelvy	New	2/01/21	New Prior Authorization form
ADHD Stimulants	New	4/01/21	Exceptions to ADHD policies

Pharmacy HCPCS Code Updates

The following pharmacy related HCPCS codes have been updated and detailed information for these codes can be found by using the Utah Medicaid Coverage and Reimbursement Code Lookup here https://health.utah.gov/stplan/lookup/CoverageLookup.php.

0001A	Adm sarscov2 30mcg/0.3ml (Pfizer 1stDose)
0002A	ADM SARSCOV2 30MCG/0.3ML (Pfizer 2nd Dose)
0011A	Adm sarscov2 100mcg/0.5ml (Moderna 1st Dose)
0012A	Adm sarscov2 100mcg/0.5ml (Moderna 2nd Dose)
90376	RABIES IMMUNE GLOBULIN, HEAT-TREATED, HUMAN, IM/SQ
90377	RABIES IMMUNE GLOBULIN, HT&SOL HUMAN IM/SQ
C9069	Inj. Belantamab mafodontin-blmf, 0.5mg (BLENREP)
C9070	Injection, tafasitamab-cxix, 2 mg (MONJUVI)
C9071	Injection, viltolarsen, 10 mg (VILTEPSO)
C9072	Injection, immune globulin, 500 mg (ASCENIV)
C9073	Brexucabtagene autoleucel ca (TECARTUS)
J0585	Injection, onabotulinumtoxinA, 1 unit (BOTOX)
J0693	Injection, cefiderocol, 5 mg (FETROJA)

J1325	Inj. epoprostenol, 0.5 mg (FLOLAN, VELETRI)
J1817	INSULIN FOR ADMIN THROUGH DME(PUMP) PER 50 UNITS
J1823	Injection, inebilizumab-cdon, 1 mg (UPLIZNA)
J2212	Inj. Methylnaltrexone, 0.1 mg (RELISTOR)
J3285	INJECTION, TREPROSTINIL, 1 MG (REMODULIN)
J7212	Factor viia recombinant, 1 mcg (SEVENFACT)
J7352	Afamelanotide implant, 1 mg (SCENESSE)
J7686	TREPROSTINIL, INH. NONCOMPD, DME,1.74 MG (TYVASO)
J9144	Daratumumab, hyaluronidase, 10mg (DARZALEX FASPRO)
J9210	INJ., EMAPALUMAB-LZSG, 1 MG (GAMIFANT)
J9223	Injection, lurbinectedin, 0.1 mg (ZEPZELCA)
J9281	Mitomycin instillation, 1 mg (JELMYTO)
J9316	pertuzumab, trastuzumab, hyaluronidase-zzxf, 10mg
J9317	Inj. sacituzumab govitecan-hziy, 2.5 mg (TRODELVY)
M0243	IV infusion, casirivimab and imdevimab
Q0243	Inj. Casirivimab and imdevimab, 2400mg
Q5122	Inj. pegfilgrastim-apgf, biosim, 0.5mg (NYVEPRIA)
S0013	Esketamine, nasal spray, 1 mg (SPRAVATO)

Pharmacy Biosimilar Policy Update in Manual

The Utah Medicaid Pharmacy Manual biosimilar policy section on "Biologic Medications and Substitutions of Biosimilars" has been updated to include this additional language:

"Utah Medicaid evaluates reference products and biosimilars for safety and efficacy and may 'prefer' one or more over others. When a prior authorization is received for a 'non-preferred' reference product or biosimilar the Medicaid staff will try to contact the requesting provider to ask that they switch to the 'preferred' version. As per above, the State will not mandate interchange/substitution of biosimilars unless they are listed as interchangeable."

ADHD Stimulant Policy Expanded to Promote Safe and Appropriate Use

Utah Medicaid policy supports the safe and appropriate use of ADHD stimulant medications when prescribed to Medicaid members. This policy is developed in alignment with the American Academy of Pediatrics and the University of South Florida clinical guidelines.

