November 2023

Utah Department of
Health & Human Services
Integrated Healthcare

MEDICAID INFORMATION BULLETIN

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

23-76 Provider Enrollment Contracts

With the end of the Public Health Emergency (PHE) on May 11, 2023, Provider Enrollment will restart the auto-closure process in January of 2024 that was previously waived per 1135(b)(1)(B).

Per Utah Administrative Code R414-23-4, the Department may automatically close a provider contract for any of the following reasons:

1. Failure to revalidate within the required five-year cycle as directed by 42 CFR 424.515.
2. Expiration of professional license, or expiration of any license associated with the program for clinical laboratory improvement amendments (CLIA).
3. Upon state or federal reporting of a deceased provider.
4. Failure to bill Medicaid for one or more years without notification.

Providers who fail to complete their revalidation timely, will be closed at the end of their revalidation cycle. For questions or concerns, contact providerenroll@utah.gov.

23-77 Changes to Non-Traditional Benefits

With the renewal of Utah's Medicaid Reform 1115 Demonstration (formerly known as the "Primary Care Network Demonstration Waiver"), the Centers for Medicare and Medicaid Services directed Utah Medicaid to eliminate the disparity between the Traditional Medicaid benefit plan and Non-Traditional Medicaid benefit plan, effective January 1, 2024.

The following Medicaid programs will now have the Traditional Medicaid plan benefits:

1. Parents on Adult Expansion Medicaid or members receiving Parent/Caretaker Relative (PCR) Medicaid
2. 12-month Transitional Medicaid
3. 4-month Transitional Medicaid
4. Family Medically Needy Program (Spenddown)

The following changes will be made to Non-Traditional benefits:

1. Benefit packages will be aligned so the entire Adult Expansion population has the same state plan benefits as the Traditional population.
2. All language addressing the benefit plan changes will be removed or updated in systems, documents, and webpages.
3. Language in the Medicaid provider manuals and the Coverage and Reimbursement Lookup Tool will remain until January 1, 2025, so that providers have access to the information for billing purposes.
4. The list below is a summary of the benefit changes. More detailed benefit change information is available online in the Benefits Comparison Chart.
    a. Non-Emergency Medical Transportation (NEMT)
    b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services available for eligible PCR 19 and 20-year-old members
    c. More physical therapy and occupational therapy visits

d. Speech services
e. Audiology services
f. Medical supplies and medical equipment
g. Long term care

Members may call a Health Program Representative (HPR) with questions at (801) 538-6155 or 1-800-662-9651. The following online resources are also available to members:

Medicaid website: https://medicaid.utah.gov/

Medicaid Member Guide: https://medicaid.utah.gov/medicaid-benefits/

Non-Emergency Transportation and UTA Transit Card information: https://medicaid.utah.gov/non-emergency-transportation/

View benefits, eligibility status, health plan details, and request a UTA Transit Card at MyBenefits: http://mybenefits.utah.gov

23-78 Managed Care ARPA Supplemental Payment Delays

ARPA supplemental payments made to providers by the managed care plans have been delayed. Managed care plan ARPA supplemental payments are based on encounter data submitted to the Department. Since PRISM launched in April 2023, the Department has not been able to fully absorb encounter data files into the PRISM system and therefore, has not been able to generate the lists of providers and corresponding amounts the plans should pay them.

To work around these current system limitations, the Department has requested data from the managed care plans that will allow the Department to calculate the supplemental provider payment amounts and then direct the managed care plans to make those payments to providers for the supplemental payments that would have been made through the end of SFY 2023 (June 30, 2023). The Department anticipates providers would begin receiving these outstanding provider payments from the managed care plans in November 2023.

In addition to the outstanding supplemental payments for SFY 2023, the payments for the first quarter of SFY 2024 (July 2023 - September 2023) may also be delayed. The Department's preference is to utilize the encounter data in PRISM and follow the normal process of sending provider payment files to the managed care plans based on encounter data. In the event encounter data has not settled sufficiently, the Department will employ the same work around to get the first quarter of SFY 2024 payments made to providers.

NOTE: Providers have continued to receive the quarterly ARPA supplemental payments directly from the Department based on their FFS claims submissions.

23-79 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee is reviewing Anti-VEGF (Intravitreal) agents in November.

P&T Committee meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/pt-committee.

