Interim May 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 May 1, 2021

21-32 Medicaid Provider Directory

Section 5006 of the 21st Century Cures Act amended § 1902(a) of the Social Security Act requires states to provide an online provider directory for Medicaid members. In July 2021, Utah Medicaid will implement an online provider directory titled the Medicaid Provider Directory. The directory will be searchable through a web page that will be hosted by the Utah Medicaid website. The purpose of the directory is to help Medicaid members find a provider by type, specialty, and location thereby increasing access to care. We will also host an application programming interface (API) compliant with the Interoperability and Patient Access Final Rule. Members will be able to access the API through a third-party application of their choice.

Federal law requires that specific information be made available to the public. Most of the information in the provider directory will come from Utah Medicaid's PRISM Provider Enrollment System.

As part of this process, Utah Medicaid acknowledges that some provider data needs to be updated to improve usability for members. For the best user experience, members need to be able to find accurate provider contact information and understand which providers are accepting new clients. To improve the accuracy of data, Utah Medicaid is adding the following fields to the PRISM provider management system beginning June 16, 2021:

- Public Phone Number
    - This is intended to be your preferred phone number for public contact. **This is a required field and we are asking you to update this information at your earliest opportunity after June 16, 2021.**
- Public Email Address
    - This is intended to be your preferred email contact for the public, if you want to provide one. This is an optional field and we ask you to update it at your convenience after June 16, 2021.
- Accepting New Clients
    - This field already exists for Individual/Sole Proprietor Applicant Types. We will be adding the field so it is available for these additional Enrollment Types:
        - Group Practice
        - Facility/Agency/Organization
        - Atypical Agency
        - Atypical Individual
    - We ask you to update this field at your convenience after June 16, 2021. Until this is identified as "Yes" or "No" by providers, it will be blank.

We greatly appreciate your participation in this project.

21-33 Electronic Visit Verification (EVV)

Compliance with Federal Regulations, Effective January 1, 2021

The Centers for Medicare and Medicaid Services (CMS) requires 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. Requiring both Personal Care and Home Health Services agencies to submit EVV data beginning on July 1, 2021, will reduce confusion and assist agencies to identify 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.

21-34 Physician Assistant Billing Changes

In accordance with Senate Bill 27, Physician Assistant Act Amendments and Senate Bill 28, Physician Assistant Mental Health Practice passed during the 2021 Legislative General Session, Utah Medicaid is in the process of creating a pathway for eligible Physician Assistants to bill Medicaid for appropriate services. Pending CMS approval of Utah's State Plan Amendment, the target effective date is October 1, 2021, with retroactive effective enrollment dates and billing capabilities effective May 5, 2021. As a result, we request that providers wait to bill for these services until the Division can complete the necessary programming to allow Physician Assistants to bill. When the claims system is updated and CMS has approved the amendment, notice will be given so held billings may be submitted for adjudication.

Utah Medicaid requires any provider, including Physician Assistants, to submit claims only for services permitted within their scope of practice, training, and licensure in accordance with Utah State statutes and federal regulations. Scope of practice is outlined by the Division of Occupational and Professional licensing in Administrative Rule.

Physicians Assistants currently enrolled in Utah Medicaid may retain or update their provider type to one of the following:

- Ordering, Referring, and Prescribing Only - if you will continue to only order, refer, and/or prescribe for Medicaid members;
- Rendering/Servicing - if you will be providing services on behalf of a group; or
- Individual/Sole Proprietor - if you will be providing services independently and billing on behalf of yourself.
    - For this applicant type, you must upload a completed W-9.

To review your current provider type and make any desired changes please visit https://medicaid.utah.gov/become-medicaid-provider.

For any questions regarding this process please contact the Provider Enrollment Team at 1-800-662-9651, press option 3, then option 4.

Physician Assistants who plan to operate independently or become a rendering/servicing provider will be assigned provider type 25. Physician Assistants are required to verify services are covered through their provider type prior to rendering services to enrolled Medicaid members. More information about coverage will be added here: https://health.utah.gov/stplan/lookup/CoverageLookup.php.