Effective July 2020, age edit limitations apply when a claim for an ADHD stimulant is processed through the pharmacy point of sale:

- ADHD stimulant prescriptions for children under 4 years of age.
- ADHD stimulant prescriptions for Adzenys ER suspension (susp.), Dyanavel XR, Desoxyn, Adhansia XR, Jornay PM, and Cotempla XR Orally Disintegrating Tablet (ODT) for children under 6 years of age.

Also, effective April 2021, a multiple agent edit and a cross-class edit limitation will apply when claims for ADHD stimulants are processed through the pharmacy point of sale:

- Three or more unique ADHD stimulant medications prescribed concurrently for at least 30 days in the last 45 days.
- Cross-class prescribing of ADHD stimulant medications from the amphetamine class and the methylphenidate class for at least 30 days in the last 45 days for children under 18 years of age.

Exceptions to ADHD stimulant safety edits are reviewed on a case-by-case basis by submitting the "ADHD Stimulants" prior authorization form https://medicaid.utah.gov/pharmacy/prior-authorization.

Insulin Pens Day Supply Policy Update

In 2019, the FDA requested the new wording "dispense in original sealed carton" on boxes of insulin pens for safety reasons. Therefore, breaking up boxes is no longer recommended.

Effective April 1, 2021, pharmacy point of sale claims for insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation. Day supply on submitted claims should reflect the actual days the medication will last and/or expire. See below information from the FDA:

www.fda.gov/drugs/drug-safety-and-availability/fda-advises-health-care-professionals-and-patients-about-insulin-pen-packaging-and-dispensing

Continuous Glucose Monitors

About 50 percent of diabetic patients have uncontrolled diabetes (HbA1c >7%), and are at higher risk for complications including retinopathy, neuropathy, kidney disease, and diabetic ketoacidosis.[1] Patients who are on multiple daily insulin injections (MDI) or continuous subcutaneous insulin infusion (CSII) are at higher risk for hypoglycemia.[2] Real-time continuous glucose monitoring (rtCGM) devices measure and display glucose levels continuously and can alert the patient if their glucose level is too high or too low, which is not possible with self-monitoring of blood glucose.[2] Studies show that both type 1 and type 2 diabetic patients, including pregnant patients and pediatric patients, on MDI or CSII using rtCGM experience more significant reductions in HbA1c (average 1%) and lower rates of hypoglycemia.[2]

The DUR Board and P&T Committee reviewed continuous glucose monitors (CGM) for the management of diabetes mellitus to consider inclusion on the preferred drug list and prior authorization coverage criteria (March 2021, February 2021 respectively). Meeting minutes can be found on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/ and https://medicaid.utah.gov/pharmacy/pt-committee/.

Effective April 1, 2021, Utah Medicaid covers CGM through the pharmacy point of sale system. The Dexcom G6 CGM system will be the preferred product and Freestyle Libre and Guardian Connect systems will be non-preferred. The Utah Medicaid PDL can be found at https://medicaid.utah.gov/pharmacy/preferred-drug-list/. A clinical prior authorization will be required for coverage for all CGMs and can be found at https://medicaid.utah.gov/pharmacy/prior-authorization/.

Coverage of CGM CPT Codes can be found in the Coverage and Reimbursement Code Lookup at https://health.utah.gov/stplan/lookup/CoverageLookup.php.

Code	Description
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

Coverage of CGM HCPCS Codes:

Code	Description	Information
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply	Closed, bill through the POS
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system	Closed, bill through the POS
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	Closed, bill through the POS

References:

1. Centers for Disease Control and Prevention (CDC). Coexisting Conditions and Complications. https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-undiagnosed-diabetes.html
2. American Diabetes Association. Standards of Medical Care in Diabetes - 2021. https://care.diabetesjournals.org/content/diacare/suppl/2020/12/09/44.Supplement_1.DC1/DC_44_S1_final_copyright_stamped.pdf

21-28 1115 Primary Care Demonstration Network Waiver – Approval to Reimburse Institutions for Mental Health Diseases (IMDs) – Psychiatric Hospitals

The Centers for Medicare and Medicaid Services (CMS) has approved an amendment to Medicaid's 1115 Primary Care Network Demonstration Waiver regarding reimbursement for psychiatric hospitals which are considered IMDs.