23-80 Pharmacy Prior Authorization Processing

Pharmacy prior authorization requests received for pharmacy services, including pharmacy related HCPCS codes, must be complete upon submission. An incomplete submission means required information is missing, which may result in the prior authorization being denied. The Utah Medicaid pharmacy team attempts to contact providers to obtain additional information for the prior authorization request at least two times. Providers and their staff are encouraged to complete the prior authorization request to include the exact medication name the member will be using, or indicate if a substitution is not permissible.

Medication Name/ Strength:	Dose:
❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider's intent is for a member to use a brand product, they will check "Do Not Substitute". In the example below, the request would be reviewed for the non-preferred name brand Percocet 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☒ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider submits a prior authorization request without indicating "Do Not Substitute", the request will be processed for the preferred Generic/Brand equivalent. In the example below, the request would be reviewed for the preferred generic equivalent, Oxycodone/APAP 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

In all cases, providers should submit prior authorization requests using the most current form available on the Utah Medicaid Pharmacy Website, complete all fields legibly, and include all supporting documentation required for the pharmacy service requested.

23-81 Pharmacy Policy, Coverage, Prior Authorization and HCPCS Codes

The Utah Medicaid Preferred Drug List is updated monthly and is the most up-to-date source of information pertaining to drug specific pharmacy coverage, limitations, and policies, in addition to the Utah Medicaid State Plan, Utah Administrative Rule, Utah Medicaid Provider Manuals and Medicaid Information Bulletins, and Pharmacy prior authorization forms.

Pharmacy prior authorization forms and pharmacy related HCPCS codes are reviewed and updated at a minimum annually, but may be updated more frequently as drug labels are expanded.

Per the Utah Medicaid Provider Manual Section I: General Information, 2-3 Member Eligibility Verification, Providers who administer and bill Utah Medicaid for pharmacy related HCPCS codes shall verify member eligibility. Pharmacy related HCPCS code coverage and the HCPCS NDC Crosswalk shall be used together to verify coverage, reimbursement, and covered NDC's for pharmacy related HCPCS.

To access the most recent pharmacy resources, go to https://medicaid.utah.gov/, click on Healthcare Providers, Medicaid Pharmacy Program.

23-82 Physician and EPSDT Services Provider Manual Revisions

Next Generation Sequencing (NGS)

Identifying a molecularly confirmed diagnosis in a timely manner for an individual with a rare genetic condition can have a variety of health outcomes, including:

- Guiding prognosis and improving clinical decision-making, that can improve clinical outcome by application of specific treatments as well as withholding of contraindicated treatments for certain rare genetic conditions.
- Surveillance for later-onset comorbidities.
- Reducing financial and psychological impact of diagnostic uncertainty.

- Eliminating lower-yield testing, and additional screening(s) that may later be proven unnecessary once a diagnosis is achieved.

Next-generation sequencing (NGS) includes genetic testing options such as whole exome sequencing (WES) and whole genome sequencing (WGS) and can detect the most significant variant types, meaning genetic alterations with sufficient evidence to classify as pathogenic.

Whole Exome Sequencing (WES)

WES focuses on the genomic protein coding regions (exons). It is a cost-effective, widely used NGS method that requires fewer sequencing reagents and takes less time to perform bioinformatic analysis compared to WGS. Although the human exome represents only 1-5% of the genome, it contains approximately 85% of known disease-related variants.

WES is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in EPSDT eligible members when all of the following criteria are met:

- After all other appropriate diagnostic testing has been performed, and the member remains undiagnosed (e.g., targeted single-gene testing, panel testing, MRI, etc.), and
- Results of such testing are expected to influence medical management and clinical outcomes directly.

Whole Genome Sequencing (WGS)

Whole-genome sequencing (WGS), in contrast to (WES), may detect larger deletions or duplications, triple repeat expansions, and pathogenic variants in deep intronic regions; regulatory regions that are outside of the coding regions; and untranslated gene regions.

WGS is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in members aged less than one year of life and currently admitted to a Neonatal Intensive Care Unit (NICU) or other intensive care setting, when all the following prior authorization criteria are met:

- Test is ordered by one of the following provider types, who has evaluated the patient and family history, and recommends and/or orders the test:

- Neonatologist or intensivist in collaboration with a medical geneticist or certified genetic counselor.
- The patient has been evaluated by a board-certified clinician with expertise in clinical genetics and counseled about the potential risks of genetic testing.
- Pre and post-test counseling is performed by an American Board of Medical Genetics or American Board of Genetic Counseling certified genetic counselor.