Behavioral Health Services

In accordance with Senate Bill 28, Physician Assistant Mental Health Practice, and Section 58-70a-501 of the Utah Code, effective May 5, 2021, Physician Assistants specializing in mental health care may be qualified to engage in the practice of mental health therapy.

Utah Medicaid covers an array of behavioral health services to address mental health and substance use disorders. These services are delineated in the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.* The following sections of this provider manual are updated to include Physician Assistants specializing in mental health care as qualified providers: Chapter 1-5, A., Providers Qualified to Prescribe Behavioral Health Services, Chapter 2-2, Psychiatric Diagnostic Evaluation, Chapter 2-7, Psychotherapy with E/M Services, and Chapter 2-8, Pharmacologic Management (Evaluation and Management (E/M) Services).

In most areas of the state, behavioral health services are provided by or through managed care plans. Medicaid members enrolled in managed care plans must get behavioral health services through their managed care plans (i.e., Prepaid Mental Health Plans or Utah Medicaid Integrated Care Plans).

Please refer to the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services,* Chapter 1-3, Medicaid Behavioral Health Service Delivery System, for complete information on managed care plan coverage of behavioral health services, as well as Medicaid members, providers, and services carved out of managed care plan coverage.

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

Accountable Care Organization (ACO) and Utah Medicaid Integrated Care (UMIC) Plans

Utah Medicaid managed care ACO and UMIC plans will allow providers enrolled under the plan's Physician Assistant provider type to bill claims, pursuant to SB 27 and SB 28. ACO and UMIC plans also have the target date of October 1, 2021, to have this change effective in their systems. Providers should work directly with the individual managed care plan for claim questions, or to resolve billing issues pertaining to this change. Contact information for each plan can be found on the website at https://medicaid.utah.gov/managed-care/.

21-35 Laboratory Services – Update to Urine Drug Testing Policy

Utah Medicaid policy aligns with ASAM Guidelines that encourage individualized, medically necessary drug testing, with more frequent testing early in recovery and less frequent testing as the patient becomes more stable in recovery.

Court-ordered drug testing without a medical indication, or routine screening/blanket ordering of testing at defined intervals, are not indications of medically necessary drug testing.

Medicaid policy covers presumptive qualitative drug testing and definitive quantitative drug testing for all eligible Medicaid members when prescribed by an enrolled Medicaid provider acting under the

scope of their license. Annual and daily quantity limits apply, as defined by R414-12-5, Laboratory Services, Service Coverage and Limitations.

Effective May 1, 2021, urine drug testing reimbursement rates and quantity limits are updated as follows:

Policy Prior to May 1, 2021			New Policy		
Code/Description	Rate	Quantity Limit	Code/Description	Rate	Quantity Limit
80305	$11.99	12/30 days	80305	$11.99	60/year
80306	$15.99	12/30 days	80306	$15.99	
80307	$63.95	12/30 days	80307	$51.50	
G0480	$64.51	6/30 days	G0480	$64.51	16/year
G0481	$99.25	6/30 days	G0481	$99.25	
G0482	$133.99	6/30 days	G0482	$99.25	
G0483	$173.69	6/30 days	G0843	$99.25	

Exceptions to established limits will be evaluated on a case by case basis through the prior authorization process. Urine Drug Screen prior authorization criteria can be found at: https://medicaid.utah.gov/prior-authorization/.

Prior authorization requests can be submitted for review to the Medicaid Prior Authorization team at (801) 536-0162 (fax) or by calling (801) 538-6155 options 3, 3, 6. For any additional questions on coverage or reimbursement, please refer to the Medicaid Coverage and Reimbursement Code Lookup tool at: https://health.utah.gov/stplan/lookup/CoverageLookup.php.

21-36 Prior Authorization Forms

New prior authorization forms have been developed for the following:

- Urine Drug Screen Prior Authorization Request for Quantity Limit Exceptions
- Dental Prior Authorization Request Form

Providers are required to submit requests on the most current request forms. Requests on outdated forms will be returned beginning August 1, 2021. Prior authorization forms are found at: https://medicaid.utah.gov/forms or by calling (801) 538-6155 options 3, 3, 6.