Under this amendment, the federal IMD exclusion that excludes Medicaid reimbursement for individuals age 21 through 64 in IMDs is waived. For Medicaid members in this age group, admissions on or after January 1, 2021, may be eligible for Medicaid reimbursement.

Allowed Lengths of Stay

Under the approved amendment, stays of up to 60 days may be reimbursed based on medical necessity.

Licensing and Certification or Accreditation Requirements

In order to receive Medicaid reimbursement under this amendment, psychiatric hospitals must be licensed by the Department of Health, and must have Medicare certification, or be deemed Medicare-certified through accreditation by the Joint Commission on Accreditation of Healthcare Organization (JCAHO).

Medicaid Enrollment

In order to obtain reimbursement, psychiatric hospitals must be enrolled with Medicaid.

Psychiatric hospitals currently enrolled as Medicaid providers are enrolled as QMB-only providers in order to receive payments for co-insurance and deductible for Medicaid members dually eligible for Medicare and Medicaid.

To bill Medicaid for members age 21 through 64 enrolled in the fee for service network, psychiatric hospitals' enrollment will need to be changed from QMB-only to the Facility/Agency/Organization (FAO) applicant type. Provider Enrollment staff will work directly with the enrolled psychiatric hospitals to change the enrollment. Under this enrollment change, psychiatric hospitals will still be able to obtain crossover payments for dually eligible Medicaid members.

Prior Authorization Requirements

Psychiatric hospitals must obtain prior authorization (PA).

Medicaid Members Enrolled in Prepaid Mental Health Plans (PMHPs) or Utah Medicaid Integrated Care (UMIC) Plans or the Healthy Outcomes Medical Excellence (HOME) Program

Inpatient psychiatric stays are covered under these managed care plans. For Medicaid members enrolled in these plans, psychiatric hospitals must contact the plans regarding their PA requirements. Psychiatric hospitals not part of a plan's network must contact the plan regarding becoming paneled with the plan or to discuss referral processes to a paneled hospital.

Medicaid Members Enrolled in the Medicaid Fee for Service Network

Psychiatric hospitals must obtain a non-clinical PA at admission as notification of admission. A non-clinical PA request must be submitted to Medicaid 's PA Unit within one business day of the admission. A non-clinical PA request may be approved for up to seven days.

PA request forms for psychiatric hospitals may be accessed at https://medicaid.utah.gov/forms/.

For inpatient stays that may exceed seven days, psychiatric hospitals must obtain a clinical PA. Psychiatric hospitals must submit a clinical PA request with a maximum of seven days per request. Along with the PA request, the psychiatric hospital must also submit documentation of medical necessity that addresses InterQual criteria for inpatient psychiatric stays. The psychiatric hospital must also specify the number of additional days being requested and the anticipated discharge date.

Psychiatric hospitals must submit a clinical PA request to Medicaid's PA Unit no more than two business days before the end of the current PA-approved treatment period.

For admissions on or after January 1, 2021, programs may submit retroactive PA requests to Medicaid's PA Unit by close of business April 30, 2021. For admissions on or after May 1, 2021, programs must follow the PA submission timeframes specified above.

PA requests can be faxed to the PA Unit at (801) 323-1587, or emailed to fax_mentalhealthservices_prior@utah.gov.

Please send any questions to Medicaidbh@utah.gov.

21-29 1115 Primary Care Demonstration Network Waiver – Approval to Reimburse Institutions for Mental Health Diseases (IMDs) – Licensed Mental Health Residential Treatment Programs with 17 or More Beds

The Centers for Medicare and Medicaid Services (CMS) has approved an amendment to Medicaid's 1115 Primary Care Network Demonstration Waiver regarding reimbursement for mental health residential treatment programs with 17 or more beds which are considered Institutions for Mental Diseases (IMDs). Under this amendment, the federal IMD exclusion that excludes Medicaid reimbursement for programs of this size is waived. Under the approved waiver, these services are limited to adults age 21 through 64. Admissions on or after January 1, 2021, may be eligible for Medicaid reimbursement.