- Clinical indications:
  - Absence of definitive diagnosis based on standard clinical workup.
  - Unclear disease identity based on patient's phenotype, or the patient has phenotypic characteristics outside of, or in addition to, what has been established for the disease.
  - A genetic etiology is the most likely explanation for the phenotype or clinical scenario or the affected individual is faced with invasive procedures or testing as the next diagnostic step (e.g., muscle biopsy).
  - No other causative circumstances (e.g., environmental exposures, injury, infection) can explain the symptoms.

Coverage and Reimbursement Lookup Notes

- 81425 - *Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis.* REQUIRED: Available for EPSDT members under one year of age and admitted to the NICU or other intensive care setting with an unexplained congenital or neurodevelopmental disorder. LIMITATION: WGS requests are limited to 1 unit of CPT 81425 and 2 units of CPT 81426 per lifetime for each member. OTHER: Refer to the Physician Services and EPSDT Services Provider Manuals for additional information.
- 81426 - *Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (e.g., parents, siblings).* REQUIRED: Available for EPSDT members under one year of age and admitted to the NICU or other intensive care setting with an unexplained congenital or neurodevelopmental disorder. LIMITATION: WGS requests are limited to 1 unit of CPT 81425 and 2 units of CPT 81426 per lifetime for each member. OTHER: Refer to the Physician Services and EPSDT Services Provider Manuals for additional information.

Quantity Limits

- CPT 81425 will be limited to 1 unit per lifetime per member.
- CPT 81426 will be limited to 2 units per lifetime per member.

23-83 Long Term Acute Care Hospital Length of Stay

The Utah Administrative Code, R414-515 Long-Term Acute Care has been updated as follows:

R414-515-5. Service Coverage.

(7) Each approved prior authorization is for a 28-day period.

R414-515-6. Preadmission Review

An LTAC provider shall submit prior authorization requests to the Department at least 24 hours before the expected admission. If the member does not admit within 48 hours of the prior authorization approval, a new prior authorization must be submitted.

The Hospital Services provider manual, Chapter 14 *Long-Term Acute Care (LTAC)*, has been updated as follows:

14-1 Requirements

To adjudicate correctly, the billing provider indicator for LTAC in the provider record in PRISM must be a "Y" and claims must be reported using revenue code 0760. This will ensure that the appropriate rate is applied to the claim. All other billing procedures and practices apply to LTAC claims. These may be found in General Information: Section I Manual.

14-2 Limitations

- Documentation for preadmission, continued stay, and retroactive review must be submitted in a timely manner as outlined in Administrative Rule R414-515 Long Term Acute Care, or the request shall be denied.

- An LTAC will not be reimbursed for denied dates of service or for any subsequent dates of service related to that episode of care.
- The predominant clinical findings will be used to determine the severity of illness criteria for the primary condition.
- If the member does not admit within 48 hours of the prior authorization approval, a new prior authorization must be submitted.

23-84 Recreational Therapy

Beginning January 1, 2024, individuals licensed to provide recreational therapy services according to Utah Code Annotated 58-40 may report recreational therapy services delivered to Medicaid members. Providers must follow the policy outlined in the Rehabilitative Mental Health and Substance Use Disorder Services manual Chapter 2-19, Recreational Therapy, and enroll as a Medicaid provider as outlined on https://medicaid.utah.gov/become-medicaid-provider/.

For members in managed care plans, recreational therapy services are covered under the behavioral health managed care plans; Utah Medicaid Integrated Care (UMIC) plans, Prepaid Mental Health Plans (PMHP), and the Healthy Outcomes Medical Excellence (HOME) program.

For members not in managed care plans, recreational therapy services are covered under fee-for service Medicaid.

Chapter 2-19 Recreational Therapy

Recreational Therapy means a treatment service designed to restore, remediate, and rehabilitate a member's level of functioning that utilizes activity-based interventions to address the assessed needs of members with illnesses and/or disabling conditions, as a means to psychological health, recovery, and well-being.

Qualified Providers:

Individuals licensed to provide recreational therapy services practicing within the scope of practice according to Utah Code Annotated 58-40, Recreational Therapy Practice Act.

Limits:

Recreational therapy services must be referred by a mental health therapist as defined in Utah Code 58-60-102 and are limited to a general acute hospital, youth residential treatment facility, behavioral health program, intermediate care facility, assisted living facility, skilled nursing facility, psychiatric hospital, and mental health agency.