21-37 Section I: General Information Provider Manual Updates

Coverage policy found within Section I: General Information, Chapter 11-2, *Unacceptable Billing Practices,* has been updated with the following underlined language to align with current Medicaid 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. 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, or facility visits. These services are considered part of the providers' or facilities' rates unless otherwise specified in policy.

21-38 Medical Supplies and Durable Medical Equipment

The prior authorization for HCPCS code T5001, *Positioning seat for persons with special orthopedic needs,* has been removed. A limitation of 1 every 3 years is still in place. The Coverage and Reimbursement Code Lookup special note has been updated to the following:

> Description: This code is used for reporting positioning seats, which includes car seats, for persons with special orthopedic and/or neurologic needs that meet the following requirements.
> Required: 1) Member unable to sit safely in a conventional chair, booster seat, or high chair. 2) Requires specialized positioning to safely perform essential activities of daily living. 3) Exhibits significant head and trunk instability and/or weakness, hypotonicity, hypertonicity, athetosis, ataxia, spasticity, or 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.
> Limitation: 1 every 3 years

21-39 Speech, Language, and Audiology Services

Effective April 1, 2021, the coverage of cochlear implants and other related components has been updated to allow coverage of these services for eligible EPSDT members starting at 9 months of age. This update is made in alignment with FDA recommendations. The following CPT and HCPCS codes have been updated to align with this policy:

- L8614- *Cochlear device, includes all internal and external components*
- L8617- *Transmitting coil for use with cochlear implant device, replacement*
- L8618- *Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement*
- L8621- *Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each*
- L8622- *Alkaline battery for use with cochlear implant device, any size, replacement, each*
- L8623- *Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each*
- L8624- *Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each*
- L8625- *External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each*
- L8628- *Cochlear implant, external controller component, replacement*
- L8629- *Transmitting coil and cable, integrated, for use with cochlear implant device, replacement*
- 69714- *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy*
- 69715- *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy*
- 69717- *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy*
- 69718- *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy*
- 69930- *Cochlear device implantation, with or without mastoidectomy*

21-40 Pharmacy Services Updates

Oral Buprenorphine & Buprenorphine/Naloxone Products

Effective February 1, 2021, The *Opioid Use Disorder Treatments* class was updated on the preferred drug list (PDL), adding buprenorphine single agent tablets to the preferred products. On March 1, 2021, the *Oral Buprenorphine & Buprenorphine/Naloxone Products*, prior authorization form was updated to reflect approval criteria for quantity limits, dose limits, and non-preferred products. The PDL can be found at https://medicaid.utah.gov/pharmacy/preferred-drug-list. Prior Authorization forms can be found at https://medicaid.utah.gov/pharmacy/prior-authorization.

Pharmacy Prior Authorization Updates

Pharmacy prior authorization forms have been updated as follows:

PA Form	Status	Effective	Information
Androgens	Update	3/1/21	Minor criteria updates
Anti-vascular Endothelial Growth Factor Therapy	New	3/1/21	New clinical form for drug class
Antipsychotics in Children	Update	3/1/21	Minor format updates
Buprenorphine & Buprenorphine/Naloxone	Update	3/1/21	Criteria and coverage updates
Epidiolex	Update	3/1/21	Minor criteria updates
Hydroxyprogesterone	Review	3/1/21	Annual review, no changes
Botulinum Toxins	Update	3/15/21	Minor update to notes
CGRP	Update	3/15/21	Minor update to notes
ADHD Stimulants	New	4/1/21	Exceptions to ADHD policies
Continuous Glucose Monitor	New	4/1/21	New clinical form for CGM coverage
Hepatitis C	Review	4/1/21	Minor updates to criteria
Medication Coverage Exception	Update	4/1/21	Minor updates to verbiage
Wakefulness Promoting Agents	Update	4/1/21	Criteria update to *Nuvigil (armodafinil) Provigil (modafinil) Sunosi (solriamfetol) Wakix (pitolisant)* form
Cialis (tadalafil)	Review	5/1/21	Minor format updates
Reyvow (lasmiditan)	Review	5/1/21	Minor format updates
Verquvo (vericiguat)	New	5/1/21	New clinical form and criteria

Prior authorization forms can be found at https://medicaid.utah.gov/pharmacy/prior-authorization

Continuous Glucose Monitors

About 50% 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

Pharmacy Continuation of Care Policy

Members transitioning to Medicaid from other payers may encounter differences in pharmacy coverage (preferred/non-preferred status) resulting in a claim denial. Non-preferred policy requires that the member try and fail at least one preferred agent; however, exceptions may be made when a request is received for a continuation of care.