Allowed Lengths of Stay

Under the approved amendment, stays of up to 60 days may be reimbursed based on medical necessity.

Licensing and Accreditation Requirements

In order to receive Medicaid reimbursement under this amendment, mental health residential treatment programs with 17 or more beds must be licensed as a mental health residential treatment program by the Utah Department of Human Services, Office of Licensing. These programs must also have Joint Commission on Accreditation of Healthcare Organization (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. Documentation of licensure and accreditation are required as part of the Medicaid enrollment process.

Medicaid Enrollment

In order to obtain Medicaid reimbursement, these residential treatment programs must be enrolled with Medicaid. For information, please refer to https://medicaid.utah.gov/become-medicaid-provider/.

Prior Authorization Requirements

Programs must obtain prior authorization (PA).

Medicaid Members Enrolled in Prepaid Mental Health Plans (PMHPs), Utah Medicaid Integrated Care (UMIC) Plans or the Healthy Outcomes Medical Excellence (HOME) Program

This service is covered under these managed care plans. For Medicaid members enrolled in these plans, programs must contact the plans regarding their PA requirements. Programs that are not part of a plan's network must contact the plan regarding becoming paneled with the plan or to discuss referral processes to a paneled provider.

Medicaid Members Enrolled in the Medicaid Fee for Service Network

Programs must obtain a non-clinical PA at admission as notification of admission. A non-clinical PA request must be submitted to Medicaid 's PA Unit within one business day of the admission. A non-clinical PA request may be approved for up to seven days.

If the program has obtained a PA from a PMHP, UMIC plan or HOME for a Medicaid member who changes to the Fee for Service Network, then the program's first PA request to the Medicaid PA Unit must be a clinical PA request, following the clinical PA request policy below.

PA request forms for mental health residential treatment programs with 17 or more beds may be accessed at https://medicaid.utah.gov/forms/.

For stays that may exceed seven days, programs must obtain a clinical PA. Programs must submit a clinical PA request with a maximum of seven days per request. Along with the PA request, the program must also submit documentation of medical necessity that addresses InterQual criteria for mental health residential treatment programs. The program must also specify the number of additional days being requested and the anticipated discharge date.

Programs must submit a clinical PA request to Medicaid's PA Unit no more than two business days before the end of the current PA-approved treatment period.

For admissions on or after January 1, 2021, programs may submit retroactive PA requests to Medicaid's PA Unit by close of business April 30, 2021. For admissions on or after May 1, 2021, programs must follow the PA submission timeframes specified above.

PA requests can be faxed to the PA Unit at (801) 323-1587, or emailed to fax_mentalhealthservices_prior@utah.gov.

The *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated to add a new Chapter 2-17, Mental Health Residential Treatment in Licensed Mental Health Residential Treatment Programs. This chapter includes requirements related to the provision and reporting of this service.

Updates have also been made to Chapter 1-4, and Chapter 2, Scope of Services, to reference this service. Chapter 4, Procedure Codes and Modifiers, has also been updated to include the procedure code for this service, H0017. A new Chapter 6, Prior Authorization Policies and Procedures for Licensed Mental Health Residential Treatment Programs with 17 or More Beds, has also been added.

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

Please send any questions to Medicaidbh@utah.gov.

21-30 Centers for Medicare and Medicaid Services (CMS) Approval of Behavioral Health Receiving Centers

Effective October 1, 2020, CMS has approved Medicaid reimbursement for behavioral health receiving centers.

Behavioral health receiving centers must be licensed by the Department of Human Services, Office of Licensing, or must be a facility that is licensed as an outpatient hospital.