Procedure Code and Unit of Service:

- H2032 - *Activity therapy, per 15 minutes* for recreational therapy interventions, assessments, and treatment plan formulation.
    - Use the HQ modifier with H2032 for group interventions.

Record:

Documentation must include:

1. Date, start and stop time, and duration of the service,
2. Setting in which the service was rendered,
3. Specific service rendered (i.e., assessment),
4. Signature and licensure of the individual who rendered the service.

23-85 School-Based Skills Development Services

In accordance with the Centers for Medicare and Medicaid Services (CMS), effective August 1, 2023, Local Education Agencies (LEAs) are no longer required to enroll individual providers with Medicaid. The LEAs themselves must continue to enroll with Medicaid and have an NPI to report services to Medicaid. In alignment with this policy, the School-Based Skills Development provider manual has been updated to remove the enrollment requirement from Chapter 1-3, Program Eligibility. Chapter 3-2, Claims Processing, has been updated to add the following language:

F. Providers should not be listed individually on School-Based Skills Development claims.

23-86 Wheelchair Initial Evaluation Form – Policy Reminder

Due to recent provider questions regarding clinicians permitted to complete the initial wheelchair evaluation form, the following reminder of existing policy has been included. The policy regarding wheelchair evaluation forms can be found in the Medical Supplies and Durable Medical Equipment provider manual, Chapter 8-14.2, Wheelchair Evaluation Forms, which states:

When requesting a wheelchair, DME providers must:

- Complete and submit the required wheelchair evaluation forms.
- Submit the applicable form(s) with the PA request.
- Maintain the original wheelchair evaluation forms within the DME provider member record.

Wheelchair Initial Evaluation Form:

- Required as part of the wheelchair PA request.
- Completed before requesting a wheelchair.
- Performed by a physician, licensed physical therapist, or licensed occupational therapist.

Except for Section 8, measurements of the initial evaluation form and all required sections of the evaluation form must be completed by the evaluating therapist. Only physicians, licensed physical therapists, or licensed occupational therapists are permitted to complete the form.

In addition, the letter of medical necessity must be member specific and, in accordance with Utah Administrative Code R414-1-2(18), not include any prepopulated generic statements or copy/paste statements used for other wheelchair requests.

23-87 Dental Services Performed in an Inpatient Hospital / ASC Setting

Beginning November 1, 2023, CPT code 41899, used for reporting dental related procedures performed in an ambulatory surgical center or an outpatient hospital, will no longer require prior authorization for members eligible for dental benefits.

The Dental, Oral Maxillofacial, and Orthodontia Services provider manual, Chapter 8-5, Sedation and General Anesthesia, has been revised to remove the reference to these dental services requiring prior authorization.

23-88 Bundling of X-Rays and Root Canals

For diagnostic purposes, Medicaid allows the reporting of *D0220 - intraoral - periapical first radiographic image* as ancillary to root canal services. All other x-rays performed prior, during, or after root canal procedures are included in the global payment rate.

For payment to adjudicate properly, the primary root canal procedure must be billed on the first claim line, and the x-ray must be billed subsequently. If you are unable to bill sequentially, the root canal must be billed separately on a claim first, and then an additional claim for the *D0220 - intraoral - periapical first radiographic image* may be billed after.

For additional code specific details, please refer to the Medicaid Coverage and Reimbursement Lookup Tool.

23-89 Routine Dental Services for Nursing Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities

For members residing in nursing homes, the Utah Medicaid State Plan states that the per diem payment rate covers routine services. Such routine services cover the hygienic needs of the patients. Supplies such as toothpaste, shampoo, facial tissue, disposable briefs, and other routine services and supplies specified in 42 CFR 483.10 are covered by the Medicaid payment rate and cannot be billed to the patient.

Routine Services are outlined as follows:

ICF/MR patients only:

1. Annual dental examination.
2. Physical therapy, occupational therapy, speech therapy and audiology examinations.

A periodic oral evaluation is done to determine the patient's dental health status since the previous check-up. A limited evaluation is problem-focused on a particular dental health problem or concern presented by the patient.

Dental providers billing routine services for ICF/ID benefit plan members, all claims will be denied, and should be billed directly to the care facility.

For additional codes specific details, please refer to the Medicaid Coverage and Reimbursement Lookup Tool.