Continuation of care (COC) is defined as evidence of the patient being on the requested medication for a minimum of 60 out of the last 90 days, unless the medication is used emergently. Evidence, or supporting documentation, to request support of approval must be submitted with the Medical Exception Prior Authorization Request and may include any of the following:

- Chart notes
- Fill history obtained from the controlled substance database or dispensing pharmacy claims history
- E-mail messages provided by prescriber's clinical staff
- Letter of medical justification
- Medicaid claims history
- Verbal or written attestation of medical need provided by prescriber's clinical staff

If sufficient documentation does not exist, the request will be evaluated against clinical judgement and a limited transitional fill may be approved. In this instance, adequate documentation may be required for additional approvals. Information on continuation of care policy can be found in the Medicaid Pharmacy Manual at https://medicaid.utah.gov/utah-medicaid-official-publications/?p=Medicaid%20Provider%20Manuals/Pharmacy/.

21-41 Updates to the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services

Effective May 5, 2021, in accordance with Senate Bill 28, Physician Assistant Mental Health Practice, physician assistants specializing in mental health care in accordance with Section 58-70a-501 of the Utah Code, are qualified to engage in the practice of mental health therapy.

Therefore, the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services,* has been updated to address this change.

Chapter 1-5, A., Providers Qualified to Prescribe Behavioral Health Services, Chapter 2-2, Psychiatric Diagnostic Evaluation, Chapter 2-7, Psychotherapy with E/M Services, and Chapter 2-8, Pharmacologic Management (Evaluation and Management (E/M) Services), have been updated to include physician assistants specializing in mental health care in accordance with Section 58-70a-501 of the Utah Code as qualified providers.

Also, clarifications regarding qualified providers have been made in Chapters 2-10 and 2-11, and other revisions for clarity and consistency throughout the manual have been made in Chapter 1-5, Chapter 2-2, Chapter 2-8, and Chapters 3-1 through 3-4.

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

21-42 Updates to the Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness

Effective May 5, 2021, in accordance with Senate Bill 28, Physician Assistant Mental Health Practice, physician assistants specializing in mental health care in accordance with Section 58-70a-501 of the Utah Code, are qualified to engage in the practice of mental health therapy.

Therefore, Chapter 1-4, Qualified Targeted Case Management Providers, section C., of the *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness* has been updated to include these physician assistants as qualified providers. This section has also been revised for consistency with updates being made in Chapter 1-5 of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

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

21-43 Prior Authorization Updates for Behavioral Health Services

The deadline for retroactive prior authorizations for admissions to Institutions for Mental Health Diseases (IMDs) on or after January 1, 2021, has been extended to the close of business May 31, 2021. For admissions on or after June 1, 2021, programs must follow the PA submission timeframes specified in the April 2021 MIB.

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.

21-44 State Agency Realignment Coming July 2022

Governor Spencer J. Cox signed H.B. 365, "State Agency Realignment," which consolidates the Utah Departments of Health and Human Services and moves a few eligibility policy components of Medicaid and CHIP from the Department of Health to the Department of Workforce Services by July 1, 2022.

The primary goals for the realignment are to:

- Promote health and the quality of life for individuals accessing services in the health and human services field.
- Align health and human services policy.
- And more efficiently and effectively manage health and human services programs that are the responsibility of the state and create a person-centered system.

A robust public involvement and planning effort is underway. Follow hhsplan.utah.gov and #hhsplan on agency social media channels to receive updates, submit feedback, participate in workgroups and meetings, and engage in the planning process.