To qualify for Medicaid reimbursement, behavioral health receiving centers must provide services in accordance with Rule R523-21 of the Utah Administrative Code. They must have the capability to provide behavioral health and physical health assessments and services for up to 23 hours to individuals experiencing any level of behavioral health crisis in the community, and are no-refusal centers capable of accepting referrals, individuals who walk in or are dropped off, as well as individuals first responders bring in for crisis services. Behavioral health receiving centers are staffed 24 hours a day, 365 days a year. Reimbursement is per diem. Medicaid reimburses these centers on a fee for service basis. This service is not covered under Medicaid's managed care plans.

The *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated to add a new Chapter 2-18, Behavioral Health Receiving Centers. This chapter includes requirements related to the provision and reporting of this service. Updates have also been made to Chapter 1-4 and Chapter 2, Scope of Services, to reference this service. Chapter 4, Procedure Codes and Modifiers, has also been updated to include the procedure code for this service, S9485.

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

Please send any questions to Medicaidbh@utah.gov.

21-31 Updates to the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services

In accordance with Chapter 1-1, Authority, the term 'behavioral health' is to be used when provisions apply to both mental health disorders and substance use disorders; however, this term was not consistently used. Updates have been made throughout the manual for consistency in using the term 'behavioral health'.

Chapter 1-2, Definitions, has been updated to include a definition for Accountable Care Organizations (ACOs) and Adult Expansion Medicaid Members. Minor updates have also been made to the definitions of Enrollee and Healthy Outcomes Medical Excellence Program (HOME). Integrated Care Plans has been changed to Utah Medicaid Integrated Care (UMIC) Plans. The manual has been updated to use 'UMIC Plans' throughout.

Chapter 1-3, Medicaid Behavioral Health Service Delivery System, has been updated to include more information about UMIC Plan coverage of behavioral health services.

Chapter 1-4, Scope of Services, has been updated to include Assertive Community Outreach Treatment (ACOT), along with Assertive Community Treatment, and to include clinically managed residential withdrawal management which had been inadvertently left off of this list when Chapter 2-16 was added to the manual. Mental health services in licensed mental health residential treatment programs and behavioral health receiving centers have also been added to this list in accordance with the new Chapters 2-17 and 2-18.

Chapter 2, Scope of Services, has been updated to include assertive community treatment (ACT) and Assertive Community Outreach Treatment (ACOT), mobile crisis outreach teams (MCOT), and clinically managed residential withdrawal management. These services were inadvertently left off the list when Chapters 2-14, 2-15 and 2-16 were added to the manual. Mental health services in licensed mental

health residential treatment programs and behavioral health receiving centers have also been added to this list in accordance with new Chapters 2-17 and 2-18.

In Chapter 2-13, Substance Use Disorder (SUD) Treatment in Licensed SUD Residential Treatment Programs, the age range has been corrected to state age 21 through 64. In the 'Who' section, #8 has been revised to remove reference to foster parents or other proctor parents as this limitation applies in the context of psychosocial rehabilitative services (Chapter 2-11). Also, certified peer support specialists had been inadvertently left off this list. They have been added under a new #10.

In the 'Limits' section, #10 has been corrected to be consistent with the 1115 Demonstration Waiver.

Other clarifications have been made to include UMIC Plans and HOME when the PMHP is referenced.

Chapter 2-17, Mental Health Treatment in Licensed Mental Health Residential Treatment Programs, and Chapter 2-18, Behavioral Health Receiving Centers, are new chapters.

Chapter 4, Procedure Codes and Modifiers, has been updated to correctly refer to Assertive Community Outreach Treatment (ACOT), and to include procedure codes H0017 for mental health residential treatment programs and S9485 for behavioral health receiving centers.

Chapter 5, Prior Authorization Policies and Procedures for Licensed Substance Use Disorder Residential Treatment Programs with 17 or More Beds, has been updated to clarify when programs must submit clinical prior authorization requests to Medicaid's Prior Authorization Unit instead of non-clinical prior authorization requests.

Chapter 6, Prior Authorization Policies and Procedures for Licensed Mental Health Residential Treatment Programs with 17 or More Beds, is a new chapter.

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